A Narrative study: Mental health service users' experiences of physical restraint

by

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This thesis is dedicated in loving memory of my sister

Lynda Oldham

Abstract

During the past thirty years, there has been increasing concern regarding physical restraint and its association with death, injury, pain and emotional upset. Internationally there has been a shift to reduce the use of all forms of restraint. Policy and guidance in the United Kingdom, for health and social care staff, advises a preventative and de-escalatory approach in managing service user aggression and violence. If restrictive interventions are deemed necessary, these should be used for the shortest time possible, with staff using the least restrictive means to meet the immediate presenting need and physical restraint reserved for only when absolutely necessary. Yet disparities in the use of restraint remain, questioning this professional rhetoric of last resort.

This thesis reports on a study exploring the narratives of service users who have experienced physical restraint. This qualitative study collected data from interviews with 11 service users who have experienced physical restraint. Stories were analysed using Frank's (2010) guiding questions for analysis and his suggestion for focused attention on a selection of stories. In keeping with this approach four stories are presented, three involving a quest narrative; Rory: a story of a resistance; Jane: a story of injustice; Rose: a story of trauma; and one a restitution narrative; Finlay: A story of saving life. While each story is unique, there are also similarities across all stories.

Consideration was given to the inter-relationship with other stories told about mental health service users and some of the grander narratives which underpin care practices or are influential within society. In this sense, individual stories were considered in the context of the narrative inter-relationships between all of the stories which acts to construct our knowledge of the world and even our sense of who we are. The powerful narratives of neoliberalism and biomedicine, in particular, are considered for their potential influence in the social process of conceiving and telling of these stories.

The concept of last resort and least restrictive measure are misnomers, as the physical and emotional aspects of restraint are revealed. The ‘otherness’ of service users is also divulged as service users discuss such concepts as a lack of dignity, dehumanisation and feeling ignored. However, the calming impact of restraint is also uncovered as viewed through the lens of one storyteller. The importance of the therapeutic alliance is a strong theme within all stories and is considered against a backdrop of the contemporary pressures on nursing staff. Related to this, are the organisational perspectives of staff working within mental inpatient health settings, including the somewhat difficult issue of balancing care and control in a mental health system, which legitimises the use of violence to some extent. Narratives of mental illness, distress, trauma, violence, power and control are storied by participants in this study. The powerful meta-narratives surrounding these concepts, including the stories told about mental health service users are similarly reflected upon.

The storytellers also reveal the different facets of their identities including those of ethnicity, gender and survivor. The loss of identity and a medicalised illness identity were storied by some participants, yet towards the end of their stories participants presented themselves with more empowered identities, emphasising their sense of the importance of organisations that seek to work in a co-productive manner. Three of the four service users are positioned in their stories as ‘formal’ experts by experience, displaying their perception of this role in its contribution to mental health services in contemporary practice.

Recommendations for future practice are considered including no restraint environments and restraint reduction initiatives, such as Safewards and the Six Core Strategies©, including the REsTRAIN YOURSELF Programme in the United Kingdom. Connected to this are considerations regarding the ward environment and organisational culture, which are also deliberated upon within this thesis.

Ultimately, individuals' narratives are somewhat constrained by a powerful hegemony of neoliberal and bio-psychiatric power but this need not preclude resistance and potential for change. The Power Threat and Meaning Framework is suggested as a conceptual and empirical basis for the provision of help and support that is more reflective of both individual narratives and their interaction with wider social narratives. Narrative re-storying is implicated as one way to support individuals and communities, which challenges the narrative of individual deficit and medicalised illness. Professionals may need to develop more sophisticated ways of understanding and working with narrative in the work of recovery. There is no ready-made roadmap to get to absolutely non-coercive mental health care, however, attending to the stories offered by service users, such as those in this study, may point the way towards a more values-based, or moral, turn in services.

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CHAPTER ONE. INTRODUCTION

In offering this narrative research study of mental health service users' experiences of physical restraint, I first outline the aim and objectives. I then describe the evolutionary journey leading to my interest in how physical restraint impacts service users. My background, personhood, and values are presented to reflexively frame my position in the study, with relevant commentary at appropriate junctures throughout the thesis.

Research aim and questions

The aim of the research:

- To explore stories of service users with mental health problems who have been subjected to physical restraint within inpatient services.

Specific research questions examined:

- What stories do service users tell about their experiences of physical restraint whilst they were mental health inpatients?
- What impact do these experiences have?
- Do the findings from this study concur with or contradict other research which has examined the impact of physical restraint on mental health service users?

My Story

On reflection, my interest in exploring mental health service user experiences had started in my professional career as a social worker. Before this, my knowledge of mental health service users had been somewhat influenced by the media, with mental health being stigmatised. I left school to take up administrative duties in the Civil Service, which was very different from my eventual career choice. In my early 20s I successfully applied for a job supporting single homeless people in Manchester. I recall trepidation in taking up this post, fearing the unknown, but soon came to enjoy the job, rapidly dispelling any prior myths and misconceptions about homelessness. At this time in my life, I was somewhat frightened of people diagnosed with a mental disorder, and my knowledge was limited. However, I came to discover that many homeless people experienced mental health issues and I began to see this group differently. I became conscious of the inequality and prejudice faced by people with mental health issues.

From this experience, I was motivated to pursue a social work degree. I felt this would build my knowledge further, assisting me to specialise in a career which would challenge discrimination and social injustice. Despite, diverse course content there was perhaps limited focus on mental health. Nonetheless, placement experiences exposed me to different fields of practice, including a voluntary agency named ‘Having a Voice'. This organisation was formed by service users and promotes recovery, advocacy and social inclusion. With hindsight I can acknowledge the influence on my values, with service user engagement and ‘voice' being fundamental throughout my social work career and beyond. The placement itself exposed me to different service user groups.

One was the ‘Hearing Voices Network’, a support group for people who have been diagnosed with what psychiatrists refer to as ‘auditory hallucinations'. This encounter again exposed me to the strength of the service user experience and the support available, which I witnessed as having a powerful impact on service users' lives. It was immediately apparent to me how the service user voice was powerful and supportive of recovery. This placement sparked an impassioned interest in matters of service user voice, which continues to the present.

Upon finishing my degree, I took up a post in a hospital social work team. Given my interests, I requested assignment to an older persons’ mental health ward. At that time, apart from one exception, I did not witness physical restraint. However, I found that service user engagement was lacking on occasions and the ward culture was based upon a medical model of care, as opposed to a social model, with a lack of collaborative working or attention to service user voice. This at times caused conflict, prompting lengthy discussions with ward staff about service user engagement.

In 2003, a development opportunity arose to manage a hospital social work team. Throughout this time, service user voice was central to my practice and something I espoused to practitioners I managed. In 2007 an opportunity arose to support the implementation of the Mental Capacity Act [MCA] (2005) across health and social care. I found this legislation to be empowering for individuals, with its principles of least restrictive practice, decision-making with regards to best interests, and outlining acceptable restraint practice. In 2009, I became Safeguarding Adults Manager in social services, investigating and managing referrals surrounding potential abuse.

During this time, I undertook a master’s degree in safeguarding studies at the University of Salford. My dissertation centred on different types of restraint used in various settings, and I was encouraged by my supervisory team to study the subject further at doctoral level. In 2013, I took up a lecturing post at The University of Central Lancashire, where I have remained since. Moving into academia created more opportunities to develop my passion, skills and knowledge of research and further embrace my passion for empowered service user voice. My ambition to extend my research via doctoral-level study was encouraged and supported by the University management team.

Deciding upon a research topic

Reflecting on my role as safeguarding manager, I realised some mental health service providers had been defensive in their practice of restraint. Moreover, I was concerned about the Winterbourne View revelations of abusive and illegal restraint practice, in breach of individuals' human rights (Flynn, 2012). With my initial interest thus prompted, master’s study findings and other research suggested restraint had a detrimental impact on service users' physical and psychological well-being. I published a paper on this phenomenon (Cusack, McAndrew, Cusack, & Warne, 2016) and attended two international conferences. This study and dissemination activity motivated me to explore the phenomena further, specifically surrounding mental health service users' perspectives of physical restraint.

There is a plethora of research surrounding safe management of violence and aggression, supported by a strong policy context in the United Kingdom (National Institute for Health and Care Excellence [NICE], 2015). Research to date has mainly focused on quantitative approaches, measuring the administration of restraint and perspective on its use, as opposed to the impact of it. An integrative review of the latter forms a later chapter of this thesis, a version of which has been published (Cusack, Cusack, McAndrew, McKeown, & Duxbury, 2018, see Appendix One). Given the limited research from a service user perspective on the impact of restraint, it has been pertinent to explore this for my study.

I have never personally undertaken physical restraint but have witnessed this in a mental health service. I recall questioning whether the situation may have been dealt with differently, without physical restraint and being upset for the service user who was visibly disturbed and crying out that she was in pain. I wondered what it must have felt like for the person experiencing such physical force, yet accepted I could only imagine this. Following this incident, I remained upset and found it difficult to manage emotionally for some time, as I kept reflecting on what I had witnessed and heard. In considering this area as a research topic, I did not feel my lack of experience in undertaking physical restraint was disadvantageous to me. As a social worker, I had managed service users with behaviour that presented challenges for staff. I feel I have been able to successfully engage with individuals in situations of conflict and been able to defuse situations from escalating, using my interpersonal skills.

I remain interested in the service user perspective, believing it is imperative that power imbalances and injustices are challenged. As a social worker, it had been part of my training and practice to listen to the service user perspective, supporting service users to have a voice in decisions affecting them, wherever possible. Indeed, inherent within social work values include the concepts of equality, dignity, respect for human rights and placing the service user at the heart of practice (Banks, 2012). My witnessing of restraint existentially challenged such values.

My empirical and practice knowledge of restraint has thus afforded me with a greater understanding of this restrictive practice, including the impetus to reduce this. I have read extensively around this issue. I have seen the impact of restrictive practice and, on occasion, the defensive attitudes of staff who have justified its use. I feel that a preventative approach in managing any potential conflict and the avoidance of the need for restrictive interventions should be at the heart of practice on mental health wards. I feel that service users should be fully involved in their care, including care planning and discussions about the best way to support them should they start to feel agitated. I consider physical restraint should be used as a last resort in situations when there is risk of serious harm, and de-escalation has been tried and failed. I believe physical restraint has adverse outcomes for both staff and service users experiencing it, with long-lasting consequences, including detriment to therapeutic alliance. This can be seen within the findings from the extensive literature review within this thesis. My passion for the subject has driven my enthusiasm for salient research. Given my interest in physical restraint and service user experience, I decided that this was the field which I wanted to research. I felt that in doing so, there was potential to build on limited available evidence.

In undertaking this study, I faced a dilemma regarding use of language when referring to individuals who have experienced physical restraint when admitted to mental health wards. The language used to refer to users of mental health services is perhaps more diverse than any other health and social care sector (Lester & Gadsby, 2010). McLaughlin (2009) considers the power dimensions and hierarchy of control in the use of terminology to describe specific groups of individuals but is unable to offer any suitable terminology. The use of the term consumer was considered for this study, as it is viewed as being an improvement over the identification of people with mental ill-health as ‘patients' (Hensley, 2006). However, this term appears to be used to refer solely to individuals with mental illness, with no similar reference made to individuals with physical illness i.e. a person with heart disease is not referred to as ‘cardiology consumer' (Repper & Perkins, 2003). Consumerist associations with freedom of choice also sit uneasily within restrictive service environments. Additionally, to consume is to ingest, therefore, there are subtle suggestions that this term is perhaps a one-way process, with no reciprocation, consequently this term neglects a person's potential to give back to society (Hensley, 2006).

There is no universally accepted term for the group of participants I have studied. In my social work career, the term service user has been adopted to refer to individuals who receive, support and services from formal agencies. Participants in this study mainly referred to themselves as service users, therefore this term was chosen for my thesis in fidelity to their position. The exceptions to use of this term are in reference to studies within the integrative review chapter, reflecting search terms and the vocabulary used by specific researchers.

My doctorate journey

Having decided to research adults’ experiences of physical restraint, I needed to decide a research question and a methodology. A qualitative approach was appealing from the onset, allowing me to focus on experiences, hearing and learning from the service user voice. I was then faced with various choices which are explored in the methodology chapter of this thesis. I was immediately drawn to the narrative approach. Owing to my professional background in social work, I value service user experiences and understand the importance of facilitating individuals in telling their stories to illuminate relatively unexplored perspectives (Phillips, MacGiollari, & Callaghan, 2012). On a personal level, I am attracted to narrative research because of my interest in stories that people tell, possibly relating to my experience of this as a child in the retelling of my ‘family history', and ‘those that have gone before'. However, I recognised the need to consider a range of approaches before deciding on the methodology best suited to answering the research question.

Acknowledging I have a social identity and background that may impact on the research, I adopted a reflexive stance, which will be discussed in more detail in the methodology chapter. I kept a diary throughout the research process for critical self-awareness and to reflect on the impact of key decisions. Extracts from this diary are included at pertinent points within the thesis. The following is an early entry, reflecting positioning at the start of my journey:

> “*I was thinking about how I need to take a balanced view of this area of study. I am influenced to some extent about my own experiences within this subject. I was talking today with a colleague about the fact that I was embarking on the doctoral study. He was a former mental health nurse and had undertaken ‘Control and Restraint Training’. We seemed to come from different positions. I have seen the poor practice in hospitals around restraint. I recall the time in the mental health ward when I witnessed an elderly lady being restrained. At the time I thought this was heavy-handed. I have also been aware of this in safeguarding when referrals came into the team about restraint. There was some resistance from the hospitals when we wanted to investigate these referrals, so this*

just made me question why there was some resistance. Yet I must remind myself that these incidents may have impacted on my perspective. Not all care is poor, so I need to reflect when I have seen good practice, but perhaps we do not always remember good practice. I feel that we need to think about how we would want our loved ones treated in the same situation and that has always been my barometer of care".

Before concluding this chapter, I present key dates of times of events (table one).

Table 1 Key dates of research activity

	2017						2018						2019				
	Feb	Mar-April	May-Jun	July-Aug	Sep-Oct	Nov-Dec	Jan-Feb	Mar-April	May-Jun	July-Aug	Sep-Oct	Nov-Dec	Jan-Feb	May-Jun	July-Aug	Sep-Oct	Nov-Dec
Integrative review (and ongoing)	▨	▨	▨														
Ethics form				🟩													
Selection And recruitment					▨	▨											
Interviews							🟧	🟧									
Transcribing & checking								🟦									
Data analysis									🟨	🟨							
Complete Findings Chapter											🟧	🟧					
Complete Methods Chapter													▨	▨			
Final Checks/ amendments															🟨		
Submit for comments															🟨		
Amendments																🟧	
Final submission																🟧	
Work on paper																	🟥

Chapter conclusion

In this introductory chapter, I have presented the research aim and objectives and my journey leading to an interest in exploring service users' experiences of physical restraint, service user voice and early considerations of an appropriate research approach. Subsequent chapters will focus on the study itself. Chapter Two provides an overview of physical restraint and service user experiences, including definition of terms and exploration of key issues stemming from the research aim. Chapter Three presents discussion and findings from the available evidence on the outcomes of physical restraint for mental health service users, with an integrative review of consequential physical and psychological harms. Chapter Four outlines the research methodology, the underpinning theoretical perspective, the framework of study and details how the research was undertaken. Chapter Five presents findings. Chapter Six provides discussion of these findings and, finally, Chapter Seven outlines the contribution to knowledge arising from this study, its strengths and limitations, along with implications for practice and suggestions for future research.

CHAPTER TWO. BACKGROUND

A version of this chapter has been published (Cusack et al., 2018).

Having positioned myself within the research and discussed my doctorate journey in the first chapter, Chapter Two provides discussion of relevant issues. This includes consideration of the context in which physical restraint takes place and definitions of key terms. The chapter then reflects on the policy and legislative framework, considering the importance of reducing restrictive practice, highlighting the role of physical restraint in causation of physical or psychological harm. Discussion problematises the mantra of ‘last resort' regarding physical restraint and the impact upon therapeutic relationships. The chapter concludes with a consideration of service user involvement at a policy and research level.

Inpatient mental health wards

All inpatient mental health care should aim to provide a safe, therapeutic environment (Joint Commission Panel for Mental Health, 2013). There are different types of wards for individuals requiring psychiatric inpatient care. Acute wards admit people for assessment and treatment; whilst psychiatric intensive care units (PICU) provide more intensive support for individuals assessed as needing this; primarily because of physical violence or absconding (Bowers et al., 2008; Stevenson, 2012). Additionally, rehabilitation wards help individuals achieve independence and reintegration back into the community (Care Quality Commission, [CQC], 2015). There are also specialist wards including secure units; eating disorder units; personality disorder units; and mother and baby units (CQC, 2015). Some individuals enter hospital on a voluntary basis whilst a majority are detained under the Mental Health Act [MHA] (1983, amended 2007).

When an individual poses a significant risk to others, there is a risk of escape that cannot be managed safely within other inpatient mental health settings and they need psychiatric care and treatment, detention can be provided in a secure unit (NHS England, 2018). Individuals in these units will have complex mental disorders, and often have co-morbid problems of substance misuse and/or personality disorder, connected to offending or seriously irresponsible behaviour (NHS England, 2018). As a result, most individuals arrive at these units via the criminal justice system, often with Ministry of Justice restrictions imposed (NHS England, 2013). The therapeutic setting is carefully managed under restrictive security measures with high, medium and low secure units (NHS England, 2013).

Conceptions of mental health and illness

In England and Wales, mental disorder has been defined for the purposes of the 1983 MHA (amended 2007) as *"any disorder or disability of the mind"* 1. (2). Yet, such definitions are contested and notions of mental health, as opposed to ill-health or mental distress, can be equally contentious but need not be conceived as simply an absence of a diagnosed psychiatric condition. Thus, it is pertinent to consider the medicalisation of mental health and social functions of diagnosis.

There is a longstanding sociological contribution to understanding deleterious effects of labelling (e.g. Becker, 1963; Goffman, 1961; Lemert, 1972; Scheff, 1966). Scott (2010) suggests that, whilst some service users find a psychiatric diagnosis for their distress helpful, labelling people with a diagnosis makes certain assumptions about the person and risks distancing service users from professionals. Within this thesis, whilst psychiatric terminology is used when referring to individuals who carry a diagnosis, it is acknowledged that such labelling is viewed differently amongst users of mental health services. Conferment of diagnosis might bring validation for some, for others this renders individuals not fully visible nor understood in the full complexity of being human (Probst, 2015). Lester and Gadsby (2010) state how lawyers, psychiatrists and service users will all have differing views on definitions of mental illness. Once a psychiatric label has been applied, individuals inducted into services become eligible for legitimated application of various restrictive measures, including physical restraint.

Physical restraint

Internationally there is no agreed definition of physical restraint. In the United Kingdom this has been defined as: *“any occasion in which staff physically hold the patient preventing movement, typically to prevent imminent harm to others, or self, or to give treatment, or to initiate other methods of containment”* (Bowers, Van Der Merwe, Paterson, and Stewart 2012, p.31). Another well-recognised and succinct definition has been provided by the Department of Health, [DH] (2014, p. 26) as: *"any direct contact where the intervener's intention is to prevent, restrict, or subdue movement of the body of another person"*.

For this study, the DH (2014) definition will be used. In the United Kingdom mechanical restraints, such as straps and shackles are not routinely used (Stewart, Bowers, Simpson, Ryan & Tziggili, 2009). Physical restraint, as defined here, is favoured, however, there are concerns about its safe use (Mind, 2013) also resonant with policy and legal developments.

The Narrative of biomedicine

Since its beginnings in the 19th century, a principal epistemological and practical question faced by psychiatry is whether a medicine of the mind can work along with the same principles as medicine of the tissue (Bracken et al., 2012). Numerous critics have pointed out the limitations of a psychiatric episteme bound to biomedicine that privileges the organic over the psycho-social, locating mental distress almost singularly in the brain, and thus mandating physical treatments, usually medication (see Read et al., 2009). Furthermore, an enmeshment of medicine and psychiatry, in particular, with societal systems of governance and control means that critique does not stop with reservations about treatment; generating controversy about the coercive function of psychiatry. Psychiatric power then extends into wider society, with increasing medicalisation (psychiatrisation) of hitherto untouched forms of mental distress or human behavioural diversity, and the patient, the subject of psychiatry, is increasingly defined in terms of a distinctly individual pathology in line with the individualising ideals of capitalist, now neoliberal, production (see Foucault, 2006: Rose, 1986; Scull, 1979). The institutions of psychiatry, the psychiatric professions and their practices can thus be seen to constitute a powerful psy-complex that bridges medicine, the state and the interests of capitalism (Rose, 1985, 2019).

Bean (1985) suggests that latter-day confidence in a medical approach in the management of troublesome and dangerous people can be traced to the 1959 Mental Health Act and its preceding Royal Commission in 1957. This legislation consolidated psychiatry as a medical specialty to act on behalf of the state. This was delegated in two ways: one being the role of *paternalism.*

This can be understood under the ethical tradition of JS Mill in that all adults should always enjoy freedom, unless they committed a crime in law (Pilgrim, 2015). However, the state had a role of protection for those whose mind was deemed inadequate due to immaturity, idiocy or lunacy. The second role for psychiatry was in relation to *policing* the actions of individuals threatening society's moral order (Pilgrim, 2015). Since the birth of the profession in the mid-19th century, the coercive nature of rule enforcement has remained intertwined with psychiatry. The psychiatric emphasis on 'duty of care' or a 'right to treat', has always sat aside an emphasis on public order (Bean, 1980, 1985; Scull, 1985; Ingleby, 1985).

In addition to the problematic nature of control within contemporary psychiatry, the biomedical model presents a narrative, which offers further challenges. The biomedical model dominates in psychiatry, comprising an illness framework with emphasis on diagnosis, aetiology and prognosis (Rogers & Pilgrim, 2017). This assumes that problems related to emotional distress or 'unusual' behaviour can be explained in a similar way to that of physical illness (Johnstone et al., 2018). This medicalised approach functions through use of medical language (e.g. symptoms, disorders, illness, treatment), through practice (e.g. diagnosis, hospitalisation, administration of drugs) and through research attempting to find genetic and biological causes of 'mental disorders' (Johnstone et al., 2018). The validity of diagnosis based on symptoms has been challenged by some psychiatrists (for example Szasz, 1961), whilst others have offered a bio-psycho-social model which takes into account social and biological circumstances (Engel, 1980); yet this has been criticised in practice for continuing to prioritise and privilege the biological (Pilgrim, 2002, Pilgrim et al., 2008).

Despite reservations about a medical model within psychiatry, the biomedical approach is still prominent, with its focus on diagnosis and medication.

Diagnosis is fundamental in framing thinking and responses to people's difficulties. The process of diagnosis is internationally codified by two tools: The World Health Organisation's International Classification of Diseases (ICD) and the American Psychiatric Association's 'Diagnostic Statistical Manual' (DSM)[1]. The fifth edition of the latter was launched in 2013, amongst significant controversy. The then chair of the DSM-5 task force, David Kupfer, acknowledged that psychiatry had been trying for decades to find bio-markers to deliver diagnoses with reliability and validity, but had failed (Kupfer, 2013)[2]. Diagnostic reliability is acknowledged within the literature as being low, with individual preferences amongst psychiatrists for diagnosing specific conditions (Johnstone, 2014; Thomas, 2014; Johnstone et al., 2018). In terms of validity, diagnosis also relies on the subjective observations of an individual's subjective state, made by psychiatrists and other mental health workers (Johnstone, 2013; Thomas, 2014; Johnstone et al., 2018). This can be problematic even on its own terms: for example, a large majority of people with a diagnosis of general anxiety would also meet the criteria for a mood disorder (Brown & Barlow, 2009). Furthermore, ethno-centric bias embeds a Western world view (DCP,

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[1] The American Medico- Psychological Association (now the American Psychiatric Association), produced the first 'Statistical Manual for the use of Institutions for the Insane' in 1918 (Rogers & Pilgrim 2017).

[2] Grant (2015) develops this line of argument by outlining that are no genes, biomarkers or evidence for disease processes have been compellingly established for functional mental health problems.

2013), risking discrimination and neglect towards various groups (Bayer, 1987; Busfield, 1996; DCP, 2013; Fernando, 2010; Shaw & Procter, 2005). Psychiatric diagnosis is centred on complaints regarding what individuals think, feel and do, with psychiatrists consequently relying on their subjective judgements in trying to match people's feelings and behaviour to the diagnostic criteria (Johnstone, et al., 2018). Apart from a few exceptions which overlap with neurology, diagnosis is based wholly on symptoms based on the subjective complaints made by the individual or others (Johnstone et al., 2018). Research to date has not been able to identify *'any 'signs' – objective bodily characteristics which are reliably associated with these subjective complaints and which might reasonably be thought to be causing them*' (Johnstone & et al., 2018, p23).

A further significant limitation of the diagnostic model of mental distress, is the location of problems within the individual, rather than in a social context or within relationship difficulties (Johnstone 2014), whilst also over-emphasising biological treatments, such as medication (DCP, 2013). Outside of arguments about reliability and validity, it is relevant to consider the potential financial implications and questions raised by the DSM-5's task force in their links to the pharmaceutical industry; as nearly 70 percent of individuals on the task force had financial connections to drug companies, arguably feeding the primacy of medication and the categories of disorder which justify them (Cosgrove & Wheeler, 2013). In the same year that the DSM-5 was launched, the British Psychological Society's Division of Clinical Psychology (DCP) issued a position statement. The summary is:

> *'The DCP is of the view that it is timely and appropriate to affirm publicly that the current classification system as outlined in DSM and ICD, in*

> *respect of the functional psychiatric diagnoses, has significant conceptual and empirical limitations. Consequently, there is a need for a paradigm shift concerning the experiences that these diagnoses refer to, towards a conceptual system not based on a 'disease' model'* (DCP, 2013, p.1).

Having looked at a brief history of the role of psychiatry and issues surrounding the validity and reliability of a diagnostic framework within mental health, it is relevant to consider neoliberalism and its enmeshment with psychiatry. With its emphasis on individual freedom, autonomy, choice, self-sufficiency and responsibility a neoliberal political landscape can be seen to dovetail with key aspects of bio-psychiatry and its function within governance systems (Johnstone et al., 2018). Although individual freedom and choice appear to resonate with a sense of equality, neo-liberal policies have greatly increased inequality, fragmentation of communities, and damage to the environment (Chomsky & McChesney, 2011; Klein, 2008; Sayer, 2016). Inequality has been seen at all levels within society, with associated mental distress blighting the lives of the poor and excluded and even extending to the more affluent members (Fisher 2009, 2012; Wilkinson & Pickett, 2009). Johnstone et al. (2018) point to how austerity in the United Kingdom, deemed ‘essential’ for financial recovery, has been accompanied by sharp rises in reported rates of distress, suicide and prescriptions of psychiatric medication (Barr et al., 2015; Psychologists Against Austerity, 2015; Stuckler & Basu, 2014).

Problematic nature of a diagnostic emphasis (Coercion)

The whole of the psy-complex, including nurses has two competing roles, one about care and mental health gain and the other about social control on behalf of third parties (Pilgrim, 2015). The professions within mental health care are thus seen to be engaged in ‘dirty work’ on behalf of the state (Szasz, 1963; Emerson & Pollner, 1975).

Decisions about coercion within mental health care ostensibly pivot on the identification of 'mental disorder' and an assessment of risk (Sidley, 2018). The former is based on an individual’s symptoms matching those listed in the DSM-5 or ICD-11. Meaning a person’s liberty and any coercive treatment relies on such diagnosis (Sidley, 2018). As can be seen from the discussion above, the symptoms assigned to each diagnostic label are questionable on the grounds of validity and reliability. Hence, even on its own terms a psychiatric assessment of risk is believed to be an inaccurate measure to determine presenting or future violence (Witteman, 2004; Morgan, 2007). That the whole system of risk assessment and management tends towards risk aversion and containment in practice is understandable, if not justifiable, if psychiatry’s social control function within a wider risk society is acknowledged (Beck, 1992; Lupton 2013).

Legislative and policy framework

Whilst the law and associated professional protocols and guidance can be seen to exist within, and enable, the complex of enmeshment between psychiatry and the state (see Rose, 1986), a commentary on key instruments is necessary for locating the subject matter of this thesis. The guiding principles for the human rights of people with mental health issues have been defined by the World Health Organisation (WHO) in 1996, the use of physical restraint contravening such principles could be interpreted as unlawful (Cusack, McAndrew, Cusack, & Warne, 2016). For example, section 2 of Principle 8, ‘Standards of Care', states, "*Every patient should be protected from harm, including unjustified medication, abuse by other patients, staff or others, or other acts causing mental distress or* *physical discomfort*" (WHO, 1996, p.16). Internationally there has been variance in policy surrounding restrictive interventions (Royal College of Nursing, 2008). Nonetheless, there have been shifts to reduce restrictive interventions (McKenna, 2016) with concomitant policy and guidance produced for health and social care staff (DH, 2014, 2015; NHS Protect, 2013; NICE, 2015; Royal College of Nursing, 2016; Skills for care and skills for Health, 2016). Campaigning groups have similarly produced guidance for service users challenging restraint usage within mental health services (Mind, 2015). Furthermore, the high use of restraint may be an indicator of poor-quality care within mental health settings (Sacks & Walton, 2014).

The United Nations (UN) Convention on the Rights of Persons with Disability declares aspects of compulsion and coercion are unlawful (Minkowitz, 2007; Plumb, 2015). Furthermore, Article 3 of the European Convention on Human Rights (Council of Europe, 1950), prohibits torture, inhumane or degrading treatment or punishment, and poor practice, which could include when staff undertake physical restraint. Moreover, the UN's Special Rapporteur on torture, Juan E Méndez, has called for a ban on coercion, including physical restraint (UN's Human Rights Council, 2013). The MHA (1983, amended 2007) has been subject to an independent review and government has pledged a new Bill. Presently, in England and Wales, best practice guidance is found in the MHA Code of Practice, which urges avoiding restraint wherever possible, using a preventative or de-escalatory approach towards individuals in distress (DH, 2015).

In England and Wales, the MCA (2005) and Deprivation of Liberty Safeguards (DoLS), are currently subject to revision, with a relevant Bill sitting within Parliament at the time of writing. The MCA (2005) states restraint on a mentally incapacitated adult should be proportionate to the likelihood and seriousness of risk posed, and where all other less restrictive means have been attempted. The DoLS, introduced via an addendum to the MCA (2005), outlines the process when an individual lacking capacity may need to be deprived of their liberty when at risk of harm to self (Ministry of Justice, 2008). What constitutes a deprivation of liberty has been defined by the courts in a landmark case. In March 2014, the Supreme Court provided an updated definition of ‘Deprivation of Liberty', when ruling on two cases; P v Cheshire West and Chester Council and P and Q v Surrey County Council (2014) (UKSC, 19). This ruling stated that individuals who are the responsibility of the state, who lack the capacity to make decisions about their care and residence, who are subject to continuous supervision and control, and who also lack the choice to leave their care setting are deprived of their liberty (Cusack et al., 2016).

Mental health legislation in most jurisdictions permits detention and restricts privacy and freedom of movement (Hem, Gjerberg, Husum, & Pedersen, 2016). However, whilst this more restrictive legislation exists, there is also protective legislation. For example, within health and social care in England, the Care Act (2014), seeks to protect adults at risk of abuse, including any abuse or neglect experienced because of restrictive interventions such as physical restraint.

Service user and survivor voices

Perhaps for as long as psychiatry has existed there has been advocacy and agitation for change, often driven directly by patients and their families. An interesting paradox of the discursive symbiosis between psychiatry and neo-liberal power has been the rise of user, refuser and survivor activism within disparate new social movements and more mainstream involvement initiatives.

The former arguably arise where voice and representation are not catered for and the latter are ushered in ostensibly by a consumerist turn in the polity. The contemporary field manages to sustain both vehicles for user voice whilst continuing in many ways to constrain and silence this voice (Beresford 2019).

Whilst there have been changes in policy and services to accommodate user involvement, the calls from the survivors' movement for positive changes to the status and social conditions of individuals with mental health needs are still marginalised (Rutter, Manley, Weaver, Crawford, & Fulop, 2004). Smelser (1962) an early commentator on new social movements, questioned whether conservative interest groups make some comprises to such groups in diffusing their more progressive demands for social change. Rogers and Pilgrim (2017) propose whether such comprises made by the state seeks to dilute the strength of demand for changes in status and social inclusion within society. Similarly, others argue that policies promoting public engagement and involvement might perhaps conceal a wider mission of governance and social control (Cooke & Kothari, 2002). Service users can be social movement activists (Brown & Zavetoski, 2005), with groups, and psychiatric survivor collectives asserting progressive political claims for improving society (see for example Crossley, 2006; Spandler, 2006; Beresford & Branfield, 2012). Foucault (2002) aptly presented the struggle for grassroots change in their right for a voice: *'Years, decades of work and political imagination will be necessary, work at grassroots, with people directly affected, restoring their right to speak"* (Foucault, 2002, p.288).

Person-centred practice, shared decision-making, service user participation and recovery are all aspects of service user involvement, which necessitate attention to user voice within the care and treatment context (Storm & Edwards, 2012). Shared decision-making has been acknowledged as a cornerstone of person-centred practice, promoting a recovery-based approach for mental health service users (Deegan & Drake, 2006; Deegan, Rapp, Holter, & Reifer, 2008; Drake, Deegan, & Rapp, 2010; Duncan, Best, & Hagen, 2010). Some have questioned whether service user movements are widely known and viewed as part of recovery orientations in hospital culture (McCubbin, 2009; Davidson, Rakfeldt, & Strauss, 2010), whilst others note how progressive and critical service users have voiced concerns about the legitimacy and harmful impact of coercion and restrictive practices (Cusack et al., 2016; Duxbury, 2015; McKeown et al., 2019a; Rose et al., 2015). Chapman (2010) articulates how such concerns about legitimacy can add to staff dilemmas about use or perceived overuse of restrictive practices within teams. In embracing the importance of service user involvement, it is relevant to discuss the service user voice present in both contemporary policy and guidance, as well as within research. In doing so, the prevailing and historical narrative of service user centeredness is exposed, which is at the heart of this study. A summary of these initiatives will now follow.

Service user-centeredness: Policy and guidance

Notions of service user voice and involvement are privileged in various international policy initiatives (European Commission, 2005; WHO, 2005, 2009). The NHS Constitution (2015) sets out fundamental principles for delivery of care for all service users, including mental health care. One of these principles puts service users at the centre of their care, by incorporating decision-making and service user preferences (NHS, 2015). Likewise, NICE guidance (2012) proposes that service users should be active participants in their care. NHS England (2016) has also outlined this as a key issue in mental health care:

"Services must be designed in partnership with people who have mental health problems and with carers" (NHS England, Mental Health Taskforce, 2016, p.20). Guidance for reducing restrictive interventions in health and social care outlines this fundamental principle of placing service users at the centre of their care and links this to recovery (DH, 2014, 2015). Such policy has prompted salient developments and research, highlighted in the next section.

Inquiry into service user voice in mental health services

Research exploring service user experiences about their involvement within mental health services highlights a lack of participation in decision-making. From a service user perspective, a lack of involvement in planning and decision-making regarding care and treatment has been reported (Soininen et al., 2013). The coercive nature of mental health wards has led to a disconnect between policy and practice (Morant, Kaninsky, & Ramon, 2015), raising concerns about implementation of service user involvement in practice (Bee et al., 2008). Whereas professionals suggest they are already practising in a person-centred way, service users report being informed of decisions, rather than involved in making them (Farrelly et al., 2016). It has been argued that service user involvement challenges paternalistic professional attitudes in making decisions about service users' health care without due consultation (Coulter, 1999). It is proposed shared decision-making should only be restricted at times service users pose significant risk to self or others (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005).

It is relevant to consider ways in which service users' choices can be respected should they become unable to make decisions at a future point, because of diminished capacity, such as advance statements and advance decisions to refuse treatment under statute (Campell & Kisely, 2010), or how staff should manage an individual if they should become distressed. This important consideration in care planning is legislated for in the MCA (2005), which allows individuals to make advance decisions to refuse treatments . However, section 63 of the Mental Health Act (1983, amended 2007)[3], removes some of the rights for decision making for detained mental health service users (Senasinghe, 2017), in forcing medical treatment against any individual's wishes, creating inequalities within the legislative framework for such individuals. Joint care planning with service users may also offer opportunities for how to best manage potential challenging behaviour, yet some professionals have reported difficulty in supporting collaborative care plans (Storm & Davidson, 2010). Authentic involvement ought to demonstrate shared dialogue between nurses and service users, validating the perspectives of each party (Lloyd & Carson, 2011).

Co-production

Having considered initiatives that are designed to place service users at the centre of care, it is relevant to consider the concept of co-production. Slay and Stephens (2013) define co-production as a: *"relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make to improve quality of life for*

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[3] Section 63 states that an approved clinician can enforce medical treatment regardless of whether or not a detained patient has mental capacity to refuse such treatment. Case law has determined that a range of acts ancillary to the mental disorder treatment are allowed under Section 63.

people and communities" (p.3). Yet, as Needham and Carr (2009) suggest co-production can be defined and implemented in several ways. It is recognised at a micro-level, as individuals being thoroughly involved in shared decision-making in achieving outcomes better suited to their individual needs, strengths and goals. This presents substantial challenges for individuals detained under coercive legislation; yet is achievable in some form, for example in the formation of safety plans should individuals become upset or agitated at some future point in time.

Although co-production is about individuals having more control at an individual level, the concept of co-production as a vehicle for peer support presents challenges. Voronka (2016) warns there is an assumption that all people with lived experiences will have the skills to support others. Yet the notion that people with personal experience of mental illness are involved in developing, supporting and the provision of services reflects a shift from the discourse in mental health with its roots in the 19th century (Hutchinson, 2016). There remain barriers to implementing a shift to co-production as services can be focused on targets and standards (Boyle & Harris, 2009). Therefore, mental health services need to be outward-looking and involve service users in building mutual networks to meet the demands of scarcely resourced services (Boyle & Harris, 2009. Interestingly, proselytisers of coproduction such as Dzur (2018) anticipate existential benefits for professionals engaging in more democratic relationships, who may escape some of their own alienation within bureaucratic or coercive systems by virtue of improving the relationships of care.

Ultimately, the success or otherwise of progressive attempts to democratise the social relations of care will be transacted at a nexus where two powerful societal stories collide: the one narrating conservative forces marshalled to control and contain dangerous and inconvenient madness, propping up mainstream psy-professional knowledge and practice (Rose 1996); the other narrating a story of emancipation and democratic citizenship, expressed by critical survivor voices and their progressive allies amongst staff and the wider public (Crossley 2006). The former story has achieved hegemonic[4] ascendancy and, as such, exerts great influence in sustaining the status quo, including permeating the consciousness of individual practitioners in the mental health system and associated professional education; as much as any practitioner may experience disquiet or uncertainty regarding aspects of compulsion and coercion, few doubt the essential legitimacy of the system they work in or their position within it (Krieger et al. 2020; Wilson et al. 2017). Thus, hegemony is maintained.

The latter, alternative, or counter-hegemonic, story has substantial transformation of psychiatry or its dissolution as its goal. Because radical alternative narratives represent a challenge to hegemonic power, their appeal to the bulk of practitioners is limited, as they are so bound up within systems of legitimation that it is a significant reach for them to glimpse the promise of alternatives or, importantly, view them as realistically achievable. In the middle of these competing narratives, is another discursive territory, optimistically invested in reforming the system in the present. Arguably, restraint minimisation approaches, and other efforts to soften and equalise therapeutic and caring relationships, are firmly located in this reformist territory (Burstow et al., 2014).

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[4] Hegemony refers to the often-subtle ways in which dominance is achieved in society through webs of cultural transmission of ideas that come to be understood as common sense and whereby populations become seemingly complicit in their own subjugation (see Gramsci, 1982). Critics such as Laclau and Mouffe (1985) or Day (2005) question the subsequent deployment of Gramscian thinking in propagating a self-defeating pessimism that social change can be achieved in the face of hegemony.

As we shall see in this thesis, a number of the participant storytellers in my study may be seen to have set aside any grander ambitions for psychiatric transformations, if indeed they had possessed such, to mobilise their energies and contributions to change within available systems of involvement and staff education. It is my view, given the obviously deleterious impact of restrictive practices right now, that such efforts at reform are warranted. Otherwise, we might stand aside satisfied in possession of a truly radical critique, but making absolutely nil material impact for the welfare of variously oppressed service users and staff in the here and now. In this sense I concur with Peter Sedgwick (1982: 42) that apparently radical individuals who offer no immediate, workable and scalable solutions for mental health care may as well be the *‘most adamant of conservatives*’. If Frank (2002) is correct in his optimistic view that stories themselves can contribute to social change, then the potential for these stories may go further.

Reducing restrictive interventions: the evidence-based context

The use of physical restraint dates back 300 years. Colaizzi (2005) reports how John Connolly, a 19th century psychiatrist, proposed mechanical restraints could be avoided, preferring seclusion and physical restraint for managing violent behaviour in asylums. However, unease over its use has increased latterly because of risks involving associated pain, injury and death (Deveau & McDonnell, 2009).

It has been reported that on average physical restraint is undertaken five times a month on mental health wards, typically lasting ten minutes (Stewart et al., 2009), with nurses believing coercive measures to be justified in relation to risks of harm to staff and service users (Kaltial-Heino, Korkeila, Tuohimäki, Tuori, & Lehtine, 2003; Lee, Gray, Gournay, Wright, Parr, & Sayer, 2003; Larue et al., 2010). Yet, in an integrative review of nurses' decision-making in restraining service users, danger to self or others was not always present prior to restraint use (Laiho et al., 2013). Additionally, mental health service users have reported restrictive practices being employed in favour of de-escalation techniques in relation to violence and aggression (Price et al., 2017).

Whilst restrictive interventions are not to be used as a punishment, they can be used in a punitive way (Price et al., 2017), harrowingly exemplified at Winterbourne View Hospital. A Panorama programme aired in 2011 showed this private hospital for people with learning disabilities operated a culture of disdain with illegal and dangerous restraint use by staff untrained in restrictive interventions (Flynn, 2012). There appeared to be a ‘bouncer’ mentality, and service users being wrestled to the floor and having staff sitting on them was a daily occurrence. Multiple cases of abuse were found, including physical, sexual, psychological and organisational. Additionally, therapeutic interactions were very limited, amongst a young, untrained and inexperienced staff group, with high turnover (Flynn, 2012).

The DH’s (2012) review of Winterbourne concluded that assessment and treatment units, such as Winterbourne, can have a culture of containment which becomes an institutional pattern of care. With increasing public and professional concern regarding restrictive interventions, a subsequent survey from Mind (2013) suggested wide variation in restraint use across mental health services. In light of continued concerns about restraint practice, official guidance urged a preventative approach. This included: service user involvement in planning their care and support; staff using least restrictive interventions; avoidance of deliberately inflicting pain; and avoiding restraint practices impacting individual's airway, breathing or circulation (DH, 2014; NICE, 2015). These guidelines recommend that an individual's human rights are always protected during their care and physical restraint should only be used as the last resort, or in an emergency (DH, 2014; NICE, 2015).

The recording of restraint incidents is often insufficiently completed (Stewart, at al., 2009). However, a recent monitoring report outlined disparities in restraint use across England and Wales (CQC, 2017), suggesting the concept of ‘last resort’ may present challenges. The incidents of restraint, that are recorded, appear to be increasing. In 2016, 66,681 restraint incidents were reported in 50 of 58 mental health trusts in England; of these, 12,347 involved prone restraints (Merrick, 2016); a position discouraged in policy and guidance because of risks of suffocation (DH, 2014, 2015), with 38 restraint-related deaths in the United Kingdom in the period 2002-2012 (Duxbury, 2015). Contrary to policy guidance, some argue that, apart from obese individuals, prone restraint is not high risk if carried out correctly without force to a person’s back or hips, hence banning prone restraint may place staff at risk and may result in its use being driven underground (Paterson Bennet, & Bradley, 2014).

Moreover, focusing solely on the risks posed to individuals in the prone position, may detract from the fact there are potential dangers in a variety of positions (Hollins, 2010). Research suggests restraint in an upright seated position poses higher respiratory system risks (Parkes, 2008; Parkes, Thake & Price, 2011). The most unsafe restraint position, particularly in obese people, involves hyperflexion, when a person is bent forward from the waist while seated (Paterson et al., 2014).

In considering the aspect of ‘dangerousness', it is relevant to briefly explore how violence may be interwoven within the mental health system. Progressive survivor movements argue physical restraint reveals more extensive or epistemic violence visited by psychiatric services upon service users (Lieggo, 2013; Russo & Beresford, 2014). Gadsby (2018) eloquently describes how, for some, everything permitted under mental health legislation is violent, including the more obvious, such as forced medication, to the less visible forms, such as prejudiced assumptions surrounding expectations. For others, the sharing of one's state of mind could be interpreted as illness, and coercion may likely result (Gadsby, 2018).

Looking at the macro (societal) and meso (organisational) context of care, Grant (2015a) argues that mental health nurses to some extent become stripped of capacity for kindness by their own experiences of intersectional oppression. In conjunction with this, nurses are then socialised to the custom and practices of institutionalised psychiatry. Nurses are rendered untrustworthy; although conflicted, they feel the need to report to others, confidences shared by service users (Gadsby, 2018). Similarly, many mental health settings are characterised by the low status of frontline staff, rigid professional hierarchies and favouring of bio-psychiatry over social models (Bloom, 2010); identified by some as ‘corrupted cultures’ (Paterson et al., 2013). These circumstances disempower many staff and if the behaviour of a service user threatens a staff member's fragile self-esteem, they have ready access to powerful means by which to restore this, via deployment of coercive measures (Bloom, 2010). Regardless of root causes of restraint misuse, over time staff become socialised into patterns of behaviour (Bloom, 2010). The saturating impact of such cultures, once established, can be so powerful that practice staff would normally define as abusive, if not criminal, becomes accepted (Leele & Gaile, 2007).

For service users with past trauma, entering such institutions can be a threat and their underlying pathology may predispose them to conflict and aggression (Paterson et al., 2013). Staff supporting service users affected by trauma need extraordinary skills in managing such situations, being mindful of their own verbal and nonverbal communication, so that aggressive reactions are not triggered (Paterson, McIntosh, Wilkinson, & Smith, 2011). Associated concerns have also influenced contemporary interest in the importance of models of trauma-informed care, particularly concerning the extent services may re-traumatise individuals (Bloom & Farragher, 2010; Muskett, 2014; Sweeney Clement, Filson, & Kennedy, 2016), providing further support for a last resort standpoint regarding restraint.

Restraint as a last resort

Restraint is legitimated as a response to behaviour that challenges services (DH, 2014) and it is recognised that effective inpatient care may at times include the use of restraint (Whittington, Bowers, Nolan, Simpson, & Lindsey, 2009). Renwick et al. (2016) report 40% of individuals in United Kingdom services show aggression during admission; the highest in Europe. A consequence of this violence is that both service users and staff are affected (Holmes, Rudge, & Perron, 2012). Whilst United Kingdom policy and guidance are clear on restraint being used as a last resort for adults in mental health services (DH, 2014, 2015; NICE, 2015, Royal College of Nursing, 2016), there appears to be no published understanding of ‘last resort' which means perception and enactment appear to be problematic (Riahi, Thomson, & Duxbury, 2016).

Studies have identified that restraint has been used as last resort in managing safety concerns, related to the presentation of violence from service users (Perkins, Prosser, Riley, & Whittington, 2012; Wilson, Rouse, Rae, & Kar Ray, 2017). Yet, in the post-incident analysis of physical restraint, violence was rarely mentioned as a cause of restraint use in one study (Ryan & Bowers, 2006). Whilst, evidence suggests that staff acknowledged a progressive approach to restraint is desirable, with restraint in a horizontal position being the last resort, the majority of restraint incidents have been in this position (Perkins, Prosser, Riley, & Whittington, 2012).

Whilst the misuse of physical force or power are viewed as acts of violence towards service users (WHO, 2002), violence posed by service users has been universally acknowledged as an indicator for use of restraint (Whittington et al., 2009). However, psychotic behaviour has been reported as the most frequent reason for using restrictive interventions, even without presence of violence (Keski-Valkama et al., 2009). Whilst staffs' use of restrictive practices has been viewed as a response to violence from service users and influenced by internal factors; service users suggest they have felt driven to violence, viewing restrictive practices as unnecessary and heavy-handed (Rose Evans, Laker, & Wykes, 2015). Restraint is seen in diverse circumstances, other than violence, such as the refusal of medication, self-harm, property damage and verbal aggression (McKeown, Scholes, Jones, & Aindow, 2019a), questioning a preventative and stepped approach to restraint. Additionally, restraint use can be influenced by organisational factors such as the time of day or the type of ward (De Bendicts et al., 2011). Team culture can also have an impact. For example, greater expression of anger and aggression amongst the staff team, as well as insufficient safety measures, have been found to increase the likelihood of restraint (De Bendicts, 2011).

Staff composition, staff experience, staffing numbers and the presence of security staff can all influence inconsistencies in restraint use, indicating that staff-related issues merit further consideration (Riahi et al., 2016). Poor staff morale and staff changes can increase likelihood of restrictive interventions, whereas positive staff practices are associated with reductions (Papadopoulos, Bowers, Quirk, & Khanom, 2012). Although restraint use is regulated by the CQC, training on the use of restrictive interventions remains unregulated in health and social care settings by the government at present in United Kingdom (Paterson et al., 2014). Training should include preventative approaches which change service user and staff experiences (Huckshorn, 2005). Given the problematic issue of last resort, physical and psychological harm resulting from physical restraint will now be explored.

Physical/psychological Harm

The Hippocratic Oath states "*First, do no harm*" and is the basis for medical ethics. Addressing what constitutes an abusive act, the NHS (2015) proposes that physical and psychological abuse includes the inappropriate use of coercion, with the latter, including, emotional abuse, humiliation, blaming, control, and intimidation.

Whilst physical and psychological harm because of physical restraint can be seen in various other places, (Fish & Culshaw, 2005; Jones & Kroese, 2006; Parkes, 2002; Parkes, Thake, & Price, 2011; Stubbs & Hollins, 2011), this study focuses on its impact for service users subject to restraint in mental health settings. Prior to 1996, there was no relevant published research from a service user perspective (Ray, Myers, & Rappaport, 1996). A summary of the research exploring physical and psychological harm caused by physical restraint follows, however, Chapter Three of this thesis reviews evidence from existing research in detail.

Harm can be demonstrated in several ways. Misuse of physical restraint appears to be under-reported by service users (Cusack et al., 2018), nevertheless, they have suggested staff have used excessive force in carrying out restraint (Brophy, Roper, Hamilton, Tellez, & McSherry, 2016; Whitelock, 2009), or reported how they would not be taken seriously when disclosing such poor staff practice (Cusack et al., 2016; Whitelock, 2009). In the Mind (2013) survey, more than half of mental health service users reported suffering ‘abuse' from professionals because of restraint. Evidence suggests that sometimes restraint is used all too quickly in the management of service user distress, with a ‘bouncer mentality' reported (Lee et al., 2003; Flynn, 2012). Such beliefs and actions can infuse ward culture (Pereira, Dawson, & Sarsam, 2006). Furthermore, cycles of controlling aggression with aggression can render organisations dysfunctional and toxic for staff and service users (Paterson et al., 2011; Smith, 2013).

Chapman (2010) describes how post-restraint debriefing justifies its use amongst staff, rather than learning lessons to avoid future incidents. In contrast, nurses have also reported tension in using restraint, (Bonner, Lowe, Rawcliffe, & Wellman, 2002; Duxbury, 2002; Lee et al., 2003) suggesting it can be humiliating for service users (Bonner et al., 2002; Duxbury, 2002; Lee et al., 2003). These are important issues that nursing staff are well placed to address (Cusack et al., 2018). Demonstrating compassionate attitudes and behaviours and acting as positive role models for neophyte nurses and other healthcare staff may help to reduce, and subsequently eradicate, restraint (Bloom, 2010).

Physical restraint has been reported at times as abusive (Brophy et al., 2016; Knowles Hearne and Smith, 2015; Whitelock, 2009) and ‘anti-recovery’ for service users (Dos Santos Mesquita & Da Costa Maia, 2016). In the extreme, restraint has been implicated as contributor or cause of death (Aitken et al., 2011). Many service users are survivors of trauma and there has been developing awareness of trauma in psychiatric settings (Elliot, Bjelajac, Fallot, Markoff, & Reed 2005; Muskett, 2014), including potential for restraint to traumatise or re-traumatise previously abused individuals (Bonner et al., 2002; Brophy et al., 2016; Cusack et al., 2016; Knowles et al., 2015; Sequeira & Halstead, 2004; Steinert, Bergbauer, Schmid, & Gebhardt, 2007; Wynn, 2004). Furthermore, Hammer, Springer, Beck, Menditto, & Coleman (2011) reported 70% of secluded and restrained service users had past histories of childhood abuse.

Excessive force transacted during physical restraint can cause physical pain or injury to service users and a sense of loss of control over one's life can cause psychological harm, with fear and anxiety about future restraint (Brophy et al., 2016; Knowles et al., 2015; Sequeira & Halstead, 2002; Wilson et al., 2017; Wynn, 2004). Associated dehumanisation processes undermine service users’ sense of worth making them feel ‘sub-human' (Brophy et al., 2016; Knowles et al., 2015). Ultimately, the distressing impact of physical restraint can have an impact on an individual's well-being (Bonner et al., 2002; Haw, Stubbs, Bickle, & Stewart, 2011; Sequeira & Halstead, 2002; Sequeira & Halstead, 2004; Wynn, 2004). Having discussed the impact of physical restraint on service users, the next section of this chapter will explore initiatives to reduce restraint.

Initiatives to reduce restraint

No restraint environments

Some organisations believe that it is possible to provide care without restraint. One example is the model of care in Trieste in Italy, which built upon Franco Basaglia's *Democratic Psychiatry* movement (Foot, 2015). In Trieste, an 'open door- no restraint' system of care operates and is deemed as a positive initiative in facilitating recovery (Mezzina, 2014). The Trieste model incorporates a wider concept of mental health that is centred on the whole person and their social background. Support is delivered in a network of community health centres, a network of supported housing facilities, several social enterprises and one general hospital unit (Mezzina, 2014). The no restraint policy extends to every aspect of the service and the combination of health and welfare is considered to have supported its success; in that there has been a shift from reparative medicine to participatory health (Mezzina, 2014). This model of 'no restraint' environments has not been taken up internationally.

Six Core Strategies ©

Research exploring the reduction of coercive practices focuses primarily on the concept of recovery. One such model, which considers recovery is Huckshorn's (2005) 'Six Core Strategies' which foregrounds trauma-informed care. The 'Six Core Strategies' of restraint reduction (Huckshorn, 2005) is used in some service settings and studies have found a significant reduction in both restraint and seclusion (Azeem et al., 2011; Riahi, Dawe, Stuckey, Melanie, & Klassen, 2016; Putkonen et al., 2013; Wisdom et al., 2015). Huckshorn's (2005) six strategies focus on: leadership towards organisational change; the use of data to inform practice; developing a workforce where training focuses on recovery;

the use of restraint and seclusion reduction tools; the consumer role, including consumers, advocates and carers in restraint reduction initiatives; and debriefing techniques.

In the United Kingdom, the REsTRAIN YOURSELF Programme adapted Huckshorn's (2005) six core strategies of restraint reduction, to suit the United Kingdom context; this has been evaluated with a mixed-methods study, involving mental health nursing staff (Duxbury et al. 2019). In this study, staff reported how their attitude to coercive practices had changed, as did their relationships with service users. Service user empowerment was also reported in this study related to their direct involvement in safety plans. The safety plans sought ways to communicate with service users, including times when they were upset, yet their use was also inconsistent across all wards involved (Duxbury et al., 2019) This study also exposed some of the inadequacies of the resourcing and organisation of routine ward care, with distinct demarcations of ward space into staff and patient areas and associated limited face to face contact, exacerbated by shortfalls in staff knowledge and staffing levels (McKeown et al. 2020).

The Safewards Model

The most celebrated restraint reduction initiative to date is the Safewards model, which is included in NICE guidelines (2015) regarding the management of violence and aggression and has been implemented in a number of international settings. The multi-component Safewards approach involves attention to situations in mental health wards which create potential 'flashpoints' for conflict, placing a strong emphasis on the culture within hospital settings (Bowers, 2014). The Safewards model is developed from literature reviews and empirical evidence and comprises ten interventions: clear mutual expectations; soft words; mitigation of bad news; talk down; use of positive words; getting to know each other; mutual help meetings; calm down techniques; reassurance; and discharge messages (Bowers, 2014; Bowers et al., 2015).

The Safewards model is reported to have decreased conflict by 15% and containment by 24%, in 31 wards across England (Bowers et al., 2015). Although the methodology in Bower's et al.'s (2015) study is criticised by some for its lack of rigour (Mustafa, 2015); others argue that the methodology is robust and rigorous (Cabral & Carthy, 2017). It is argued that the implementation of Safewards in forensic settings is fraught with difficulty (Price, Burbery, Leonard, & Doyle, 2016). Nonetheless, in a pilot study within a forensic setting Safewards was found to create safer less restrictive wards, despite a strong organisational resistance to change (Cabral & Carthy, 2017).

The ward environment

It is relevant to consider the environmental settings in which restraint occurs. In a study by Borckardt et al. (2011), an 82.3% reduction in restraint and seclusion was found by implementing systematic interventions to five inpatient wards. In this study, interventions included: changing the physical environment, making it less clinical; changing the rules and language used on the ward; involving service users in plans about their treatment; and providing trauma-informed training for staff. Similarly, in a study by Wilson et al. (2018) environments which focused on healing and recovery were reported by both staff and service users as a mechanism to reduce incidents of physical restraint.

Organisational culture

Inter-related to the ward environment is the ward culture. Organisational culture is an important consideration in looking at a complex set of measures available to reduce restraint. Although stressful climates and high workloads may be seen to lead to an increase in restraint, there remains limited research in these areas (Gooding et al., 2018). However, studies have found that staff shortages have been implicated in a perceived rise in violence (UNISON, 2017), impacting on opportunities to build a therapeutic alliance (Bee et al., 2008; McAndrew et al., 2014) and serving as a barrier in attempts to reduce restraint (McKeown et al., 2019b). Furthermore, the use of temporary staff contributes to various discontinuities in care, with a related lack of engagement with staff, service users and organisational policy (McKeown, et al., 2019b).

The Power Threat and Meaning Framework

The Power Threat and Meaning Framework is an over-arching structure for identifying patterns in emotional distress, unusual experiences and troubling behaviour, conceived as an alternative to psychiatric diagnosis and classification systems (Johnstone et al., 2018). The foundational document sets out the conceptual and empirical basis of such a system and is intended as a resource. The framework is theoretically eclectic, '*not tied to any specific theoretical orientation or set of practices, such as behavioural, cognitive, psychodynamic or systemic'* (Johnstone et al., 2018, p.13). The framework can be drawn upon directly to inform practice or can provide a meta-framework to compliment other existing models and bodies of evidence. The framework represents a radical alternative to simplistic biomedicine by '*drawing on* *assumptions, theoretical frameworks and evidence that are appropriate to understanding the behaviour and experience of embodied persons within their social and relational environments, rather than the (mal)functioning of bodies'* (Johnstone et al., 2018, p.13). As such, patterns of coping and survival can be employed to construct helpful narratives of different kinds, both within organisational and self-help settings (Johnstone et al., 2018). These sort of critical alternatives to mainstream psychiatric narratives arguably offer the discursive means by which an ongoing dialectic of change might realise tangibly different forms of help and support for the mentally distressed. Having discussed initiatives to reduce restaint, the wider connotations, for both staff and service users is explored in the impact of physical restraint on the therapeutic alliance.

The impact of physical restraint on therapeutic relationships

Professional guidance on the best practice in working with service users within mental health settings emphasise importance of the therapeutic relationship (NICE, 2009; Royal College of Psychiatrists, 2009). The healing power of interpersonal relationships has long been remarked upon, for example featuring notably in nursing traditions (see Peplau, 1952) and recognised by Rogers (1965; 1967) who stressed acceptance, genuineness and understanding of service users by the professionals working with them. Therapeutic relationships and alliance between service users and staff are thus fundamental in mental health care (Roche, Madigan, Lyne, Feeney, & O'Donoghue, 2014; Warne & McAndrew, 2004) with good communication and interpersonal skills having potential to prevent or minimise need for restraint (Cusack et al., 2016).

Getting to know the service user is seen as the main role of mental health nursing (Winship Reper, Bray, & Hinshelwood, 2009). From both a staff and service user perspective, communication and good relationships between the two groups has been reported as preventing physical restraint, as de-escalation techniques are deemed more effective when positive alliances are formed (Wilson, Rouse, Rae & Kar Ray, 2018). Yet, some barriers have been reported in achieving a successful service user-nurse therapeutic alliance. These include high workloads, (Bee et al., 2008; McAndrew, Chambers, Nolan, Thomas, & Watts, 2014), high levels of staff turnover or sick leave and lack of staff commitment (Bee et al., 2008), and insufficient time for talking and listening to service users (McAndrew et al., 2014).

From a service user perspective, fear of restrictive interventions and use and misuse of staff power, including restraint, are also suggested as barriers to building therapeutic relationships (Kaminskiy, Ramont, & Morant, 2013; Paterson et al., 2011). Service users report communication with staff is too often about rule enforcement (Stewart et al., 2015). Arguably, the use of restrictive interventions arouses staff ambivalence and can also result in unintentional injury to service users or impair therapeutic alliance (Bowers, 2014). Restraint can thus have a negative impact on relationships between staff and service users, with both groups feeling victims of restraint (Cusack et al., 2016; Duxbury, 2002; Lee et al., 2003). While staff attribute aggressive behaviour to individual pathology, service users have reported being victims of controlling nurses, each perspective potentiating problematic relationships (Cusack et al., 2016; Duxbury, 2002).

Restraint has been described as a ‘necessary evil' for intervening in a context of dangerous, aggressive or challenging behaviour (Perkins et al., 2012), yet arbitrary use of restraint is often deployed (Gudjonsson, Rabe-Hesketh, & Szmukler 2004; Keating & Robertson, 2004). Nurses who work in secure settings are often called upon to deal with safety issues such as risk to others (Mason, Lovell, & Coyle, 2008) and it is queried whether those working in such environments can achieve both security and therapeutic roles or whether these roles conflict (Knowles et al., 2015). Restraint in such environments is seen as a means for staff to control a difficult, sometimes precarious setting, yet from a service user perspective restraint is reported as a means by which staff demonstrate their power, undermining any alliance with service users (Knowles et al., 2015).

Repeated exposure to aggression and violence has potential to cause trauma for both staff and service users (Bonner et al., 2002). For staff affected, despite clinical supervision and debriefing following restraint, some may struggle to maintain a therapeutic relationship with service users (Blumenthal, 2010). In the longer-term, unresolved tension has the potential to impact the individual, the team and the organisation (Bloom, 2010), ultimately leading to counter-aggression towards service users (Paterson et al., 2011).

Chapter conclusion

The policy and legislative framework represent a driver for reducing restrictive interventions, including physical restraint, in mental health services, yet evidence suggests inconsistent impact on practice. Service user experiences of restraint have been expressed through a relatively small number of qualitative and quantitative studies, which are discussed in the following integrative review chapter of this thesis. Several first-hand service user accounts of being subject to coercive practices criticise the concept of ‘coercive care' (e.g. Gray, 2009).

Nevertheless, service user voices are somewhat limited in research projects and there remains a need to elicit user perspectives on coercion, including physical restraint (Tingleff, Bradley, Gildberg, Munksgaard, & Hounsgaard, 2017), supporting a rationale for the importance of this study.

Having introduced terms from the research question, the setting in which restraint takes place, relevant legislation and policy, the narrative of biomedicine, service user /survivor voices, involvement at a policy and research level initiatives to reduce/eliminate restraint, the impact of physical restraint on the individual, including therapeutic relationships, , the next chapter will provide a thorough review of literature pertaining to the physical and psychological harm caused by physical restraint.

CHAPTER THREE.

INTEGRATIVE REVIEW

A version of this chapter has been published as Cusack et al., 2018.

Introduction

The previous chapter set out the key issues impacting on the use of restraint, the policy and legislative context, and concerns about its practice. This chapter offers an integrative review of whether deployment of physical restraint causes physical or psychological harm, specifically relating to inpatient mental health service users. The chapter details the search strategy for this review and evaluation of data retrieved from the inclusion criteria, then outlines key themes identified from identified papers salient to the review focus. This provides the context for the present study and strengthens the need for this research exploring narrative experiences of service users who have experienced physical restraint as inpatients. When discussing participants from the included studies of this review, language reflects how participants were referred to by original authors. Therefore, the terms service users, consumer and patients are used interchangeably.

A comprehensive and methodical approach was used, first scoping the literature to fully understand the phenomenon. The focus of the search was adult inpatients within mental health settings, where concerns identify physical or psychological harm caused because of physical restraint. The detailed search undertaken included both experimental and non-experimental research. Appropriate databases were searched using a combination of key terms to identify relevant papers, whilst professional networking, hand searching, and author searching were utilised to broaden the search. Robust inclusion/exclusion criteria were employed to ensure relevant academic papers were identified and included. The process of quality assessment of retrieved papers involved three reviewers led by myself. The two other reviewers being Professor Sue McAndrew and Lecturer Frank Cusack (both from the University of Salford). Papers were appraised using a recognised critical appraisal tool.

Aim of the integrative review

This review aimed to explore physical or psychological impacts of physical restraint on people admitted to mental health care inpatient settings.

The literature

The available literature spanned service user, carers and staff views, which do not exist in a vacuum nor are they always divisible from each other within discrete publications. It was felt that the inclusion of carers' and staff' views would supplement direct views from service users, and not detract from the focus of the review in exploring the impact of physical restraint for mental health service users.

Method

An integrative review methodology was utilised as it allows both experimental and non-experimental research to be included (Whittemore & Knafl, 2005). Integrative reviews are an approach which "*reviews, critiques and synthesises representative literature on a topic in an integrated way*" (Torraco 2005, p356). Integrative reviews provide a potential opportunity to develop practice and policy, building on existing research (Whittemore & Knafl, 2005).

Cooper's (1998) framework for research synthesis was employed. Cooper proposes a five-stage approach to the literature review; problem identification; literature review; data evaluation; data analysis; and the presentation of results. As Cooper (1998) suggests, problem identification is related to the research questions and the reviewer must distinguish relevant from irrelevant studies to include. The data collection stage is concerned with finding what procedures to use to locate studies and decide which relevant materials to examine. The inclusion/exclusion criteria, devised from the research question, guided decisions regarding inclusion in the review. A number of relevant databases in health and social care were searched, using a wide set of search terms. However, this alone could not be relied upon. Therefore, hand searching, author searching and journal searching were additionally employed.

The data evaluation stage centres on assessing the quality of the evidence to decide which papers to include. A quality assessment tool and the Critical Appraisal Skills Programme (CASP) framework assisted this process. Analysis and interpretation in Cooper's framework involve deciding what procedures should be used to synthesising the evidence and making inferences about the findings. This involved comparison across all papers to look at the emerging themes, assisted by a grid, developed to support this process. Finally, public presentation in Cooper's framework encompasses the reviewer deciding what information should be used in the final review report and, therefore, separating the important from the unimportant information. Public presentation, for this review, involved displaying and discussing the findings and making comparisons with other studies. The review was presented and accepted for publication in a peer-reviewed journal (Cusack et al., 2018), in conjunction with presenting this process within this chapter of my thesis. Each stage of Cooper's (1998) framework will now be expanded upon.

Problem identification

The purpose of this review was to appraise and summarise the available findings regarding physical restraint practice, raising concerns of any physical or psychological harm caused to service users resulting from its use. There is a gap in research evidence in this area. Few commentators focus on harms caused for adults within mental health inpatient settings as potential or actual ‘abusive practice', though Whitelock (2009) states an underreporting of abuse stemming from the misuse of physical restraint within mental health services. An in-depth understanding of this phenomenon may assist in undertaking future research, particularly exploring the impact for service users, to add a unique perspective to existing knowledge and influence practice at an individual and organisational level.

Literature Search

Using terms related to components of the topic area, (Table 2) the CINAHL, EMBASE, Psy Info, MEDLINE and Cochrane databases were searched. Hand searching was also employed as referenced articles, in other literature reviews and studies, identified further research for exploration. Journal searching, professional networking and searches of the published work of authors, from key titles in the associated field of research, was employed to ensure thorough searching (Aveyard & Sharp, 2013).

Table 2 Search Terms

Setting AND	Perspective AND	Intervention AND	Evaluation
Hospital **OR** **Psychiatric hospitals** **OR** **Institutional setting** **OR** **Institution** **OR** **Institutional care** **OR** **Psychiatric unit** **OR** **Nursing care** **OR** **Psychiatric nursing** **OR** **Psychiatric ward** **OR** **Psychiatric service** **OR** **Psychiatric unit** **OR** **Psychiatric care** **OR** **Psychiatric setting** **OR** **Mental health ward** **OR** **mental health setting** **OR** **mental health unit**	Vulnerable adults OR Adults at risk OR Inpatient OR Psychiatric patients OR Mental health patients OR Consumer OR Client OR Service user	Behaviour control OR Coercion OR Containment OR Control OR Manual restraint OR Physical restraint OR Restraint OR Restraint physical OR Restrictive intervention	Violence OR Abuse OR Abuse of patients OR Patient abuse OR Abusive practice OR Sexual abuse OR Trauma OR Risk OR Risk of injury OR Adverse effect OR Adverse health care event OR Adverse impact OR Elder abuse OR Harm OR Injury risk OR Physical abuse OR Safeguarding OR Safety behaviour OR

			Post-traumatic stress disorder

The inclusion/exclusion criteria (Table 3), were devised from the research question. It was imperative to ensure the search was structured to avoid drift (Aveyard, 2010). Studies published from 2000 to April 2019 were included in this review. The year boundary of 2000 was chosen as this was when the first national guidance was published in England attempting to define and address adult abuse in health and social care (DH, 2000).

Policy and guidance were excluded in favour of evidence-based research using qualitative, quantitative and mixed-methods. Although randomised control trials are often referred to as ‘gold standard' research, with perceptions of greater validity and reliability, they can be limited in their lack of explanations of interventions and ability to provide practitioners with a clear toolkit of effective actions (McLaughlin, 2007). Given the relative lack of evidence to date, it was felt a systematic review would not be appropriate.

Table 3 Integrative review inclusion and exclusion criteria

	Inclusion Criteria	Exclusion criteria
Date	Post 2000	Pre 2000
Population	Adults (over 18)	Children, adolescents
Setting	Inpatient mental health hospital settings	Non-mental health settings, non-hospital settings
Intervention	Physical restraint causing physical, psychological harm	Other forms of restraint,

Study Type	Mixed-methods, qualitative, quantitative	Thesis, books, chapters, discussion papers, commentaries, editorials
Language	English	Other languages

Data evaluation

There were three stages for screening retrieved articles. The first stage involved screening of titles, where papers were included for further reading of the abstract. Inclusion/exclusion criteria were employed to retrieve potentially relevant articles. The second stage involved screening abstracts and papers using the inclusion and exclusion criteria. The third stage involved reading the remaining articles in full, for the final decision for inclusion of papers in the integrative review. Duplicates are generally automated within the database platforms (Clapton, 2010); however, duplicates within individual databases were manually removed.

Papers, which met the inclusion criteria were appraised using the Critical Appraisal Skills Program (CASP) tools, developed to critically evaluate a wide range of literature (Whittaker & Williamson, 2011). An appraisal tool was not available from CASP for mixed-methods studies; therefore, Riahi, et al.'s (2016) modified CASP appraisal tool was applied for the mixed-methods studies within this review. Methodological features were assessed for overall quality. Papers were evaluated using Walsh and Downe's (2006) Quality Summary Score (see Table 4).

Table 4 Quality Summary score (Walsh & Downe, 2006)

Key to Quality Rating	
A	No or few flaws. The study's credibility, transferability, dependability and confirmability are high
B	Some flaws, unlikely to affect the credibility, transferability, dependability of the study
C	Some flaws which may affect the credibility, transferability, dependability and/or confirmability of the study
D	Significant flaws which are very likely to affect the credibility, transferability, dependability and/or confirmability is high

This Quality Assessment Tool gives ratings from A to D against any flaws in the papers. D rated papers are considered of poor quality and therefore a decision was made to remove any papers that were assessed as D rating. No papers were rated as D, meaning that all papers at this stage were included in this review. Led by myself as researcher, two academic reviewers assisted in appraising each paper and a comparison of findings took place to ensure quality and consistency. Ten papers were finally included in this review (See figure 1).

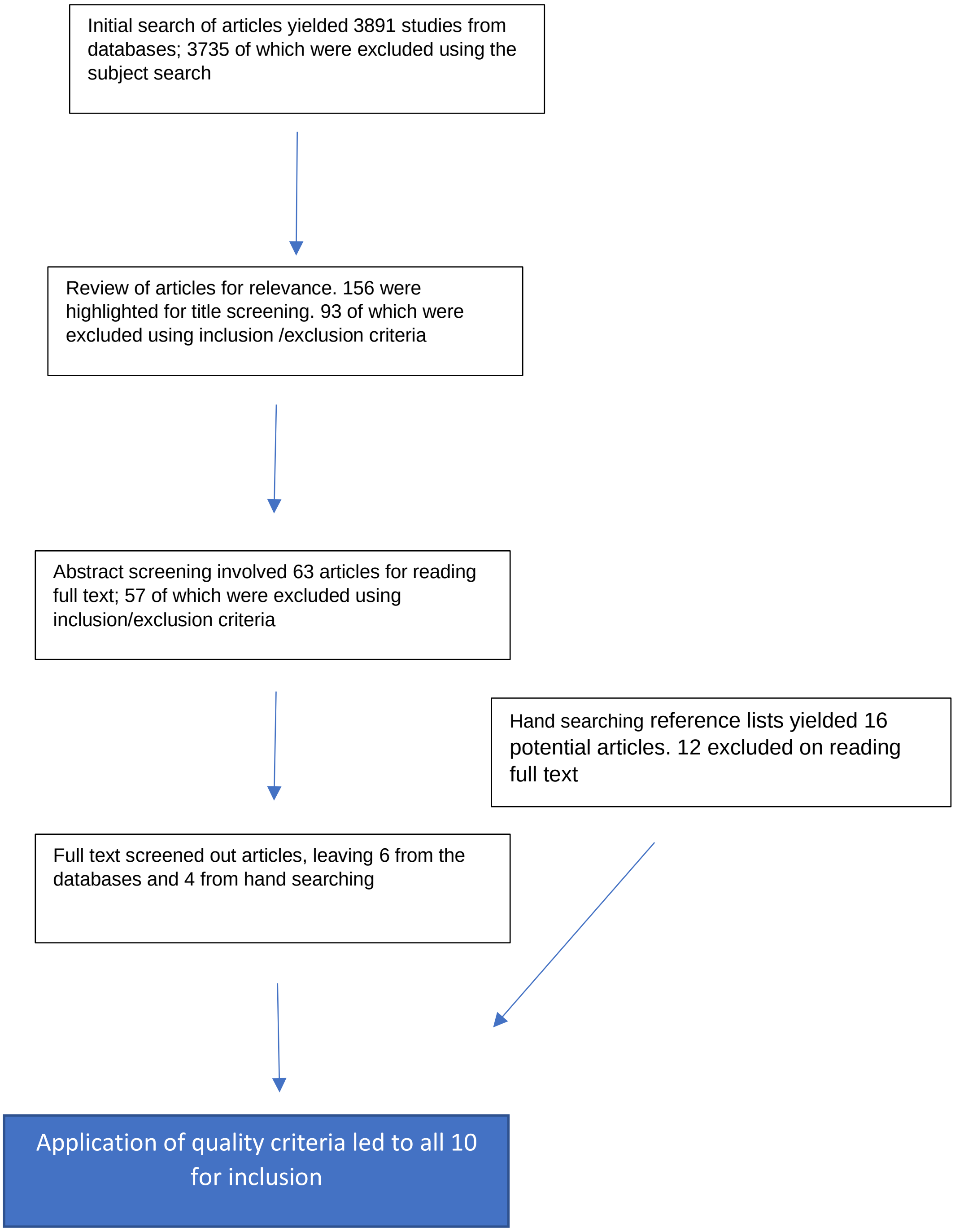

Figure 1 Flow diagram of Literature Search

Data analysis

Analysis of data involved constant comparison across the included papers to identify themes, patterns and variations within the findings (Whittemore & Knafl, 2005). This approach allows systematic categories to form (Whittemore & Knafl, 2005). A grid was devised to facilitate this process, and articles were read and re-read allowing formulation of distinct themes, whilst also acknowledging variations within studies. In total, eight main themes were identified focused on physical or psychological harm for mental health service users who have experienced physical restraint on mental health wards. Table 4 summarises the studies and the key themes arising within each paper.

Table 5 Summary of articles

Authors, Year, Country Quality rating	Study Type and analysis	Aim	Sample and setting	Main themes from physical restraint
Bonner, Lowe, Rawcliffe and Wellman (2002) United Kingdom ***Quality rating C***	Qualitative semi-structured interviews. Thematic analysis	To establish the feasibility of using semi-structured interviews with patients following restraint. To gather information on factors which patients and staff felt helpful or unhelpful in their experience of restraint following restraint and to report on lived experiences of people involved	12 staff and six patients in an inpatient mental health ward in the South of England	Trauma/re-traumatisation Feeling ignored Inhumane conditions Distress Fear
Brophy, Roper, Hamilton, Tellez and McSherry (2016) Australia ***Quality rating C***	Qualitative. Focus Groups Inductive analysis (NVivo software)	To examine the lived experiences of consumers and carers around the use of seclusion and restraint	30 mental health consumers and 26 carers in four cities and one regional centre	Trauma/re-traumatisation Inhumane conditions Fear Control Power

Haw, Stubbs, Bickle and Stewart (2011) United Kingdom ***Quality rating*** ***B***	Mixed-Methods. Qualitative Thematic analysis Quantitative Statistical analysis	To report on forensic rehabilitation of inpatients' experiences and preferences for physical restraint, seclusion and sedation	57 patients in a forensic psychiatric setting	Feeling ignored Distress Dehumanisation Power Calm
Knowles, Hearne and Smith (2015) United Kingdom ***Quality rating*** ***C***	Qualitative Interviews Thematic analysis	To examine the impact on the staff-patient therapeutic alliance	8 patients on a medium secure unit	Power Dehumanisation Trauma/re-traumatisation
Lee, Gray, Gournay, Wright, Parr and Sayer (2003) United Kingdom ***Quality rating*** ***C***	Mixed-Methods Qualitative Thematic analysis Quantitative SPSS- Statistical analysis	Seek views of psychiatric nurses in their experience in use of restraint	338 psychiatric nurses in regional, secure and psychiatric intensive care units in England and Wales	Dehumanisation Power
Sequeira and Halstead (2002) United Kingdom ***Quality rating*** ***A***	Qualitative (Grounded Theory). Semi-structured interviews	To examine the experiences of physical restraint procedures from a service user perspective	14 inpatients in a secure mental health setting	Power Distress Fear Control Calm
Sequeira and Halstead (2004) United Kingdom ***Quality rating*** ***A***	Qualitative (Grounded Theory). Semi-structured interviews	To examine the experience of physical restraint by nursing staff in a secure mental health setting	17 nurses in a secure mental health setting	Trauma/re-traumatisation Distress Power

Steinert, Bergbauer, Schmid, and Gebhardt (2007) Germany ***Quality rating*** ***A***	Quantitative SPSS- Statistical analysis	To look at how seclusion and restraint might cause Post Traumatic Stress Disorder and re-victimisation	117 mental health inpatients	Trauma/re-traumatisation
Wilson, Rouse, Rae and Kar Ray (2017) United Kingdom ***Quality rating*** ***A***	Qualitative Thematic analysis	To improve understanding of restraint for both staff and patients, who have direct experience or have witnessed restraint	13 patients and 22 staff in adult mental health inpatient environments.	Fear Power Dehumanisation Distress
Wynn, R. (2004) Norway ***Quality rating*** ***B***	Qualitative Grounded Theory Interpretive analysis	To allow patient to share experiences of physical restraint	12 patients	Trauma/re-traumatisation Distress Fear Control Power Calm

Results

The integrative review found no research which has specifically explored the narrative experiences of service users who have experienced physical restraint as inpatients on mental health wards. However, in this review research articles were found which have reported physical and psychological harm for people who have experienced physical restraint as service users in mental health settings. These articles include both service user and staff perspectives on the impact of physical restraint for service users. Some are implicit about the possibility of restraint being used abusively (Brophy et al., 2016; Haw et al., 2011; Knowles, et al., 2015; Wynn, 2004).

In total, ten articles were included in the final analysis: one quantitative, two mixed-methods and seven qualitative. Of the seven qualitative papers, two reported on findings from the same study, however, each of these explored different participant perspectives: staff and service user views respectively. A decision was made to keep these separate, as each paper identified some thematic differences. All ten articles were primary research, with single studies from Norway, Germany, Australia and seven from the United Kingdom. Respective study aims were to either examine services user experiences, including views from carers, and/or nurses' experience of physical restraint. Five of the papers looked exclusively at patients' perspectives (Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002; Steinert et al., 2007; Wynn, 2004). One paper looked at service users and carer views (Brophy et al., 2016), two papers examined nurses' views (Lee et al., 2003; Sequeira & Halstead, 2004), whilst two included both patients' and nurses' perspectives (Bonner et al., 2002; Wilson, et al., 2017).

The quantitative paper (Steinert et al., 2007) examined how seclusion and restraint might cause Post Traumatic Stress Disorder and Re-victimisation. One hundred and seventeen inpatients diagnosed with schizophrenia, who had experienced restraint in the previous six months, participated in the study located in a psychiatric inpatient setting in Germany. Validated tools were used to collect the data and appropriate statistical tests were used in analysis. Results were generally representative of patients with schizophrenia in the locality, but not of all patients with this diagnosis. Ethics approval was not discussed in the paper; nonetheless, informed consent was sought and patients who were well enough to participate were included in this study. When looking at patients' experience of previous trauma, patients could not always recall whether the trauma had occurred before or after coercion, which was a limitation, nonetheless the interview in this study was easy to follow for patients, allowing more patients to be included. A further limitation in this study was that staff attitudes and behaviour were not analysed.

Of the two mixed-methods papers Lee et al. (2003) sought views of psychiatric nurses in their experience in the use of restraint. Two hundred and sixty-nine psychiatric nurses in randomly selected regional secure and psychiatric intensive care units in England and Wales were a sub-set of a larger postal survey. Although a large sample, responses may not have been representative of all nurses, therefore external validity and generalisability could be questioned. Haw et al.'s (2011) study reported on 57 forensic psychiatric inpatients' experiences and preferences for physical restraint, seclusion and sedation. A semi-structured interview was used for qualitative data collection; medical records, demographics and clinical decisions were used for the quantitative aspect of the study. Ethical approval was noted. A major limitation of the qualitative data collection was that interviews were not audio-recorded, meaning data could have been missed or misrepresented. Researchers worked at the hospital where data was collected, with potential for biasing findings. Furthermore, 22% of patients were deemed too unwell for interview; although an ethically sound decision, important findings may have been unreported. A further 20% of patients declined to be interviewed, also possibly influencing findings. SPSS (version 14) was used to analyse the data. The chi-square test was used to examine differences between groups and the Mann Whitney test for differences between medians. Two researchers independently analysed the qualitative data, identifying key themes.

Sequeira and Halstead (2002) used a grounded theory approach to examine experiences of physical restraint procedures from a service user perspective. Fourteen inpatients in a secure mental health setting participated in this study with data collected using audio-recorded semi-structured interviews, subsequently transcribed. Ethical approval was not reported, although the researchers state informed consent was gained from participants. Patients were interviewed within 12 hours of physical restraint; therefore, experiences were recent. Closed and open questions were used, the latter aiming to reduce bias and reveal findings from the patient's perspective. The researchers used bracketing to minimise subjective bias arising from their personal positioning. Thematic analysis was employed assisted by data analysis software. Two researchers from different backgrounds analysed the data, texts were read and re-read and coded. Any disagreements were discussed until consensus was reached, in a process designed to improve rigour, credibility and dependability. Transferability in this study was arguably limited due to small sample size.

In Sequeira and Halstead (2004), 17 nurses in the same secure mental health setting participated in this arm of the study. Again, ethical approval was not reported. The study examined the experience of physical restraint by nursing staff in a secure mental health setting. A grounded theory approach was also used here, with semi-structured interviews as the data collection method. This included a random sample of nurses who had been involved in restraint in the previous eight days. Sampling bias was avoided as random sampling was used. Interviews were recorded, and again open and closed questions were used. Saturation of data ensured adequate data were collected and any further data collection was unnecessary. Bracketing was used to minimise bias. To improve reliability and credibility two researchers undertook analysis using supportive software. Coding proceeded independently with disagreements discussed until consensus was reached. The authors’ divergent backgrounds, (Psychology and Medicine), contributed to quality and rigour of process and findings. Some of the data was triangulated to patients’ views. Credibility was demonstrated as findings were shared with participants.

Wynn’s (2004) explored experiences of physical restraint amongst 12 mental health inpatients, on a single psychiatric ward. A grounded theory approach was used, and participants were interviewed following restraint. The two researchers worked in the hospital where the participants were patients, therefore there was potential for bias, for example constraining participants’ full openness. Nonetheless, the researchers were not treating any of those interviewed. Purposive sampling addressed all patients who were restrained, with appropriateness to participate discussed with the medical team. On average, patients were interviewed 11 days following restraint, therefore some details of the incident may have been forgotten. Participants were asked to speak openly about their experiences. A guide was used as a prompt if participants did not spontaneously offer their accounts. Interviews lasted between 15 and 45 minutes, a relatively short duration to develop depth of discussion. Some patients discussed suffering from heavy psychotic symptoms during the interviews, which may have influenced their recall and attention. A nurse was present during interviews potentially to the detriment of data quality. Ethical approval and informed consent were gained. However, withdrawal from the study was not discussed, leaving a question mark over those involved who reported heavy psychotic symptoms. The interviews were recorded and analysed by reviewing the transcripts repeatedly. Common themes were clustered, which were then further explored and examined for uniformities.

Constant comparison to reduce the number of categories took place. Robustness was shown in the analysis process and this was a key strength within the project. This was a small study, so transferability of findings is limited.

Knowles at al. (2015) explored the impact of physical restraint on patient-staff therapeutic relationships in a medium secure setting in the North of England. Ethical approval was gained. The study was publicised across the service enabling participant self-selection for inclusion. One individual deemed too unwell by clinicians was excluded from the study, with a further seven excluded for not meeting inclusion criteria. Eight participants were interviewed, seven males and one female. Although the sample size was adequate for thematic analysis, transferability was limited due to research being carried out on one site. The sample was also further limited by recruitment of only one woman, meaning gender differences could not be adequately explored. Patients were interviewed using a semi-structured schedule, which was adapted based upon the participants' responses. Researchers did not have the opportunity to build up a relationship before the interview, which may have constrained participants' inclination to talk openly; some participants had expressed fear of consequences in talking about restraint. Thematic analysis involved initial reading of the data and identification of codes. Codes were then connected across transcripts, which were used to generate themes, these were then reviewed and refined. Quotes and descriptions were used to illustrate each theme. Rigour was shown in the procedural process for analysis by using a respected six-stage approach to thematic analysis (Braun & Clarke, 2006).

Brophy et al. (2016) examined the lived experiences of 30 consumers (service users) and 26 carers concerning use of seclusion and restraint. Ethical approval was gained, and participants came from four cities and one regional centre in

Australia. Focus groups were the data collection method. This may limit findings as focus groups can prevent all voices being heard from the included participants. A convenience sample was used to recruit participants and, due to the voluntary nature of self-selection, this may not be representative of all consumers and carers. The small number of participants in each focus group also limited transferability. Open discussion was used in the focus groups and these were audio-recorded. Facilitators of each group discussed eligibility before the discussion started. 25 Australian dollars was given to the participants in gratitude for participation, yet this could be deemed as biasing the recruitment process. Transcripts were initially analysed by a researcher independent of focus group facilitation. Text was read and re-read, structured into categories, and coded for phrases, meanings and words. Categories were continually refined and coded and confirmed by team discussion into common themes. Preliminary findings were discussed and commented on by two advisory groups of consumers and carers. More than one person was involved in analysis and respondent validation confirmed credibility of findings. Rigour was shown in the procedural steps of this research, which deepened understanding from a service user and carer perspective.

Wilson et al.’s (2017) study explored staff and patient experiences of restraint within adult mental health inpatient environments. This included participants who had either witnessed physical restraint, or with direct experience of being restrained as patients or undertaking this as staff. Participants included 13 patients, 10 of whom were inpatients and three former inpatients. Patient participants included six males and seven females, aged 18-65, who had all self-selected for inclusion in the study and were deemed broadly representative of patients at the hospital. Patients who had experienced traumatic experiences because of physical restraint, may not have felt able to put themselves forward for inclusion in the research. Staff participants included eight ward/deputy managers, three health care assistants, two occupational therapists, six nurses, two psychologists and one housekeeper; ages ranged from early 20s to late 50s. Length of experience working within the Trust ranged from 4 months to 20 years. Semi-structured interviews were undertaken, full informed consent was obtained, and interviews were video-recorded and transcribed. The study relied on previous recollections of restraint, potentially affecting the dependability of data from former patients and staff whose last experience of physical restraint occurred some years previously. Dependability was demonstrated in the data analysis process, with the use of Braun and Clarke's (2006) steps for thematic analysis. Two academic authors worked independently to read and re-read transcripts, assigning initial codes to the data, followed by a review of themes, and labelling these for the findings. The two researchers met to discuss and agree themes, strengthening trustworthiness of the findings. Two other researchers, who were involved in this study, subsequently validated these findings. Additionally, the service user advisory group read a sample of transcripts from the patient interviews and commented on preliminary themes. As this was a small sample, transferability was limited, nonetheless, this paper adds to the growing body of evidence.

Bonner et al. (2002) aimed to establish the feasibility of using semi-structured interviews with patients following restraint and to gather information on factors which patients and staff felt helpful or unhelpful in their experience of restraint. This focus included reporting on the lived experiences of the people involved. Participants included 12 nurses and six patients from a mental health ward in the South of England. This study was a pilot study and semi-structured interviews were used for data collection. Duration of the interviews was 30 minutes, which may have prevented in-depth discussion, and to some extent limited findings. Patients were interviewed if they had been subject to restraint, and their consultant was approached to ask for suitability to consent before asking them for permission to participate. Key workers also assessed the patient’s fitness for the interview and their ability to consent to the study before participants were approached. Mechanisms had been in place to protect patient’s well-being; interviews would have been terminated if the patient became distressed. These considerations showed sound ethical consideration. Staff involved in restraint were approached by a member of the research team to request their participation. In examining the findings, rigour was shown as three researchers were involved in data analysis. Transferability is limited from a small sample, however, new areas for research were identified.

Quality rating

A Quality Summary Score tool (Walsh & Downe, 2006) was used to categorise papers. Of the ten papers identified for inclusion in this review, four (Sequeira & Halstead, 2002, 2004; Steinert et al.,2007; Wilson et al., 2017), met the score for the highest quality rating. Two papers (Haw et al., 2011; Wynn, 2004) met the second-highest quality rating; and four papers (Bonner et al., 2002; Brophy et al., 2016; Knowles et al., 2015; Lee et al., 2003) met the third.

Themes

The purpose of the review was to establish whether physical restraint raises concern based on the psychological or physical harm it may inflict for mental health inpatients. Strategies used for this were to categorise, summarise and distinguish the emerging themes that transpired from a thorough reading and re-reading of the papers. Crucial texts from the papers were highlighted and then organised into groups of text on the grid. Categories were continually evaluated for underlying similarities. As the papers were re-read these categories were added to, which involved constant comparison in identifying similar themes (Strauss & Corbin, 1968). Although eight different themes were identified several were naturally inter-related, such as themes of power and control. The subtle nature of this interplay will be examined further, as each theme is elaborated upon within this review. The eight themes identified were: Trauma/re-traumatisation; Distress; Fear; Feeling ignored; Control; Power, Calm; and Dehumanisation.

Trauma/re-traumatisation

Trauma and re-traumatisation were thematically represented across papers in the review (Bonner at al., 2002; Brophy et al., 2016; Sequeira & Halstead, 2004; Steinert et al., 2007; Wynn, 2004). Bonner et al.'s (2002) study, which examined people's experiences following a restraint incident, reported how physical restraint re-traumatised three (50%) of the participants. Indeed, for one of the participants, this had involved a previous experience of rape, whilst another described how physical restraint rekindled memories of childhood abuse. Similarly, in Wynn's (2004) study, focused on patients' experiences of physical restraint, two of three female participants and one male, 25% of the patients interviewed, reported how physical restraint had brought back previous trauma. The male participant had spent time in a hospital in his childhood and difficult feelings resurfaced when he was restrained. Whilst the two female patients reported how physical restraint brought back memories of sexual abuse. Interestingly, staff perspectives regarding re-traumatisation for patients being physically restrained raised concerns around its use (Sequeira &

Halstead, 2004). Although in the same study, other staff described how they were hardened to the experience of restraint, with a substantial number suggesting that they had no emotional reactions.

Brophy et al.'s (2016) study, focused on the lived experiences of people who had been restrained, reported how the trauma of being physically restrained was ‘anti-recovery’. Many participants raised concerns not only about re-traumatisation, but how restraint itself caused future trauma. One carer described this as follows: *“I can say that my son is so traumatised by these events, that he lives in fear of being picked up at any stage. He’s marked”.* (Carer in Brophy et al., 2016, p.4).

In a corollary of this, reported in the study by Knowles at al. (2015), one patient was extremely distracted within the research interview itself by thoughts of previous restraint and reported being often preoccupied with vivid thoughts and dreams about restraint.

Furthermore, there was also a link found between exposure to physical restraint and the prospect of patients being restrained in the future, as Steinert et al. (2007) found a lifetime experience of seclusion and physical restraint brought a seven-fold probability of the use of seclusion and restraint for participants.

Feeling ignored

There was a sense of patients feeling that professionals ignored their wishes and feelings. In Bonner et al.’s (2002) work, involving a small sample of six patients, three interviewees expressed how they felt distressed. Yet professionals appear to have ignored this before the physical restraint episode. The same patients also felt ashamed and isolated after the incident. This was deemed an important issue by participants within this study, as while disturbing feelings were escalating, staff intervention may have de-escalated the situation. One of the three participants was provided with additional staff time, but despite this, she attempted a serious act of self-harm. Yet for another patient, repeated unheeded warnings to staff about pending aggression had left the patient feeling ignored.

In the study by Haw et al. (2011), focused on forensic inpatients' experiences and preferences for physical restraint, seclusion and sedation, when asked about creating an advance statement about physical restraint, some participants highlighted how physical restraint was unacceptable to them. In these situations, an advance statement would allow a written recording to be made about how to manage their behaviour if they became agitated. However, 11% of participants stated they had made such an advance statement yet none of the case notes or care plans evidenced these statements. Seventy-nine inpatients were interviewed in Haw et al.'s (2011) study. Forty-three participants felt physical restraint should not be used at all, with 38 reported that talking to them might calm situations, avoiding restraint. Thirty-nine participants felt being restrained, whilst sitting up, would help them to breathe. It is best practice for patients to be fully involved in their care as far as possible (Haw et al., 2011). Whilst a large proportion of inpatients indicated specific preferences as to how and whether physical restraint is undertaken, no statements were found, suggesting a need for improvements in communication and recording.

Dehumanisation

One theme raised in several of the studies concerned perceived in-humane conditions in which people were restrained. One person in Bonner et al.'s (2002) study described being left in urine-soaked clothing for 3 hours following restraint; furthermore, she was too ashamed to tell anyone. In Brophy et al.'s (2016) study participants clearly linked poor practice in the act of physical restraint to feelings of de-humanisation; one participant declaring:

> *"You literally get dehumanised and it's sort of that once you have become almost, well not completely, but treated in a sub-human way. You can do things that you would not normally do"* (Brophy et al., 2016, p.5).

Participants in Brophy's (2016) study suggested staff showed a lack of empathy to consumers, who viewed them as uncaring. Participants in Wilson et al.'s (2017) study echoed feelings of 'otherness' reporting finding physical restraint to be dehumanising, such that they were not treated as *"decent human beings"* (Wilson et al., 2017, p.504).

Participants in Brophy et al. (2016) thought staff used excessive force when carrying out physical restraint. One participant in this study considered that training emphasised restraining people, as opposed to de-escalation techniques. Similarly, Lee et al. (2003) sought the views of psychiatric nurses in their experience of using restraint. In this study, there was a worrying concern regarding some staffs' attitude to restraint; with some colleagues possessing a "*Deck them first"* or "*bouncer"* mentality (p.427).

Restraint was also seen as a 'legal' way to hurt people. In Lee et al.'s (2003) study, concerns were raised about joint locks and flexion being used to induce pain and achieve compliance, and restraint being undertaken for overly long periods. One participant reported restraint lasting six hours. In Haw et al.'s (2011) and Brophy et al.'s (2016) studies similar concerns over pain and excessive force were found. For Haw et al. (2011), physical pain was the commonest sensation reported, with one participant declaring: *“They hold you down hard and dig their nails to put your face on the ground”* (Haw et al., 2011, p.576), and another reporting: “*I had my thumbs bent back, so I could not move it for days”*, (Haw et al., 2011, p.576).

Haw et al. (2011) also identified patients’ concerns about breathing difficulties experienced during physical restraint and a sense that staff were punishing them and exerting power. One participant felt abused, commenting how the staff had referred to their ‘low’ intellect.

Knowles et al. (2015) also reported excessive force being used during restraint, making participants feel abused, worthless, helpless and demeaned. Feeling abused and helpless under restraint can also be linked with imbalances of power, which is another theme within this review.

This theme of dehumanisation during physical restraint is worrying and suggests that individuals’ Human Rights not to be subject to torture and inhuman or degrading treatment (Council of Europe, 1950) have been contravened in the practice of physical restraint as reported in these studies.

Distress

Given the previous theme, it is unsurprising that distress caused by physical restraint formed a substantial theme amongst the papers reviewed. In Bonner et al.’s (2002) study this was a particular concern for two female patients when restrained by male staff members. Patients’ emotions were exacerbated by paranoid ideas about nursing staff, with links to the theme of fear. One patient felt staff were going to kill them. Nurses also reported personal distress in this study, describing being uncomfortable about undertaking restraint. This distress continued in the aftermath of restraint for both patients and staff, with fear of further incidents for both groups. This is an example of the interplay between themes in this integrative review, highlighted in this instance by relationships between themes of distress and fear.

In Haw et al.’s (2011) study, 15 of 57 patients stated that restraint provoked unpleasant thoughts, typically feelings of humiliation and loss of dignity. Again, distress resonates here with the theme of dehumanisation. In Wynn’s (2004) study, patients felt restraint violated their integrity making them feel anxious, angry, hostile and distrustful of staff, exemplifying how physical restraint damages staff-patient relationships. Individuals felt restraint had been unnecessary, feeling unfairly treated with one patient reporting restraint was an ‘abusive act’. Most patients in Wynn’s (2004) study felt restraint had been a wholly negative act, yet others reported it was necessary to manage their distress; though nobody reported it as positive.

In Wilson et al.’s study (2017), restraint was predominantly distressing for both staff and patients, particularly so when witnessed for the first time, with one patient participant being “*horrified*” (Wilson et al., 2017, p.503), about the amount of physical restraint witnessed on the ward. However, two staff members reported no emotional impact for themselves, viewing restraint as a necessary part of the job. Staff agreed restraint was necessary and used as a last resort, suggesting they did not envisage a restraint-free environment.

Sequeira and Halstead (2002) found most patients reported some negative psychological impact, with a sense of fear and panic, about impending possibilities that restraint could occur, this was expressed by one patient as: *“something horrible was going to happen”* (Sequeira & Halstead, 2002, p.13). Patients reported how nurses talking during restraint was particularly upsetting for them: *“they talk and joke amongst themselves…You get angry, I get angry then”* (Sequeira & Halstead, 2002, p.13). However, nurses said they used laughter to reduce stress during incidents, suggesting a breakdown in communication between staff and patients here (Sequeira & Halstead, 2004). In the main, patients reported anger, anxiety and mental upset as a consequence of restraint. Unresolved anger related to restraint possibly contributed to patients holding grudges (Sequeira & Halstead, 2002). In the companion study (Sequeira & Halstead, 2004), some nurses were upset when de-escalation had not worked, whilst others reported no emotional response or described working on automatic pilot during restraint. Gender and status appeared to influence staff responses, with several female qualified staff expressing significant distress about restraining patients. Whilst unqualified male staff were more commonly detached or indifferent to patients being restrained, some staff also reported anger towards patients perceived as intentionally or frequently precipitating physical restraint (Sequeira & Halstead, 2004).

Fear

Aligned to distress there is the notion of fear. In Bonner et al.’s (2002) study, staff’s fear of patients was deemed by patients to be an indicator for future restraint. Similarly, in Brophy et al.’s (2016) study participants reported that mutual fear contributed to restraint use. A carer expressed this fear as the difference felt from staff towards patients: *“Staff are frightened…. there’s a culture of fear in Australia like fear of difference, I think it adds to it*” (Brophy et al., 2016, p.8).

Similarly, fear was a feature of Wynn’s (2004) findings with patients reporting being afraid of future restraint because of previous experiences of restraint. One woman discussed how restraint had made her feel more scared and aggressive, whilst several other patients felt under the threat of restraint from staff unless they calmed down. Again, this reverberates with the theme of power in this review. Similarly, Sequeira and Halstead (2002) identified patients' fear of future restraint was partly due to their prior experiences of restraint, perpetuating a climate of fear and panic regarding restraint: *"Sometimes me keep dreaming things, having nightmares. Don't know why. I do worry about it"* (p.13). Thus, anxieties about restraint extended well beyond particular incidents.

Fear, both during and following restraint, was also found in Wilson et al.'s (2017) study, with a culture of fear present throughout the patient journey. One person related this to an incident when she felt excessive force was used by four staff members; as she had been dragged to the floor, on her knees and taken to her bedroom. Whilst staff members acknowledged patients' fears, a large proportion also cited their own fear when witnessing or carrying out restraint, particularly the first time, suggesting restraint is a negative experience for both staff and patients.

Fear is thus a common denominator before, during and after physical restraint episodes, and for some people, fearfulness continues for a significant time after the event.

Control

Brophy et al. (2016) note how restraint was seen as a way to control consumers with excessive force. Excessive force was reportedly used to prevent escalation of challenging behaviour and to manage risk, involving multiple staff, both clinical and non-clinical. Furthermore, restraint was reported as a first, rather than last resort in responding to agitated patients. Poor practice of de-escalation was attributed to problematic organisational cultures and attitudes of mental health staff.

Several patients in the Wynn (2004) study identified approaches which would have calmed situations and improved their sense of security in an unthreatening way. Patients in this study felt compelled to defend themselves to re-exert control. One person commented: *“I think things would have turned out better…if they had left me alone in my room”* (Wynn, 2004, p.131). Others appreciated a need to control their agitation, acknowledging risks to themselves.

Sequeira and Halstead (2002) found patients’ experience of loss of control during restraint made them feel degraded. Nonetheless, a subset of female patients felt their agitation, before restraint, made them feel out of control, wanting another person to take control: *“You feel safe and you know your responsibility to behave is taken away from you. So, you’ve got a lot of weight off your shoulders. So, you’ve not got any responsibility for your behaviour”* (Sequeira & Halstead 2002, p.14). This shows some interplay between aspects of control and the calming effect physical restraint can have for some patients.

Whilst some women spoke of expectations staff would restrain them when they were agitated, reporting purposively using this behaviour to trigger restraint (Sequeira & Halstead, 2002), some staff have expressed anger at patients who were thought to deliberately bring about restraint (Sequeira & Halstead, 2004). Nursing staff also reported boredom, frustration and low morale in relation to restraining patients. These feelings were stronger when intervening with patients felt to intentionally provoke restraint to control their behaviour (Sequeira & Halstead, 2004).

Power

Wynn (2004) locates notions of control related to restraint as an abuse of staff's power over patients. Perceived misuses of power are associated with judgements of excessive force (Brophy et al., 2016; Haw et al., 2011; Knowles et al., 2015), restraint as first resort, and exercise of control (Knowles et al., 2015; Lee at al., 2003). Patients collectively reported being afraid of restraint occurring again if they did not follow staff directions, so fear was also present. In the extreme, potential abuse of power in the use of physical restraint were associated with the aforementioned *'bouncer mentality'* attributed to some staff (Lee et al., 2003, p.427).

Haw et al. (2011) similarly found patients experienced restraint as punishment, related to exertion of staff power and undue force: *"They don't just restrain you, they put loads of force on you"* (Haw et al., 2011, p.577). Some participants felt this was a training issue: *"On this ward, a lot of people get restrained aggressively without proper techniques"* (Haw et al., 2011, p.577).

Knowles et al. (2015) suggested power imbalances between staff and patients might add to an abusive dynamic: several patients depicting staff as powerful perpetrators and themselves as victims. Patients characterised restraint as barbaric, medieval and torturous. In the same study, two patients recalled being interviewed in seclusion by staff following physical restraint, who asked them to admit fault for the restraint occurring. One participant admitted culpability for fear they would not be released from seclusion unless they did so.

Sequeira and Halstead (2004) found that, though staff did not disclose hurting patients deliberately, some disclosed thinking about hurting patients intentionally and were upset at these thoughts:

> “*Sometimes I think what I could do is twitch his arm a bit more. You don’t do it but even the thought of it makes me feel guilty. It’s all the adrenaline and it’s not going anywhere. It’s all about power”* (Sequeira & Halstead, 2004, p.7).

These researchers also identified staff concerns about how their colleagues could inadvertently or, perhaps, intentionally hurt people: *“Any member of staff could lose control. That frightens me a bit”* (Sequeira & Halstead, 2004, p.7). In complementary interviews with patients (Sequeira & Halstead, 2002) restraint was perceived as a punishment that might incite further violence and aggression. There might also be bravado amongst some nurses asserting control of situations: “*I’ve gone in and stopped another patient on my own…I think it’s protection, everybody’s got this natural instinct to go and protect somebody who’s totally innocent, so it doesn’t scare me” (*Sequeira & Halstead, 2004, p.6).

Brophy et al. (2016) reported restraint related disempowerment of consumers, who would be disbelieved if reporting abusive practice. Use of excessive force to prevent further escalation of incidents and combat risk was deemed poor practice. One participant questioned staff training for emphasising exercise of power by staff over patients. Carers in this study felt powerless when staff did not listen, despite their valuable knowledge of consumers (Brophy at al., 2016).

In Wilson et al.’s (2017) study patients conceived restraint as a demonstration of staff power, leaving them with a wholly negative experience following restraint. Similarly, comparisons were made with being in prison or the army, with some staff considered like “*prison wardens”* (Wilson et al, 2017, p.505). One staff member acknowledged the patient-staff power dynamic, recognising restraint as a “*symbol of strength and power”* that staff hold over patients, (Wilson et al., 2017, p.504).

Calm

A surprising theme emerging from this review concerned positive and calming aspects of being physically restrained, highlighted in three of the studies. Wynn (2004) found that, although patients reported anxiety, fear and anger at being restrained, some also reported how physical restraint had a soothing effect. This could result from the continued presence of staff during physical restraint: *“Being in restraint calmed me down”* (Wynn, 2004, p.132).

Sequeira and Halstead (2002) found some female patients instigated restraint to release or contain upsetting feelings, achieving a sense of safety and security, but only when restrained by female staff. In contrast, these same patients reported feeling angry and emotionally upset at being physically restrained. There are connections here with the theme of control, and women bringing about restraint to control their feelings. Anger was evoked in some staff who saw this behaviour as manipulative (Sequeira & Halstead, 2004).

Haw et al. (2011) suggested that, whilst seclusion was deemed to have a more calming influence for some patients than physical restraint; the latter was reported to potentially calm situations and promote self-awareness: *“It helps de-escalate the situation and helps me to reflect on my behaviour”* (Haw et al, 2011, p.572). Nevertheless, the overall negative aspects of physical restraint far outweighed positive impacts.

Discussion

Overall, the identified themes in this review suggest that physical restraint can and does lead to physical and/or psychological harm for service users/patients in mental health settings. This manifests in several ways, including patients being traumatised because of the restraint itself or revisiting past trauma (Bonner et al., 2002; Brophy et al., 2016; Knowles et al., 2015; Sequeira & Halstead, 2004; Steinert et al., 2007; Wynn, 2004). Fear plays a role, on the part of the staff and for patients/consumers before, during and following restraint (Bonner et al., 2002; Brophy et al., 2016; Sequeira & Halstead, 2002; Wilson et al., 2017; Wynn, 2004). Harms can ensue from excessive control exerted by ward staff and deemed problematic by patients, resulting in physical and emotional pain or injury (Brophy et al., 2016; Knowles et al., 2015; Sequeira & Halstead, 2002; Wynn, 2004). Dehumanisation can be a powerful feature of care, with experiences of restraint carried out in-humanely (Bonner et al., 2002; Brophy et al., 2016; Haw et al., 2011; Lee et al., 2003; Wilson et al., 2017). A misuse or potential abuse of power on the part of staff has been noted (Brophy et al., 2016; Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002, 2004; Wilson et al., 2017; Wynn, 2004). Patients feeling ignored when in need of support from staff (Bonner et al., 2002) has negative psychological impacts; with patients feeling ‘subhuman’ or ‘othered’ because of their experiences of physical restraint (Brophy et al., 2016; Wilson et al., 2017). Disregarding individual’s preferences, including specifically for behaviour management, extends to advance statements, despite legislative provisions and recognition that it is best practice for patients to be fully involved in their own care (Haw et al., 2011).

Distressing experiences of restraint as felt by both patients and staff can combine to have a negative impact on patients' well-being (Bonner et al., 2002; Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002, 2004; Wilson et al., 2017; Wynn, 2004). In the extreme some patients felt their life was threatened during restraint (Bonner et al., 2002). Conversely, for a minority of patients, physical restraint was viewed positively, potentiating a sense of calm or allowing others to take control (Wynn, 2004; Sequeira & Halstead, 2004; Haw et al., 2011).

Other studies, in different settings and with different service user groups, report similar findings. Studies of restraint in learning disability facilities (Fish & Culshaw, 2005; Jones & Kroese, 2006) have shown how restraint techniques have the potential to cause harm (Parkes, 2002; Parkes et al., 2011; Stubbs & Hollins, 2011). Service users also report concerns about the deployment of restraint including staff sitting on them; bending thumbs back and verbal abuse (Fish & Culshaw, 2005; Jones & Kroese, 2006).

Individuals who experience seclusion and restraint most frequently have been reported as being 75 times more likely to be subjected to physical abuse (Beck et al., 2008), suggestive of a cycle of abuse. Restraint use has been reported as a first-line response by staff, when their safety or the safety of others has been threatened (Duxbury, 2002; Foster, Bowers & Nijman, 2007; Perkins, Prosser, Riley, & Whittington, 2012), yet there appears to be an over-estimation of risk based on a patient's behaviour (Foster et al., 2007). Furthermore, fear of incidents escalating to violence can result in over-estimation of threat, preventing staff from adopting alternative ways of providing a relationship that is more therapeutic (Duxbury, 2002; Foster et al., 2007; Perkins et al., 2012);

amidst a belief that restraint is a ‘necessary evil’ for controlling behaviour (Perkins at al., 2012).

Countries vary in their use of different forms of restraint, with containment methods used in some countries and not in others (Bowers et al., 2007); reflecting variance in policy across jurisdictions (Royal College of Nursing, 2008). Having discussed the policy and legislative framework in the United Kingdom in Chapter Two, it is pertinent to consider the same for the other countries in this review.

Brophy et al. (2016) considered the Australian legislative and policy context. Physical restraint is regulated in the states where the study took place and the capital territory in Australia, but not in the Northern Territory. In 2008, a recovery-orientated approach was set out in national mental health policy in Australia (Australian Health Ministers, 2008) and there is now a national framework for recovery-orientated mental health services (Australian Health Ministers, 2013).

In Germany, coercive interventions in mental health services are regulated through the federal law of guardianship. Additional public laws (similar to mental health legislation in other countries), variously regulate coercive measures in the 16 German federal states (Flammer & Steinert, 2015). In Norway, the Mental Health Care Act 1999 governs coercion, including physical restraint and the holding of patients was subject to registration in regulations from 2007 (Wynn, 2015).

A key strength of this integrative review is its robust methodology. Additionally, similarities with previous reviews have been found. However, new insight has been gained with synthesising the findings from primary studies and providing new information, adding to the body of knowledge in this area and a consensus discussion took place to agree which published papers would be included in this review. A further strength is its purpose in looking at non-experimental and experimental studies to provide depth and breadth of knowledge. This could also be viewed as a limitation in its use of diverse methodologies to synthesise knowledge and generate conclusions. A limitation of this review was the small number of papers meeting the inclusion criteria. Generalisation may be limited, in that restraint is practiced differently across the globe and some countries may favour different forms of restraint to manage behaviour, including mechanical restraint (Bowers, 2007), making comparisons difficult.

An integrative review to examine patient perceptions of physical restraint in different and from different age groups was undertaken by Strout (2010). Key findings cross over with current study: re-traumatisation, dehumanisation, distress, fear and abuse of power. While this current study supports the findings from Strout's integrative review, three different themes emerged: restraint brought about by patients to calm their feelings of agitation; control as a feature of physical restraint, including both the loss of control for patients and staffs' excessive control regarding physical restraint use; and patients feeling their wishes or preferences were ignored during restraint. This current review included a more focused approach concerning adults only, who have been in mental health settings and subjected to physical restraint. Additionally, this current study included a framework (table 1) to structure the search.

Chapter conclusion

New insights have been achieved through synthesising findings from primary studies and providing new information, which adds to an existent, but small, body of evidence regarding the physical and psychological implications of restraint. Evidence related to service user, carer and staff voices was included in the review, justified on the basis that certain key papers present multi-stakeholder views and that these voices merit being heard on the subject of harms caused by restraint. The reviewed literature evidences some common ground across different stakeholder perspectives and care has been taken to distinguish perspectives from different constituencies throughout. Re-traumatisation, dehumanisation, distress, fear, abuse of power, control, the calming aspect felt by some individuals and feelings of being ignored, were all important identified themes. Those working within mental health settings could readily address all these themes. There appears to be a gap in knowledge encompassing the narratives of service users who have experience of being physically restrained. This group of service users has unique and invaluable insight, and the future exploration of personal stories regarding the physical and psychological implications of physical restraint in mental health settings would help gain a more in-depth understanding of this phenomenon and thus enable the quality of inpatient mental health care to be improved.

Implications for practice and research from review

The majority of staff within mental health services are nurses; therefore, their ability to involve service users as active partners in their care may decrease the number of restraint-related incidents. In view of this, education and training will have a central role in efforts to reduce restrictive interventions, including initiatives, such as ‘Safewards’ (Bowers, 2014) and the REsTRAIN YOURSELF Programme (Duxbury et al., 2019), the latter adapted from the US six core strategies approach (Huckshorn, 2005). Such initiatives are central to promoting positive therapeutic alliances between service users and staff, as well as managing challenging behaviour.

Recognising service users as active partners in their care should be the basis of good practice. Involving service users in their individual care planning has the potential to ensure they are empowered, encouraging service users to be more in control of their lives, and acknowledges their unique perspective regarding their own experiences. Similarly, further studies are needed to explore the perceptions of service users who have experienced physical restraint within mental health settings in an attempt to improve services and better meet the needs of those experiencing mental distress. Listening to, and learning from, the perspective of individuals who have experienced physical restraint, will allow for more inclusive approaches in future planning and delivering of care within mental health settings.

CHAPTER FOUR.

METHODOLOGY AND METHODS

In the previous chapter, I identified findings from the integrative review, with a number of studies reporting on the physical and psychological harm experienced by service users as a result of physical restraint. There was limited exploration from the perspective of mental health service users who have been subject to physical restraint and the unique perspective of service users' narratives is missing. Researchers propose that the contribution of service users' experience and perspective can lead to a reduction in coercive practices (Kontio et al., 2012; Steinert, 2016). Only a small number of studies have explored service users' views in situations before, during and after coercive measures have been used.

This chapter outlines the methodology of my study, which in part, sought to address the stories service users tell regarding physical restraint. Firstly, the research aim and questions are reiterated, then a theoretical and philosophical framework is set out, including my affinity for social constructionism in allowing me to explore the concept of physical restraint from the perspective of those who experience it. The chapter then explores differing research approaches before justifying my choice of narrative inquiry. Discussion then focuses on steps taken to collect and analyse data, along with considerations of ethics and trustworthiness.

Research aim and questions

Aim:

- To explore the stories of service users subjected to physical restraint within mental health inpatient settings

Specific research questions examined:

- What stories do service users tell about their experiences of physical restraint whilst they were mental health inpatients?
- What impact do these experiences have?
- Do findings from this study concur with or contradict other research which has examined the impact of physical restraint on mental health service users?

Framework of the research

Having decided on salient research questions, the theoretical approach to the study needed consideration. Research is understood within a specific paradigm, informing theoretical perspectives, which then shape the methodology; referred to as a ‘plan of action or strategy' (Crotty, 1998). Paradigms influence research at a fundamental level (Cresswell, 2013), as researchers’ philosophical assumptions are integral to the research process. Guba and Lincoln (1994) propose paradigms can be characterised through:

- Ontology, which considers what reality is.
- Epistemology, the basic beliefs of our knowledge.
- Methodology, how the researcher goes about finding out what they believe can be known.

Additionally, researchers bring their own values to research. This is referred to as the axiological assumption (Guba & Lincoln, 1988). A person's ontological position, relating to what is out there as reality, informs the epistemological position, concerning what and how we can know about it, which informs the methodology.

My research scaffolding has been constructed with an ontological position assuming the subject matter is complex, and contingencies are unavoidable (Guba and Lincoln, 1994). Crotty (1998, p.42) argues: "*all knowledge and therefore meaningful reality as such is contingent upon human practices, being constructed in and out of interaction between human beings and their world and developed and transmitted within an epistemological social context".* This aligned with my own view, supporting exploration of the lived experiences and worldview of the participants in my study.

Interpretive framework

I rejected positivism for this study. A positivist paradigm is closely associated with scientific methods of positivity and reliability. Crotty (1998, p.5) states how positivism is the epistemological view "*that things exist as meaningful entities, independently of consciousness and experience, that they have truth and meaning residing in them as objects"*. This approach has somewhat dominated health sciences, proposing scientific truth exists, and this emerges from what can be observed and measured, with methods free from or with minimal bias (Topping, 2012). An objectivist view considers knowledge exists in objects that are independent of consciousness. This view did not align with the aim of my study, which sought to explore individual subjectivities regarding experiencing physical restraint. In this respect, construction of meaning emanated from the worldview of participants affected by the phenomena under study.

My own epistemological position aligns with the constructionist approach, based on the belief that knowledge of reality is constructed from the interaction between individuals.

Similarly, Guba and Lincoln (1989, p.83) propose:

- *“The researcher–respondent relationship is subjective, interactive and interdependent*
- *Reality is multiple, complex and not easily quantifiable.*
- *The values of the researcher, respondents, research site and underlying theory cannot help but undergird all aspects of the research.*
- *The research product (e.g. interpretations) is context specific*”.

For this research, I wished to explore experiences of mental health service users regarding physical restraint and any subsequent impact this had upon them. I was mindful this research should be rooted in the views of participants themselves and co-constructed with myself as a researcher. I was drawn to the constructionist approach as it centres on reality from the participant's perspective, lending itself to qualitative methods (Crotty, 1998).

There are several interpretative frameworks and philosophical beliefs within a broad constructionism, however, I found social constructionism appealing. Gergen (2015) argues that reality is socially constructed by and between those who experience it. Reality can be different for individuals and is based on our unique understanding of the world, influenced by our experiences within it (Berger & Luckman, 1966). In this respect, reality is influenced by cultural, historical, political and social norms at the time and within the context of the experience. Social constructionism allows for the different meanings of reality to be acknowledged, yet at the same time allows similarities uniting individuals to be recognised (Ashworth, 2003).

I felt that a social constructionist worldview was most relevant to this research and aim to explore service users’ subjective accounts. In this respect an interpretation of the experiences of these individuals aligned itself to this approach. Having undertaken an integrative review, I was drawn to exploring subjective experiences of mental health service users in the act of physical restraint, the stories people tell about this phenomenon and the impact of restraint on service users.

I will now more closely consider Guba and Lincoln's (1994) philosophical assumptions in relation to ontological, epistemological and axiological beliefs, and link these with social constructionism. In terms of the ontological question and nature of reality, qualitative researchers embrace the concept of multiple realities, often represented in the different perspectives of individuals (Cresswell, 2013). My study aimed to explore the reality as experienced by each participant and report the different perspectives. As Cresswell (2013) highlights, within social constructionism, our multiple realities are constructed via our interaction with others. Although influenced by other people, human beings are active agents in the construction of reality from their perspective (Holloway & Freshwater, 2008). Social constructionism endeavours to express common forms of understanding, as they are in the present, may have been in the past and how they may potentially develop in the future (Gergen & Gergen, 2003). People's experiences can be ascertained from the stories they tell; indeed, central to constructionist research is the reconstruction of people's stories in giving meaning to their experiences (Gergen & Gergen, 2003), aligning with my own research aim.

In respect of epistemology, qualitative researchers wish to get as close to the objects of inquiry as possible, with knowledge derived through the subjective experiences of people (Cresswell, 2013). As Ross (2012) argues, participants reflect reality from their own perspective and these often emotionally laden accounts reflect our human makeup. Furthermore, Guba and Lincoln (1988, p.94) assert, researchers should minimise '*distance*' or *'objective separateness'* between themselves and the participants. Social constructionism is grounded in an epistemological sense that reality is co-constructed between researchers and participants, shaped by individual experiences. This concept interested me. I value service user experiences acknowledging the unique perspective service users bring from their experiences, whilst being drawn to co-constructed realities.

Qualitative researchers make their values known, this being the axiological assumption characterising qualitative research (Cresswell, 2013). In qualitative studies, the researcher reflexively acknowledges values and biases (Cresswell, 2013). The researcher acknowledges their qualitative findings represent interpretations of the story (Denzin, 1989). The researcher's individual experiences and background shape interpretation (Cresswell, 2013). The researcher's role, therefore, is to interpret the meaning of others (Cresswell, 2013).

Reflexivity became an important consideration in my study. Generally, in qualitative research, the researcher makes their 'position' explicit (Hammersley & Atkinson, 1995). Cresswell (2015) urges the researcher makes clear their experiences of the phenomena and how these have shaped interpretation. As a social worker and safeguarding manager, I held views on the experiences of individuals who, in my opinion, had been abused because of inappropriate restraint practices. Equally, as discussed in Chapter One, I was conscious that my standpoint was shaped by experiences of witnessing what, at times, I considered to be poor quality care regarding physical restraint. In order to consider the influence of my experiences, for example relating to findings and conclusions, I reflected constantly on my position, values and experience throughout the study. For example, keeping a diary and discussions during academic supervision. Excerpts from my diary appear throughout this thesis and an excerpt is included in Appendix Two. Gergen (2015) highlights how values, correctly, motivate our research.

Research design

Having decided that an interpretive (qualitative) approach, from a social constructionist worldview, was the most appropriate for my study, I needed to choose a specific design. The strength of an interpretive methodology is the richness and depth that may be gained. Furthermore, within an interpretive methodology, value is given to the participants' views, which seeks to understand the world in which they live (Parahoo, 2006). My choice of an interpretive approach was to allow the findings to be led by the participants (Crotty, 1998). Nonetheless, I acknowledge that as a researcher I will inevitably collect, analyse, interpret and present findings, thus my influence cannot be avoided. I consider that declaring my reflexive position allowed transparency to exist in terms of my potential influence on the findings.

Co-constructing stories with the individuals involved in this study, acknowledged them as active participants, rather than passive ‘subjects' under study (Frank, 2010a; Trivedi & Wykes, 2002). From this point of view, my background and experiences enabled me to value the other person's lived experiences, (Veseth, Binder, Borg, & Davidson, 2017). The involvement of mental health service users in research has become popular and is seen to add value (Kara, 2013). However, as seen in the integrative review, research exploring the service user perspective of physical restraint is limited (Wilson et al., 2015).

In deciding which specific qualitative research design to follow, I considered different approaches and deliberated on which design was most appropriately aligned with my research questions and the characteristics of my participants. In doing so, I reflected on the sensitivity of the topic under study, as individuals may have felt unease in talking about restraint. Additionally, I considered that, as service users, their experiences were important and could provide rich data, aligned with the research question. I explored five main approaches before selecting my chosen approach. The alternatives will now be outlined, with my chosen approach described in greater detail towards the end of this section.

Phenomenology

I initially considered a phenomenological approach. Phenomenology is concerned with participants’ lived experiences of a phenomenon (Cresswell, 2013). Two questions form the foundation of phenomenological explorations: ‘What have you experienced in terms of this phenomenon? And ‘What contexts or situations have typically influenced or affected your experiences of the phenomenon?’ (Moustakas, 1994). Moustakas (1994) proposes that these questions assist in gaining a common understanding across the participants.

Phenomenology is ultimately concerned with the meaning of human experiences (Ross, 2012). There are different types of phenomenological research, the main two in health sciences being descriptive and interpretive, or hermeneutic phenomenology (Todress & Holloway, 2012). Descriptive phenomenology is attributed to Edmund Husserl, whilst hermeneutic phenomenology is credited to Martin Heidegger (Ross, 2012). Hermeneutic researchers are cautious about finding commonalities as they wish to emphasise diversity and difference, with the researcher mediating between the different meanings of the lived experiences of individuals (van Manen, 1990). Hermeneutic researchers do not propose that researchers can suspend their preconceptions in the area of study, suggesting researchers should explicitly declare these and use them positively (Todress & Holloway, 2012), facilitating understanding of the strengths and limitations of researcher knowledge and presumptions (Todress & Holloway, 2012). Conversely, descriptive phenomenology considers it essential that researchers should suspend their beliefs and personal biases (Natanson, 1973), a process known as epoché or bracketing.

Typically, between 5 and 25 participants are included in a phenomenological study (Polkinghorne, 1989), a number feasible for my research. Whilst, the research question concerned with experience sat well with this approach, I was also interested in a chain of experiences, the connection of events and the different characters that are important in making sense of events. My final decision to choose narrative inquiry over phenomenology was a positive choice in favour of the narrative approach, considering what I wanted to achieve from the research, rather than necessarily a negative appraisal of phenomenology. In making this decision I drew upon the work of Lindsay (2006), who directly compared the two approaches. Lindsay (2006) suggests that phenomenology aims to gain understanding through description and shared experiences, with interpretation involving themes and patterns; whilst within a narrative approach, co-participants explore experiences for meaning-making, knowledge construction and living a life in more awareness. I found the latter appealed to me more for this study and the merits of the narrative approach are discussed in greater detail later in this chapter. A wider reading of the earlier work of Frank (1982, p.67), suggests that his conception of narrative inquiry was at least in part informed by Foucault’s adamant rejection of phenomenology as a philosophical perspective that too readily privileges the individual subject as the sole author of her own stories; in denial of the important and powerful influence of wider discourse:

> *We must not fear to comprehend the subject as having far less sovereignty than he would choose to believe he has: the objective of social science is to depict humanity, not to flatter humans* (Frank, 1982, p.67).

Grounded Theory

First developed by Glaser and Strauss (1967), grounded theory is undertaken when little is known about a phenomenon (Holloway & Todress, 2012a). Grounded theory has its theoretical roots in symbolic interactionism, with emphasis on the process of interaction between individuals and the way in which they construct their social reality based on meanings and comprehend social roles, as influenced by significant others (Holloway & Todress, 2012a). Charmaz (2006) has proposed a more flexible and open analytic approach to grounded theory, rather than a rule-led rigid approach.

The purpose of grounded theory is to generate theory from the data and observations made (Aveyard & Sharp, 2013). It has a disciplined and organised approach to data collection and analysis (Punch, 1998). Data collection can involve interviews, observation and documentation (Holloway & Todress, 2012a). The researcher is guided by preliminary research questions and goes on to collect some initial data, at which point analysis begins (Punch, 1998). Guided by emerging themes from the initial data collection, further data is collected, in a process known as theoretical sampling (Glaser & Strauss, 1967). In this approach data collection and analysis are undertaken simultaneously, field notes or memos are written throughout, and inform analysis (Holloway & Todress, 2012a). Constant comparison of data continues until no new concepts can be found that are fundamental for the development of emerging theory (Strauss & Corbin, 1998; Dawson, 2009).

From my literature review, Wynn (2004) and Sequeira and Halstead (2002) both used a grounded theory approach to explore service users' experiences of restraint. Cognisant of its use in the aforementioned studies, I discounted this approach as my aims were not to generate further theory. Furthermore, grounded theory suggests that a full search of the literature would be inappropriate, with researchers commencing inquiry with few assumptions (Holloway & Todress, 2012a). I began my study with some prior relevant knowledge, further enhanced by extensive reading, and could not realistically claim no assumptions concerning subject area. It is also suggested that sample sizes for grounded theory typically involve 20 or more participants (Cresswell, 2013). I had reservations that recruitment of service users would meet this number, relying on participants coming forward voluntarily, given the sensitive topic and needing to negotiate access to service users. Therefore, with fewer numbers involved, data saturation may not be achieved.

Ethnography

Whereas grounded theory explores meanings of reality from participants with similar characteristics relevant to the study, shared cultural context is not necessary; for example, being located in the same place. Ethnography, on the other hand, is the interpretive study of individuals in their culture or subculture (Fetterman 1998). A full-scale ethnographic study would involve fieldwork and data collection over a long-time period (Punch, 1998). Therefore, elements of the ethnographic approach are used in many studies, rather than producing a full scale solely ethnographic study (Wolcott, 1988)

According to Roper and Shapira (2000), data collection can be from observation, study of documents or by asking for information from the group. Whilst participants I wished to study may be deemed to belong to a specific service user group, those having experienced physical restraint within a range of settings, a lack of consensus on uniformity of culture might not justify an ethnographic study. Classically, ethnographers need prolonged engagement and immersion in the setting (Holloway & Todress, 2012b) not necessarily lending itself to my research questions or pragmatics of time. Perhaps, given I am not a psychiatric nurse, nor a full-time member of a mental health inpatient care team, I would face challenges joining a clinical team and justifying this approach. Even for researchers studying other groups in clinical settings, time is a restriction, meaning that ethnographic studies are often underdeveloped (Holloway & Todress, 2012b). Although I feel cultural influences are relevant in research, this has not been the focus for my study.

Case Study

Case study design traditionally looks at bounded systems, such as a process, activity or multiple individuals (Creswell, 2013), exploring a case or cases within real-life settings (Yin, 2009). Whilst, it is presented as a methodology or research strategy (Denzin & Lincoln, 1994; Merriam, 1998; Yin, 2009), Stake (2005) argues it is a choice of what is to be studied, bounded by time and place. Case studies can involve different methods of data collection, such as interviews, observations or audio-visual material (Creswell, 2013). Stake (1995) refers to the exploration of a unique case, which needs a detailed description to provide insight as an ‘intrinsic case', whereas seeking to understand a specific problem or issue of a case or cases, is referred to as an ‘instrumental case' (Stake, 1995). Although data analysis may differ in case study research, detailed descriptions are emphasised (Creswell, 2013). Additionally, themes can be organised in a chronology and, for multiple cases, across the cases for comparison of similarities and differences (Creswell, 2013). Yin (2009) proposes that the researcher can replicate the procedures for each case, but as each case is different, the representativeness of cases for inclusion in the study is important (Creswell, 2013). Given the detailed description involved, the researcher in a case study typically chooses no more than five cases (Creswell, 2013).

In planning a case study, a data collection matrix is commonly proposed to allow researchers to decide the amount of information that is likely to be collected from the case or cases (Creswell, 2013). Although I found aspects of case studies interesting, from the onset of my study I was drawn to an approach allowing individuals to theorise about their lives to some extent, which lends itself to a narrative approach (Creswell, 2013). A case study is generally context-dependent and therefore, describes organisations and people in detail, which can compromise confidentiality (Clarke & Reed, 2012). As such this approach was not chosen, as I was not studying people in an organisation, nor would any potential breaches of confidentiality be ethical in this sensitive subject. A case study is best suited to an in-depth understanding of a case, whereas the narrative approach allows the stories of individual experiences to be told, providing powerful insights.

Narrative inquiry

Having considered the main qualitative approaches, and reflected on my ontological, epistemological and axiological position, I will now discuss these influences on my chosen methodology. Within a qualitative approach, the researcher follows an inductive, ground-up logic, as opposed to one that is handed down entirely from theory or the perspective of the researcher (Creswell, 2013). I found a narrative approach appealing because of the inductive nature, where the participant's story and a unique account is used as the data collection method. In a narrative approach, the otherwise *“invisible”* are encouraged to “*tell their story”* to generate understanding from the storyteller's first-hand experience (Gergen, 2015, p.73). Furthermore, I believe narrative inquiry can lead to greater service user involvement in the research process, which encourages the ‘user voice' in research that seeks to transform care (Lloyd & Carson, 2012).

There are several ways in which data can be collected in narrative inquiry, the primary source is from the verbal stories of participants and achieved via interaction with the researcher (Holloway & Freshwater, 2007). This allows participants to share their unique and individual accounts (Holloway & Freshwater, 2007).

Narrative inquiry thus sits within the interpretive paradigm (Crotty, 1998). Its use in health and social care has increased over the last 20 years (McAdams & McLean, 2013). Emerging, in part, from the belief that humans are natural storytelling animals (Gottscall, 2012), narrative inquiry gathers insight into peoples' lives and experiences, through their stories (East, Jackson, O'Brien, & Peters, 2010). In seeking an approach that recognised the ‘user voice', I found narrative inquiry afforded this opportunity for this purpose. Participants in narrative inquiry, as active agents in their experience, are enabled to assert themselves and achieve self-esteem (Holloway & Freshwater, 2007). Furthermore, on a personal level, I was drawn to this approach as I am intrigued by hearing stories. I have fond recollections as a child of sitting around a fire in the evenings and hearing the wonderful stories my parents and grandparents told in recalling their own lived experiences. The stories people tell are linked to their cultural knowledge (Holloway & Freshwater, 2007). As a narrative researcher, it is important to pay attention to the aspects of an individual's experiences that are linked to their socially constructed position in life, as influenced through an individual’s culturally constituted world (Josselson & Lieblich, 2015). Stories work with people, for people, and on people, impacting on what people can see as real (Frank, 2010a).

The potential of stories also drew me to the narrative approach. Stories have the potential to encourage people to act, invite political mobilisation and promote change (Reissman, 2008). As Clandinin and Connelly (2000) suggest, narrative approaches put humans at the centre of the research process, whilst at the same time, legitimising their subjective experiences as a way of understanding their lived world.

Having identified narrative inquiry as a suitable approach for my study, during the initial stages of research, I was left with some confusion in how to use such an approach. From the wealth of literature, I discovered, there was no single way in which stories could be considered. Indeed, different authors lay emphasis on, and analyse different features of a story.

According to Labov and Waletzky (1967, p.12) narratives are "*the oral versions of personal experience*". Labov and Waletzky (1967) demand specific and necessary elements from narratives: - an abstract, as a summary of the story; the orientation of the story, for example the time and location and participants; the complicating action, the actual events, what actually happened; the evaluation of these event by the storyteller; and the final resolution where the storyteller would signal that their storytelling was coming to a finish by providing a coda. The coda allows the storyteller to consider what the story means to them and how it relates to them in the present. This approach has been criticised by some as being too rigid and deeply structured, as well as being complex (Elliot, 2005). Thinking about this as an approach for my study, I was unconvinced that every story told would include all these aspects. Furthermore, I was not confident that such a structured process should be followed. A rigid approach meant that I, as the researcher, would control the data, rather than letting the story be co-constructed between myself and the participant.

Other narrative approaches consider the sequence of events and passage of time, referred to as temporal analysis. Clandinin and Connelly (2000) consider narrative sequentially (the temporal order of events). Data are analysed from three categories, continuity (past, present, future); interaction (personal and social); and, places (physical or storytelling places). I considered this approach, yet this too appeared structured and unappealing, therefore, I discounted this as too prescriptive. I considered how stories are told and felt that people, in the telling of their stories, may not follow a pre-determined sequence.

In contrast to these approaches, Alasuutari (1997) proposes a sociolinguist approach, where the self and identity of the individual storyteller has a function in the narration. The individual chunks their story into units that are identifiable in respect of prosodic information, (for example intonation), pauses and syntax (Chafe, 1980). Gee (1991) concurs with this, suggesting that in a sociolinguistic approach, attention is placed on how a story is told, the pauses in a story and other aspects of interrupting speech, as it is presented to the listener in distinct segments. In this approach, there is an assumption that the individual personality of the storyteller can be understood by the researcher (Alasuutari, 1997). As I am not an expert in sociolinguistics and I was also concerned about the potential for misinterpretations within non-verbal communication, I, therefore, dismissed this approach for my research.

Dialogical narrative analysis

Riessman (2008) suggests ‘Dialogical analysis'; a broad approach interrogating how talk among the teller and listener of a story is interactively produced and performed as a narrative. Dialogical perspectives are inspired by the work of Mikhail Bakhtin, a Russian Literary critic and Philosopher. According to Bakhtin, no story is ever finalised, furthermore, stories exist through relationships with others (Smith & Sparkes, 2008).

Introduction to socio-narratology

In my wider reading about narrative inquiry, Art Frank's (2010a) book *Letting stories breathe; a socio-narratology* was influential. This led me to socio-narratology as version of dialogical narrative analysis. Frank (2010a) defines this as *an inquiry into our ways of mirroring and improving our lives* (Frank, 2010a, p.202). Socio-narratology attends to stories as actors, studying what the story does, rather than a portal into the mind of a storyteller. Frank (2010a, 2012) proposes how stories are influenced by the narrative resources of the storyteller. A person's access to narrative resources is dependent on their social location. In this context, stories are narrated in the places they live and work, which of these stories were taken seriously and particularly what stories are exchanged as tokens of membership (Frank, 2010a).

Frank himself writes from within a sociological tradition, substantially impacting medical sociology and medical humanities disciplines in particular, with other notable contributions to a sociology of the body and bio-ethics (e.g. Frank 2002, 2003, 2005b). His work has been informed by various sociological scholars, notably Max Weber, Pierre Bourdieu, Michel Foucault and Mikhail Bakhtin (see Frank 2002, 2013b). Of course, much of this underpins Frank's specific privileging of narrative as a social phenomenon and means of inquiry. Importantly, however, the sociological lens also allows Frank to locate the idea of storying within broader socio-cultural contexts, processes and forces, that may open up or close down possibilities for different stories or potentiate critical thought regarding the function of different stories in the social realm. Thus, Frank (2002) states, in his critique of medical consumerism:

> *Sociological interpretation begins with the counterintuitive presupposition that the effects of medical consumerism may ultimately be as great, and possibly greater, on those who do not themselves receive these services but live in a society of which these services are a part* (p.16).

In this vein, Frank (2002) quotes Bauman's (2000) *Liquid Modernity* at length to highlight a problematic de-politicisation of a public in thrall to media/cultural forms, such as the chat show, which purport to express highly personal stories but default to the insincere reproduction of consumerism. Within this malaise of modernity, neoliberalism becomes entrenched whilst the personal narratives individuals regard as their own serve as little more than rehearsals of more singular stories operating in the service of a 'truth' that belongs elsewhere, and arguably does not serve their interests. The consequence for Bauman is a rather pessimistic conclusion that there is diminishment of appreciation for ideas of 'common good' or a better society worth striving for; in effect, the dismantling of what Bauman refers to as Politics with a capital P, driven by motivated, agentic, activist individuals. At this juncture, Frank (2002, p.112) demurs with Bauman and sees an alternate route to realisation of a common good '*and how to negotiate living with uncertainty ... While he [Bauman] finds a symptom of these problems in the prominence afforded to narrative, I find a potential solution'*.

In defining dialogical research, Frank (2005a, 2010a, 2012) concurs with Bakhtin that no story is complete; one story calls forth another, both from the teller and listener. Furthermore, the researcher can affect the participant in shaping their future; with analysis not being morally neutral about good and bad future directions, as there is a rudimentary recognition that the future is open

(Frank, 2010a, 2012). The relationship between life and stories are reciprocal, with neither having temporal precedence over the other (Frank, 2010a, 2012)

Similarly, Frank (2010a) recognises that individuals are regularly doing their own analysis in making sense of the stories they hear. He goes on to outline how dialogical analysis is dependent on three elements- the story, the teller and the listener. Frank (2010a) proposes that socio-narratology, as a narrative approach, develops the study of literary narratives and is not reliant on a specific underlying model of competence. Rather, socio-narratology recognises how being human, particularly being social beings, necessitates the competence to tell and understand stories. Frank (2010a, p.73) argues that socio-narratology attends to stories as actors, studying *"what the story does, rather than the understanding of the story as a portal in the mind of a storyteller"*. Storytellers and listeners are enabled to be who they are because of the story. The stories are "*never theirs, except as reassemblies of fragments on loan. These fragments include standard motivational schemes for characters, plot occurrences and recognisable style*" (Frank, 2010a, p.14). Stories are representations of people's lives, reshaping the past and imaginatively proposing the future (Frank, 2010a, 2012). Stories, therefore, revise an individual's sense of self, situating people in groups (Frank, 2006). Frank (2010a), influenced by Alistair MacIntyre's classic work on selfhood, proposes that whilst narrative identity can be seen in what a person may be during their lifetime; it becomes dialogical as part of the interlocking stories in which individuals learn about their identity through the stock of stories within their narrative resources (Frank, 2010a, 2012).

Dialogical narrative analysis and other forms of narrative analysis: the distinctions

Reissman (2008) makes the distinction between dialogical analysis and other forms of narrative analysis, such as thematic, visual[5] and structural analysis. Thematic analysis keeps a story 'intact', by theorising from the case, as opposed to component themes across cases. Generally, in this approach the researcher's focus is on the 'told'; in what participants report of events and experiences, rather than the 'telling'. Primary attention is given to 'what' is said and some albeit minimal focus on 'how' narrative is spoken or written. Issues of audience and the subtle 'give and take' between speakers as they make meaning fade (Reissman, 2008).

Whilst both thematic and indeed structural analysis explores 'what' is spoken and 'how', the dialogical narrative approach asks *'who' an utterance may be directed to 'when' and 'why' that is, for what purposes*? (Reissman, 2008 p.105).

Frank (2010a, 2012) describes the work of Labov, in his structural approach, as having a horizontal dimension, in its unfolding in time. This includes time within the story and the time of the storytelling. Stories in Labov's approach have 'fully formed' narratives (Frank, 2010a, 2012). Dialogical narrative analysis is vertical, and unlike Labov's account of stories, this approach informs us how the distinctive capacities of stories lead people to tell them (Frank, 2010a). In contrast to other narrative approaches, dialogical narrative analysis is interested in characters, point of view, genre, suspense, and, importantly imagination: "*A*

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[5] Reissman (2008) discusses how visual analysis integrates words and images from aesthetic representation made by artists who communicate with images. Visual inquiry, like dialogical narrative analysis, spans a broad spectrum, however, the exemplars in her book draw on thematic and dialogical/performance analysis. 2008).

narration that does not animate imagination might display all of Labov's elements of being fully formed, but most people would not consider it much of a story" (Frank 2012, p. 42)[6].

Frank (2005a, 2010a, 2012; 2013a) states that dialogical narrative analysis is dialogical in opposition to monologue[7] where speech is single voiced, it asserts rather than engages (Frank, 2010a). In this sense, stories in monologue silence alternative theoretical frameworks that would challenge them. In dialogical analysis there is a focus on bringing voices into contact with each other, enabling a voice to be heard alongside other voices that expressed similar experiences, therefore giving form. Stories are always borrowed in parts; no story is ever singularly anyone's own. (Frank, 2012). People's sense of who they are is influenced by the stories they hear, stories they tell, and the stories told about them, therefore "*whoever people are is already the result of multiple emplotments"* (Frank, 2010a, p138).

These acts of multiple emplotment are influenced by wider cultural narratives, including for example how institutional settings may impose their preferred and accepted narratives on individuals or groups (Frank, 2010a). However, people are not fools in accepting any narrative which is forced on them, and people also resist emplotment asserted by others (Frank, 2010a). People need the widest range of narrative resources to work with (Frank, 2010a).

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[6] Frank (2012) argues that stories should have enough aspects that include characters, suspense, and imagination. In considering this he proposes the following: *"What is enough can be determined by the bedtime test. If a self-respecting child wants to hear a story before bed, simply telling a complicating action is rarely enough; a story has to make that action suspenseful, and that usually hinges on strengths and flaws of the characters who deal with the complication"* (Frank 2012, p42-43).

[7] Monological research imagines the words of participants as raw material. Participants can respond to *what the researcher requires* to make their point; a quotation functions to illustrate a theme that the researcher has located within the data (Frank, 2005).

The researcher by their questions and even by their observing presence, instigates self-reflection that will lead the participant to not just report aspects of their life, but to change that life (Frank, 2005a). To understand dialogue is to appreciate the participants' capacity to change and begins with recognition of the storyteller's unfinalisability[8] (Frank, 2005a, 2010a, 2012)

What is a story?

It is relevant at this juncture to discuss what a story is within dialogical narrative analysis. What stories are ought to remain fuzzy at the boundaries (Frank, 2012, p.42). Frank (2010a) suggests that the usage of the terms story and narrative overlap so frequently that sustaining the distinction can prove problematic. However, he proposes that "*a narrative includes multiple stories featuring characters who share some problem or developmental trajectory"* (Frank, 2010a, p.199). "*Narratives make no mention of individual persons; stories depend on characters" (*Frank, 2010a, p.200)[9]. Stories depend on imagination and are driven by character (Frank, 2010a, 2012). Stories have their distinct effects, for example whether to instruct, explain, entertain, or enrol others into action (Frank, 2010a, 2012). The narratology aspect of socio-narratology investigates stories' effect on people in "*their capacity to enable them to do the work they do"* (Frank, 2010a, p.15)[10].

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[8] Frank (2010a, 2012) refers to the work of Bakhtin, in that to finalise is to claim the last word, especially about who an individual can be. Finalisation terminates dialogue as it leaves the other person with nothing to say or be.

[9] Frank (2012) refers to the work of Tilly (2006) who exemplified the difference between a technical account and a story. Technical accounts have a sequential order with some causal relation between these events, however, they depend on specialised knowledge authorised by experts (Tilly, 2006). *"They assume some knowledge of previously accumulated practices, and findings…they signal relationships with possessors of esoteric knowledge* (Tilly, 2006, p. 131)

[10] Frank (2010a, p.3) succinctly describes how *stories work with people, and always on people, affecting what people are able to see as real, as possible, and as worth doing or best avoided*. Stories have the capacity to deal with trouble, but also can cause trouble (Frank 2010a).

A story exists when enough capacities are at play (Frank, 2010a). Stories in being *stories must have a sufficient number of capacities, and sufficiently depends on how the capacities are used, as well as the tolerances of those who receive the story* (Frank, 2010a, p.28). Frank (2010a) suggests a list of stories' capacities, in doing so consideration is given to their ability: to deal with human troubles, yet also to make trouble, to display and test people's character; to make one particular perspective not only plausible but also compelling; to make life dramatic and remind people that endings are never assured; to inform people to what counts as good or bad, and how to act/ not to act; to display how stories are shaped by other stories for the teller and the listener; to report truths that have been enacted elsewhere; and how stories have the capacity to arouse people's imagination and arouse emotions, by making the unseen visible and compelling.

I was therefore mindful of the capacities of stories during the research process. Prompted by Frank's (2010a) considerations of what the capacities of stories might involve, the following aspects were considered at all stages of the research, not least in analysis: how the story displays and tests character and how far the story grants characters multiple and conflicting identities; whether the characters and the plot changes; for characters in the story, whether trouble is at play and for whom; how characters in the story respond to trouble; whether there is suspense in the story; whether stories have the capacity to leave open the interpretation of what happened and how to respond to it; whether there are any unexpected twists and turns; whether there is a sense of what counts as good or bad in the story; how stories are shaped by other stories; whether stories change plots and characters, allowing individuals to locate themselves in the characters in the plot; whether the stories resonate with other stories, including the stories that teller and listener know; whether there are symbiotic relationships; what particular truth the story claims; and how does the story inspire people’s imagination.

I was drawn to dialogical narrative analysis and decided on this as my chosen approach as it offered a degree of structure, yet it was flexible in its ability to allow the researcher analysing the data to adapt this framework to suit the individual research. Respect is given to the initial and obvious story, as it is told, but allows the listener to delve deeper into the story for unspoken meaning (Frank, 2010a). Stories are not just about recounting past events, but project possible futures and the projections affect what comes to be (Frank, 2010a, 2012). Consideration is given to bearing witness in the gathering of voices, expressing similar experiences, so they can be heard collectively in respect of the multiple voices heard in a single storyteller's voice (Frank, 2010a, 2012). Although Frank's early work, in the 1990s, concentrated on illness, his more recent work does not discuss illness, taking a wider perspective on how stories can be used to improve human lives and relations (Hyden, 2012).

Method

The aim of my research was to explore the stories of service users with mental health problems, who have been subjected to physical restraint within mental health inpatient settings. Given the exploratory aim of my study, this qualitative research design would provide me with the richness and depth of data needed to address this aim. Given the aim of my study was to explore people’s experiences of being restrained, it was fitting that I interviewed service users with experience of this. Having discussed the narrative approach more generally and justifying the rationale for my approach, the specific methods using this approach will now be outlined.

Data collection

Narrative research allows participants to have a degree of control over the data being collected, making participants both subjects and objects in the construction of sociological knowledge (Finch, 1984). In considering how data might be collected, numerous methods were available. Though, these include accessing letters, diaries or books, the primary source for narrative data is the stories people tell (Holloway & Freshwater, 2007). Furthermore, social constructionism tends to use inductive analysis of emergent ideas, obtained through interviewing and analysing texts (Cresswell, 2013), aligning with my theoretical framework. I was drawn to listening to the participant's stories within an interview, to collect data and co-construct participant's stories.

I considered interviewing, the most popular means used in qualitative research (Bryman, 2008), to be an appropriate means of collecting data from participants in my study. Though, the power balance between interviewer and interviewee, need to be considered when undertaking interviews (Barbour & Schostak, 2005). Whilst a question and answer model of interviewing is applied in some qualitative interviews, there are limitations. Mishler (1986, p.67) prefers unstructured interviews for narrative inquiry:

> *“Looking at how interviewees connect their responses into a sustained account, that is, a story, brings out problems and possibilities of interviewing that are not visible when attention is restricted to question-answer exchanges”*.

I felt that unstructured interviews allowed participants to tell their stories, without the influence of a set of questions, which potentially could influence the direction of the discussion. Using unstructured interviews for my data collection allowed storytellers to tell their story and allowed me, the listener, to enter the lived experiences of participants, generating new insight and perspectives. I believe this approach allowed participants to explore their personal understandings of themselves and the impact of their experiences of physical restraint. The narrative interview is most effective when interviewers suppresses their desire to talk (Holloway & Freshwater, 2007). Kvale (1996) describes this as a journey in which interviewer and interviewee travel together, and where the latter tells the former about their lived experience. I saw participants as experts in their experience and did not wish to compromise the interview by directing the conversation or interrupting their story.

Recruitment

Recruitment of participants was not complicated. I had a list of agencies to approach (Appendix Three). I had chosen to recruit participants connected with third sector mental health organisations, as I felt this would lead me to find individuals with experiences of physical restraint within mainstream mental health services whilst obviating some of the challenges of recruiting directly within the NHS. I was reasonably confident that my first choice on the list would be receptive to involvement. This agency is a national organisation and I was aware that they had undertaken research and campaigning around restraint. Although a national charity, I approached a senior manager in the north-west regional office and explained my intended study. I was surprised when the manager responded in, what I perceived at the time, to be a negative way, declining to be involved in the study. This response saddened me a little, but it also made me feel quite naïve about my expectations of involvement of this agency. Below is a reflexive diary entry following this encounter:

> *“I approached my first choice of an agency today. I was convinced they would be positive in being involved with the study for recruitment. I had a conversation with a senior manager, who declined to help as ‘there was not a problem' with physical restraint, in their area. I felt slightly frustrated at the individual in failing to acknowledge this issue. Nationally, the agency does lots of campaigning and research about restraint, so why does this individual not see the importance? I feel naïve in assuming this agency's willingness to be involved. I am a little concerned that other agencies may also not want to be involved. I spoke with my supervisory team, who also were surprised. In some ways this made me feel a little less disheartened. We (supervisors and I) discussed the need to contact my next agency choice and so tomorrow I will contact them. Looking back on what has happened today, I realise I must not expect everyone to feel the same way about research in respect of physical restraint. From the agency’s perspective, there is ‘not an issue', and there may not be. The point of my research is to explore the experiences of individuals who have experienced restraint. They are the experts”.*

Following this first encounter trying to recruit participants, I moved to the next agencies on my list and received much more positive responses. I telephoned two organisations and followed up with emails. In introducing myself, I gave my name, along with an outline of my study and requested consideration of recruitment for my study within their agency. A recruitment poster had been designed to publicise the research (Appendix Four). I offered to answer any questions and was available to talk to potential participants, following circulation of the poster. The two national mental health charities that agreed to be involved with recruitment were Rethink and the National Survivor User Network. Both agencies publicised my research, circulating the information amongst members. In addition, I wrote a blog (Appendix Five) for Rethink to promote the study on their website. The National Survivor User Network promoted my study in their members' newsletter. Participants were invited to contact me directly by phone or email.

I aimed to interview between 8 and 12 service users who had been subject to physical restraint on a mental health ward. I felt this number of participants would provide a diverse selection of stories. The time since restraint had occurred was not a vital aspect of recruitment, although experiences before the DH (2014) guidance on reducing restrictive interventions would not have reflected current practice. Recruited participants had all experienced restraint since 2014. The stories people told were more important, as restraint continues to be used, with continuing concerns about its practice (CQC, 2017).

When determining the number of participants to be included in the study, I was mindful of the rich data needed. Morse (2000, 2001) proposes sample size[11] in qualitative inquiry need to reflect the scope of the study, the study design, the nature of the topic and the quality of data. Patton (2002) suggests, depth and the richness of information from the data, along with the observational capabilities of the researcher, provides insight and meaningfulness, not simply

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[11] The use of the word sample in this aspect of the thesis is an attempt to explain the number of participants required in a narrative study and the way in which participants were recruited. Discussion in this section illuminates the terminology used by authors in the quoted sources.

the sample size. There is no ideal sample size in narrative research, rather this is guided by the phenomena or group being studied, the rationale of the research (Holloway & Freshwater, 2007). Much qualitative research speaks of data saturation, as a key concept in deciding ‘sample size’ when no new themes emerge. However, Frank (2010a) does not emphasise samples, nor data saturation. For Frank (2010a), participants make their lives meaningful through dialogue, *no one’s meaning is final and no one meaning is final* (p.99). Therefore, any commitment to data saturation may not make sense at the level of individual stories or is in danger of finalising stories.

Frank (2010a) refers to Flyvbjerg (2006) who suggests that when the objective is to gain the largest amount of information on a given problem, a truly representative sample may not be the most appropriate strategy; atypical or extreme cases may reveal more information as they may activate more actors and more basic mechanisms in the topic under study (Frank, 2010a). I followed Frank’s objections to representative sampling techniques and used a purposive approach to gain a broadly diverse sample; reflective but not absolutely representative of available diversity. This approach allows researchers to recruit participants who possess the necessary experience and ability to answer the researcher question and also provides an opportunity to gain the rich data needed for the study (Morgan, 2013). The sample used for this study included self-selected participants, those wishing to be involved were included. This gave me access to a wider range of participants on a national basis, rather than from a defined population within a locality.

Having been influenced by Frank's (2012) approach to selecting stories for focused attention within the analysis, I was mindful that a small selection of stories would be included in the findings of my thesis, so requiring a sufficient number within the analysis to identify these. Twelve participants responded to the recruitment. One person withdrew from the study early on; therefore 11 people were interviewed, which I considered a sufficient number to support Frank's (2012) notion of focused attention on a selection of stories. I sent each person a Participant Information Sheet (Appendix Six) and Consent form (Appendix Seven) when they agreed to participate and followed this with a preliminary meeting or phone conversation with each participant prior to the interview. The socio-demographics of each anonymised participant is included in Appendix Eight.

The interviews

Participants were offered a choice of being interviewed in-person, by telephone or Skype. Four interviews took place at the university campus, and seven over the telephone. Telephone interviews have been used in previous studies as a means of data collection and deemed an effective tool in collecting data (Carr & Worth, 2001). Indeed, telephone interviewing has the potential to allow participants to feel relaxed and therefore able to discuss sensitive information (Novick, 2008). There are, however, some considerations, such as interviewing people with hearing impairments (Carr & Worth, 2001) and building trust with people not met in person. Therefore, any difficulties for people with hearing impairments and opportunities in securing quiet, private spaces for the interviews were discussed with participants, letting them choose how they wanted to be interviewed. I had also spoken with participants on at least one occasion prior to the interviews, either on the phone or in person, enabling me to build a rapport. I explained to the participants my role as student and my professional job as lecturer, which I have held for over six years. This information was also contained within the Participant Information Sheet, the blog used for recruitment and was on the consent form. Although I recognise my social work role was influential in my interest in the service user voice and the topic under study, I no longer identify my present professional role as that of a social worker and as a result did not raise this with participants. That said, I did not withhold this fact if asked about it. Indeed, several participants queried whether I had trained as a nurse and I responded truthfully by explaining I had not been a nurse but acknowledging my previous role and training as a social worker.

For the university interviews, I was able to ensure quiet space without interruption, and this was an important consideration to assure privacy. I ensured the interview room was comfortable and furniture was arranged to allow for a relaxed environment. I placed myself in a chair next to the participants. Refreshments were available. I was conscious of the aforementioned power issues within research, so wanted to make the room comfortable and put participants at ease. For telephone interviews, a mutually convenient time and date was agreed. Researchers need to have good ‘social skills' to allow participants to feel at ease as an ethically appropriate stance in allowing participants to relive their stories without suffering unnecessary stress (Holloway & Freshwater, 2007). Due to my social work training and previous role as a social worker, I felt I had gained good interpersonal and communication skills. I was able to use these skills in interaction with participants, both by telephone and in person. The participants were given the choice of an audio-recorded interview or for me to take notes and no participants objected to being recorded.

The interviews allowed time at the start for introductions, confirmation of the voluntary nature of the research, gaining consent, a discussion around the right to withdraw and an explanation of the focus of the research. Participants were also made aware that time out could be taken during the interview to allow for practical /emotional breaks. Interviews were planned for roughly one hour, with additional time made available for participants to ask questions, debrief or manage any emotional issues that might have arisen. The interviews lasted between 27 minutes and 81 minutes. The storytellers differed in the way they told their story to me. Some of the storytellers spoke almost continually, whilst others needed support by the use of prompt questions in order to continue with their story.

As interviews were unstructured, an opening interview question invited participants to talk and a list of potential prompts and probes were available to enable stories to be explored further (Appendix Nine). The opening question was present to facilitate the storytelling process, rather than direct it (Holloway & Freshwater, 2012). I had met with a professor[12] at the University, whose specialism was dialogical narrative analysis. She advised me to keep my opening question simple and asking the participants about their experience of the topic under research. She also advised me to use prompt questions, as shown in the unstructured interview schedule. Having spent a significant amount of time thinking about this, I composed my opening interview question as influenced by this advice and the approach proposed by Holloway and Freshwater (2012). I settled on: ‘Can you tell me about your experiences of being physically restrained on a mental health ward?’ On undertaking the interviews, I found the subsequent unstructured interview schedule was not

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[12] This professor is acknowledged in Franks (2010a) book ‘Letting stories breathe’

successful with every participant, for example I found that one participant was not as forthcoming with telling of their story as the others, despite prompts.

During the interview, it was quite difficult not to ask leading questions, or rely on my previous professional background as a social worker (Barbour & Schostak, 2005). Some of the issues raised made me want to offer a response, which is a common issue in an atmosphere of openness and intimacy (Kvale, 1996). Had I done so, this may have interrupted the flow of the story, or otherwise affected the narrative. I did refrain from interrupting the story in this way. My main role in the interview being an active listener, allowing the interviewee to tell their story in their way.

Transcribing the interviews

All 11 interviews were transcribed by the university's internal transcription service, protecting confidentiality and security, as digital copies were not sent electronically to a third party. I acknowledge limitations to transcription, as the interaction between words and gestures cannot be captured (Reissman, 2008). I checked each transcript for accuracy, amending any errors. I kept swear words, colloquialism and slang in the transcriptions, as they were told in the story (See Appendix Ten for an extract from one of the transcripts). I believe transcribing the interviews facilitated accurate capture of what was said and was also a useful tool in analysis in looking at the story, how it was told and in considering the spoken text in the analysis.

Analysis

I shall briefly discuss the potential and limitations of dialogical narrative analysis before discussion regarding the process of analysis for this study. Frank (2012) proposes how commitments to dialogical analysis do not mean the analyst affirms the story told. Other characters in the story may tell different stories. Yet I was cognisant of not diminishing the story from the teller's perspective. When people tell stories that deprecate others, dialogical analysis asks what has driven storytellers to ‘hold their own in the story', particularly if their stories are injurious (Frank, 2010a, 2012). When referring to ‘holding one's own', Frank (2010a, 2012) explains this as the storyteller sustaining the value of one's self or identity in response to whatever threatens oneself. In consequence, there are limits to the appreciation of the stories of others (Frank, 2010a, 2012). However, by pushing those limits and placing the stories back into the conditions of the storyteller’s life, as influenced by stories they have grown up with, a sense of how they could and should respond to their experiences is presented (Frank, 2010a, 2012). Atkinson (1997) criticises this, questioning the methodological rigour of Frank's earlier work as being full of unsubstantiated assertions of storytellers. In response, Frank (2010b) suggests in his approach, ‘ethics comes first', in that anything which counts as ethical is derived from the stories that people know. Stories teach us what is ‘good' and ‘bad', therefore without stories, there is no appreciation of action being ethical, or not (Frank, 2010b).

Frank and Atkinson have different perspectives on the appreciation of stories. According to Frank this means recognition of why the story matters to the storyteller and also being answerable to the storyteller in one's analysis of their story (Frank, 2010a, 2010b). A methodical approach is important as there is a risk of reducing stories to inert material lacking in spirit, which Frank views as reductionism (Frank, 2010b).

Atkinson (1997) suggests Frank devotes significant attention to illness narratives, whereas Frank (2000) suggests that Atkinson hears storytellers only as service users, and neglects medical staffs' response to them, thus seeing illness narratives as only what is relevant to medicine (Frank, 2000). More recently, Frank (2010a) has moved away from narratives around illness. This has included exploring the broader focus in stories, including consideration of characters whose voices are silenced (Frank, 2010a).

In my study, for example, this could be professionals caring for service users, who may be portrayed negatively. In doing this, analysis takes on macro-ethics (Carter, 2007). I was aware of considering other characters within the stories, whilst not devaluing the story from the teller's perspective. This also meant telling the stories of when professionals got it right or nearly right, as well as stories when professionals were deemed to have not done so. Carter (2007) advises researchers take a considered and balanced approach before ‘peddling' purely shock and awe stories that may compound stereotypical views of health care professionals.

There is no universally agreed formula or process to analyse narrative data (Atkinson, 1997; Frank, 2010a; Pheonix, Smith, & Sparkes, 2010). Indeed, influenced by Bakhtin's concept of no story ever being finalised, Frank (2010a, 2012) discusses his ambivalence towards interpretation. Some interpretations within narrative inquiry, seek to finalise stories, which potentially cuts off dialogue by claiming the last word (Frank, 2010a, 2012). The idea proposed by Frank (2010a, 2012) is that stories people tell are influenced by the storyteller's experience of past stories. In the telling of the story, the story is animated. The storyteller gives life to the story, but the story is already there waiting to be told; yet stories are never finalised (Frank, 2010a, 2012).

In seeking a process for interpretation, Frank (2010a, p.72) suggests that dialogical analysis is a '*movement of thought'*, and he offers a series of questions, which can be changed or modified for analytical purposes. In doing so, Frank (2010a) offers a heuristic guide as opposed to a procedural guide to analysis. He describes this approach as being more of a practise of criticism than a research method; as *"critical thought can appreciate how expert people are about their own lives while examining ways in which any person's or groups self-awareness is limited*" (Frank, 2010a, p.73).

In using Frank's (2010a) proposed questions to interpret the data, the researcher is able to use particular questions, choosing the ones that are most useful. The three issues informing all these questions are: What is at stake and for whom? How does the story define or redefine those stakes? How does the story change people's sense of what is permitted, possible, responsible or irresponsible?

Frank's (2010a, 2012) dialogical analysis refuses to define rigid rules in analysis, as rigidity does not allow for any thought to move. Frank's (2010a) questions for analysis include the following: What makes the story narratable? Who has self-regard in or are there difficulties for others in the story in respect of self-regard? What is the impact of being caught up in one's own story? What are the forces of fear? How does the story remind people both individually and collectively of who they are?

Frank (2012) refined these questions[13] and for the purposes of analysis these refined questions were integrated into Frank's (2010a) original guiding questions for the purposes of analysis within this study. These questions offered me a degree of structure to support analysis. I felt they would allow me to consider obvious and hidden meanings within the stories. In turn, these questions might support sub-stories and typologies of stories. Frank (2010a, 2012, 2013a) suggests there are three core narratives (typologies) available to any unique story: the restitution narrative; the chaos narrative; and the quest narrative. The restitution narrative involves someone getting sick, then they get treatment and have some version of health restored. The protagonists here can be medics, who enact restitution; with the sick person being cast as a passive character. The plot of a chaos narrative casts the protagonist within complex obstacles, such as untreatable medical problems, financial difficulties, family problems, etc. Everything in the person's life blocks them from moving forward. In the quest narrative, there is movement, with the ill person cast as an active character, who finds some form of meaning to illness. The illness is not a good

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[13] The refined questions are: "*Resource questions: What resources shape the story? What resources affect how listeners comprehend the story? How are narrative resources distributed between different groups; who has access to which resources, and who is under what form of constraint in the resources they utilize? What other narrative resources, if available, might lead to different stories and change people's sense of possibility in such settings? What might be preventing those alternative narrative resources from being mobilized (*Frank, 2012, p.44). Circulation questions: *Who tells the story to whom? Who would immediately understand that story and who wouldn't? Are there some people you wouldn't tell that story to and why not? How the story is framed to anticipate certain readers and to be ignored by others?* (Frank, 2012, p.45). Affiliation questions: *Who will be affiliated into a group of those who share a common understanding of a particular story? Whom does the story render external or other to that group? Who is excluded from the 'we' who share the story?"* (Frank 2012, p45). Identity questions: *"How does the story teach people who they are, and how do people tell stories to explore whom they might become? Lastly, what is at stake questions can be asked such as "How does the storyteller holding his or her own in the act of telling that particular story, in that way? How do the stories that some people have available convince them of what they have to do and to be in order to hold their own?"* (Frank, 2012, p.45).

thing, but the protagonists in this narrative find ways to work with their illness, keeping their lives moving in a way they perceive as forward.

Having decided on this approach to analysis, as outlined above, I wanted also to consider the capacities of the stories as outlined by Frank (2010a). Frank (2010a) thus poses further questions in this regard: For characters in the story, what trouble was at play? Was there suspense? Who are the perceived heroes and villains within the characters? Was their suspense within the story? Was there a sense of good or bad morals within the story? What opinions were articulated? Did characters change as the story evolved? Whether aspects resonated with stories others told, including links and relationships across the stories told, as well as any difference (uniqueness)?

I have been influenced by Frank's (2012) suggestion for focused attention on a selection of stories from the completed interviews. Selection of stories for focused attention is based on *phronesis* (Flyvbjerg, 2001), a process where the analyst's capacity to hear, from the total collection of stories, identifies those needing to be written about (Frank, 2012). Judgemental choices in this regard partly flow from what has been learned in fieldwork, yet are also based on values (Frank, 2012). Flyvbjerg (2001, p.57), states how "*choices must be deemed good (or bad) in relation to certain values and interests in order for the good and bad to have meaning*".

In another study about illness, Williams (1984) also chose this focused approach and reported on three stories from 30 people interviewed. Stories were not chosen because they were typical, but because they were vivid (Williams, 1994). Each person's story might be unique, but representative, in that unique stories are valuable for understanding a concept (Frank, 2010a). Dialogical analysis is grounded in specific ethical commitments, not least the unfinalisability of storytellers (Frank, 2012). All 11 people interviewed in my study told different experiences of physical restraint, on different types of mental health wards. There were some unique differences across all stories, along with commonalities. Choosing stories for focussed attention was a fundamental task of my study, as I needed to decide which particular stories to focus on for detailed attention.

Starting with Frank's (2010a, 2012) questions for interpretation, I commenced the process of analysis. Choosing stories for focused attention does not mean that all other stories remain unanalysed, therefore all stories were included in analysis at this stage. As a first analytic step, immediately following the interviewing, I made some notes of my initial interpretations of all of the stories. Reissman (2008) proposes that a general principle in the dialogical approach is that researchers carry their identities with them into the research setting, reflexively questioning their influences on the interpretation and production of data. Therefore, to start with, I attended to the whole shape of the story, including my own subjective reactions and relationship to the stories. I was cognisant that I could be caught up in my own set of stories. Hence, I considered my own position, and how this may have affected the story told by the storyteller; including my interactions and my own narrative resources, as influenced by my own stories. I also considered my position within the interpretation, that of a female, middle-class[14] academic, from a working-class background. I noted my feelings, thoughts, and any confusion within my diary.

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[14] Class is a complex and contested aspect of identity. For me, my occupation may objectively locate me as middle-class, but often signifiers such as family heritage and accent etc. more readily reflect working-class positioning. I have reservations in referring to myself as middle-class.

Taking each interview in turn, I listened again to each digital recording and made notes of what I felt was the essence of the story. This also included the concept of narrative resources within stories and the context of the story, an analytic process supported by Frank's (2012), 'resource' questions and 'circulation' questions. I made written notes and referred to these notes in further analysis. On listening to the recordings, as per Frank's (2010a) advice at this stage of analysis, I also translated events into mental images and attempted to see the story from the point of view of a minor character, such as one of the nurses.

In the order that the interviews were undertaken, I then read and reread the transcriptions, and subsequently listened to the interviews again. I diligently made notes on my interpretations of each story, guided by Frank's proposed questions for analysis (2010a, 2012). These notes could be seen to begin to construct summaries, or condensed accounts, of each story. This is described by Kvale and Brinkman (2009) as constructing a narrative from episodes throughout the interview. Intercut with this process of analysis, unfolding as the series of interviews proceeded, I met and conferred with my supervisory team, sharing my analysis with them and refining it in discussion. I believe that bringing third parties into the analytic process assisted in confirming the credibility of my interpretation and supported me in ensuring I had followed the correct approach, whilst not missing any major issues or ideas around the story and interpretation.

In the first instance, my meeting to discuss the analysis with supervisors occurred on completion of a provisional summary of the stories contained in the first two interviews. From here, I felt more confident in the analytic process and proceeded in this manner to independently analyse subsequent stories and transcriptions;

intermittently meeting to share analysis and discuss with my supervisory team. I typed headings of Frank's guiding questions[15] on a word document to help me work with the stories at this stage of analysis. On this document I made notes from the transcript, including segments of transcript and my interpretations of this, whilst also attending to significant omissions within the stories and connections to other stories[16].

Smith (2016) states that writing is a continuous part of analysis, allowing the researcher to revise and edit the selection of stories and theory. The analysis proceeded via cycles of close reading and re-reading texts, making notes and refining these at each turn. In this process of re-reading my own thoughts and connections with stories, I identified narrative structure and narrative themes. Multiple drafts were compiled and discussed individually with members of my supervisory team. These drafts were amended as I proceeded through stories, again led by the guiding questions for interpretation, and with consideration given to broader sociological contexts beyond the interview. Therefore, within the analysis it was relevant to consider the stories told by the storytellers, the influences of my own stories and the wider stories operating and influential in society, including those propounded by professional groups, academics, the media etc., and how these may be bound up with broader systems of legitimation, governance and control. This brings the analysis and the eventual discussion of findings into the sociological realm. Although themes were emerging in analysis,

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[15] Frank's (2010a) guiding questions were used for this process, with the addition of Frank's (2012) 'affiliation' and 'identity' questions.

[16] At this stage it was also important to look at the grander narratives, for example dialogical narrative analysis explores 'Institutional emplotment' (Frank 2010a). This concept considers how institutional settings can sometimes impose their own preferred and accepted narratives.

this process was beginning to articulate different aspects of the stories or characters in the stories[17].

Having completed this analytic stage, I selected four stories for more focused attention. Such an approach is articulated and justified by Frank (2012) and appears in other published studies utilising Frank’s approach. For example, this was successfully illustrated, in a narrative study of the life stories of Sami elders which uses a selection of the available narratives to good effect (Blix, Hamran, & Normann, 2013). For Frank (2012) such a selection of stories does not dilute the narrative analysis, rather it strengthens it because *for analysis to remain truly narrative each story is considered as a whole; methods that fragment stories serve other purposes* (p.43). In some sense, this process of selection also implicitly acknowledges the influence of wider stories ‘out there’ that operate in society to influence, or in some instances constrain, the stories that we tell; that is, however fond we are of our own perspective or viewpoint, these are seldom unique, and are often shared by many others (see below pp 125-127).

There is no set procedure which directs what steps a researcher takes in choosing stories for focused attention. According to Frank (2012, p.43), the selection is based on “*practical wisdom gained through analytic experience*”. Frank (2012) suggests that his own writing had the best response when he felt that the stories had chosen him, and that selection of stories is based on what has been learned during the research process, even if a substantial part of this knowledge remains tacit to the researcher. In practice this means *“the analysts*

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[17] It was important not to fragment the stories into themes as “*these themes are tentative beginnings of the more significant task of representing individual struggles in all their ambivalence and unfinalizability*” (Frank, 2005, p. 192).

cultivated capacity to hear from the total collection of stories, those that call out to be written about" (Frank, 2012, p.43).

The judgement for my selection of stories was made from what I had learnt throughout the research. This was informed from the insight I gained through diligent engagement with all stories, and the stories were chosen because of their distinctness to the phenomena being explored. The four stories selected, represented diversity regarding individual's experiences of physical restraint. From my perspective, the excluded stories were less vivid, and less expressive regarding distinct aspects of physical restraint. I acknowledge that another researcher may have chosen different stories, yielding different stories to be told. "*Narrative analysis gives audibility to some stories, recasts how other stories are understood, and necessarily neglects many stories. But one analyst's neglect is another's possibility- less cause for criticism than for appreciation. The dialogue always continues"* (Frank, 2012, p.50).

From the final draft of each selected story, I referred again to Frank's guiding questions, (See Appendix Eleven for an extract from a worked example of one of these questions that supported analysis at this stage of the process) and continued to attend to the transcripts as part of on-going analysis, moving back and forth as the analysis required.

I also attempted to draw on relevant sociological theory within the process of interpretation of the narratives, with recourse to my wider reading, including, for example, applied sociological writings dealing with key issues in the mental health context; notably how power is distributed, enacted and resisted, and how this relates to powerful available narratives functioning to delineate how mental distress can be made sense of, and how such epistemes might order and structure society as we know it, resulting in various unjust outcomes (Foucault 1970, p.74; Frank 1982).

From this perspective, we can see that Frank does not view the narratives that individuals are able to give voice to as essentially belonging just to them. Hence, the stories we tell are not merely our own stories; they are also the conduits and expressions of grander narratives.

Narrative is ‘out there’ in society, available to be drawn upon, pulled apart or put together, and given voice to. This available talk belongs to everyone and no one: it infiltrates us, creates and shapes morality, renders things legitimate or illegitimate, defines responsibility and the salience of events, how characters are to be understood, what is the scope of action, what is to be favoured or resisted etc. Framed like this, people are clearly both storying and storied beings; we construct stories, but stories can be also seen to construct who we are and the world we live in: *homo narrans* (Czarniawska 1997, Fisher 1984, Niles 1999); *homo narrans narratur* (Curt 1994). Frank acknowledges that his narrative analysis has a certain promiscuity: posing multiple questions in the process of analysing and making sense of the social situation of the stories. For example, the approach demands that we constantly ask what else, or what else might this story or utterance be connected to?

In writing the findings for the thesis, the interpretation continued, as consideration was given to other stories ‘out there’ in society. Frank (2012) refers to how these other stories are told from diverse perspectives. These stories are found in policy, scholarly literature, the mass media, relevant professional discourse and practice, service user movements, anywhere. In this sense meaning-making was not uniquely personal but derived from wider cultural narratives available to both the storyteller and myself; in listening to and also analysing the stories. I believe I was able to keep the stories whole, avoiding fragmentation (Frank, 2012). The pragmatics of producing a research paper, or in this case a thesis, demand to a greater or lesser extent, that these stories are edited and truncated to fit the required format. The stories were condensed for this purpose. Each of the selected stories was narratively distinct from each other, but not precluding the non-selected stories having shared features.

In producing a final draft for each story, the typology of each story and the narrative identity were fundamental considerations. Identity is never final, therefore Frank (2010a, 2012) proposes that narrative identifying may be a more useful concept reflecting this ‘unfinalisation'. Simplistic concepts of self can be problematic, potentially suggesting people only have one identity, or identity is always stable (Smith & Sparkes, 2008). Self and identity are better conceived as multidimensional and connected to social, historical and cultural contexts (Brockmeier & Carbaugh, 2001; Polkinghorne, 1988). In summary, people are influenced by stories they have heard and to some extent, stories that are told about them. Individuals may take on multiple identities, which change over time. The analysis has explored the connection between how the concept of self was identified and how this was influenced by the many relevant societal narratives and the key stories that exist in social contexts. These stories are significant in providing meaning and defining action, not only in the context of the past and present, but also future. I found the resource questions particularly helpful in considering these wider narratives, during all stages of the analysis.

Having used Frank's (2010a, 2012) questions to support analysis, including consideration of identity, the typologies helped frame the findings of each story.

Typologies help to appreciate how storytellers are positioned by their narrative resources, to tell the stories they feel comfortable telling and can take seriously (Frank, 2010a, 2012). From my analysis, two of Frank's core typologies (2010a, 2012, 2013a) were present. These were the quest and the restitution narratives; the most common being the quest narrative. Therefore, in my findings I framed the stories within their corresponding narrative typology. Frank's (2010a, 2012) guiding questions also allowed identities[18] to be revealed as the stories unfolded. In doing so, the research aim was addressed as the impact of physical restraint for storytellers was revealed, connecting with the identity of participants.

I did not return the final stories to participants as part of the interpretive process. Reissman (2008) argues there are some limits to doing so as stories are not fixed, and memories and meanings change as time goes on. Furthermore, participants may not agree with our displays of their talk, and more specifically how we analyse this (Reissman, 2008). Josselson (2011) argues that if researchers have done their work well, they are likely to offer a dissonant counterpoint to participants' self-understanding of the story. Having considered the data collection transcription and analysis, I shall now discuss ethical considerations.

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[18] Frank (2010a) uses the term interpellation, a phrase coined by Louis Althusser, suggesting that stories hail people to assume identities. A person may hear themselves designated into an identity and cannot resist the hailing. The question is why people take up these identities. The collection of stories that interpellate an individual depends on their narrative habitus (a term adapted from Pierre Bourdieu's habitus); is their disposition to like or dislike something or recognise it as strange/obscure or familiar, comfortable or uncomfortable? (Frank, 2010a).

Ethical considerations

Before recruiting participants, it was necessary to seek ethical approval from the University of Central Lancashire STEMH ethics committee. I was granted ethical approval (Appendix Twelve), and ethical considerations remained important throughout the whole phase of the study.

To ensure awareness of the nature of my study and expectations of participation, the Participant Information Sheet was sent to all participants expressing an interest in taking part before interviews took place. My telephone number, email and postal address were provided, and people were encouraged to contact me to ask questions before deciding to participate and at any point in the research. Additionally, participants were given the option to withdraw from the research up to the point at which the data had been collected.

Confidentiality and anonymity

Maintaining confidentiality is closely linked to preserving anonymity, for example not revealing someone's role that could make them identifiable (Ross 2012). I took the utmost care to ensure that confidentiality and anonymity were protected. Participants were allocated pseudonyms, at the point of interview, to protect their identity. Furthermore, I scrupulously avoided identification of names or features, such as role in service user movements within my writing. Some biographical details of participants were modified to protect anonymity in this thesis. I ensured written and audio-recorded materials were kept in locked storage at the university and used appropriate password protection for digital data storage. In accordance with the University of Central Lancashire’s (2015) research data storage and the Data Protection Act (2018), data will be kept for five years.

I was duty-bound to follow the University's code of conduct (University of Central Lancashire, 2015), which outlines the need to respect privacy and confidentiality. However, this code also states how necessary information must be shared with agencies and health care professionals, where the interest of the public and/or service user safety overrides the need for confidentiality. I was cognisant to consider my position regarding this, should an issue be disclosed in interviews which placed participants or others at risk. Breaches of confidentiality can be justified in some circumstances, following an assessment of the risks posed (Beauchamp & Childress, 2013). The Participant Information Sheet and Consent Form referred to such circumstances. Fortunately, this situation did not arise, but had this done so, I would have stopped the interview immediately to discuss and explain to the participant that I would need to take this issue further.

Informed Consent

Beauchamp and Childress (2013) propose that the mental competence of a participant should be assumed in the first instance when obtaining informed consent. The MCA (2005) provides the legislative framework concerning important principles for people without the mental capacity for specific decisions. For this study, I assumed participants to have the mental capacity to consent to taking part in the research unless I had doubts about this, drawing upon relevant professional experience (Hem, Heggen & Ruyton, 2007) as the practice lead on the MCA (2005). In the event, all participants clearly possessed full competence to give informed consent to participate. Should there have been any doubts, the interview would not have proceeded.

Informed consent was gained at the start of each interview, which involved the participants' prior reading of information provided and familiarisation with the consent form, as well as discussing and asking any questions about any issues on the consent form. For telephone interviews, informed consent was gained before the interview and the consent form was returned beforehand. Additionally, a discussion about informed consent took place at the beginning of the telephone interview. Consent involved giving participants the option to participate in the research and respecting their decision to withdraw up to the point of the completion of data collection (Ross, 2012).

The potential to cause distress

When dealing with sensitive subjects and vulnerable individuals, there is always a risk of upsetting people. In this study, talking about past traumatic experiences around physical restraint with a potential of causing distress and harm (Johnson & Long, 2012). Furthermore, careful consideration is needed in any narrative inquiry about any resultant distress caused (Warne & McAndrew, 2010). Although I could not eliminate the risk of distress, several strategies were employed to reduce the potential for distress and to manage this, had any upset been apparent.

At the start of the interview, I checked that participants understood the focus of the interview, were aware of the option to suspend the interview to take a break and would be able to withdraw from the interview before its completion. A list of support networks was provided on the Participant Information Sheet and given to the participants before the interview. These organisations could help if the participant needed help/support.

Time was also set aside at the end of the interview to allow participants the opportunity to discuss any unresolved emotional distress caused, due to recounting the event (Warne & McAndrew, 2010). Furthermore, during interviews, an experienced mental health professional was available in the next room, should a participant have become distressed. This was an important consideration and ensured that support could be offered at the time of distress if this was an issue. A follow-up phone call to check on participant's welfare was also planned if any participants became distressed. Fortunately, none of the participants became distressed during the interview.

Being trustworthy

A subjective approach seeks to understand why things are the way they are and why people respond in the way they do. There remains a need for evaluating standards of quality within a qualitative study, but quantitative standards are inappropriate in presenting measures of quality in qualitative research (Lincoln & Guba, 1985). Lincoln and Guba (1985) proposed that the trustworthiness of a study is important in evaluating the quality and outline four criteria for assessing this: credibility, transferability, dependability and confirmability. According to Lincoln and Guba (1985), credibility is confidence in the reality of the findings, for example how the findings articulated by the researcher reflect the reality for participants. Transferability is how findings are applicable to other settings. Dependability is the measure of consistency should the study be repeated, perhaps most equivalent to reliability in quantitative research. Confirmability reflects the extent to which findings are shaped by participants and not influenced by researcher bias, interest or motivation.

In respect of establishing credibility, it was important to establish an environment where participants felt able to provide honest and accurate information (Shenton, 2004). Time at the start of interviews was spent building rapport by using common courtesies and asking questions, such as asking about a participant's' well-being and how they had travelled to the venue. During the interviews it was important to actively listen to the stories participants told without interruption. As discussed, participants had also been made aware of confidentiality and anonymity and were assigned pseudonyms. I felt these steps helped participants feel relaxed and comfortable enough to tell me their stories and to be as open as possible. I do acknowledge that there is no single truth that can be uncovered by providing the correct environment. Lincoln and Guba (1989, p.83) propose how the researcher-participant relationship *"is subjective iterative and inter-dependent*", therefore creating the best setting conditions for interview was contingent on several internal and external factors relating to the participant telling their story.

Another way credibility can be strengthened is by peer debriefing (Lincoln & Guba, 1985; Spall, 1998). This is highlighted in the way researchers work with colleagues, with the expectation that they hold impartial views on planning, methodology, data collection, analysis of data and any researcher bias which may be unduly influencing the study. Throughout my research, I worked closely with my supervisory team, who member checked the ethics, participation process, interview questions, data collection techniques and methods for analysis of my data. My supervisory team provided feedback during the study. As discussed, this had included listening to selected interviews and reaching agreement regarding initial interpretation. Apart from the study needing to be my own work, it was deemed inappropriate for supervisors to be involved in detailed analysis. Further, the stories told could have several interpretations and it was my own which was ultimately given priority. My transcripts were available to my supervisory team should they have had any concerns about my findings.

In terms of establishing transferability, dependability and confirmability, I needed to show an audit trail of each stage of the research and the decisions made (Koch, 1994). Cresswell and Millar (2000) recommend that a 'thick description' of the research setting should be provided in studies. So far in this chapter, I have included a description of the data collection methods, the recruitment process, an explanation of the interview and the details of the data analysis. An audit trail was available to my supervisory team and evidence of the aspects of each stage was seen and discussed with the team throughout the study. I am aware of my own potential to unduly or unintentionally influence the study. Given this, I adopted a reflexive approach, which is important in establishing confirmability (Lincoln & Guba, 1985) and this will now be discussed.

Introducing Reflexivity

Reflexivity was an important consideration in every part of this research. I, as the researcher, had a keen interest in the subject under study and held certain perspectives on the use of physical restraint. Reflexivity is frequently used in qualitative research and is deemed as an integral part of practice, whereby the researcher reflects continuously on how their actions, values and perceptions can influence the research setting and in turn affect data collection and analysis (Topping, 2012). Further, Morrow (2006) proposes that reflexivity is a strategy that researchers can adopt for understanding the phenomenon under exploration and where self-examination permits assumptions and biases that could influence the study to be recognised. In respect of the findings published, I acknowledge the limitations and potential for bias, yet also the strengths of subjectivity. As discussed, I kept a diary of my thoughts and feelings throughout the research. This helped in allowing me to acknowledge any issues where my own thoughts, feelings and perspectives, had any potential to influence the research process. Reflexivity is suggested to support credibility and confirmability within qualitative research, as the researcher is aware of the impact of their own beliefs and assumptions. The stories that participants told were influenced by a range of circumstances. These included my own relationship with the participants, the interview setting, the question I posed and the reasons I asked this question (Lieblich, Tuval-Mashicah, & Ziber, 1998).

I did not assume I could gain insight into the truth around the experiences of physical restraint as told by the participants in accessing unchanging stories. The stories were co-constructed by the participants and myself as a researcher in line with Frank's (2010a) conviction that participants are not subjects, but active participants. Frank (2000) states that stories are told *with* and not to listeners. This has been fundamental in my understanding of the premise of co-construction. Participants are not data for analysis, they co-construct with the researcher what counts as data (Frank 2010a). I was influenced by Frank's (2010a) assertion that participants are not a source, "*but a teacher that is a partner in dialogue"* (p.114). Frank (2005a) states how the research report offers an account of how the participant and researcher come together in some shared time and space which has diverse effects on each other. "*These mutual effects that each has on the other continues to reverberate to the readers of research reports*" (Frank, 2005a, p.968). In this sense the stories breathe.

In the context of the storytelling and the interpretation, Reissman (2008) acknowledges how the storyteller will be influenced by the researcher who the story is told to and the researcher's prior concepts will influence the listening and interpretation. Josselson (2011, p.42) articulates this as follows:

> *"When we assert that the interview is co-constructed, we are recognizing that we are co-creating a dialogue between aspects of ourselves and aspects of our participants. Which voices emerge to narrate is determined by our impact on the participant and his or her assessment of us in terms of who the participant thinks the audience is. Our participants are performing with us particular constructions of themselves in response to whom we seem to them to be and what we have asked them to tell us about".*

The interest in dialogical narrative analysis "*is in hearing multiple voices find expression within any single voice"* (Frank 2012, p.35). A storyteller speaks of their own story, but no story is ever one's own as they are made up of fragments of previous stories, rearranged but never original (Frank 2012).

Furthermore, these stories cannot escape the influence of powerful meta-narratives that pervade the social world, culture and popular expectations (Lyotard, 1984). Frank (2012) refers to Bakhtin in his offering of two conceptional terms to explain this dialogic relationship between teller and listener and the wider social world: Polyphony and Heteroglossia. The former emphasises how one speaker's voice is always resonant with the voices of specific others, people who they listen to and whose response they anticipate. In this sense stories are also resonant other's stories and cultural narratives, examples of these others may include medical professionals, fellow service users and loved ones. Heteroglossia emphasises how the story is assembled from multiple codes of language and genre. The others who are present are the generalised speech community, rather than specific individuals. The multiple codes may include codes of professional jargon, emotional expression, codes reflecting plot progression and codes governing which genres to present.

In this study, I believe that the participants and myself co-constructed the narratives. The relationship between myself and participants had an impact on what and how the story was shaped. Participants revealed their subjective understanding of meanings, including their perception of experiences and knowledge of themselves within the story. My own part in this took several forms, which were also influenced by my subjectivity. My participation in the construction of stories was influenced by my own mean-making horizons[19]. I participated in this at several levels: the creation of the research question, as co-creator of the interview contexts and as the reader and writer of the text for further analysis (Josselson, 2011).

The stories in this study developed from my dialogue with participants and then thorough my dialogue with the stories as part of the analysis, including the multiple voices within each story. I believe that my understanding of each story was impacted by my own concepts of meaning, as influenced by my own narrative resources and horizons. In addition, the wider stories and grand narratives out there in society were influential within interpretation and meaning making. I believe this occurred at a sub-conscious level, in the impact of these

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[19] Frank (2010a) refers to Portelli (2003) in his assertion that no two people's horizons will ever overlap, nor will they completely diverge. Dialogue requires difference otherwise there would be nothing to talk about. It also requires similarity otherwise there would be no basis for understanding each other. Initial understandings may change in response to the story and storyteller. Interpretation requires and observes the shifting of horizons (Frank, 2010a)

on both the storytellers and my own sense of meaning and interpretation. I also considered this occurred at a conscious level as I sought connections with the other stories and grand narratives, as part of the analysis process.

Reflexivity was maintained in the analysis, as the audio-recorded data and transcription were available to others not involved in the interviews to audit it (Crabtree & Miller, 1999). I had been part of the storytelling process, as the listener, and as such may have potentially privileged some stories over others, providing insights into their meaning within a theoretical framework (Reissman, 2008). At times, I was concerned that my reading and interpretation of the stories may be perceived as ‘incorrect or inaccurate'. In my analysis, I endeavoured to demonstrate integrity and professionalism, interpreting the stories openly, faithfully and honestly.

In adopting a reflexive approach, “*we come as close to the rigour that is required of good qualitative research”* (Etherington, 2004, p.32). I deem that credibility and confirmability were strengthened by adopting this reflexive approach throughout my research. The process, practicalities and analysis were discussed on an ongoing basis in academic supervision. My diary helped to facilitate self-reflection for me as a researcher, including thoughts, feelings and perspectives. This addresses trustworthiness, clarifying and explicating my own interests and consideration of how these influenced strategies and procedures (Holloway & Freshwater, 2007).

Chapter conclusion

This chapter provides an overview of the methodology used, with a detailed discussion of the process and practicalities of the study. Throughout the research process, I needed to make several decisions about my methods, and in doing so my awareness and understanding developed, as I planned my study and applied a narrative approach. The analysis process was particularly challenging and, although I found the narrative approach was the right methodology, I was a novice to begin with. This further consolidated my awareness of the difference in working with a narrative approach, using stories, as opposed to collecting data through traditional qualitative methods. The next chapter presents my findings.

CHAPTER FIVE.

FINDINGS

This study examined stories from the experiences of service users regarding physical restraint. All 11 people interviewed related different experiences of physical restraint on different types of mental health wards. Four distinct narratives were identified. The act of choosing four stories for focussed attention was an axiomatic task within this narrative analysis. According to Frank (2012, p.43), such choices are based on "*practical wisdom gained through analytic experience".* Each of the selected stories were narratively distinct from each other and revealed the impact of physical restraint for the storytellers.

Within my analysis, two of Frank's three core typologies (2010a, 2012, 2013a) were present, these being quest and restitution narratives. The most prominent, however, was the quest narrative. This chapter now seeks to present the findings by telling the four stories, framing these within their corresponding narrative typology. Subtle matters of nuance within the stories, such as how they connect with, or project, aspects of participants' identities are also revealed.

Stories play a role in linking individual personal troubles to public issues (Frank, 2002), thus consideration is given to the public agenda around physical restraint. This allows for individual experiences to be contemplated and discussed in relation to policy in this area. The stories in themselves do not define individuals nor delimit further understanding of them. Indeed, there are tensions with ending stories, as no story is ever finalised (Frank, 2010a, 2012). Rather, I consider these stories, and what they reveal about personhood within society, to be located in a specific time and place. Yet, they are potentially ongoing or open-ended. I have deliberately included substantial quotes from storytellers, to keep stories whole, accurately representing the stories as they were told. This chapter is structured to present each story individually, in further attempts at keeping stories whole and unfragmented.

The four stories

In the following section, I present the stories chosen for focused attention: Rory, Jane, Rose and Finlay's stories. Frank's (2012) approach presents the analysis as individualised stories in the voice of the person who most exemplifies that story, yet other people may have voiced aspects of the same story. The stories, as told by the storytellers, are presented in the past tense to reflect narration of past events. This acknowledges stories can change when told at different times (Frank, 2005a, 2010a, 2012). In drawing on the main facets of each story, a conclusion of each story is presented which considers what each story tells us. This aspect of the storytelling brings attention to the main aspects of the story and as such is undertaken as a live and present tense review of each story. This chapter presents the stories as distinct narratives, Headline issues will be accounted for in the 'what the story tells us' sections for each story, however, these will be taken up in greater depth in the discussion chapter which follows and will present a synthesis of how the voices may intersect or contest each other (Frank 2010a, 2012).

Rory: a story of resistance

Introduction to the character

At the time of the interview, Rory was 39 years of age, identifying as Black British. He had just moved into a new flat and lived alone. He talked about how he liked football, his favourite team being Liverpool. He discussed how he did not attend matches due to his dislike of large crowds. He also told me of his other interests including watching films and that his favourite films were the original Jungle Book and The Wizard of Oz.

Rory had been in several institutions, including a psychiatric intensive care unit, a medium secure unit and a high secure unit. He also described spending time in prison as an adult and in a young offenders' unit, as a teenager. Rory discussed a part-time job, at the local mental health services, involving him in staff training related to his experiences as a service user. He was very proud of changes he had made in his life and his successful reintegration into the community. He described turning a corner in his life and intends to write a short book about his experiences. He presented himself as a confident man, who was able to articulate and present his views.

The story told

Rory storied his character and identity as a fighter; portraying his struggle and fight with and within the system. He alluded to the unjustified actions of others and his consequential reaction to this. He told of how he felt his mental distress impacted upon his behaviour, which he described as violent and aggressive at times. Rory's storied his resistance to restraint, justifying his actions, at times, as consequences of his mental distress. For instance, he discussed how, on one occasion he perceived a member of staff to have invaded his privacy. From Rory’s perspective, he was ill and, in his view, not accountable for his violence in this encounter. The incident was seen by Rory as having led to his being restrained. It is interesting how illness was implicated by Rory in explaining and excusing his actions.

In telling his story, Rory used language illuminating his perception of restraint, as a fight with staff members, with his masculinity at stake. He saw himself as fighting back. For example, he described staff “*jumping on him”*, provoking retaliation. Feeling threatened, he indicated that he had fought back as several members of staff were painfully restraining him, yet he asserted the pain was not unbearable. Again, this capacity to tolerate pain implicitly referenced his masculinity within the story. Here Rory depicts that he had felt threatened and exerted his power in fighting back. Rory viewed how his response in this incident precipitated further violence, as staff struggled to overpower him. At the same time, he reported that staff attempted to maintain Rory’s safety by protecting his head, though Rory failed to acknowledge this as a caring response.

Restraint viewed as unjustified

A fighter identity surfaced in Rory’s acts of resistance within his story. Rory's role in his depiction of the incident flips the notion of last resort, in that he positioned himself to have no other option but to fight; resistance becoming his first resort. This situation was portrayed as perhaps troublesome for staff on the receiving end of violence. Rory justified his actions in terms of both diminished responsibility and staff provocations. He claimed a personal lack of insight, connected to distress at the time and that a staff member invading his privacy caused him to react:

> "*He got in my space so there was a kettle on the side, I went to hit him with the kettle and then they just all jumped on me, restrained me, I'm shouting at them and screaming at them. They weren't hurting me too bad, it was hurting but nothing like getting beat up. So, they incapacitated my arms and my legs by holding them, so the only thing I had left was my head, so I was just smashing my head off the floor and they restrained me by pushing my head to the ground*"*.*

Although Rory depicts incidents where he has been violent, prompting the use of restraint by staff, he also suggested incidents were in his view, staff used restraint irresponsibly. In this regard, Rory saw himself subject to unfair treatment by nursing staff, thus a victim identity was visible within his story. In one such incident, on a high secure unit, Rory described the build up to being denied access to the shop to purchase goods:

> "*They have got a shop you can go to, to buy stuff. It is still within the grounds and they said to me next week, if you are good, you'll be able to go yourself and buy your own stuff*"*.*

In describing what followed, Rory viewed the subsequent restraint incident to be unjustified. Again, the language he used, for example being "*jumped on"* suggests Rory viewed the restraint as a fight. He reported the number of staff members who rendered him helpless. His story spoke of the physical size of the staff member who "*bear-hugged*" him. Rory also emerges in the story as fighting back, despite being outnumbered. In Rory's view he had tried to avoid trouble; the staff were depicted by him as hostile and aggravating. Rory suggested that he asserted his strength in fighting back. Yet as Rory spoke of initially walking away attempting to avoid trouble, a sense of martyrdom was intimated within this aspect of his story. He presented himself as having been pursued and provoked, finally succumbing as he was overpowered. The professional ideal of restraint as last resort is undermined here in this aspect of Rory’s story:

> “*So, I've walked out the interview room, slammed the door behind me, and I was walking down the corridor to my door and they just jumped on me. We ended up halfway down the corridor. I was trying to punch them when they grabbed my arms and put me on the floor, so I was kicking them and then one of the staff, big member of staff, has bear-hugged my legs*”*.*

Rory offered his elaboration on the incident, justifying his response within this ‘fight' as he charged at staff instinctively, but eventually, his resistance was futile:

> “*Once he's jumped on me then the other staff have jumped on me, so that's when I've started fighting with them and the corridors about the length of this corridor with loads of bedrooms on. It started there and then as I'm charging them, and they are charging me. They've got hold of me and sort of went all the way down the corridor and then fell on the floor*”*.*

Although Rory felt this restraint was unjustified, his account of events recognised the difficulty for the staff in judging service users' actions, nonetheless his sense of unfairness persisted:

> “*The problem is the staff don't know what's going on in your head, but I've been restrained. Like the time when I was walking down the corridor*

> *in (name of the hospital) and they jumped on me. They didn't need to restrain me. I was pissed off*".

Despite the perception of unjust use of unreasonable force, where Rory demonstrated resistance, he also represented his compliance. Yet this was only because he had little strength left. He talked of fighting with the staff, but the force of the staff incapacitated him. His masculinity appears to be simultaneously bolstered by resistance and susceptible to diminishment under eventual overwhelming staff force. Rory portrays himself as a strong male character, resisting restraint practices to the limits of his capacity:

> "*Once your legs are incapacitated that's, say your strength is 100% and you're are fighting on the floor with them, you come down to the floor and they're on top of you that'll bring your strength to 80%. So, you've got 80% strength left to fight with them. Once someone bear hugs your legs you can't get leverages, you've only got the top half of your body and your strength goes to 10%. You become manageable then on the floor, but if they can't get your legs for a bit you can have a good fight*".

Rory told how other service users had witnessed restraint visited on him. He spoke of an 'independent onlooker', but still part of the 'group' of service users, to whom they both belonged, reflecting a 'them and us' scenario and hinting at concerns regarding legitimacy. In this aspect of his story, another voice is heard albeit indirectly. The witness alluded to the sheer force used, ratifying the extent and severity of the fight; the observed restraint extending substantially, both spatially and temporally. Here, Rory invokes the testimony of this other service user:

> *“He said well I'd come out my room and just seen you all the way down the corridor. I said, don't even ask man they jumped me. I had my back to them and they jumped me*”*.*

Concerns over staff practice

Rory reflected on his perception of how his illness led to his suspicions regarding staffs' actions, culminating in a rooftop protest at the hospital, which was a further example of resistance. He alleged that he had climbed onto the roof of the hospital in protest of constant searching of his body. He eventually came down from the roof and he told that this led to an emotionally, as well as physically damaging restraint episode. In telling his story he presented an illness identity, as he looked back on this he viewed that his suspicious thoughts about staff’s motives in searching him were influential.

Rory alleges that he had been searched numerous times each day because, in his view, he was known for carrying weapons. Rory perceived these searches, at the time they occurred, as sexual assault. Yet when telling the story, Rory was able to reflect on this and he considered that paranoia, at this time, affected his judgement: “*I think they are touching me up, which they weren't, which I realise now that I'm well”.* Rory suggested his objections to these searches prompted the rooftop protest, leading to restraint.

Somewhat ironically, being subject to an intimate search following the rooftop protest was experienced by Rory as an actual sexual violation in his reflection of this. This left Rory with a real sense of sexual assault, which remained with him as he told his story. Rory represented this as distinct and different from his previous feelings of being sexually assaulted. His identity in the story changed from being a fighter, through an act of resistance in the form of a rooftop protest, to a victim of sexual abuse by a faceless and nameless staff member. Rory told that the staff member’s face was unrecognisable as masks were part of the riot clothing. This occurrence was mentioned multiple times in the telling of his story, suggesting this troubling incident haunted him, and his view of it as sexual violation remained, unfuelled by suspicious thoughts:

> “*I couldn't tell who was what and he put his hands on my bum and parted my arse cheeks to make sure, well I'm assuming, to make sure I didn't have no weapons or glass secreted on me, but, in all the restraints I've had, I have never had no one do that to me and even though I was unwell at the time. It still sticks out in my mind as, even to this day, I feel like I was indecently assaulted. I feel like I was touched up in some way*…*I've been battered in other restraints in other places and they feel horrible and they stick with me and I feel like it wasn't justified. The restraint at (name of the hospital) where he's parted me bum cheeks it's just the weird feeling that goes with it. I can't... like I've been touched up or something. I'd rather be battered by the police all day than go through that again*”*.*

Rory’s identification of himself as a victim was strengthened by his language: *“never had no one do that to me”'* and “*I feel like I was indecently assaulted'*. Interestingly, Rory represented himself as being unwell at the time, yet not irrational; feeling sexually violated despite his state of mind. This contrasts with his perception of his thoughts in feeling sexually violated because of previous rubdown searches.

In considering how staff had undertaken physical restraint, Rory reported pain associated with its use. Although Rory spoke about his ability to manage the pain experienced, he also described how restraint was potentially excessive and dangerous at other times. In telling his story, staff were not generally referred to by name, which suggested to me that there had been a lack of any positive relationships with staff. Rory reported how the pain was intense and he had experienced this pain on many occasions, further reflecting a victim identity:

> “*Someone they will have your arm bent to here but in a lock, but someone will have it bent so your fingers are here. Oh, it's a nightmare the pain. It's like having a major toothache in each wrist. It's the pain of it, it's a dull, it's not sharp it's a dull, just like a bad toothache but in your wris*t…*You'll usually hit the ground, still in the headlock so your head will be here. You'll hit the ground like that, but what usually happens you are not going from upright to ground straight away. The member of staff who is holding you, he'll put you in a headlock and he'll go down to his knees and then on the floor with you. The problem you've got, and it's happened to me again loads of times, is you are in a lock here and you are in a lock here and a lot of the time, If he doesn't move when he moves your arms are going like that or up there or do you know what I mean? You run the risk of snapping your arm, but maybe they are more controlled than I know cos I've had hundreds of restraints, as I said, in all different places and I've never had my arm broke*”*.*

Witnessing restraint

Rory also reported witnessing what in his opinion, was unjustified restraint. In telling the story, Rory casts other service users as victims. He suggested there had been insufficient justification for restraint: *“I've seen people get restrained in (name of the hospital), just for shouting”*. In contrast to his storying of staff, regarding two specific examples of perceived service user victimisation, he referred to the service users by their first names. This perhaps further suggests a ‘them and us' scenario.

Rory depicted service users as vulnerable, due to their unstable mental health or distress at the time of the incidents. From Rory’s perspective, the service user’s vulnerability is compounded by staff failing to de-escalate the situation. Though Rory is black, as was the service user in this scenario, he does not explicitly refer to racism, despite the apparent connotations of his account of events:

> “*That morning he wasn't well and he's running round doing monkey noises saying I'm a monkey I'm a monkey. He was a black lad and we're looking at him what's he doing what's the point in that? The staff said to him look stop it (name). You've got to stop it now, or you're going to your room and he was still carrying on for about five minutes and they just jumped on him and restrained him and they could've just grabbed him by his arm and said come on we've told you you're going in your room, but they ended up jumping on him and, not only did they jump on him and restrain him and put him in a strip cell, but the next day they moved him to one of the high dependency wards. Just for running round the ward saying I'm a monkey give me a banana. That's what he was shouting*”.

In a racially sensitive situation, Rory, depicts the ridiculousness of the other service user calling himself a monkey, building a depiction of an obviously unwell individual. Staff were reported by Rory as “*jumping on”* the service user and the perceived injustice of the situation was remarked upon. Rory suggested the service user had disturbed the ward environment, as opposed to posing a direct risk to anyone, questioning the actions of the staff. For me, this narration of events also begs a question as to whether race played a part in the staff response, and whether dangerousness and race become problematically conflated in such circumstances.

Rory reported how restraint was used on another service user, who in Rory's opinion was ill. From Rory's perspective, this service user's illness made him unaccountable for his racist language towards a staff member. This was the first and only time that Rory referred to a staff member's name in his telling of his story, and even here, he is uncertain whether he recalled the name correctly. In this situation, Rory views the staff member as lacking sensitivity to the service user's illness. The restraining staff are reported again as having *"jumped on"* this service user. For me, the question in this aspect of Rory's story remains unanswered as to whether staffs' actions were due to a concern about potential violence, or in defence of a colleague confronted with racist abuse:

> "*I've seen him get restrained. He was arguing with a member of staff, but he wasn't well. He was just arguing with a member of staff called [name]. I think it was [name]. He ended up calling [name], in my presence, he ended up calling [name] a black bastard and I think [name] got a bee in his bonnet out of it. So, then [name] was screaming at him and becoming irate and they just jumped on him and restrained him and bought him to the floor. It's just not nice to witness".*

In witnessing restraint, Rory narratively transformed himself from victim to potential rescuer. He referred to people who have not been admitted to the wards as normal, perhaps suggestive of boundaries; as mental distress works to ascribe boundaries to what is normal and what is not. Rory displayed empathy, wanting to help, but being intimidated and perhaps impotently disempowered. Rory depicts himself here as being further victimised and traumatised as he bore witness to restraint. Rory stated he felt unable to help, yet inferred that he wanted to help:

> "*If a normal person sees restraint it can be very, very intimidating, but for someone who has been restrained and been in a bad way and been treated badly. When you see someone restrained, it feels a little bit worse. You feel really bad for them. You don't know whether to go up and start shouting and try and help them. All these emotions come with it. It's common sense if you've been through something bad yourself and then you see someone else going through it. You sort of have an empathy towards them*".

Signs of restraint

In conjunction with experiencing restraint personally and witnessing restraint on others, Rory also represented his understanding of the signals when restraint was about to occur, creating unease for those within the environment. Rory referred to the bell ringing, which brought tension to the story, as the auditory sound signalled a potential restraint episode was about to occur. The bell was referred to several times within the story:

> "*A bell will be pushed, and all staff will jump on you…I've heard the bell go off and I've come out my room at (name of the hospital), and (name of the hospital) and seen people getting restrained on the floor*"*.*

> *"When the bell goes cos someone is kicking off, they could be shouting. They would be down the corridor, back to the wall, you dick heads, you*

> *knob heads I hate you. So, someone will press the bell or pull the alarm and about twenty staff will come running".*

In Rory's story, visual prompts were presented that signalled restraint was about to occur, as staff removed clothing. From Rory's perspective, there appeared to be some planning, and perhaps some conspiracy is suggested with Rory's choice of language. This planning started with a meeting. Of interest was Rory's referral to this as a *"pow-wow"*, suggestive of Native American culture involving a distinct group. This reinforces how staff were storied as a distinct group, in conflict with service users. Such depiction of events implied that a good therapeutic alliance was absent on the wards. Rory's resistance fighter identity is present here, as he observes tactics:

> "*They'll go and have a pow-wow. So, you'll see four or five of them maybe six of them seven, eight, nine, ten all talking you'll see them taking their ties off. If it's in a hospital, they may take their jumpers off, so they've just got their t-shirts on and then they'll come out and you know there is going to be a restraint*".

The expert by experience: a transformed identity

Towards the story's conclusion, Rory reflected on potential ways to prevent a situation leading to restraint. The importance of a therapeutic alliance was considered, and Rory reiterated this as he explained how staff should engage with service users to build a relationship with them. In considering how a therapeutic approach may reduce or prevent future incidents, he deliberated on his own experience in how nurses might engage with individuals, including not judging future actions based on a person's history. There was implied criticism by Rory, that there had been a failure to do this and he made reference to the stories that are told about service users in their medical files:

> "*If you've been playing cards for a week with this guy an hour a day and he is presenting in a certain way. If it was me you'd go up and say, Oh (name) come on man you're kicking off come and chill out with me and have a game of cards or let's go and sit in your room and listen to some music mate. This is what I'm getting at. Get to know the service user don't just read a file and a book and say wow*".

At the end of the story, as it was told, but not finalised, Rory had changed his role from a service user to an educator, with an empowered role presented. This was seen in Rory's language and perception of himself. He presented himself as fighting the system still, but through constructive resistance via his involvement in education and less hostile means. Though his identity as a fighter was still present in the story, with a new motivation to change the system, in this respect he told of giving something back. He positioned himself to be the expert and staff were the ones who needed to learn. He posits that they had sought his advice explicitly having acknowledged disproportionate restraint responses:

> "*So, I can speak to doctors and speak to nurses and tell them about seclusion and tell them about restraint…They even said this at the (organisation's name) when I was speaking to them. They said do you think it's a good idea when loads of staff come running in and it makes everybody else feel irate and it turns into a football match fight? I said, no, it's not a good idea. I said, what you should really do is you have two people with the guy who is ready to kick off. When you've pressed the*

> *bell a member of staff goes to the door who is letting them on and says right it's just him, this is how he is. You ten or you twelve stay there and you two go up and just give them a little support. If we need more support, I'll come and get you*".

From Rory perspective, the lack of therapeutic engagement and staff getting to really know a service user was present in his story and articulately described in one sentence, capturing Rory's preference for a person-centred approach. In doing so, there is a resonance with storytelling: "*I had a phrase that I feel like I'm a library book where people just read me and then just put me back and I said on the ward I need people to get to know me*".

Similarly, meaningful activity was also represented by Rory as a preventative approach together with the potentially explosive situation of providing insufficient daily activities. Here Rory discussed the advice he had given to mental health staff, as reduction of therapeutic sessions had been managerially considered:

> "*They want to start cutting out a lot of the O.T. sessions, like making cards, playing pool all this stuff. They want to cut it out and I'm saying to them, look you cut all that out people who are tormented have got nothing to do all day. I said look at your records and you tell me how many people have assaulted people or self-harmed when they have been playing a board game, a game of pool, a game of chess, a game of scrabble? None, none have they checked it none, and they want to stop doing that and I said here's my point, right there*".

What the story tells us

From the perspective of this story, several examples of practice around restraint were told, contrary to received professional rhetoric around its use, which included his storying of pain, excessive force and restraint used as a first resort, as opposed to a last resort. This exercise of power is legitimised by policy and legislation (MHA, 1983, amended 2007; DH2014; DH2015; NICE 2015). This includes Rory's perception about staffs' use, or indeed, misuse of power and questionable restraint practice. In doing so, Rory's own narrative identity transpires from his story as someone engaged in resistance. From my perspective, the resistance narrative, with a fighter identity, serves as a resource for Rory. This manifested itself throughout the story, as Rory talks of how he fought against restraint, both directly and indirectly. The words used such as being *“jumped on”* suggests restraint experienced as battle. In a sense Frank's (2010a, 2012), guiding question ‘who is holding their own’ is relevant here.

In the story, Rory demonstrates a degree of self-regard as a strong male character. His strength suggestive of being worthy of respect in his story and his description of events involving acts of resistance (Frank 2010a), despite his portrayal of being overpowered at times by the sheer force of staff involved in restraint. Frank (2010a) suggests that individuals can be described as ‘holding their own' in situations where they seek to avoid a threat to the value of oneself. Rory offered combative resistance as staff sought to overpower him, perhaps perceived as a threat to his masculinity. From my own perception, Rory's resistance is demonstrated as strong, yet ultimately futile.

In one example, another service user is alleged to have witnessed the extent of the salient resistance. In this regard, Rory demonstrates perhaps that he need not be the ‘final' authority on the incident. This witness, as a minor character (Iser, 1978; 1993), was able to confirm the extent of Rory’s resistance, describing, illuminating and ratifying events from their perspective.

It is relevant to consider Rory’s resistance with respect to his masculinity, where a fighter identity is articulated. For me, physical aggression is suggestive as being a means for Rory to control his environment and the staff’s actions. In reflecting on Messerschmidt’s (1993) action theory, masculine resources, such as fighting, are available to an individual as a demonstration to others that they are manly. Rory’s behaviour is narrated, at times, as extreme and possibly hypermasculine. Mosher and Sirkin (1984) propose that the hypermasculine man believes violence and aggression is a vehicle to display power over others and their environment. However, Pitt and Sanders (2010) are critical of the adoption of the term hypermasculinity. Although the term is an efficient way in which to refer to behaviour that outlies masculine performance, it risks marginalising individuals who are already in marginalised groups, such as working class and black men (Pitt & Sanders, 2010). Therefore, caution may be required in not marginalising Rory further.

Nevertheless, in my interpretation of his story, Rory’s masculinity figures throughout, revealed in the nuanced aspects of the story intertwined with different components of identity also present. Rory displays his vulnerability at times, as he discusses being hurt due to fighting back and discloses a traumatising incident when, in his opinion, he felt sexually violated and he tells a story of trauma in this aspect of his story. At stake here, as in other aspects of his story, are threats to his masculinity coupled with presentations of vulnerability as a service user at the mercy of nurses. At times Rory reports being outnumbered, exposing his vulnerability in his inability to fight and overcome people restraining him. In these situations, Rory's victim identity emerges within the story. Frank (2010a) proposes victims can make their victimisation narratable. In telling their stories, victims can find empowerment, rendering what happened visible, compelling the claims of one's own experiences (Frank, 2010a).

In considering victim identity further, Rory's perceptions of justice reflect this and are revealed in choice of words. Senses of injustice are presented by Rory, amidst his feelings that staffs' action were disproportionate. For example, "*they jumped on me, they didn't need to restrain me"* is resonant with victimisation. Conversely, Rory himself positions himself to pose a substantial threat to staff at times, perhaps placing them in a victim role; for example, hitting a nurse with a kettle as his privacy was invaded. In his acts of resistance, to paraphrase Frank (2010a, 2012), Rory portrays himself as holding his own, yet restricting others in holding their own, threatening their safety. Rory attributes his behaviour to pathology, thus an illness narrative identity is resourceful for Rory in excusing his aggression.

In witnessing restraint, Rory presents an example of a young black man who in his opinion, presented no physical threat of violence yet is restrained. However, racial abuse directed towards a black staff member is suggested to result in restraint of the 'offending' service user. Rory implicates this action as unfair due to his perception of the service user's illness. In this sense, Rory perceives illness to exculpate responsibility for racist comments, so no blame is attached, and subsequent action in restraining the individual appears punitive and inappropriate.

Rory’s story ends on a seemingly redemptive note. This, in turn, shapes new aspects of his educator identity. Rory reports how, in a new role, he is called upon to speak to doctors and nurses to recount his experiences of seclusion and restraint. This reveals an empowered identity, signifying redemption at the end of his story. In this role and identity, he presents himself as reformed. To paraphrase Frank (2010a, 2012), he ‘holds his own’, whilst not directly threatening the safety of others. He is managing his health, but not cured in a biomedical sense. Rory’s identity transforms in his story into a more constructive, yet still perhaps combative, resistance identity; desiring to change the system from within through education.

Caution must be maintained when considering Rory’s and the other stories revealed in this thesis. As has been noted, any individual’s story is subject to the powerful influence of wider social narratives and representations, and the story that is voiced and interpreted here will also reflect or intersect with these other stories. For example, the narration of a continuity of pugilistic resistance from physical altercations with staff to the act of teaching from a perspective of ‘expert by experience’ can be questioned. The latter pedagogical role, attempting to reform the system from within may be either hopelessly co-opted or constitute a relatively weak mechanism of change in the face of a more powerful psychiatric and social hegemony. So, any actual redemption may prove hollow indeed. The role and identity of expert by experience will be considered more fully in the discussion chapter.

Other notable narratives that connect with Rory’s story include, importantly, the intersecting narratives of biomedicine, power, violence and race and masculinity. The prominence of a biomedical episteme in organising psy-practices and institutions demands scrutiny in its influence in de-limiting or opening up Rory's, and other participant's, opportunities to give voice to certain aspects of their experiences. Similarly, the extent to which personal experience framed within such discourse constructs identity and agency, including damage and degradation of these crucial aspects of self-hood are also important considerations. Thus, for Rory, identities associated with illness, traumatic victimhood, violent hyper-masculine, agentic resistance, and eventually more cooperative, educative engagement, nonetheless framed as further resistance, compete for prominence in his narration of self that is unlikely to be independent of broader social forces. These considerations are taken up in greater depth in the discussion section of this thesis.

The story continues.

Jane: a story of injustice

Introduction to the character

The second story chosen for inclusion in this thesis is that of Jane. Jane, 41 years old at the time of the interview, told me she lived with her young son, whom she home educated. She talked enthusiastically about her relationship with her son and was proud of her achievements in his education. Jane shared with me her love of travelling, talking of her recent holiday on the Scottish borders and the beauty of the countryside there. Another interest was photography, which she considered to complement her love of travelling. I found Jane to be an articulate individual.

My impression of Jane was that of a positive and lively individual, yet, she also disclosed she had been diagnosed with depression. Jane revealed she had experienced a one-off episode of psychosis. She was admitted to a mental health assessment ward, and then transferred to a psychiatric intensive care unit for a short time, before returning to the assessment ward. Jane chose to be interviewed by telephone and I was struck by her clarity of recall around her stay in the hospital. On listening to the digital recordings and reading the transcripts several times, my impression was someone who was admitted to a hospital seeking sanctuary but became let down by the mental health system.

Unlike Rory who experienced restraint on multiple occasions, Jane reported she had been subjected to restraint on one occasion, yet, the impact of this for her was profound and far-reaching.

The story told

In telling Jane's story, it is pertinent to look at the pre-incident build up. Before admission, Jane told of how she was experiencing what she described as a psychotic episode. She had been living in a caravan with her son and due to her own concerns for her mental well-being, presented herself to the police. Accompanied by her young son and having felt this was the correct thing to do, she sought help because of the way she was feeling. The police transferred her to the hospital, and she was placed on the assessment ward at two a.m. Very soon after admission, Jane reported feeling anxious about being on a mental health ward and concerned about her son’s welfare. Therefore, at four a.m., Jane suggested she had attempted to talk to the nurses:

> “*I was at the office door. It must have been about four o'clock in the morning and I'd said to them, look I needed to speak with somebody. I couldn't settle. I couldn't sleep. I‘d been shown to my room when I first arrived. So I went to the office door and I said I need to speak to somebody and they were just like oh go back to bed, you have to go to sleep, you'll see somebody in the morning, and I said but I need to speak with somebody now and I was terrified because of the feelings that I was getting was telling me that my son was still in danger because obviously, he wasn't with me*”*.*

In this aspect of the story, Jane presented herself as vulnerable, being confused, upset and frightened. In her opinion, the fear was rational as she was unaware of the welfare and whereabouts of her son, yet she felt ignored by the nurses. Jane positioned herself as a terrified individual and the nurses as uncaring, because Jane needed someone to talk to. Unwilling to accept their response, Jane tells of persisting to engage with the nurses, reinforcing her perception of the nurses' lack of engagement: "*I said I need to speak to somebody now, the morning is no good, but they just really weren't interested*".

Jane's sense of not being listened to was compounded by the nurses being preoccupied with computer games. Their response suggested to Jane that she was interrupting and needed to go back to bed; in effect, 'bedtime' was staff time:

> "*All they were doing was sitting on the computers, playing on a Japanese tower matching game. They weren't really interested, and I kept saying I need to speak to somebody, I need to speak to somebody, but they were saying you'll have to go to bed and speak to somebody in the morning*"*.*

Later that morning at 10am, there was, what Jane perceived to be, a contentious encounter with a doctor. Here Jane described feeling insulted at being told she was unwell. Jane felt patronised as the doctor, an authority figure, questioned her mental health. Beforehand she had felt herself to be an equal, not a passive service user. The exact words of the doctor were not reported by Jane, yet the encounter is summarised in her story:

> "*He was saying that I was very unwell, well I didn't feel unwell. I still question it now because if I was unwell then I must be unwell now as well and I must have been unwell for all of my life because nothing's really changed other than the fact that I'm not getting strong feelings. Yes, I was getting strong feelings at the time but do feelings make somebody unwell? I just felt insulted by what he was saying to me in the interview in the room*"*.*

Restraint viewed as unjustified and violent

The altercation with the doctor was followed by what Jane inferred as irresponsible action by staff. Only 10 minutes after, she alluded to forceful action by staff in running towards her aggressively and grabbing her. Jane displayed her compliance, in her narration of this incident, in not resisting. She was troubled as to why she had been restrained and subsequently injected with medication, particularly as this was soon after her new admission to the ward. There was no acknowledgement by Jane of any attempts from staff in seeking to persuade her to take medication. The nurses were portrayed as villains, who attacked her. Jane positioned herself as an innocent victim, harmlessly talking to people; posing no threat. Jane implied the number of staff involved in this incident was excessive; four men and two women, with the men aggressively handling her. This aspect of her story gave an impression, to me, of a ‘rabbit caught in headlights':

> “*I believe I was talking to some cleaners and six people, four men and two women, came running down the corridor and they were full of aggression and just pumped up with energy and I didn't know where they were going, but they were running towards me. They grabbed hold of me. The four men grabbed a hold of me, took me into a bedroom, pinned me face down on the bed. The two women proceeded to pull down my pants to show my bum and put two needles into my bum. At this time, I was well. I didn't know what was going on, so I was just saying ok, ok, ok, ok. I didn't fight back because I didn't quite understand why that was happening to me*”*.*

As Jane elaborated on her story, her language illuminated her perception that excessive and dangerous force had been used. This came through in her description of being *pushed* onto the bed, her head in the pillow in a prone position: "*I was taken into a bedroom and pushed onto a bed, my head in a pillow, two of them had my arms, two of them had my legs"*.

The next reaction for Jane was disbelief. She described being in shock, questioning whether this incident had involved mistaken identity, positioning herself as an innocent bystander:

> "*I was in shock because I didn't understand what was going on and it seemed to happen very quick, so I didn't have much time to react or think about it. It was shock. I thought that they'd gone for the wrong person, I just thought what are you doing it for? I didn't quite understand*"*.*

Following the restraint and subsequent injection, Jane depicts herself as having challenged the action, fighting back in a small way, to gain some control back: "*I said to them whatever you've just done it hasn't worked*". As she reflected on the incident, Jane viewed that there had been no risk to herself or others, which challenged the justification and legitimacy of this restraint: "*I wasn't a threat to anybody after. I wasn't a threat to myself"*. Attempting to make sense of what happened, the doctor on call was clearly seen by Jane as the person who initiated the restraint. She asserted that he had sought revenge as his autonomy and intelligence had been questioned in the earlier encounter. Jane positioned the doctor to be an abusive figure, who used restraint as a punishing abuse of his power. Thus, in her story the doctor was vilified by Jane; having misused his authority, begging a moral question of right and wrong. Jane positioned herself as vulnerable, as staff restrained her. Additionally, in Jane's opinion, the restraint occurred as a consequence of her defending her position as an intelligent person with the doctor, emphasising the power imbalance: "*Basically, I think that it was done because I insulted the doctor by saying that I'm more intelligent than you and he's abused his power of authority*".

In considering the impact of restraint, Jane deploys powerful and vivid language to portray how she felt violated. The physicality particularly troubled her: "*Just the touching, being physically touched in an aggressive manner*"*.* Jane made comparisons to other forms of restraint or actions that overpowered people or animals. The aggressiveness presented by Jane, being a clear negation of legitimate caring human touch: "*I would rather have been shot with a dart or been tasered than to be physically touched by another human being in such a manner"*. These strong comparisons suggest Jane's assessment of the intrusive and brutal nature of the incident.

The emotional protector

Following the incident, there was some interaction with a nurse who had not been involved in the restraint. This nurse was seen by Jane to be caring, which she attributed to his status as a former service user. Disclosing his former mental health service user status, Jane felt he had understood why she was troubled by the event. He was perceived, by Jane, as consoling her. Jane considered this nurse as good, potentially on her side, whereas the other nurses were bad, indicating a moral perspective on the staff's actions.

My perception of this aspect of Jane's story, was how group identity presented itself in this interaction. As the nurse had been a former service user, Jane felt this nurse had been able to empathise with her. His actions perceived as protective, as he sat silently, allowing her time to recover:

> “*After I was sitting outside the room and a male nurse came and sat next to and we must have sat quietly. We didn't say anything for about 15 minutes, 20 minutes we were just sitting there. I was in quite a shock actually and then I turned to him and I said shall we go for a cigarette? So off we went for a cigarette*”.

The voice of this protector is silent, although, in Jane’s opinion, he had understood what she was experiencing, and she believed his compassion to be real. This suggested he had understood the incident through the lens of a service user. He was the only nurse in the story mentioned as engaging with Jane positively and providing emotional support:

> “*We just sat there quietly but he was lovely. I felt that he had come to sit next to me just to make sure that I was all right. He'd actually been a patient himself. He told me that he'd been a patient, but he had changed to being a nurse so he's whipped things around for himself. So, I felt that because he had been a patient that he understood where I was. He came to sit next to me just to comfort me. I was quite frightened*”.

In this regard, there may be some tension in the story, as the intentions of this nurse are unknown. Beyond providing support, I considered how it is also possible he came to pacify Jane, avoiding a complaint.

From Jane’s perspective, her trust with the rest of the medical team caring for her had been lost, which implied a negative impact on the therapeutic alliance between herself and the nursing staff. This distrust manifested itself to most of the other nurses on the ward. It was in discussing this loss of trust that Jane spoke of her view that the restraint was an assault, raising safeguarding concerns about potential physical abuse:

> “*They weren't really doing anything to gain my trust. They lost my trust of not just the six people that work there, but most of the staff. I went very, very quiet. I didn't speak. I didn't say anything I just felt I wasn't there to be assaulted. I was there to be helped*”*.*

In considering fight or flight, following the restraint, Jane described her attempt to abscond from the ward that evening, prompted by concerns about her safety and anxiety for her son, whom she felt she needed to protect. From my perspective, the incident suggested mistrust with the whole system, including the authorities who were looking after her son. Here her identity as a mother, in her role of protector were presented and she positions herself to have acted instinctively:

> “*I'd been pacing up and down the corridor because the episode that happened to me didn't just happen to me. It happened to my son too and I didn't want to say anything to anybody because I was frightened that my son might be brought into it and I was trying to protect him. Plus, the fact that they'd lost all my trust. I just thought I was completely by myself. So, for the most of that day. I was pacing up and down the corridor trying to figure out what I was going to do to be with my son and to be safe and make sure he's safe. So, at about five o'clock the corridor was empty there was nobody about. It was very quiet, so I saw an opportunity to run. So, I raced through the doors on the wards that were just held by a magnetic lock with my shoulder and I ran and as soon as I burst through the doors the alarm went off. So, I knew I was being chased. I could hear them coming after me, so I hid in a doorway and a few of them passed me, but one guy saw me and just started laughing. It was more of a game of hide and seek. So, I thought I'm not going to get anywhere, so*

> *he took me back to the ward, but he was fine. It was more funny than anything else*".

Quest for justice

Jane depicted a quest for justice aspect to her story. After being discharged, she reported scouring her medical records; implying that her intention was to look at the rationale for the restraint used upon her. Here we see a stronger character, no longer a victim. Jane was troubled to find the injection was administered to prevent her from absconding:

> "*I've since got my medical records and it doesn't mention anything in my medical records about me being aggressive or being disruptive. There is nothing mentioned. The only thing that is mentioned is that the doctor that I'd seen at 10 o'clock in the morning, that morning, has said that it was done to try and prevent me from running off the ward*".

Unhappy about the incident of restraint and viewing this as a physical assault, Jane revealed how she took formal action and reported the incident to the police. She positioned herself in the stronger identity of survivor, fighting back and seeking some form of reparation. Morally, she positioned herself as being wronged, yet accepted no action came from this. However, she suggested that she felt listened to by the police, perhaps vindicated, as they took it seriously and followed the correct procedure:

> "*I have tried to take it up with the police which they have looked into it on assault charges, but because I've got no evidence or no witnesses at the time. There's not very much they can do about it. They have been really good in questioning people about it at the time*".

From Jane’s perspective, contacting the police had gone some way to resolve the incident and helped her move on:

> “*I feel a bit better actually since taking it up with the police now. I only took it up with the police last year. I've only started to talk about things within the last eighteen months and open up. So, I feel that it's helping towards my recovery*”.

Restraint: longer-term implications

Despite some recovery, long-term consequences of restraint were reported by Jane. For years following discharge, Jane expressed a correlation between the incident and onset of her depression; feeling well leading up to the incident but now diagnosed with depression. In Jane’s opinion, she connected the restraint incident to her current diagnosis of ‘depression’. Here, I felt her character changed, as she saw herself as the ‘wronged' individual, a ‘wounded storyteller’:

> “*I didn't really think too much about it at the time, but since that happened, I've gradually been getting worse, suffering from depression…I'm on medication for depression. I've been on the medication for depression for about five years*”*.*

In Jane’s view the restraint incident was an assault with long-term and distressing consequences:

> “*I'm associating that with the assault… I've got no doubt about that. Over the years there have been times I've gone to bed at night and I've cried myself to sleep just because, I think well I went into hospital. I took myself to a police station because of these feelings. I've always been*

> *honest about my feelings that I was having at the time and I felt that I was being a good person, but sometimes when I've gone to bed and I've cried myself to sleep. I feel that I've been punished for being good*".

Telling the story as a means of recovery

Jane told of having addressed what had happened by formal routes and considered her own recovery from this. The story revealed how Jane presented herself as not being fully recovered from the incident but accepted, more than resolved, what had happened. She positioned herself as stronger, living independently, and aspired for a future with her son. Her identity as a survivor was presented and her role as mother restored. Jane conveyed how she felt that telling the story helped in her recovery, yet she articulated that this was partial and may never be completed:

> "*I feel that it is getting better even speaking with you today I feel as if things are beings relieved, not necessarily resolved. They might never be resolved, but by talking about things I do feel a lot better. I'm hoping that in the next year to two years, that I'll be totally off my medication for depression and feeling much better within myself, like I was before I got admitted into hospital*".

Reflections on the justification of physical restraint

Towards the end of the story, Jane considered the use of restraint. She reflected on its justification and proposed that in situations of extreme risk, it is an intervention of last resort:

> "*I just think that in some cases yes, physical restraint might be necessary. If somebody is being aggressive to the point where they are*

> *going to cause damage to somebody else or harm to themselves, then yes, I do feel that that is probably absolutely right to take that type of intervention. In my case, I feel that it wasn't necessary. I wasn't a threat to anybody after. I wasn't a threat to myself. Yes, I might speak my mind and some people might not like*".

Conversely, Jane reflected on her perception of excessive use of restraint, not only in her own experience, but through the experiences of others. Restraint has led to death in some cases and Jane reiterated this point:

> "*I do think that in my case, it was a matter of abuse of authority and I think that too many cases are actually an abuse of authority. I've done research myself on the internet and I found out that there have actually been 64 deaths. I think to have one death it should be questioned, never mind 64. It is a very old-fashioned procedure There's more modern techniques*".

In closing her story, Jane considered therapeutic relationships, in her suggestions of how she felt that service users ought to be treated when newly admitted to a ward; particularly if frightened, as she was. In this regard, she considered the moral values of compassion, care and communication towards service users:

> "*If I was a nurse, I would have spoken to the patient. I would have asked them quietly if I could speak to them, take them away. I would have listened to them. I would not necessarily given them what they needed but try to help them to get what they feel they need. The patient is in a better position to know what they need at that time than anybody else because the patient knows who the patient. A new patient that goes in*

> *gets a buddy, not necessarily another patient, just somebody who is not a nurse. Obviously works for the mental health, but just somebody who maybe has been a patient. Just to settle somebody in, somebody to talk to so that they know there is somebody there for them. They can say, can I do this can I do that, what's the rules, what's going on? Especially people who have never been in a hospital before*”.

What the story tells us

The essence of the story is presented as one of injustice. Jane's story uncovers her perception of the inappropriate use of restraint, excessive force, lack of dignity and poor communication in mental health care, exacerbating feelings of vulnerability. These issues will be addressed further in the discussion section. Although Jane discusses only one incident of restraint, the impact on her wellbeing is storied as being extensive and long-lasting. A narrative of trauma features prominently in Jane’s account of her experiences, correlating with other storytellers. For Jane this relates to a one-off incident, which perhaps makes her storying of the impact even more powerfully profound. She perceived the restraint to be very violent and abusive. Like other of the participants, Jane’s story in this regard intersects with wider narratives of trauma, violence, power and control which are taken up in the discussion section of the thesis. An interesting element of this will be exploration of tensions between notions of compliance and control, cooperation and resistance as framed by an overarching bio-psychiatry. This discussion also traverses the territory of risk, its prominence in the organisation of mental health services and wider resonances in a society discursively obsessed with risk minimisation (Beck 1992).

Jane positions herself as compliant when being restrained, yet afterwards she challenges the staff's action. This show of resistance is seen in her words to staff “*whatever you've just done it hasn't worked*”. Much later, following discharge, she ‘holds her own’ (Frank, 2010a, 2012), presenting a stronger challenge by reporting the incident to the police. I feel Jane’s identity as a survivor is a resource for her, particularly as she tells of seeking restitution. To paraphrase Frank (2010a), these events support enactments of resistance.

At stake for Jane in her story is her safety, dignity and integrity, which are presented as being threatened. Also, at stake is the safety of her son, whom she is separated from when hospitalised. Jane talks of being admitted to the hospital, seeking sanctuary, having gone to the police to declare she was feeling unwell and experiencing ‘psychosis’. Jane alleges she was not being listened to by nurses. From Jane’s perspective, the support she requires is not just for herself, but ensuring her young son is safe and supported. The fact that nurses are perceived by Jane as being more interested in computer games exacerbates her frustrations. Her role as a mother, unable to see her young son, represents her maternal identity. Frightened for herself and son, the reported reaction of the nurses appears to question their perceptions of Jane; perhaps viewing her as a service user, to the exclusion of mother.

Jane revisits staff reasoning for her restraint when scrutinising her medical notes, which state Jane was an absconding risk, but Jane questions this risk. It is interesting to consider here the storied lives of service users through medical notes. From a dialogical perspective, staff socialised to the narratives of institutional psychiatry are likely to have their own view of reality, which may often fail to correlate with service users’ views (Grant, Leigh-Phippard, & Short, 2015).

Jane's identity is framed as a victim during the restraint, with suggestions by her that staff acted excessively, if not overtly violently. This is seen in Jane's language, reporting staff to be “*full of aggression”* and “*grabbing”* her. The number of staff alleged by Jane to have been involved, also hints at excessive and brutal force. Jane subsequently reports her loss of trust with the staff because of her perception of unjustified assault and misuse of power. The narration of violence is not unique to Jane’s story and can be seen to reflect wider narratives which infuse psychiatric concepts and practices with the potential for violence (Holmes et al., 2012; Liegghio, 2013) operating in contrastive juxtaposition to idealised notions of nursing and psychiatric care (see Gadsby, 2018; Grant, 2018), which challenge the therapeutic alliance in mental health care. These issues will be taken up further in the discussion section.

As a consequence of these felt vicissitudes of care provided and her view of having transcended them, Jane claims a survivor identity, surviving the system as much as her diagnosed condition. As the story unfolds, however, facets of her vulnerability remain. She does not hesitate to associate the restraint incident with her current diagnosis of depression: “*I've got no doubt about that”.* This aspect of the story resonates again with the dominance of bio-psychiatry in labelling mental illness, a process returned to in greater depth in the discussion chapter.

Yet in talking about the incident she depicts some recovery. Reporting it to the police is a fundamental step in feeling listened to, taken seriously, vindicated and moving forward. For me, her survivor identity is strong in this aspect of her story. The police investigation provides some meaning as they acknowledge the incident as a potential assault.

It is argued that healing or restitution is not able to take place until the full extent of service user grievances have been acknowledged (Spandler & McKeown, 2017). This is certainly poignant in this aspect of Jane’s healing. It is relevant to consider the concept of agency, as Jane discusses the healing process. Jane's personal agency is visible in her autonomy and ability to influence events. Reporting the incident is presented as an autonomous act, which appears to have helped her healing. Furthermore, Jane suggests that talking about her story as part of the interview also aided her recovery. However, critics such as Smail (2005) discussed the illusion of autonomy which conceal social interpretations of actions and emotional distress[20]. Frank (2013, p.75 proposes that ‘*People tell their own unique stories, but they compose stories by adapting and combining narrative types that cultures make available’*. People do things with stories, often creatively, with those resources[21]; that is agency, exemplified in storytelling (Frank, 2010b). Whilst agency is a contestable notion and may obviously be constrained by social structure or the operation of power (including powerful discourses), arguably it is never completely absent in social relations (Bhaskar, 2008; Bourdieu, 1977; Giddens, 1984). Margaret Archer, working within a critical realist perspective, argues that previous sociological theorising tended to over-emphasise either structure or agency in a misplaced quest to attribute determination of one upon the other and in doing so fails to address the fact that social change does indeed happen and individuals do have a role in this. Highlighting the importance of temporality, Archer allows for an inter-dependence of structure and agency within which structures both constrain and

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[20] Smail (2005) works with the term ‘magical voluntarism’ – the belief that people have the power to be to be whatever they want to be. This being the prominent ideology and unofficial religion of contemporary capitalist society, influenced by such reality TV ‘experts’ and market forces, as much as by politicians.

[21] Frank (2010b) argues that people do not make up a story, they combine and paly off resources.

enable agentic actors; interaction between the two over time changes both the original structures, and thus opportunities for future agency.

Narrative re-storying has the potential to help recovery for mental health service users, helping individuals both therapeutically and in moving forward (Grant et al., 2015). In reflecting on the justification for restraint, Jane discusses contrasting viewpoints. On one hand, she expresses how restraint may be justified as a last resort if there are risks to self and others. Nevertheless, she also discusses her concerns about assaults and deaths associated with the inappropriate use of restraint. She deems her own experience of restraint as unjustified.

The story continues

Rose: a story of trauma

Introduction to the character

At the time of the interview, Rose was 60 years old, lived with her husband and they were about to move home. She had four children and three grandchildren, with another grandchild expected. Rose shared with me how she enjoyed baking, sewing and knitting, and loved animals.

Rose told me she was an expert by experience and was committed to improving people's experiences of mental health care, travelling the country talking about her experiences of mental health services. Rose had experienced several admissions, mainly within psychiatric intensive care units and assessments wards.

Rose has had several differing mental health diagnoses. Rose talked about her dislike of labels for her condition. She found people, including some professionals, viewed her through the lens of her diagnosis, rather than as a human being with differing roles, such as a mother, and grandmother. I found Rose to have a very engaging personality and felt at ease when talking with her.

The story told

Memories of childhood abuse resurfaced frequently during incidents of restraint within Rose's story. The act of restraint allowed this abuse to replay its presence in Rose's memory. Rose's mother was cast as a vile abuser, having abused her during her childhood and also enabled physical and sexual abuse from other adults. Rose described having been raped “*both ways”* as a child, hence the position she had been placed in during restraint was irrelevant. The act of restraint itself allowed previous abuse to replay its presence in her memory.

For Rose, fear played a part in the intensity of feelings during restraint, as she located herself as a victim of both emotional and physical harm during restraint and felt it was unwarranted:

> "*I'm scared of what's happening. I don't really fully understand why I'm being restrained, probably because I'm not exactly in the here and now and when I've witnessed restraint and even when I've been I do think there's been absolutely no need to have been that manhandled*"*.*

Rose portrays some staff as having used restraint to exert control, reflecting issues of power imbalance, with the underlying trauma represented as not understood, nor acknowledged:

> "*I find a lot of staff when I first went on the wards were, they like the control they have over you. I'm not talking of all staff because I've had a lot of good staff too, but there are some that like that level of control and then will pass you on to someone else if you are not being compliant for your meds and they will think the same thing, that I'm just being difficult and I wasn't, I was traumatised*"*.*

Re-traumatisation

During restraint, Rose located the nurses as villainous and viewed the very physical nature of restraint to be a threat to her safety and she connected this to previous trauma. Rose suggested she had dissociated herself from reality during restraint:

> “*I have been manhandled by men and women and it's got to the case where I've been frightened for my life really and then before I know it I've dissociated them and that's it. It doesn't matter whether you put me on my back or my front, I've been raped both ways from a very early age. So, the intensity of that, it's just like recreating more abuse really and I know myself by that stage it is that intense*”.

Rose reported that when she was in the hospital ward, she had a desire to be safe; free from abuse. The act of restraint was both physical in nature and emotionally traumatic, compromising feelings of safety: “*It has been physical, very physical and hurt and very, very intense and for me, it's recreated severe trauma from the past*”*.*

The issue of medication compliance was complex in Rose’s story and also associated by Rose to be linked to with past trauma. Rose alleged that her mother would control Rose's behaviour by giving her what she described as “*handfuls*" of medication. Medication became a sensitive issue because of this, and Rose was non-compliant with medication as an adult. Rose suggested she had made her wishes known about medication by writing an advance statement of her wishes not to be given certain medication. Nevertheless, in her view this statement had not always been read by staff or on occasions been lost, suggesting lack of regard for her wishes and wellbeing. Here, staff are positioned by Rose as perhaps uncaring and disrespectful of service user choice: “*As long as people bother their bottom to read my advance statement because it was a letter in my notes at first, which conveniently got lost at times*”*.*

In the telling of her story, Rose shared her fear of sleep, connected to nightmares of past abuse and restraint. From Rose’s perspective staff had misunderstood her reasons for avoiding sleep, staff in the story are portrayed as potentially ignorant minions enforcing bedtime rules. Rose suggested that this often escalated into arguments, which consequently culminated in restraint:

> "*I couldn't sleep because of memories and being in the side room, which I was sometimes, recreated a lot of memories for me and I'd keep coming out of my room and told to get back to bed, you need your sleep and I couldn't sleep and then stop wandering round the ward and then before I knew it I was arguing with them. Then the next thing restraints back in bed. You know I was restrained quite a lot really, but I don't think it was ever documented properly*".

Trauma was presented further in Rose's story as she talked about having witnessed restraint. Rose proposed that her personal experiences of childhood abuse impacted on her reaction to witnessing restraint on other individuals. For Rose, this resonated with her recollections of others watching as she had been violated as a child:

> "*I was frozen. I was literally frozen to the spot because for me, when I was abused as a child there was other people around at those times. There wasn't just me in the room there was quite a few people in the room. So again, that intensity of fear that playing out on the floor in front of me just made me routed to the spot, so much so I weed myself with fright and was then shouted at to not interfere*".

Trigger points

Rose reported on trigger points within her story connected to her childhood abuse that escalated her behaviour, leading to restraint. She told of her perception of provocative behaviour from some staff, inciting resistance from her. An example of this was presented by Rose as she told of an incident when a nurse gave her mashed potatoes with her meal, despite strict care plan guidance to avoid them. Rose reported that when she was a child, her mother had placed maggots in her mashed potatoes, so as an adult she strictly avoided them. In Rose's view, a nurse had acted irresponsibly and served mash to her, Rose's reaction to the trauma and distress was to throw the meal at the nurse, resulting in her being restrained:

> "*I mean I wouldn't eat mash you know. That was another trauma, traumatic memory. Sometimes I'd been given mash to see what would happen. I remember getting restrained really badly because I threw mash at someone and he knew, he knew, that member of staff knew that I shouldn't have been given mash and the reason why, but he still gave me mash. So, he ended up wearing it and I ended up getting restrained*".

A further trigger point presented by Rose was when a doctor, insensitively, asked her how her mother was able to rape her: "*All hell broke loose because I trashed the treatment room and then a restraint happened*".

Although Rose's story displayed enactments of resistance, there were other times when Rose suggested that she had wanted to run away when she knew restraint was about to happen to avoid this trigger point. Rose reported that she experienced acute feelings of suspense as the nurses approached, making her want to escape this threat: "*When they are approaching me I just want to run. To be honest, it's a case of fight or flight. It's a case of they are coming towards me and I need to get away from them*".

Inappropriate restraint: excessive force

Rose's story implied that unnecessary force was used during restraint, for example staff holding her too tightly. Excessive force was also deemed as abusive by Rose because of physical pain and injury. As Rose located herself an adult victim of abuse, the staff were perceived by her as heavy-handed in their use of restraint. On occasion, Rose reported that her husband noticed bruises, acting in this aspect of her story as a witness to such excessive control. Rose's use of the phrase "*manhandled"* exemplified her appraisal of excessive force, as did the various abrasions:

> "*My husband would notice I had a bruise on my arm where they held me and banged my head a few times when they have manhandled me into a room and got me in a side room. I've had my head hurt. I've had cuts on my head and scratches, sometimes not visible because obviously when they are holding you and they are holding you tight, they do bruise you*"*.*

Fear was often prominent in Rose's story. The physical nature of restraint and associated fears were represented by Rose as she described people running at her. Here, Rose positioned herself as a victim of staff who hurt her, pinned her down and manhandled her. Preceding restraint, Rose reported on the physical signs of fear, viewing unnamed staff as bullies:

> "*I've always been scared and that's probably on my face and obviously visible when I've weed myself. When people have run to me and I've been sick and that's down to sheer fear. It hurts because when I say manhandled and it's very physical. It does get very physical because you fight. They are holding your arms, they are holding your legs, they are pinning you down*".

Just as the act of restraint is suggested by Rose to have had an adverse impact on her, the threat of it also is represented as having negative impacts. As staff approached her, Rose reported that she experienced dissociation:

> "*I'd say I'm not a danger to others. I've never hurt anyone, and I never would hurt anyone. Then there's a verbal altercation if you like, with me arguing with them and then it gets more intense with them approaching me. Then it's a case of, if you don't do as you are told we will make you stay and then before I know it it's just chaotic and then I've gone then, in my head I'm not there anymore. It's total bedlam really*"*.*

During restraint episodes, threats from staff appeared in Rose's story. Rose alleges she had been told by staff that if she struggled the physical intensity of restraint would increase. In this aspect of the story, nurses were perceived by Rose as threatening and she deemed this unjust. Rose implied that her reason for struggling was prompted by fear, which was amplified further by the threats from nurses: "*I have been shouted as well, if you do struggle it will get worse and you know that's not nice. You are going to struggle because you are scared*"*.*

From Rose's perspective, she had understood that at times she had been a risk to herself, compromising her own safety. Rose reported her understanding that, from a staff perspective, such concerns warranted a response. Whilst Rose suggested that staff response was needed at such times, in her opinion their actions were excessive, unjustified and intimidating:

> "*They shouldn't do that there should be no reason for that level of force, and it is forceful, you know. I mean I understand that I'm a danger. I'd*

> *never hurt the public, but I know I'm a danger to myself, but there is still no reason for that level of force or intimidation".*

Restraint had been deemed as chaotic by Rose. She told of how restraint was quick, but other times it lasted a considerable time. Rose described being in a bubble of time, so there was some distortion about time, yet she represented the excessive nature of restraint. Rose implied that, in part, this was due to the disproportionate number of staff involved:

> "*As the situation escalates it would be four, one on each limb and possibly five with one at your head and it was chaos. It felt chaotic, intense and quick, but it was quick when I think about it now. It was quick, but it's not quick. It's like you are in a bubble in time and it seems to go on forever*"*.*

Rose alluded to another example of excessive force as she reported witnessing restraint on other individuals. Her sense of agitation was revealed in a palpable way in this aspect of her story. Rose viewed other service users on the ward as victims in situations when restraint could have been avoided. A sense of tension prevailed in her story:

> "*So, it can be quite intensive on a ward and again that atmosphere can last for hours on a ward. When a restraint happens, it can still have that anxiety and that intensity on the ward. The atmosphere is intense, and it is scary for people. When I have seen other patients restrained, I feel maybe it's not needed nine times out of ten. I can say that hand on heart they are not needed*".

Rose suggested she had attempted to take proactive action when witnessing restraint, but reported being accused of watching restraint as an act of “rubbernecking”:

> “*I will try to intervene. I can remember getting stuck behind a restraint of someone on the floor being manhandled and then I got stuck and I couldn't go backward because someone was in my way, I couldn't go either side because there was nowhere to go. There was staff all round this person. There wasn't just people on top of her, there were other people round watching and I got screamed at stop rubbernecking now. I didn't even know what rubbernecking meant*”.

The issue of human rights was presented by Rose as her story unfolded. By implication, staff were seen to have potentially neglected these rights, on occasions, as depicted by actions that Rose deemed to be abusive:

> “*I do class it as abuse, I really do. If they did it for the right reasons, well for me if it would be to stop me hurting myself. They have a duty of care to take care of me and I got injured and I would probably put that down to me struggling and carrying on. There is a reason why I'm doing that. I still think it's an abuse of someone's rights really*”.

Lack of dignity

Carrying on the theme of human rights, Rose suggested there had been indignities present within restraint practice. She alleged that she experienced injections in sensitive body regions, within a public area of the ward. Rose, located herself as a humiliated victim, treated in an undignified way in a public arena. The nurses' voices were silent, in the telling of her story, and rationale for restraining was typically not offered: “*Restraint with aid of medication, usually a* *needle in your bum, right in the middle of a ward. There's no privacy with restraint, it happens and that's it and then you are on*".

There was a sense within Rose's story that her compliance was paramount at times, particularly as she reported how she waited for restraint to occur again. This created tension and presented forced acquiescence: "*It's like you are waiting for the next time it's going to happen. It almost forces you to think that if I don't do as I'm told it's going to happen again, so I must comply. It's a horrible feeling*".

In Rose's story, nurses, at times, were deemed by her to have misunderstood her mental wellbeing, displaying dehumanising, unsympathetic and irresponsible treatment:

> "*Being restrained and thrown in the bedroom once, in the side room, and left in my wet bed because I'd wet myself. Then told I was, you know, well you've done that because you were too lazy to get up and go to the toilet. Actually, I was on a mattress on the floor and I was sedated. I couldn't get up*".

Although some staff were depicted by Rose as having been insensitive and uncaring, she felt other staff had taken time to get to know her and consequently understood her more. These staff members were portrayed by Rose as more thoughtful:

> "*Some of the nurses who have known me over many years, will know me. If they are on duty, they would let people know that there would be times when I can't take my meds. It's not because I don't want to take them. Believe me, before I get to that level of distress, and it is distress, it's not being difficult it's a level of distress. I think that I'm not in the here*

> *and now. I think I'm in the past and medication means very different things to me, like my mum when I was little would give me her medication*".

Rose considered the different responses of staff on different shift patterns, regarding the support and care offered, distinguishing between the care received from night and day staff. Day staff were positioned by Rose as more caring, and night staff less caring. For example, it had been the night staff who she alleged had left her in urine-soaked clothing and who were seen by her as more likely to use excessive force:

> "*It was the day staff that came on and saw me in a wet bed and they helped me get changed myself because I wouldn't let them near me. They got me clean clothes, but it wasn't until the morning. I think the majority of times I've been manhandled like that it has been by night staff*".

Consequences of restraint

Threats of fear and trauma were storied in the aftermath of restraint. At times this was viewed by Rose to have impacted on therapeutic alliances between herself and the staff. Rose identified staff involved in restraint, not by name, but by weight, voice tone and perfume. She indicated how their scent impacted on future relationships for weeks, and consequently relationships were soured. Rose reported how she would back away from staff because of their perfume, as she cast these staff as the ones who hurt her. Nurses' communication was also seen by Rose as problematic at times, due to her portrayal of their patronising tone of voice and language. For me, this perpetuated a sense of Rose being viewed as childlike, for example being told to be a "*good girl",* which was potentially trauma reinforcing. The nurses in question were located as nameless villains:

> “*I could actually tell you how heavy they are because when you are in that state and when I've been in that state, I've actually known how heavy they are. I can smell them if they approach me again later say after the restraint and I'm very compliant by then. I'm usually medicated to the hilt and I smell a perfume or an aftershave, then I will run off again. I will literally run off again and it's as traumatic as that and it really isn't nice. It's not just about the restraint, it's the aftermath. It really is the aftermath that can continue for hours. Tones matter a great deal to me. If someone is sort of sing-songy at me, you know be a good girl and you know we are here to care for you. If they sort of sing-song that at me then I will get even more intensely frightened and that is probably not their fault because they are probably trying to be nice, but for me, that is so re-traumatising. That probably causes more harm*”*.*

A lot of the fear culminated from Rose’s previous incidents of abuse. The abuse as a child and restraint as an adult were storied as precipitating nightmares. Rose compared the impact of restraint to previous domestic abuse as an adult. The physical force during restraint was presented as objectionable, however, the emotional impact was demonstrated as being much harsher for Rose, as she implied that she was living in fear of the next incident of restraint:

> “*It was like when I was being hit by my first husband. I could cope with the smack because that was over and done with. What I couldn't cope with was the mental stuff afterward, the waiting and the waiting*”*.*

Rose revealed a sense of guilt and shame from behaviour that had culminated in restraint. Rose felt she had been judged as a bad service user, yet from her perspective, she had been frightened. Rose tried to apologise, but when this was not accepted, Rose felt worse and went on to self-harm. In doing so, she placed herself at risk of more restraint:

> “*I've gone up to them afterwards and said sorry and I didn't mean to hit you, or I didn't mean to fight you and then there's been no conversation. It's almost like when you self-harm and in the past when people have self-harmed they've been told not to discuss it with you and that has happened quite a lot to me when I see them. If they'd spoken with me, I could have explained why that had happened because I feel bad and I feel naughty and shouldn't have done it. I will self-blame and that perpetuates itself into more self-blame and more self-harm. So, after a rethink, I’ve gone and apologised for behaving that way. I’ve been told I behaved badly and that is why I've been restrained and if you hadn't gone to run away, we wouldn't have had to do that. When actually I was running from them because I was scared of them*”.

In the aftermath of restraint, the emotional pain remained powerful in Rose’s story. Rose reported her fear of future restraint prompted stress and, in her view, impacted on Rose's behaviour, as she displayed her agitation by pacing. Rose reported that staff asked her to refrain from pacing and lie on her bed. However, she indicated that they were equally unhappy when she lay in bed, and suggested Rose was lazy, creating a no-win situation:

> *“I think when you are on a ward you know someone is becoming distressed. For me, I'm waiting for it to happen again and that makes you*

> *more agitated and more scared and the staff don't know you well enough they will see you pacing, I'm being screamed at, what are you pacing for? Go and lie on your bed. So, you lie on your bed and you get told get up because you are lazy, so you can't win*".

Rose indicated that staff justified their actions by blaming Rose for behaviour that had warranted restraint. Rose felt that some staff blamed her because of her non-compliance with medication, yet Rose told of her need for reassurance. Staff were positioned as ignorant, as they accused Rose of poor behaviour and were oblivious to her need for reassurance. Rose viewed that the act of restraint also unnecessarily extended her length of stay at the hospital:

> "*They said if you hadn't behaved like that, we wouldn't have to do that, so apportioning blame all the time. There was no need. If someone had have spoken to me or reassured me, that wouldn't have needed to have happened. It just escalated and actually, in the end, made my stay in hospital much, much longer, in fact, months longer in some cases*".

Expert by experience

Towards the end of her story, Rose positioned herself as a survivor holding her own against the system. This was in the context of helping others. Rose talked of her formal advocacy role in a reflective way and considered how care could be improved. Although from her perspective, she felt care had improved over more recent years, she proposed that pockets of poorer practice still existed. In her role as an advocate and expert, Rose identified herself as a professional. Rose reflected on her perception of the continued nature of abusive restraint on some occasions, as witnessed in this professional role: "*I think in some areas that it's prone to not being scrutinised properly and I do class it as abuse*".

Her professional identity was firmly anchored at the story’s end. She expressed her hopes for a better outcome for mental health service users and a reduction in the use of restraint:

> “*I think because of the field I work in now about trying to reduce the level of restraint and hopefully in the future reduce the need for that because we are going to give people the tools*”*.*

Her journey to survivorship had been an evolutionary one, which has been supported by the involvement of a therapist. This has been seen by Rose as having a positive influence on her wellbeing. Rose portrayed this therapist as having helped her to take more control over periods of illness. A more empowered person evolved as a sense of agency was presented in her story, telling of what was and is possible:

> “*When I got the therapist, I'd worked with for a long time now, I asked could I write something? It was before we had advanced statements and advanced directives. So, I had something in my notes about what I looked like when I became distressed and why, so it was written. I think I've got it somewhere. I think I kept it for a while and it explained, and it is not easy*”*.*

Despite some recovery from childhood abuse and restraint experienced as an adult, nightmares have persisted. Rose reported how she was still upset by these dreams and, therefore, remained a victim. The villains here are presented as both the adult abusers from her childhood abuse, and the nurses who physically restrained Rose as an adult:

> “*I'll often wake with nightmares that I've been in restrained by the perpetrators of the abuse, but also staff who have held me down and*

> *almost lay on top of me to keep me still. If you witness a restraint you can see it on the videos when they are demonstrating how to keep someone's legs still and they have got your legs parted and they have got their legs over yours and just that intensity and the weight of their legs and the weight of them on top of you. How heavy they weigh. You become equipped, when you've been abused to the level or any sort of abuse. You become acutely aware of where you are. You have heightened awareness, so you are waiting all of the time*".

Reflections of good care

When Rose reflected on what she considered to be aspects of good nursing care she was very aware of how she felt this ought to manifest itself in practice. The moral of compassionate care, the possibility for things to be different, were located within her story. Here Rose positioned herself as an expert by experience, describing her current role in services. I feel she demonstrated how her experience helped her teach others because of her understanding of life on mental health wards. Rose alluded to how the hospital ward ought to be a safe sanctuary, where service users were welcomed. Here Rose used her own experiences of fear and considered admission onto a ward as a new service user, with fear about being in hospital:

> "*I think a lot of people when they first go into hospital weren't spoken to for a long period of time and waited in dining rooms without their family. Then the level of stress got worse, as you were waiting for someone to come and see you. I think more of a welcoming, pairing and conversation when you first go in to reduce that level of fear of why you are there, and you are not there to be punished and you are there to be cared for.*

> *Maybe if someone had have said to me, we don't want you to run off (name), but you know we are here to care for you but at the moment you are just not really well enough to go off on your own and we need to make sure you are safe. So, those sort of kind, soft caring words would have helped a great deal, rather than just dumping you in the dining room and leaving you until your bed is ready which could be hours*”.

Rose considered what she judged as the paradoxical decision by professionals to remove items considered to pose a risk, such as musical equipment, conversely this act presented risks as coping strategies were removed:

> “*I think also, once they get you on a ward and they have searched you and gone through all the usual stuff they do and not taken away from your coping skills. I know some stuff was taken off me what I need like my music. They would remove my music, deeming I wasn't fit to have it and there was a significant risk of me harming myself. Actually, I needed my music, so things like stuff that comfort you*”.

Rose considered the handover period as an opportunity to communicate service user needs, particularly when individuals have experienced trauma warranting special consideration:

> “*A really good handover to say this is how you are, and this is what has happened to you, especially if there has been trauma. Whenever it took place, it doesn't really matter if it's when you are a child or when you are an adult*”.

Rose suggested how the therapeutic relationship and getting to know service users was an important aspect of nursing care. Yet, at the same time, she presented what she felt to be the barriers in achieving this, such as low staffing levels and the ward atmosphere, which she felt to be fraught on occasion. For Rose, this led to an uneasy combination of factors in allowing nurses to get to know service users, including their previous histories:

> "*If you know a little bit about the person that you are caring for it goes a long way so that you can care properly. I don't think we should blame people either. I think sometimes when wards get fraught and there is not enough staff, then people will result to try to deal with it as quickly as possible and that is not always the right way to go about it. That's all really*"*.*

Rose reflected on how she felt knowing a person can help de-escalate potentially volatile situations. She referred to her own experiences, for example when she felt the doctor had questioned the ability of her mother to rape her. Rose considered that sensitivity and knowledge of her previous history may have prevented restraint from occurring. She suggested ways in which her retaliatory behaviour may have been avoided during this incident, reducing the need for restraint:

> "*If a member of staff that maybe knew my history had gone in with me that might have been avoided. I know people say they haven't got time, but they need to make the time and then things like this wouldn't re-traumatise you. It is about making that time to make a difference for people*".

What the story tells us

Running through Rose's story are central facets of trauma and fear, with these concepts being frequently connected. Rose presented herself as both victim of past abuse, survivor of abuse in the present and perhaps survivor identity in the future, the latter identity will be taken up further in the discussion section. A stake in this story is Rose's vulnerability for re-traumatisation. In this respect, many of her experiences of re-traumatisation have the potential to cast Rose as a victim. In consequence the nurses, at times, are cast by Rose as villainous as they were perceived by her as threatening her safety. The act of restraint causes past trauma to resurface. Rose’s fear of restraint is storied as often being connected to previous experiences of both childhood abuse and trauma caused by restraint as an adult. This is explicit throughout Rose's story. In the extreme this manifests itself in how Rose talks of being frightened for her life so dissociates from the situation, this fear is viewed by Rose to impact negatively on her mental well-being. The intensity of restraint as an adult creates trauma in Rose’s story. From Rose’s perspective, the restraint is very physical, intensive and unwarranted.

Rose's narration of re-traumatisation manifests itself in witnessing restraint. She describes being frozen to the spot as she alludes to how the witnessing of restraint brought back her own childhood memories of abuse, creating a cycle of trauma. Rose positions herself as a victim of both physical and sexual abuse, as she revisits her childhood experiences of abuse. Yet at times, staff are seen by Rose to justify restraint because of her behaviour, and failing to recognise her need for reassurance, not blame. Rose positions the staff as having a narrow clinical view of trauma, as staff at times acknowledged the serious abuse of her childhood, the traumatising and retraumatising However, there is a sense within the story that some staff may not have acknowledged the cycle of trauma connected to coercion. This sense of fear and mistrust is presented in Rose's story as she talks about her fear of restraint and staff, but also talks of her mistrust with some staff. These narrative themes of trauma feature in other participants' stories and are discussed further in the following chapter.

There are trigger points for Rose, which she reports to escalate her behaviour and lead to restraint as influenced by historic abuse. An example of this presents itself as Rose discusses being given mashed potatoes. The consequence of this is suggested by Rose to result in her distress, and restraint then follows. Here, a cycle of trauma is presented as Rose reports how restraint itself is trauma-inducing. Equally, when the doctor questions whether her mother was able to rape her, the insensitivity of this is portrayed as igniting Rose's reaction. In sharing her abuse Rose has perhaps shown some trust in the doctor, yet she stories this relationship as then damaged, in view of his response. Again, From Rose's perspective, this leads to further restraint as she "*trashed"* the treatment room, so paradoxically creating opportunities for more trauma or re-traumatisation.

A further trigger point in Rose's story is being given medication**.** Rose reports being "*pinned down"'* and "*manhandled"* during restraint so that medication is administered, yet she presents staff as failing to engage with her to question why the medication is declined. This forced medication correlates for Rose with past experiences of abuse. These experiences resonate with wider social narratives of biomedical violence, centred on prevailing models of drug-centred treatment and are explored in greater depth in the discussion chapter.

Rose tells of her attempts to avoid distress and produces an advance statement about her preference for medication, yet she claims this is often lost or ignored. This statement highlights Rose's attempt to have some control in her care. Yet staff are seen by Rose to have control and at times can misuse this control. Rose suggests how some staff like the control they have over service users, posing a wider issue around power dynamics. This presents as a narration of limited choice which sits uneasily amidst the neoliberal, consumerist ideologies that have been latterly adopted into healthcare policies and practice. Rose chose to complete an advance statement[22], which she reported as being ignored by some, yet this poses a wider issue about the choices open to Rose under legislation. Rose did not suggest that she completed an 'advance decision to refuse treatment', indeed such a document has limitations for mental health users' refusal of psychiatric treatment. The concept of choice chimes with concepts of dignity and will be discussed further in the next chapter

In the context of control, staff may feel the need to balance care and control. If Rose is at risk of declining mental well-being, they have a duty of care to support her, particularly if she is sectioned under the MHA (1983, amended 2007). However, Rose's story perhaps questions de-escalatory approaches being used before restraint is enacted. There is no attempt present in Rose's story to communicate with her about her resistance to medication, yet force is reported by her as being enacted. It is relevant at this juncture to consider contradictory discourses surrounding the professional image and identity of mental health nurses, who are prominent in ensuring patients' rights and choices, in the context of instruments such as advanced directives, and being

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[22] Although this is acknowledged under the MCA (2005) as a record of a person wishes, this is not binding under this legislation.

responsible for control and custody. The paradoxical position for mental health nurses will be taken up in the next chapter.

In a similar way within Rose's story, control is amplified during restraint as she is allegedly told that if she struggles, the restraint will be more excessive; yet she tells of struggling because she is frightened. For Rose, this threat provokes fear and the story reveals how Rose reports that the level of force and nature of restraint is excessive. Additionally, the forceful nature of restraint represented by Rose appears to expose a lack of dignity, as staff are reported as restraining her in a public area, whilst pulling her underwear down to inject her with medication.

In the aftermath of restraint, Rose suggests that she feels like a naughty child. In taking on this role, she describes how she had apologised for her behaviour, as she reports that staff tell her she has behaved badly in her attempt to run away. Yet from Rose's perspective, staff have not appreciated that fear had led to her running away. I feel in this aspect of the story, staff are presented as having perhaps unintentionally compounded Rose's perception of herself as a child in the way they communicate with her, for example, talking to her in a "*sing-songy"* voice and suggesting that she be a "*good girl"*.

Rose's emotional pain is also present in her story during the aftermath of restraint, as fear of future restraint prompts stress and impacts on Rose's behaviour. This further exemplifying the narration of trauma running through Rose's story. Rose describes pacing because of this stress. From Rose's perspective, the staff's response places her in a no-win situation as she reports being told to lie in bed but is then called lazy for doing so. Emotional turmoil is also present, as Rose talks about her experience of frequent nightmares relating to childhood abuse and restraint as an adult. Rose's reluctance to sleep is compounded by what she views as staff's insistence that she goes to bed. Yet even in her waking hours, Rose suggests that she is similarly tormented from the experiences of restraint as she waits in a state of anxiety, waiting for restraint to happen again. Rose describes being unable to cope with this waiting.

Unfortunately, from Rose’s perspective, restraint has a negative impact on the therapeutic alliances between herself and the staff. Following restraint, Rose reports how she identifies the staff involved in restraint by their voice tone and perfume. This causes Rose to retreat from any contact with these staff. At the story’s end she considers the importance of a therapeutic alliance, indeed within her story she talks of good relationships with some nurses who have got to know her. This does, however, further highlight some key contradictions for nursing practice and identity, not unique to Rose’s story, which are returned to in the following chapter.

Rose does not always locate herself as a victim. Frank (2012) discusses how people often display several identities within stories. I feel Rose's identity as a survivor is a resource for her, which manifests itself whilst she is on the ward and latterly following her discharge. To paraphrase Frank (2010a, 2012) she ‘held her own’, in this sense this is against the system. Rose portrays herself as the role of a rescuer. An example of this is how she reports her attempts to intervene when other service users are being restrained, despite her implication of the trauma experienced in witnessing restraint and her assertion of staff telling her she is interfering and “*rubbernecking”*. Frank (2010a, 2012) suggests that characters can change in stories to fit with the presenting circumstances. In this aspect of the story, Rose shows empathy and wants to help. She reports that she wants to stop the restraint and to rescue fellow service users.

Rose talked about how she has taken on a professional role and had become an expert by experience, training health staff and advocating for others. In this role, she ‘holds her own’, yet does not threaten the safety of others (Frank 2010a, 2012). I believe that Rose presents with a more empowered identity, and frames recovery within her story, ending it story on a redemptive note with new aspects of identity. As such, Rose is not alone amongst the participants to begin to identify herself as an expert by experience. Whilst acknowledging the impact of being subsidiary to wider systems of governance and potential for tokenism, in the service user voice, Rose presented herself as making a difference to mental health care. Perhaps, for Rose, the years and decades of ‘grass roots change’ is still ongoing in pushing the political landscape to restore the right to speak. Rose suggests her role as expert by virtue of her lived experience can make a transformative difference to the lives of other individuals. The extent to which such optimism may be justified in the face of powerful forces of co-option and incorporation is a key point of contention for service user and survivor movements. The powerful available narratives underpinning adoption of principles of user involvement or co-production into service planning and operation can feed such optimism and arguably has influenced the stories of participants such as Rose. The discussion chapter takes up such concerns and points towards conclusions that wrestle with the various contradictions and opportunities present.

The story continues.

Finlay: a story of saving life

Introduction to the character

At the time of the interview, Finlay was 50 years of age, lived alone, and worked with a service user organisation, helping train health and social work students. He was studying for a degree and was very busy because of this. Finlay shared he had a very close relationship with his family discussing a close bond with his great-niece. He had received three clinical diagnoses: borderline personality disorder, schizophrenia and emotional and unstable personality disorder, and been detained on several assessment wards, medium secure units and psychiatric intensive care units.

The story told

Finlay's story stressed his need for nurses to take control of his distress when he had been mentally unwell. He initially positioned himself as ill, suggesting an illness identity at this point in his story. Periods of severe symptoms included his experience of intrusive and overpowering voices which he indicated as being difficult for him to cope with. On hearing the voices, he reported being at risk of self-harm and talked of how he tried to inflict pain on himself to manage the distress. He indicated that he wanted to feel pain as a release and staff subsequently restrained him:

> "*I don't just hit the wall. Generally, I try to break my arm against the wall and it's not to break my arm, it's to feel pain. The thing was they let me do it to a certain point, but there came a time when I literally started going at it hammer and tong where they put me in physical restraint*".

At certain points in time, Finlay suggested he had actively tried to kill himself and, at these moments, questioned why he was prevented to do this; unable to comprehend staff trying to stop him. In hindsight, and from his perspective he believed that staff had no choice, but to prevent him from committing suicide. In his opinion, restraint was a correct course of action. He presented a degree of objectivity after the event, as he implied that his mental health improved:

> "*I could not see the whole point of them restraining me because it's my choice, but because they knew I was going to die, legally it isn't my choice, even if I didn't have mental illness. If they knew they would have to stop me. I know that now, but all (name) kept saying to me was we have a duty of care to you and all I kept saying, fuck the duty of care what about my duty of care to me?*"

The need for control

The perception that nurses needed to take control was a theme throughout the story. On one occasion Finlay reported how nurses stepped back a little, requesting him to stop. As his behaviour persisted, Finlay discussed how he felt nurses needed to control the situation and restrain him. It is possible that the nurses' intentions, in this aspect of the story, were perhaps to allow him an opportunity to change his behaviour before undertaking restraint, yet this was unacknowledged by Finlay. Finlay suggested that feeling the pain was what he deserved, and was angry with staff for not intervening earlier:

> "*They kept coming in whilst I was banging the wall. They kept going, can you stop that? I wouldn't and they kept just watching me. As soon as I started going hammer and tong at it, that was when they intervened. I didn't try and hurt them, but they had to control the situation at the time. I*

> *was so angry with them. All I wanted to do was break my arm, smash, bang, bang, the pain was all I was good for and that was all I felt I was good for*".

Finlay told how stress made him lose control. He indicated that he got angry, so self-harmed, precipitating restraint. He expressed how at these times, he felt that he was at risk, as were others. In this sense, he justified the use of restraint. Control was represented by him as being the priority:

> "*If I get stressed out, I lose control and I can't lose control. It takes a lot for me to lose control. When I do, I get hurt, someone else gets hurt and I will either lose my life or someone else will. In this case I will lose my life because I won't be able to cope with it because I never want to harm anyone*"*.*

Anger was exhibited by Finlay in other ways within the story. Finlay reported that he was not only angry about his intrusive thoughts and nurses' lack of intervention when he wanted them to take control. He also indicated being angry at his mental illness and the detrimental impact on his life beyond services. His representation of his illness identity seemed to have dislocated him from leading a life outside of hospital: "*I was angry at the fact that I was on a ward and I wasn't part of life. I wasn't having a job and I still get angry with myself for not having a paid job*"*.*

Finlay reported how nurses taking control had saved his life as he presented himself to have been indifferent to his personal safety. In doing so, he depicted how the staff had put their own safety and security at risk:

> "*There came a point where they saved my life by restraining me, but at those points, I didn't really care what damage I would inflict on me or*

> *them. All I cared about was the pain, so the more I struggled, the more pain I felt, so I struggled more*".

As Finlay reflected on how restraint was initiated, he considered that he contrived one incident, so that it resulted in restraint. Finlay reported that the intrusive thoughts were so powerful he had wanted to kill himself and played a part in instigating the restraint: "*I must have engineered a way for them to control it without risking as many people by making it because everyone was around. At least they had an idea they could prepare for it"*.

In a similar way as to how Finlay suggested physical intervention allowed staff to take control, he also asserted that the verbal interaction between the staff and himself served this purpose. Finlay reported on how the commanding voice of a nurse helped him gain control. He indicated that the stern voice of this nurse brought him "*back into reality"* and this was seen by Finlay to have controlled his agitation. Here Finlay viewed assertiveness as positive, intentions were good, not bad. This in turn is represented as having helped Finlay gain control:

> "*Then she shouted at me, if you carry on like this we will then put you on PICU and I froze. It wasn't so much what she said it was how she said it, stern voice come out and it just bought me back into reality and I stopped and that controlled that*".

Restraint viewed as justified

Within his story, Finlay suggested he was clearly aware of safety, including moments when he presented danger to himself or others. Voices of other service users and nurses were often silent in the story. The nurses were positioned by Finlay as guardians, who protected Finlay and others who may have been at risk, as he viewed his behaviour as being unsafe: "*It started intruding on the ward and got a bit unsafe for people*".

Although nurses were deemed as protectors, being portrayed almost like superheroes, needing to intervene to prevent further harm; their actions were represented as having been forceful at times, which suggested the potential for reciprocal harm being caused. The words Finlay used in his storying of nurses' actions during restraint suggested excessive force; as he reported having his arms pinned or being forced onto the bed. Despite this Finlay deemed such force as necessary and did not contest the nature of restraint as practiced on him. Finlay's story suggests he was troubled by his mental state and suicidal thoughts, so he felt the nurses justifiably exerted control:

> "*When they literally took control when I started banging the wall. They literally pinned my arms behind my back both arms and literally forced me. They put me on the bed, so they sat me down one on either side and it was like that for a while*".

In a similar way to Finlay's indication of how he engineered situations to manage strong emotions, he also suggested how staff members planned shifts to support him when vulnerable. For example, Finlay felt his care coordinator ensured being on duty when Finlay was unwell, knowing he was trying to leave the ward. The staff member in this situation was positioned as professional, supportive and caring in his attempts to prevent Finlay from absconding:

> "*He was the team leader, so he engineered it, so he was working that day. So about 1.45 or 1.30 he pulled me in and said, look do you really want to go through a confrontation for this? I got so angry with him and I just left*".

As he elaborated on this incident, the nurse in question was seen by Finlay to have taken a preventative stance, yet Finlay indicated he had pushed him out of the way. Finlay did not feel he was attacking the nurse, but the reaction is storied as having resulted in restraint. Finlay reported that the nurse *“dragged”* him to the floor during this restraint and he was struggling to breathe. At the time Finlay indicated that he was outraged by the nurse preventing him from absconding. In hindsight, Finlay considered the nurse took the correct course of action, without another choice. Finlay's concern in relaying this aspect of the story was not about how restraint was undertaken, rather emphasising his quest to leave the ward:

> “*He literally stood across it. He said I am not going to let you hurt, kill yourself. I didn't want to hurt him. I didn't attack him. I tried to push to get passed him and must have looked like I ran at him, but I ran at him to get passed him not because I wanted to hurt him. I ran past him and he dragged me to the floor. Four or five of them landed on top of me, face down. You have to remember at that point I was very much overweight. I was nineteen-twenty stone almost and it was causing me to restrict my airways and literally, I was having problems breathing*”.

During another restraint incident Finlay reported he had experienced constricted respiration. He expressed how he had felt nurses did not initially believe he was having difficulty yet monitored his breathing. Finlay told of his concerns that his struggle to breathe was disbelieved, and linked this to negative connotations of his illness, yet did not question this as unjustified in his story:

> “*I smashed my glasses whilst I was on the ward once, when they restrained me. They put me down and left me there. They had me down*

> *for half an hour, but it seemed like an hour. It could have been twenty minutes. I don't know times just seem to stand still. Then I said, I can't breathe, and they didn't believe me. I could breathe, but my oxygen was being restricted and I was having problems because of the risk the seriousness of the risk to me. Then they went and got an oxygen monitor to test my oxygen levels just to make sure I wasn't faking it. The risk in them moving me was that someone was going to get hurt. I am not proud of my actions that day, but they saved my life. I have a diagnosis, as well as schizophrenia, of emotional and unstable personality disorder and people think you are just doing it for attention. They knew I wasn't, but I always thought that people thought that. Because of that one diagnosis, people automatically presume in the past, that I do is just for attention, even family sometimes think like that. They find it hard to get past that diagnosis*".

In contrast to restraint being undertaken in reaction to Finlay's presenting behaviour, other examples that Finlay presented in his story were planned. Finlay reported that people were removed from the area, the bed was put in the middle of the room, and he suggested he was pinned down to be forcibly medicated. Finlay's story did not make any mention of attempts by nurses to persuade him to take medication voluntarily: "*They brought everybody out of the dormitories. They put a bed in the middle of the dormitory, and they pinned me down to the bed and they injected me*".

Finlay reflected on the nurses' perspectives in undertaking restraint and in doing so considered the mixed feelings of nurses undertaking restraint. He inferred some nurses felt unease at using restraint, feeling their job was not to be security guards. Nonetheless, from Finlay's perspective intervention was needed at times with nurses having a duty of care to intervene:

> "*But they saved my life, I owe them everything. So, when people argue that it's not our job to be security guards, blah, blah, blah. Hold on a second you know what you are getting into. You are saving people's lives. You know you are taking a risk. It doesn't make it right what happened, but had they not done it I would be dead. Just as a nurse on a ward takes a risk in decisions they make for their patients or a surgeon with a knife or whatever. They did what needed to be done*".

A witness of inappropriate restraint

Finlay's story also reported on his experiences in witnessing restraint. In doing so he storied a different perspective on restraint practices. In an example of this, he voiced his unease regarding how it had been carried out. In sharing this, Finlay expressed on-going anger at a nurse regarding this incident. Here the nurse was viewed by Finlay as a bully and homophobe; described by Finlay as a "*horrible man"*. Finlay considered the impact of what he felt to have been a poor nurse-patient relationship. In his perception of this experience, he questioned the nurse's professionalism, and identified what he felt had been both unfair and discriminatory behaviour. Finlay suggested the nurse to have been provocative concerning the service user's sexuality, judging this to be morally wrong:

> "*There was one member of staff, a horrible man. I won't mention the name, but they were, how can I put it, unprofessional to say the least. Unprofessional at best, abusive at worst, verbally. At that point I don't think he realised I was in there because they always put people in rooms.*

> *When people have been restrained, everyone has to go in their room. So, you might be able to hear it, but you can't see it. I knew, I looked, I saw her. I knew because they were having a conversation which I was around the corner, so they couldn't see me. I couldn't see them, but I could hear. She was gay, and her partner had been in hospital before. Something had happened between him and her, not a relationship but they hadn't had a good working relationship. He didn't like her, and she didn't like him. While she was being restrained, he was literally saying, oh yeah, yeah, you really going to harm? Yeah, yeah, you and who, yeah, yeah. I don't remember if it was that word, but he was winding her up deliberately*".

Discussing the rationale for this restraint, Finlay judged the action of the team in restraining the service user to be justified but questioned how it had been carried out. Although the other nurses present are not portrayed as villains by Finlay, and their professionalism is not questioned by him, his story did not refer to any challenge by them towards the nurse in question. However, Finlay viewed the comments as unprofessional and abusive: "*She tried to hang herself earlier as well. So, restraining her I had no issue with the restraint because it saved her life in a lot of ways, but him goading her, that's not right*".

Compared with his own experiences, Finlay highlighted what he perceived to be unequal treatment. Despite reports from Finlay about what he considered to be his own abuse directed towards staff at times, he suggested that he had not been treated in the same way: "*When I was being restrained, I was abusive, but they weren't like that with me*"

Following this incident, Finlay indicated how he felt unable to communicate with the nurse in question, which according to Finlay had impacted on their relationship, suggesting how witnessing restraint had wider implications:

> "*There was all this shit and I was so angry with him and I said it to him afterwards. I didn't talk to him about the incident, but I said to him he had the same surname as me and I said, I hope I am not related to you*".

Finlay also spoke in a general way about restraint behind closed doors, unwitnessed by others. Within this aspect of the story, fearfulness was presented surrounding the secrecy of restraint behind closed doors, as opposed to restraint in public view. The potential for poor practice to be hidden intrudes a tension into the story. From Finlay's own experience of being restrained, he felt that staff wrong-doing had not been a concern. However, he suggested he had borne witness to concerning practice which were connected to, but not confined to restraint:

> "*You are trusting that they are always doing the best for your patient. There is no cameras in there. Why do you think people get away with all this stuff? Because it becomes a culture. Even I have seen it with nursing staff, especially, and we are not just talking about physical restraint now. We are talking when people have done something, made a mistake or just said something wrong*".

For Finlay, restraint was viewed as occasionally avoidable with a more preventative approach. On these occasions, he referred to his belief that therapeutic alliance had been compromised. In this respect, he judged that staff's interaction with service users may have defused a situation. In Finlay's opinion, paperwork was deemed an obstacle to staff interacting with service users needing support:

> "*I have seen a lot of restraint and a lot of it is necessary, unfortunately. It could have been done a different way. I have seen it where it should have been done a different way. Prior to the incident, perhaps ten to fifteen minutes, half an hour before when that person was going to the staff office, going I really need to talk to someone, I need some medication; rather than saying, I am busy, I have paperwork to do, rather than letting them just escalate. De-escalating it half an hour or an hour before. It winds me up when nursing staff don't listen when there is plenty of chances to intervene in someone's life at an earlier stage*"*.*

Alternately, Finlay had also witnessed restraint where in his view the intentions of nurses had been viewed positively, preventing harm or suicide. Here the nurses were depicted as heroes again, taking the right action in an emergency:

> "*I was in the room opposite where they had to break the door down because he was trying to hang himself, and they restrained him because I heard them restrain him and they had to carry him through. He was very ill*"*.*

Finlay reported that he had witnessed situations where he judged that staff had not actively intervened yet should have done so, considering this had placed service users at more risk. He told of wanting to intervene to help manage the situation but could not. This appeared to trouble Finlay as he questioned the level of training for some nurses. The nurses' intentions are unclear in Finlay's narration of events, yet it is possible that nurses were holding back and were trying to use restraint as a last resort:

> "*I have seen it where patients are kicking off so badly, where nursing staff who may be not trained and staff on the ward and patients are at risk if they don't intervene. The problem I find is we want to intervene to help them, but we are told we can't*".

Although some nurses were perceived by Finlay to be slow to intervene, he viewed nurses as more competent in carrying out restraint than other ward staff, due to their professional status. Unqualified staff were not deemed by Finlay as having the same professional competence as nurses:

> "*Nurses do a fantastic job, but it's not just the nurses. A lot of restraint is done by people who aren't nurses. Health care assistants or whatever you want to call them, nursing assistants whatever, support workers who are trained. However, their professionalism is not the same training as nurses is*".

The expert by experience

In his role with a service user organisation, Finlay assumed an educator identity. In this role, he considered his view on the best approach in working with individuals at times of distress. Finlay presented his desires for a more preventative approach, influenced by a therapeutic relationship, with time dedicated to building this alliance to avoid situations from escalating: "*Spending an hour with someone might have de-escalated, rather than spending months de-escalating it. I often find them very tricky when you see it happening*".

Contemporary pressures on nursing staff were considered by Finlay to impact on service user experiences:

> "*But it's got worse over the years on acute wards because there is less wards, less hospitals. There is less space, and there is more pressure. There is less staff and here is the thing, they are trying to save money by doing it and making it so that you hear all about recovery. Recovery is the best way to do it I believe; however, they are doing it for the wrong reasons. They are saying recovery because it saves members of staff and they will reduce the staff budget whatever*".

Finlay's story revealed how he took meaning from his negative experiences and used these more positively in his teaching of student nurses. He suggested that nurses were able to learn from his experiences as he shared his knowledge with them. For Finlay, this entailed attempting to influence the future actions of nurses with a person-centred approach, treating people with dignity and respect. His character in the story transforms from passive service user to assertive educator, gaining control over his well-being:

> "*I teach nurses this and I say to them, it doesn't matter what you are paid to do a job at the end of the day. I want you to do the best job you can, what's best for you and what's best for your patients, be professional*"*.*

Finlay viewed difficult and prejudicial temporary staff as a problem in the workforce, potentially creating a sense of corrupted teams in his story:

> "*There is a huge issue with bank staff. I am not saying they don't do a good job some of them. There are some, there are a lot of staff who are nasty to other staff. There are a lot of staff that treat foreign staff badly*"*.*

Finlay reported how students asked him about blame towards staff from service users because of restraint:

> "*I often get asked by student nurses when I teach super mentors, and they often go, do you ever blame the nurses because we often wonder how it would feel? They often ask me that question. If they are going to restrain you, what's the relationship like afterwards? That's what they worry about, and to be honest, it doesn't worry me. That doesn't worry me because I hope they realise it's nothing personal against them*"*.*

The story appears to have helped Finlay reflect on how he has progressed through his illness. In his view, the nurses saved his life. From his perspective, treating him professionally, however, did not equate to treating him kindly, reflected in his recounting of the more forceful interventions. In Finlay's view, the actions of staff were not kind, but had been the professional and correct response:

> "*My relationships with the staff were the most important thing I had on those wards, not the section. The relationships with the staff that I got on well with, but there was times when I didn't get on well with any staff. There was times when staff couldn't afford to be friends with me, in the sense, they couldn't afford to treat me kindly. They had to treat me professionally*"*.*

Yet he suggested that a kind response was needed at other times, such as reflecting on his fears the first time he had been on a mental health ward: "*I remember the first night I went on a ward. First night hated it, I was 19 years old, I had taken a drug overdose".*

Towards the end of his story, Finlay discussed how he considered himself part of the community. His role as a student is positioned by him as positive and he felt it had served him well, keeping him out of psychiatric hospital, the story revealing an empowered identity as a student. This was in sharp contrast to his identity on the ward where he felt he had been unable to take part in life. Finlay positioned himself in this identity in contradistinction to the hospital and patient identity: “*Out here, I am not part of that community (hospital). I am part of the community now at the university but if I wasn't a student I would have nowhere to go*”*.*

What the story tells us

Finlay's story presents a different perspective, with the distinctive storying of a life claimed to have been saved because of restraint and associated valuing of aspects of control. Therefore, Finlay, despite some ambivalence, presents restraint as a more positive experience for him. That said, aspects of his story allege forceful restraint, albeit ultimately felt to be justified by Finlay. In part, questionable practice is represented in the story, yet Finlay only considers staff action illegitimate when he witnesses others’ restraint. As Finlay's personal account of restraint is framed as life-saving, at stake is his life and well-being, particularly in hospital. He defines this in his use of words about staff taking control and saving people's life. From Finlay’s perspective, physical restraint helps control his voices and an assertive, even stern, approach is effective in bringing him “*back into reality”*. Nurses in this regard are deemed professional by Finlay.

In considering events that lead to restraint, Finlay's self-harming behaviour is seen by him to be a major contributor. When Finlay exposes his frustration in experiencing voices, intrusive thoughts, and associated distress, he proposes the means to manage these symptoms is staff control in the form of restraint. An illness identity is thus presented, also positioned by Finlay in his reports of suicidal motives. Finlay suggests that he wants to feel pain, for example banging his arm on the wall, and such pain was all he felt he was "*good for*". Indeed, when experiencing restraint, he talks of struggling to feel more pain. He presents his concern, on these occasions, to include the safety others, who might be hurt. In this telling of his story as other participants did, Finlay's story can be seen to intersect with a number of broader social narratives; notably regarding illness, violence and control, which are taken up in the discussion section.

Finlay's story reflects a wider narrative of illness, that he largely accepts. Finlay described how he had been assigned three labels: borderline personality disorder; schizophrenia; and unstable personality disorder. Although 'schizophrenia' is widely accepted as a severely stigmatising diagnosis to carry, a 'personality disorder' label is frequently reported as the most stigmatising of all. This may be due to global judgements surrounding madness and badness and is known to arouse or be the result of, rejecting attitudes from staff (Johnstone et al., 2018).

Associated with this, Finlay made a connection to a feeling of 'otherness'. When Finlay was in hospital he reported that he did not feel '*part of life'* and when he was out of hospital he felt part of the community. Yet with respect to the latter, fragility was also hinted at, as he commented that his student role gave him a sense of belonging, without it he felt he would have 'nowhere to go'. This connectedness is storied as important in Finlay's life.

In terms of Finlay's explanation of his behaviour, he attributed his aggression to his illness. Whist accepting the very distressing impact of this, there remains a narrative tension here between notions of bad versus mad; with an illness concept offering exculpatory appeal for seemingly 'bad' behaviour.

In somewhat chaotic situations, Finlay indicates that his voices trouble him and his responsibility to make sound judgements is diminished. In Finlay's account of the nurses’ reactions during such periods of distress, he views their actions as morally good. In Finlay’s view he needs to be saved from himself, the nurses are identified by him as heroes, rescuing Finlay from himself. These heroes assume the role of guardians in the story, protecting Finlay from the danger. A narrative of control is present throughout Finlay’s story, but for Finlay the control is seen as positive, as nurses rescue Finlay. These themes, and implications for the psy-profession of nursing are returned to in the discussion chapter.

In his story, Finlay is angered when nurses do not intervene or are slow to restrain himself or others. In Finlay’s view, nurses’ decisions to undertake restraint are seen as part of the job, yet in the story the nurses report how they feel compromised at times, questioning their role as akin to security guards. Such tensions are also presented by Finlay in his role as an educator, with professional identity troubled as nurses are suggested to question whether blame is attributed by service users experiencing restraint.

At one point in his story, Finlay’s honesty is at stake. In his opinion, nurses might judge him because of his illness, for example when he reports difficulty breathing, he reports concerns about staff disbelieving him or seeing him as attention-seeking. When Finlay's told of his compromised breathing in the story, he indicates he was subject to prone restraint. Finlay reports nurses sitting on his chest whilst monitoring his breathing, for me this raises substantial concerns about the nurses' practice. Yet in telling his story, Finlay does not explicitly criticise this unsafe and poor practice. This suggests that he internalises the problems of this position and consequent breathing difficulties, to being overweight in this aspect of the story. Finlay also reports on examples of restraint as a planned intervention, as people are removed from the room and a bed is placed in the middle of the room, in advance of being forcibly placed in the bed and injected; suggesting a team had been formed, with the sole purpose of restraint and sedation.

In consideration of Finlay's witnessing of restraint, the stakes change, as a service user's sexuality was presented by Finlay as being used against her. In this aspect of the story, in a counter-point to the previous narration of nursing, the nurse concerned is represented as an anti-hero, goading and verbally abusing the service user. Finlay refers to this being unprofessional and abusive. He expresses his view that the nurse and the service user do not enjoy a good relationship; further undermined perhaps by the nurse's action. Finlay refers to the nurse as a *“horrible man”*, his character is portrayed by Finlay as bad. Here a narration of power is taken up in Finlay’s story, further intersecting with wider narratives of psychiatric power and control. The nurse is positioned as being verbally abusive and homophobic in a situation where power is already present in the deployment of physical restraint.

Finlay tells of how he had witnessed other restraint and “*not all good*” *yet* does not elaborate on these other examples, but his suggestions in this respect infer poor practice is a not uncommon feature of care. He also alludes to the sometimes-secret, and by implication, worryingly unaccountable, nature of restraint happening out of public view.

Although Finlay stories restraint as mainly justified, he suggests times when it could be avoided within positive therapeutic relationships. For example, he proposes how staff spending time with service users when they need someone to talk to may prevent restraint. Towards the end of the story Finlay's sense of self has changed. His identity as a student and as an educator within a service user organisation emerges. From listening and analysing the story I felt that both roles are resources for him, offering a more empowered identity. Alongside Rose and Rory, Finlay also tells a story of taking on the mantle of expert by experience in a role as an educator using his experiences to inform practice.

In his role as educator, Finlay stories reaching a stronger sense of voice, able to share his experiences for the common good. Within his story, positives are realised from his previous experiences of distress and loss of control; having changed from someone who needs support from others, to a role where he can give support to others, including the future education of practitioners. As such, he enters into the folds of power and influence in all its complicity and conflict. The discussion chapter returns to these tensions in exploration of the value of such roles and the ever-present hazards of co-option.

Interestingly, Finlay presents his role as a student is also an important aspect of his life. Finlay stories a transformed his identity, and thus his relationship with himself and others changes. Yet, this change appears fragile as he refers to not knowing what he will do when his student role ends.

The story continues

Chapter conclusion

In this chapter the narrative findings are discussed, attempting to locate the identified stories in their societal context. In this sense the ‘dialogical’ aspect of the method does not simply reflect a relationship between the storyteller and myself as the researcher and person listening to the story, though this is indeed an important aspect to consider. There is also an important relationship between the stories and the many relevant societal narratives that exist, including those which appear to define our relationship to madness and the role of psy-institutions in its surveillance and control, and how this plays into wider systems of governance and discursive spaces of contestation. As such, the participants' stories as told to me can be seen as existing in an inter-relationship to other people's stories and some of the grander narratives which underpin or are influential within society as we know it. In other words, any individual story cannot be seen to exist in a vacuum, rather there are webs of narrative inter-relationships between all of the stories which act to construct our knowledge of the world and even our sense of who we are. Hence, in this discussion chapter, I will highlight some of the more obvious intersections between the stories of the participants and powerful meta-narratives and consider uniqueness and similarities across all four stories. Consideration will be given to other grand narratives out there in society, the existing policy and evidence basis relating to coercive interventions, as well as discussing the themes revealed by listening to the individuals' stories.

CHAPTER SIX. DISCUSSION

In this chapter I consider the research approach utilised for this study and discuss why I believe it to have been an appropriate design. I will then briefly consider the relevance of the storytellers' typologies and identities, before exploring the main discussion areas across all stories and how these might reflect and intersect with broader social narratives and representations.

An appropriate design

I deemed social constructionism to be an appropriate paradigm with which to frame this study. Stories were shared by individuals who experienced the phenomenon and were based on each participant's understanding of their socially constructed reality (Gergen, 2015). Although the uniqueness of each story was apparent (Berger & Luckman, 1966), there were similarities uniting individuals' experiences within their stories (Ashworth, 2003). In exploring service users' stories of their experiences of physical restraint and whether they viewed restraint is justified, an inductive approach proved to be effective in responding to the study's aim. In choosing narrative as my methodology, I was able to put participants at the centre of research, validating and understanding their lived experiences through their stories (Clandinin & Connelly, 2000).

Dialogical narrative analysis allowed both me, as the researcher and the storytellers to co-construct the stories. To paraphrase Frank (2010a) participants co-construct research data with researchers, as part of dialogical analysis. Frank's dialogical analysis was a positive approach for this study, as it meant that stories became more than a monologue recounting past events, but projected possible futures, as stories were ‘unfinalised’ (Frank, 2005a, 2010a, 2012). In this study, participants, as social beings, were competent in both telling and understanding their stories (Frank, 2010a). Humans are essentially storytellers and are influenced by the stories they have heard; stories have meaning for individuals who create or interpret them (Fisher, 1984).

Typologies

Frank’s typologies (Frank, 2010a, 2012, 2013a) helped frame the stories and position the storyteller within the stories, which they were comfortable in sharing. Three storytellers, Rory, Rose and Jane are positioned within Frank’s quest narratives, whilst Finlay’s story is framed within Frank’s restitution narrative.

Rory’s story demonstrates a quest narrative. When ill, he positions himself as able to move forward. At the story's end, he had reintegrated into the community, and the quest typology remained present. The important transition to the community, for individuals from a forensic setting, does not display the same rights of passage as other life events, in part due to these service users being hidden from public view by professionals, families and the individuals themselves (Coffey, 2012).

At the end of the story, Rory showed a stronger sense of voice, able to share his experiences. Therefore, positives were presented from a situation of conflict and extreme suffering. The storyteller had found a way to move forward, which is a core component of a quest narrative (Frank 2010a, 2012, 2013a). Rory told of how he used his experience in his role as an expert by experience, who taught staff. He had used his combative identity in a more constructive way in helping to support changes in practice. The story teaches us how Rory is presenting himself as more empowered, residing in the community and teaching others with the benefit of his past experiences. In his story, Rory suggested how he used his experience to help staff and service users by telling his stories and sharing his perspective, which implies a sense of inherent morality to some extent. As his story ended, Rory demonstrated how he had found meaning from illness and a way to move forward (Frank, 2010a, 2012).

In her story, Jane also displayed how she had found a way to move forward. The experience of restraint had not been a positive experience, yet Jane as a central character, found some form of meaning as to what happened and a way to move forward (Frank, 2010a). Her recovery was presented as on-going and her story ‘unfinalised’. The story teaches us how Jane, although reporting not being fully recovered from the experiences, told of getting better, as she put it: “*I feel as if things are beings relieved, not necessarily resolved*”. In the telling of her story, Jane also exhibited a quest narrative. Following the restraint, she storied herself as moving forward, reporting her experience to the police, feeling listened to and in a sense taken seriously about what she had experienced. Towards the end of the story, Jane demonstrated a stronger sense of self, indicating that telling her story, as part of the study, has helped her recovery. Although she had been hurt by the experience and felt this had impacted on her mental wellbeing, she presented herself as having found a way to progress from the incident, this being a core component of a quest narrative (Frank, 2010a, 2012, 2013a).

A quest narrative was also present in Rose's story. When distressed, Rose presented herself as having some difficulties in moving forward, yet she tells that did so and successfully returned to the community with her professional role as an advocate and expert by experience. This indicates that Rose's character has changed from a service user who was passive to some extent, very often traumatised and frightened, to her presentation of an empowered practitioner. For Rose, the trauma had not disappeared, yet she indicates how she had found a way to move forward. In her story, Rose showed this as she shared how she helped service users and staff, sharing her stories, with knowledge of what she felt was right and wrong. This implies Rose’s sense of moral goodness present in her story. Involvement in service user movements has enabled some individuals' experiences of mental illness to be used positively and proactively. Indeed, for some their own mental illness experience can be a social advantage in supporting others and provides individuals with more empowered identities (Yanos et al., 2010). Rose, as the main character in her story, used her experiences for self-reflection of what she considered to be best practice in a caring environment. Rose suggested that the therapeutic support given to her had allowed her to look back and make sense of why she may have reacted in certain ways and she was able to make links to past abuse. Frank (2010a, 2012) reminds us how no story is ever finalised, Rose storied her sense of meaning from her illness and presented herself as having moved forward, which demonstrates a quest narrative (Frank 2010a, 2012).

For Finlay, the restitution narrative presented itself. A restitution narrative follows the plot that someone gets sick, they are treated and have some version of health restored (Frank 2010a, 2012). This was seen in Finlay’s story as he talked of being distressed and needing staff to take control, which the nurses did. In doing so, he shared his belief that nurses saved his life. His story suggests he was better, yet this was reliant on their care and support. At the end of this story, Finlay positioned himself to be an educator and a student, presenting these roles as more empowered identities. He reported how he had reintegrated into the community, yet there is an indication of how these facets of his identity are fragile. The fragility of his health was seen within his story as he reflected on how his student role was central to his life in the community, as he revealed: “*if I wasn't a student I would have nowhere to go”.* This indicates his identity and his role, has the potential to change.

Identities as expressed in the stories

The four stories presented in this thesis demonstrate the capacities of stories. Capacities are core features of stories that let them breathe, work and act (Frank, 2010a, 2012). In exploring the capacities of stories, it is relevant to consider the characters within the stories. In considering the characters, it was possible to identify the ‘trouble at play’, for them, which incorporated aspects of morality. In doing so, the perception of heroes and villains came forth within the stories told (Frank, 2010a). In contemplating identity, it is relevant to discuss the self-identity of storytellers and the influence of my own social world in interpreting the stories and associated identities of the storytellers.

Goffman (1962) proposes that informal labelling, for example that which is associated with the stigmatisation of mental health problems, can lead to a damaged sense of self and identity. Goffman (1961) discusses that when individuals are admitted to mental health hospitals, there is a symbolic attempt to ‘annihilate the self’ as the person is lost in a set of bureaucratic processes and a kind of social distancing from everyday life takes place. In such a scenario, the skills of staff members are integral in improving the service user experience. Self-identity is multidimensional and influenced by connections to social, historical and cultural contexts (Brockmeir & Carburgh, 2001;

Polkinghorne, 1988). Stories are seen as being socially constructed and emerge out of the social world in which the storyteller inhabits, and our understanding of stories are similarly influenced by own social world (Joyce, 2015). In listening to and interpreting these stories, the influence of my own social world has shaped the findings. Reflexivity was a helpful strategy in managing and acknowledging this influence.

In my interpretation, it was important to acknowledge the storytellers' self-identification and consider this as part of how individuals positioned themselves within their own stories at a point in time. In doing so, identities also become open-ended and consistent with Frank's (2005a, 2010a, 2012) understanding of Bakhtin's 'unfinalised' stories (Grant, 2014). In this respect, identities are not static and change as stories unfold. The storytellers positioned themselves within the stories, which shifted across time and context, the impact of identity was implicit at times.

It is also relevant to acknowledge that some studies have found a loss of a positive identity with mental health diagnosis (Pollack & Aponte, 2001**;** Nyström**,** Dahlberg & Segesten, 2002; Nyström & Nyström, 2007). This loss of identity is formed by the perceptions of self-identity and life prior to illness (Kaite, Karanikola, Merkouris, & Papathanassoglou, 2015). Therefore, the issue of self-identity becomes crucial for mental health service users (Kaite et al., 2015). In my study, multiple identities of storytellers and other characters are revealed. These identities proved to be personally challenging at times. During analysis, I felt some discomfort in how individuals positioned themselves on occasion, for example within illness identities, this will be explored further within this chapter. My challenge had been the passivity of some of these associated identities.

The extract below is from a diary entry showing my reflection what I felt to be disempowered identities:

> *25/11/18*
>
> *"When interpreting stories, I struggle with some of the identities of the participants. Whilst empowered identities are implicated, so too are identities that are less empowered. Participants sometimes refer to their illness because of presenting behaviour at a point in time, thus an illness identity comes forward. On reading academic work on illness, I have read how some individuals consider the mental illness identity a negative and stigmatising label; whilst others have written how illness explains behaviour, so in some way fault it is not with the person, but with the illness at that time. In this way, a person would not feel negativity about any behaviour at a time when they were ill. On the other hand, the opportunity for reflection may be lost in relating behaviour to illness.*
>
> *However, what I must understand is these identities are revealed from the stories and the explanations relayed by storytellers at times. For authenticity, I need to honour these identities as being ones that are adopted at a moment in time, but these are not fixed, as other identities are revealed. In the same way, I struggled with the identity of victim. Three participants talked of being a victim of either physical or sexual assault, with one participant discussing themselves as being a victim of past abuse, as restraint re-traumatised them and they dissociated from reality. These are important considerations for the impact of restraint, therefore cannot be avoided, yet as stories unfold identity changes and more empowered identities were revealed as stories were told. I am*

> *reminded of Frank here in his assertion that characters change within stories to fit in with the presenting circumstances, in this sense, the characters changed as did their identities, storytellers were not necessarily defined by what might be seen as disempowered identities".*

Reflecting on this diary entry, what disturbed me was how individuals viewed themselves. My discomfort surrounded the sense of how some participants may have been disempowered, in part by a system which takes power away from them and may not always provide trauma-informed approaches. Yet at the same time, their identities served a purpose as storytellers' actions are associated with their identity. An example of this is being ill meant storytellers deemed they were not wholly responsible for their actions, at times.

The chapter will now consider the ways in which the stories given voice to by individual participants intersect with wider narratives in society, reflecting the powerful influence of such narratives. Such intersections occur in a particular sense in relation to some of the key aspects of the individual stories, including how identity is constructed, whilst also occurring in a more general sense, highlighting similarities across all of the stories as well as their uniqueness.

Narrating power and control

Criticism of psychiatry and its association with coercion, control, and power is not new (see, for example, Foucault, 2006; Goffman, 1968; Laing, 1967; Szasz 2007). Coercive practices in the United Kingdom is on the increase (Merrick, 2016). Any consideration of experiences of violence within mental health services must acknowledge the influence of narratives of power and attempt to theoretically understand the distribution and enactment of power. Any focus on psychiatric power must also consider its close cousin, control.

The nexus of power and control is one of the key points of intersection between the participants’ stories and broader social narratives of bio-psychiatry and neoliberalism: the exercise of medically and legally justified power in the service of the identification, segregation and treatment of patients within services and, associated with this, a wider social control function expected, performed and legitimated under the remit of a risk society (Beck, 1992; Lupton, 2013).

Rory talked of his perception of nurses being controlling and at times his subjective identity was that of illness, yet he also positioned himself as a fighter in the context of his resistance; neither apparently placing him in a warm relationship with staff. Foucault presented several analyses of different forms of power (Roberts 2005), one of which was disciplinary power (Foucault, 1991).

Foucault (1982, p212) contends that individuals are *made subject to* control and dependence by others. In mental health care the 'others' may be nurses or other psy-professionals, whilst service users are invariably those *made subject to* control. Other sociologists operating from a Neo-Marxian[23] tradition, (Carchedi, 1975; Johnson, 1977; Gough, 1979) outline the contradictory position of power of professionals in a capitalist state in that they are not full members of the proletariat, but they share the vulnerabilities and interests of the working class. For example, mental health nurses would be agents of control acting on behalf of the state but would also be employees of the state, sharing certain vulnerabilities with other workers (Rogers & Pilgrim, 2017). That said,

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[23] There are other sociologists within the neo-Marxian tradition, for example Navarro (1979) who argued that the medical profession is part of the ruling class.

from a service user’s perspective, power is firmly located in the hands of professionals as legitimated agents of control within the state, who are positioned to control and restrain the various participants in this study.

Foucault coined the term 'Panopticism'[24] to describe and understand power relations within society. Panopticism is a form of power that enables an individual to be made a subject, and aware that at any moment they might be being observed and monitored, and hence modify their own behaviour.

A psychiatric ward may be understood as employing Panoptic strategies and interventions, amongst which is individual therapy (Roberts, 2005). Although such intervention is presented as a concept of care, this might be reconceptualised as creating and maintaining within service users *'a state of conscious and permanent visibility'* (Foucault 1991, p.201), therefore they are held within this power dynamic (Roberts, 2005).

The United Nations (2017) noted how coercion in mental health care perpetuates power imbalances, triggers mistrust, exacerbates stigma/discrimination causing individuals to be fearful of seeking help with services. Regardless of the best intentions of mental health professionals, the threat of coercion overshadows service user's experiences leading them to hide their feelings and needs (Rogers, 1993), therefore creating barriers for therapeutic alliances.

The idea that people are inherently risky, is frequently used as a defence by psychiatrists in human rights violations (Sidley, 2018). Assessments of risks

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[24] This term was influenced by Jeremy Bentham in the 18th century in his plans for prisons, (referred to as Panopticon), as a means to observe prisoners. Foucault stated that prisoners *are seen*, but *do not see* (Foucault, 1991). For Foucault (1991), Bentham's Panopticon was not merely understood as a historical plan, nor dream building, but as the historical emergence of a more efficient, effective and productive form of power (Roberts, 2005).

posed to self/others becomes central to coercive intervention, yet as discussed in Chapter Two, these are deemed to be an inaccurate measure for justifying incarceration (Witteman, 2004; Morgan, 2007). Risk assessment is so flawed with inaccuracies that this is unlikely to reduce incidents of violence, which so often grab media attention[25] (Witteman, 2004; Morgan, 2007).

Jane suggests tells how she deemed at risk of absconding, noting this perception of risk from reading her medical notes which she states declared her as at risk of ‘running off’, rather than her being aggressive. Paradoxically after her restraint event, Jane tried to escape; thus, the experience of coercive force appeared to increase her risk of absconding.

A slightly different take on risk is provided by Rory’s story, which intersects with wider narratives of power as he positions himself as resisting, but the power of the system proves too great and eventually he is overcome and restrained. Nurses acting as ‘agents of control’ overpower him, yet this begs wider questions about the influence of power in mental health contexts and how this shapes professional roles. Nurses, amongst other psychiatric professions, but perhaps primarily, are seen to regulate the lives of service users (Donzelot, 1979) and acknowledging this necessitates deeper understanding of systems of power and control and how these relate to wider social narratives.

Smail's (2001) spatio-temporal power horizon is relevant in considering narratives of power. This power horizon illustrates how institutions of power operate through complex lines of influence. For Smail (2001), power is divided into proximal power- that within a person's immediate environment, such as

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[25] An example of this can be seen in The Sun newspaper reporting on what they described as ‘disturbing failings in Britain’s mental health system that have allowed high-risk patients to kill 1,200 people in a decade’ (Parry & Moyes, 2013).

work, education, relationships, and distal power, such as politics, culture education, economics. According to Smail (2001), individuals are aware of proximal power in their lives, yet the distal powers are more significant in shaping subjectivity and individual suffering. We are unconscious of what sits outside of our power horizons, what we cannot know or are prevented from knowing (Smail, 2001). Such power derives both from the material social world and the operation of powerful narrative forces that prop up capitalism and its institutions, such as psychiatry (Rogers-Vaughn, 2016).

For Smail (2001) individuals have little awareness of the forces of distal power around them due to their limited knowledge about wider influences and distribution of power. In a sense Rory had a sense of proximal power in the prevailing micro-power dynamics, however, the wider appreciation of concepts of power were not acknowledged as such in his story. Smail (2001) has argued that the effective invisibility of the various types of power is intensified by the much greater salience of our bodies and feelings, and the actions of those immediately around us, in our daily lives. Hence, individuals are inclined to overestimate the influence of proximal power and consequently underestimate the influence of more distal power (Johnstone et al., 2018).

The importance of power is well evidenced and can be seen in the literature surrounding physical restraint, such as the papers discussed in the literature review for this thesis. For example, service users have expressed their sense of powerlessness in different aspects of restraint, including paternalistic attitudes from staff (Brophy et al., 2016), excessive force or restraint used as a punishment (Brophy et al., 2016; Haw et al., 2011; Knowles et al., 2015) and of their lack of influence, in not being believed by the organisation if excessive force was reported to the hospital as abuse (Brophy et al., 2016). Whilst service users are capable of recognising restraint as a show of power on the part of staff in controlling any single individual’s behaviour (Wilson et al., 2018), they may not always be aware of wider social forces, such as the dominance of biomedicine and its enmeshment with neoliberal governance in more extensive systems of control.

Jane’s depiction of events chimes with the, previously mentioned, critical disapproval of psychiatry’s association with coercive control, and power (Foucault, 2006; Goffman, 1968; Laing, 1967; Szasz 2007). These interrelated concepts have been found as themes within other research, some of which identified in the literature review of this thesis. Critique of coercive and controlling aspects of the psychiatric system features in research findings and commentary (Brophy et al., 2016; Sequeira & Halstead, 2002). Arguably, less coercive and invasive interventions would help service users gain control and improved their sense of security (Wynn, 2004). Finlay’s reaction to witnessing a restraint event he perceived as oppressive also locates the respective service user as subject to control by restraint. Finlay narrates this as oppressive practice replete with homophobic comments, in an environment where coercive control is permitted and legitimised.

Narrating violence

All of the participants tell stories of violence, and a sophisticated understanding of violence in mental health services must move beyond the typical attribution of violence to individual pathology. Put simply, violence between staff and service users ought to be made sense of in terms of interaction, rather than simply blame disturbed patients. An important critical narrative perspective views psychiatry and psy-practices as implicitly and explicitly storied with violence;

psychiatry as epistemic violence, with patient violence often constituting a reaction to this (Liegghio 2013).

Violence and how it is understood features in all of the participants’ stories. Rory’s story, in particular, is replete with violence, in that he is both an agent and a victim of violence. He describes his resistance to the force of others, in this case the nurses, which is also witnessed by another service user. For Jane, a contrast is drawn between expectations and actualities of care seen to be provided, or not, by nurses.

Violence is institutionally identified with the management and prevention of risk. Managing risk becomes part of the 'dirty work' of mental health nurses, associated with their proximity and their practice with groups considered 'dangerous' (Felton & Stacey, 2018). A perception that services are risk-averse places nurses in the central role of denying rights and liberties, however positive their relationship is (Gilbert, Slade, Bird, & Oduola, 2013). Nurses are also the point of blame when risk management goes wrong (Pilgrim, 2012b), reflecting their sub-ordinate relationship with bio-psychiatry (McKeown & White, 2015).

Yet this 'dirty work' exposes nurses to be in the frontline of managing violence. Gadsby (2018) refers to Hui's (2016) research surrounding violence within a secure mental health facility. This study found nurses in the contradictory position of care and control, with a kind of numbing of responses within a culture where dissent from violence is not permitted (Hui, 2016). Rory’s story presented a controlling response by nurses to his behaviour, for example when he talked of walking away from the encounter and returning to his room, he described a violent response. Rory’s perception of staff responses chimes with Hui’s (2016) research about violence. Professional detachment, denial of personal feelings, and the pathologizing of what is not understood become common defence mechanisms often adopted by mental health professionals (Gallop & O'Brien, 2003). Biomedicalised theories about misery, distress, and diagnosis, minimise the moral dilemmas that threaten and challenge mental health nurse's everyday practice (Warne & McAndrew, 2007).

When responding to presenting violence, a sense of depersonalisation on the part of staff is presented in Finlay's and Rory's story. The concept of depersonalisation is found in narratives that nurses rely on which make violent responses possible; the discourse within stories about service users: 'this is not them' means nurses can be violent towards the 'it' (illness), rather than a person with needs (Gadsby, 2018). This concept is also internalised by service users 'this isn't me', or it is the 'illness' (Gadsby, 2018). Some mental health nurses may dissent from violence, allowing others to do the 'dirty work' of nursing; yet nurses are part of a whole profession, and there is a risk of colluding with a system facilitating the continuation of violence within it (Gadsby, 2018). The wielding of power does not require intentional acts by individuals/groups, although it may involve these at times (Johnstone, et al., 2018).

Grant (2015) argues that mental health nurses can become stripped of their capacity for kindness by their own experiences of intersectional oppression[26], which they pass on to service users. Gadsby (2018) argues how violence goes beyond the narrow world of mental health and points to Smail's (2001, p.228) observation of distal power; the 'illusion' that our proximal experiences and interactions are the most causal in our experience, which ignores the influences of the social and political context of power. The narrative of violence is one

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[26] Grant (2015) refers to this oppression as a consequence of being neo-liberalised, classed, gendered, psy-disciplined and socialised into psychiatry.

narrative, amongst many within mental health services arguably over-reliant on a dominant bio-psychiatric conceptual framework.

Narrating mental illness and distress

The wider social dominance of a biomedical narrative is problematically worked out in the participants’ stories, not least in its influence regarding diagnostic presumptions about mental distress and the extent to which participants narrate compliance with such or resistance to it; sometimes a mixture of both. This powerful social narrative is also implicated in the social impact of labelling and stigma. It also underpins the limited choice facing users of psychiatric services; this often narrowed to physical treatments, typically medication and raises fundamental concerns about, for example, whether coercion is deemed appropriate. The serious limitations on choice call into question idealised consumerist framings of mental health care and professionally popular notions such as therapeutic alliance.

The identification of 'mental disorder' with recourse to symptoms listed in DSM-5 or ICD-11, though often unreliable, goes hand in hand with assessment of risk in a meshing of narratives of medicine and control (Sidley, 2018). The symptoms assigned to each diagnostic label are agreed by Committees of psychiatrists and packaged in formal taxonomic manuals raise, this processes also contributing to concern regarding reliability and validity, being open to influence by cultural and political contexts at the time of such agreement (Davies, 2013). Given this disquiet over the diagnostic enterprise, we might note alternate discursive social functions, such as shoring up public faith in the institutions and practitioners of psychiatry, especially their competence in identifying and protecting the public from dangerous deviance (McKeown &

Stowell-Smith 2006). From a discursive perspective, diagnostic categories can be thought of as particular conceptual surfaces through which individual subjectivities can be located and then made subject to regulation and control (Ramon, 1986). Such an understanding is associated with broader historical developments that consolidate the ascendancy of rational science over previous mysticism, afford the individual a central place in culture and as the subject of psychiatry, and link this in public consciousness to beneficence and progress (Bauman, 1992; Foucault, 1970; Parker, 1992). One obvious consequence is the extent diagnosis justifies limiting an individual’s liberty or forcing treatment (Sidley, 2018). When I communicated with Jane for the first time, she stated that she had experienced a one-off episode of psychosis (a diagnostic label) at the time of her in-patent experience, therefore she sought sanctuary but found herself effectively detained.

A narrative of illness diagnosis and its relevance to Rory’s story is pertinent to explore in contemplating some of the consequences suggested by Rory. Psychiatric diagnosis can set the scene for potentially disabling, coercive and re-traumatising interventions within mental health and related systems, including long-term use of medication, and compulsory admission, seclusion or restraint (Cusack et al., 2018; Johnstone et al., 2018). The imposition of an expert professional narrative of 'illness' may undermine people's confidence and ability to make sense of their own experiences. More subtly, the identity of 'mentally ill' may limit people's expectations of who they can be, what they can achieve, and the kind of life they can hope to live (Johnstone, et al., 2018).

Although some people welcome a diagnosis, many who have been assigned a diagnosis testify to the negative impact on their lives and identities (Johnstone et al., 2018). For some people, receiving a diagnosis may be the first stage in a 'psychiatric career' and any positive aspects of receiving a diagnosis can be outweighed by a sense of stigma, fear, shame, hopelessness, exclusion and general disempowerment (Johnstone, et al., 2018).

It is relevant at this juncture to consider labelling theory attached to a diagnosis. When labelling theory was first applied to mental health (Scheff, 1966) it was confronted with an empirical critique and lost its popularity in sociology (Rogers & Pilgrim, 2017). Gove (1982) suggested that a service user's behaviour, as opposed to the prejudices of others, influences labelling. However, other studies opposed this view and proposed that knowledge of an individual's psychiatric history predicts social rejection (Link & Cullen, 1983; Sibicky & Dovidio,1986). Link (1982) suggested that people are socialised to accept negative stereotypes of mental illness, and individuals assigned these labels are subject to different treatment from others. Rory’s story is suggestive of such difference and it questions whether he is socialised into an illness narrative, which he largely accepts in his story; including the possibility that ‘being ill’ renders him not fully responsible or accountable for his actions.

Various authors have re-examined Goffman's work on stigma in the 1950s and 1960s (Rogers & Pilgrim, 2017). A modified labelling theory offered by Link, Struening, Cullen, Shrout, and Dohrenwend (1989), suggested that provided that best practice is provided to service users from mental health care, they can experience positive benefits in their quality of life; however, whether or not an individual experiences positive or negative impacts on their quality of life, the effects of independent stigma persists from and are anchored within social processes.

In communities, Link et al. (1989) suggest that mental illness leads to suspicion, loss of credibility and social rejection, and clearly these processes of personal devaluation are transmitted in popular culture and mass media (see Philo, 1997). All parties, especially the person with the mental health problem share this assumption from childhood and these shared assumptions lead to a loss of confidence and a self-fulfilling prophecy ensues (Rogers & Pilgrim, 2017).

The mass media's role in perpetuating prejudice and stigma has been well recognised in research (Rogers & Pilgrim, 2017). The evidence around social exclusion is unambiguous, as individuals diagnosed with mental illness are likelier to live in poor conditions, encounter difficulties in job opportunities, be detained in hospital, be shunned by others and die earlier (Rogers & Pilgrim, 2017).

In Rory's story, there is a question as to whether he may have attributed his reactions at times to being ill, with all the assumptions of the limitations of illness. Thoits (1985) supports the theory of Link and his colleagues suggesting that, from a young age, we learn about appropriateness of our emotions and consequently know when one's emotionally driven actions will be considered inappropriate by others.

A notion of self-stigma, or internalised stigma, as a result of being diagnosed as 'mentally ill' has grown in currency latterly, with labels such as 'schizophrenia' indicating a greater 'severity' and being commonly experienced as more stigmatising (Johnstone et al., 2018). Rory was diagnosed with this label, which raises a fundamental question about Rory's view of his illness and behaviours. Similarly, Finlay's story presented an account of internalised, or self-stigma, as he internalised his illness, for example suggesting his difficulty in breathing may not be believed by staff during restraint.

The dominance of the biomedical narrative can operate to squeeze out of vocabulary alternative forms of expression for medically defined experiences; thus, assumed features or symptoms of psychosis are typically only describable in these terms, precluding consideration as part of a range or diversity of human experience. As medical language and thinking predominates, it is a short step from extending and using this language in the everyday to thinking in these terms when attempting to make sense of all distressing experiences. This perhaps explains how Rory presented his illness as attributable for the suspicious thoughts he felt were present due to the body searches that took place.

The clinical term 'Paranoia'[27] is used to explain experiences such as a person's belief of vulnerability and the dangers presented from others; it can serve as a reasonable and accurate response to past experiences, which can be easily generalisable to other people or situations seen as threatening to an individual (Bentall et al., 2015; Freeman et al., 2002; Read et al., 2005). Rory relayed all his traumatic past experiences to being restrained, even at a young age, and he talks about how these events have ‘stuck with him’ this raises a question as to whether such trauma may have had an impact on Rory’s beliefs about his vulnerabilities. These beliefs can be labelled by psy-professionals as delusional if they come to dominate situations which may be perceived as unthreatening to others or are expressed in indirect or symbolic ways (Johnstone, et al., 2018). However, this conceptualising is problematic not just because of the difficulties

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[27] Paranoia is defined in clinical terms; that one's life is controlled by external forces and that vigilance is beneficial and needed. However, Johnstone et al., (2018) suggest that it is not merely diagnostic terms which need to change. In order to act and think differently, the language used in psychiatry support and perpetuate the current model, They point to the DCP Guidelines on Language for professional documents which offers alternative terminology. This document suggests suspicious thoughts could replace the term paranoia (DCP, 2014).

with the concept of delusion, but also due to the strong connections between childhood and adult adversity; in this sense suspicion and vigilance may continue to be meaningful and helpful responses well beyond childhood (Harper, 2004, 2011). In this respect, there is a resemblance between the aspects of someone's 'delusional' beliefs and the circumstances of their present life and their past (Rhodes & Jakes, 2000).

Drug-centred treatment appears to dominate treatment and consequential action by staff. The bias towards physical treatments, particularly drug treatment is strong in psychiatry (Rogers & Pilgrim, 2017) Physical treatments are legitimised in part by the motive for profit as drug companies market their products to professionals, with these serving as a cheap alternative to labour-intensive talking therapies (Rogers & Pilgrim, 2017).

Demonstrating how narratives of bio-psychiatry and violence intersect, medication can be imposed on individuals against their will (Pilgrim & Rogers, 2017), which was certainly a theme presented by Rose in her story. At a time when psychiatry was arguably entrenching organic and brain-centric understandings, Brown and Funk (1986) argued that the discipline was tying itself to physical medicine with all its biological trappings. Given the pre-occupation with biomedicine, service user’s needs are ignored in favour of the political needs of psychiatrists treating them (Rogers & Pilgrim, 2017). A report by UN Special Rapporteur on the rights to physical and mental health stated that there was:

> ‘*a bias towards first-line treatment with psychotropic medications, in spite of accumulating evidence that they are not as effective as previously thought, that they produce harmful side effects and, in the*

> *case of antidepressants, specifically for mild and moderate depression, the benefit experienced can be attributed to a placebo effect'* (UN, 2017, p.6)

Johnstone et al. (2018) propose that psychiatric drugs may have an important role in alleviating many people's distress, however informed choice[28] is central to what works best for individuals. Moncrieff (2008) argues that the drug-centred model predominates in psychiatry, as it offers a range of general effects, for example sedation or emotional blunting on one's state of mind, regardless of pre-existing 'illness' (Moncrieff, 2008). However, the notion that drugs correct 'chemical imbalances[29]' are rapidly being retracted by senior figures in the field (Pies, 2014). Service users have described a difficult trade-off between beneficial and unpleasant effects (Carrick, Mitchell, Powell, & Lloyd, 2004). Whilst other service users have reported flattening of responses, feelings of emptiness, dread and agitation which might be seen to be more damaging than the difficulties for which the drugs were prescribed (Moncrieff, Cohen, & Mason, 2009).

Mental health service user's 'non-compliance' with medication has emerged as a social problem, stemming from public pressure to manage mental health service users appropriately and from the central tenet of managing and containing mental health problems more generally (Rogers & Pilgrim, 2017). Professionals override service user's in seeking consent if they feel they lack insight (Rogers & Pilgrim, 2017). However, this is perhaps debatable, indeed

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[28] **.** Informed choice depends on receiving full and accurate information in the first instance, and the actions and side effects of medication needs to be understood and may need to be explained in a different way (Johnstone et al., 2018).

[29] Pies (2014) states how psychiatrists should avoid the conspiratorial narrative of the chemical imbalance theory integrating biological and psychosocial insights instead.

Soskis (1978) found that medical patients knew less about the side effects of medication, than psychiatric patients, which shows the latter to have understanding. However, psychiatric patients are less likely to be told why they are being given certain medication, than medical patients, indicating that psychiatrists are less willing to discuss treatment rationale with patients, than their medical counterparts. This is relevant to Rose, as she was aware of the effects of certain medication, indeed she signed an advance statement to note her preferences for certain medication.

Interestingly, the fact that psychiatry functions to control identified social deviance sets up a number of key discursive challenges. At its juncture with the criminal justice system psychiatry typically finds itself having to adjudicate between madness and badness. This exposes a conceptual gap between a medical concept, where the person's sickness is to blame and a moral concept, where the person is viewed bad and blame is attached (Harper, 2013; Lafrance, 2009; Pitt, Kilbride, Welford Nothard, & Morrison, 2009). This has been characterised as the 'brain or blame' dichotomy (Boyle, 2013).

The idea of diminished agency contingent on assuming a sick role (Parson's 1951) appears to have been preferable for Finlay, as he positioned himself as not being responsible for his actions. In this way people may defend themselves against attributions of shame and guilt by self or others, but at the high price of taking on a devalued identity that identifies them as flawed, inadequate or defective, as well making them vulnerable to discrimination and social exclusion (Johnstone et al., 2018). The sick role and 'not responsible' messages can lead to frustration by staff who might see service users waiting to be 'made better' without their attempts or willingness to do so themselves (Johnstone, 2000). Finlay reported how he 'brought about' restraint to help him control his distress, yet nurses have reported their anger in such situations (Sequeira & Halstead, 2004).

Intersection with a bio-psychiatric narrative is perhaps most starkly brought into view in relation to the common linking of physical restraint with forced medication. Narratives of biomedicine are framed in Rose and Jane's story, presenting the intertwining of physical restraint, perceived as violent and enforced medication.

Both Rory and Finlay presented a narration of illness that seemingly accepted a bio-psychiatric framing. In Finlay's story, his aggression was presented as internalised, towards himself, as he attempted to hurt himself when he reported feeling unwell and felt he was not in control. For services, this typically indicates an illness identity is present. As his aggression was storied as placing himself and, perhaps more indirectly, others at risk of harm, the nurses were seen by him as needing to act and restrain him. Finlay's reasons for self-harm were suggested as his wanting to exert control over a situation where he felt out of control and he sought to punish himself. This mirrors other studies that have found that self-injurious behaviour has been a means to exert self-control and punish oneself, as well as coping with anxiety and stress (Klonsky, 2007; Nock & Prinstein, 2004).

Yet Rory's story reported his aggression to be directly focused towards others. Rory justified his behaviour at times towards staff and this was seen by him as attributable to his mental illness, indicating the illness identity to be a resource for him in explaining his actions towards staff. An example of this is as he became ill, in a forensic setting, he infers he is not accountable for his actions as he hits a staff member with a kettle as the staff member "*got into*" his “*space*”. In Tingleff et al.’s (2018) study the theme of illness related behaviour was characterised by service users’ own perceptions of themselves as psychotic, and as such lacking insight, which resulted in violent behaviour towards staff. Coffey (2012) proposes that medical labelling of a mental health condition will in effect warrant the behaviour of a person, therefore in some settings, such as forensic settings, it is not deemed as deviant. Similarly, Angermeyer & Matschinger (2003) argue that illness labels help individuals to re-order and reconstruct their experiences and thus have a role to play in bringing meaning to chaotic experiences and diminished responsibility status; whilst asserting the moral position of the individual (Coffey, 2012). Dixon’s (2018) study similarly reported how service users in forensic settings attribute mental illness to explain their deviant behaviour and found this helpful, yet others in this study found this limited self-reflection and accountability for their actions. It is argued that Ignoring an illness identity may lead to obstacles in successful treatment and rehabilitation (Yanos, Roe, & Lysaker, 2010).

A biomedical illness narrative can impose on people’s sense of meaning and questions whether Rory and Finlay were socialised in accepting this negative stereotype of mental illness. Link et al.’s (1989) argument about loss of credibility and social rejection, appear to be presented and accepted by both storytellers.

Narrating trauma

The concept of trauma is both a consequence of coercive intervention, a purported cause of the mental distress which becomes identified with psychiatry, and a vanguard concept for formulating non-medical alternative means of help and support. Despite growing critical interest in notions of trauma, the diagnostic narrative of trauma is problematic, in its narrow focus on adverse life events. The DSM-5 and the ICD-11 have recognised trauma and focused attention on the definition and its impact (Sweeney, Filson, Kennedy, Collinson & Gillard, 2018). The clinical definition of trauma[30] does not recognise the wider context of adverse events, with its focus on a*ctual or threatened death, serious injury or sexual violence* (American Psychiatric Association, 2013).The potential for trauma need not be life-threatening, and events causing trauma, include 'power over' relationships where one individual or group has power over another; therefore, services can retraumatise individuals based on the 'power over' relationships (The Substance Abuse and Mental Health Services Administration's, 2014).For example, in Finlay's depiction of a restraint event, he expressed on-going anger, suggestive that his meaning-making of this event was perhaps traumatic for him.

The Substance Abuse and Mental Health Services Administration's [SAMHSA] (2014) concept of trauma involves three factors; the event[31], people's experiences and the effects. This framework takes into account the less well-informed forms of trauma, including racism, poverty, inequality, oppression, and historical violence experienced by groups. Therefore, trauma is considered in a wider context (SAMHSA, 2014). These alternative concepts of trauma acknowledge the role of social traumas unacknowledged in the medical concepts of trauma (Sweeney et al., 2018).

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[30] The DSM-5 understands as being triggered by external traumatic events and defines it as *exposure to actual or threatened death, serious injury or sexual violence via directly experiencing or directly witnessing the event or events* (American Psychiatric Association, 2013).

[31] SAMHSA (2014) include trauma from a single event or series of events compounded over time. The common forms of trauma (physical/sexual violence, childhood abuse/neglect, community violence and natural disaster are acknowledged, as well as the less well-understood forms of trauma. Trauma can be real or a perceived threat from an external event with long-lasting consequences.

Johnstone et al. (2018) refer to Mary Boyle's (2006) cautions about the potential sanitising effects of the neat summary word 'trauma', which might evade 'spelling out the troubling and sometimes shocking experiences people have actually had' and remove attention away from issues related to power such as poverty, inequality, and discrimination (Johnstone et al., 2018). The networks of power people have embedded in their access to resources[32], has a significant role in how individuals respond to events (Johnstone et al., 2018). The fewer resources people have access to, the less they are in positions to exercise socially approved forms of power, therefore their response will be more likely to bring disapproval from others (Johnstone et al., 2018). In addition, mental health care is often traumatising and retraumatising (Johnstone et al., 2018). Trauma was presented in all stories to a greater or lesser extent which resonated with other stories about the traumatising impact of coercion (Bonner et al., 2002; Brophy et al., 2016; Knowles et al., 2015; Sequeira & Halstead, 2004; Steinert et al., 2007; Wynn, 2004).

Trauma in Rory’s story is represented in his sense of feeling sexually violated, for Jane this had been the physicality of restraint and not feeling fully recovered from her experience, being visited by nightmares at times. Yet for Rose past trauma is narrated as resurfacing because of restraint. This theme of re-traumatisation is seen in other studies (Bonner at al., 2002; Brophy et al., 2016; Sequeira & Halstead, 2004; Steinert et al., 2007; Wynn, 2004). Mauritz, Goossens, Draijer, & van Achterberg (2015) found that one-third of service users on mental health wards had experienced sexual abuse, whilst around half had experienced physical abuse. Internationally, the importance of trauma-

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[32] Resources include physical, social, economic and psychological.

informed care is recognised and within the United Kingdom the NHS has outlined this, making clear the connection between trauma and mental health (NHS England, 2018).

In presenting those aspects of his story that touch on victimhood, Rory, along with other participants reveals a narration of trauma and adversity, not least in relation to the potential of physical restraint to re-traumatise. The storying of trauma reflects the language and preferred terminology and orientation of wider critical and activist inspired demands for services to be less pathologizing and more informed by the key role of previous life trauma in the experience and expressions of mental distress. However, this movement is another that is subject to control and co-option by the dominant biomedicine it seeks to transform. Sweeney et al. (2008) point to problems with biomedical explanations about trauma and point to the work of Fowler et al. (2006) who have suggested that '*[h]igh vulnerability to [developing intrusions of traumatic events] may be conferred from genetic or constitutional factors*' (2006, p.116). This promotes a dominant biologically-oriented research agenda and treatment regime, which marginalises the social and relational facets of experiencing and surviving adversity. Within the Power, Threat, Meaning Framework (Johnstone et al., 2018) the term 'adversity' is preferred in side-stepping any medical overtone of 'trauma', but also to

> ‘*avoid the potentially misleading impression of discrete, possibly very unusual, extreme or life-threatening events impinging from outside, rather than, as is often the case, of continuous or repeated very negative experiences, embedded in people's lives and relationships and the discourses, structures, and practices of our social world’* (p.98).

Trauma connected to coercion can be seen in many ways, for example through continual observation, body searches, seclusion, restraint, and forced medication (Sweeney et al., 2018). The experience of Rory being searched by staff is presented by him as traumatising.

For Jane, her representation of trauma did not fit neatly into the medical definition of trauma as specified by the DSM-5. This suggests a very narrow view of trauma. Indeed, as Jane told me the story, her sense of the event as traumatising was a dominant feature.

A large part of the impact of adversity can be accounted for by factors which exacerbate the experience of threat which amongst other factors include interpersonal and intentional threat, loss of control, physical invasiveness, and lack of someone to confide in and act as protector (Johnstone et al., 2018, p.193). In this respect the impact of adversity started as Jane entered the ward and represented herself as having no one to confide in. Jane talked of feeling terrified and represented nurses as ignoring her. The physical invasiveness was palpable in her story as talks about the physical aggression and her analogy and how she would have preferred to be tasered or shot with a dart than physically touched. Clearly, the participants' accounts of trauma and re-traumatisation within services are resonant with wider narratives of control and its emotionally disabling impact and undermining of autonomy.

Mental health care is frequently traumatising and re-traumatising in itself, which sets up further cycles of cumulative and synergistic events (Johnstone et al., 2018). The diagnosis that an individual has been assigned can lead to feelings of shame, deficit and exclusion, as a consequence labels and interventions may multiply, leading to further cycles of trauma (Johnstone et al., 2018). Rose presented a sense of shame within her story. She reported that she blamed herself for restraint at times and tried to apologise, but from her perspective the staff blamed her for running away. However, she felt the staff had not acknowledged her fear, as she talked of running because she was frightened of the staff, revealing further cycles of trauma.

Trauma connected to coercion can be experienced through restraint, and forced medication (Sweeney et al., 2018). Rose reported that witnessing traumatic events, were trauma reinforcing, which is suggested in other studies (Frueh et al., 2005; Palm, Polusny, & Follette, 2004; Clark, Ryan, Kawachi, Canner, Berkman, & Wright, 2008). Furthermore, using power to manage presenting 'behaviour', can result in service users fearing and distrusting staff, particularly those who rely most heavily on power and control (Sweeney et al., 2018).

There appears to be a little research specifically exploring the impact of trauma-informed approaches in preventing, reducing and ending coercive practices in mental health (Gooding, McSherry, Roper & Grey, 2018). Nevertheless, Duxbury et al. (2019) found that nurses had an increasing understanding of trauma and delayed their intent to restrain when following the REsTRAIN YOURSELF Programme, a trauma-informed approach to preventing restraint.

All storytellers in this study reported on aspects of trauma within their stories Bloom (2006) argues that recovery in mental health becomes compromised, due to the complex relations between traumatised service users, stressed staff and organisations under pressure. Furthermore, the systems in place for supporting service users frequently recapitulate the experiences of trauma and service users can feel unsafe in a trauma un-informed environment, which may lead to service users becoming aggressive (Bloom, 2006). Appropriately tailored interventions need to be available to support service users who self-harm with therapeutic approaches. Initially, this approach might involve the individual finding short-term ways of managing distress or learning to tolerate it, and then longer-term therapy might then focus on the contexts within which that distress arises (Edmondson, Brennan, & House, 2016). A harm minimisation ethos can be useful, especially avoiding the afore-mentioned contradictions of imposing physical control or prohibition on individuals who use self-harm to reclaim some self-control in their lives (Spandler & Warner, 2007).

The establishment of trust is arguably an essential pre-requisite for therapeutic relations within healthcare provision (Pilgrim, Tomasini, & Vassilev, 2010). The challenges of building and securing a trusting relationship with staff was presented within all the stories and this was particularly the case for Rose whose past abuse made her vulnerable to re-traumatisation. Rose’s trigger points for re-traumatisation were storied as often being undermined or ignored, which in her view had impacted on her building trusting relationships with staff. Rose’s ability to trust others was suggested as already being compromised, due to her experiences of abuse. Sexual abuse by a parent can often result in confusion, a sense of betrayal, and harm an individual’s capacity to trust, others (O'Leary, Coohey, & Easton, 2010). Therefore, Rose’s report of the insensitive questioning of how her mother could have raped her is suggested by her to have impacted on her trust with the doctor. She told of reacting in protest to this by damaging the surrounding environment. In a telling piece of autobiographical writing, Jacqui Dillon (2010) relates how her own experiences of surviving child sex abuse and her own mother’s orchestration of this can make a case for non-medical understandings of traumatic distress and coping and for trauma informed care practices. In a study by Tingleff et al. (2018), doctors’ poor communication with service users, was found to result in overt protest reactions, which resulted in further restraint and re-traumatisation.

Re-traumatisation, as a consequence of restraint, and other aspects of coercion, including more subtle, yet impactful, communicative interventions, for individuals with histories of abuse, is well established in the literature (see for example Bonner at al., 2002; Brophy et al., 2016; Kinner et al., 2017; Knowles, et al. 2015; Sequeira & Halstead, 2004; Steinert et al., 2007; Wilson et al., 2017; Wynn, 2004). This makes mental health care potentially trauma reinforcing (Sweeney et al., 2016). The distress of abusive past experiences can also have longer-term implications on an individual's identity. Taylor (2004) proposes that a person's sense of belonging and identity can be disrupted, if not destroyed because of sexual violence.

Rose's story positioned her in a survivor identity, being an adult survivor of emotional, sexual and physical abuse; yet certain trigger points were reported by her as prompting agitation and upset, which resulted in physical restraint. This appears to have placed her in a victim identity once again. The link between trauma and mental health and the positioning of victim identity limits access to other less vulnerable identities (Sweeney & Taggart, 2018). When in a victim identity, Rose reported that she had lost her perception of reality, as she described being *'gone'* in her '*head*'; suggesting dissociation as defences against the abject terror and pain of traumatic experiences.

Rose proposed that knowledge of her childhood abuse may have avoided situations which escalated to the point of distress and subsequent restraint. In her view, the nurses who made efforts to engage in getting to know Rose, including the knowledge of her history, were seen to possess a sound relationship with her. She suggested they had been able to avoid trigger points that reignited past abuse. In considering the therapeutic alliance in such situations, as a mechanism to rebuild identity, trust is paramount, yet survivors of abuse may hold a lack of trust for those in positions of care (Muldoon, Taylor, & Norma, 2016).

Fear of restraint, as a feature within the stories, provides further examples of the emotional impact of restraint felt by the storytellers. In Rory's story, this fear was storied as implicit, as staff took off jumpers and the bell sounded, which indicated tension, and suggested that individuals became aware that restraint was imminent. For Rose, this fear is storied as causing physical consequences, such as "*wetting*" herself. Rose also reported how she felt in fear for her life at the thought of being restrained. This fear is also presented as restraint was being undertaken, as Rose suggested she did not understand why she was being restrained, which reflected her anxiety about what the consequences would be. Yet at times, it was the experience of previous restraint undertaken on the wards that evoked an anticipatory fear in Rose's story, as restraint itself was indicated by her to have made the ward environment a scary place where restraint could occur at any time. The theme of fear because of restraint is also well evidenced in literature (see for example Bonner et al., 2002; Brophy et al., 2016; Sequeira & Halstead, 2002; Wilson et al., 2017; Wynn, 2004), therefore the context and climate of fear becomes an important consideration in the use of restraint.

Witnessing restraint

It has been noted that witnessing violent or traumatising events can, in and of itself be traumatic (Palm, Polusny, & Follette, 2004; Clark, Ryan, Kawachi, Canner, Berkman, & Wright, 2008) and this extends to witnessing use of physical restraint on others, often complicated by the aforementioned personal experiences of trauma or abuse (see Cusack, Frueh, Hiers, Suffoletta-Maierle, & Bennett, 2003; Fox, 2004; Wilson et al., 2017). The absence of someone else witnessing her restraint presented an issue for Jane; as the police informed her they were unable to take her complaint about the alleged assault to a conclusion, without witnesses. Yet witnessing restraint was reported by Rose as personally re-traumatising within a narration of trauma in her story, and she presented this as detrimental to others as the ward atmosphere was affected; becoming “*intensive*” and “*scary*”. Rory and Finlay also reported their discomfort and distress in witnessing restraint, as they felt restraint to be inappropriate or unjustified at times. This correlates with other studies that have reported how service users have reported feeling distressed when witnessing the restraint of others (Cusack et al., 2003; Mayers et al., 2010; Wilson et al., 2017). Finlay alluded to witnessing many restraints and the consequences are sometimes negative for service users, yet his witnessing of homophobic comments, during the restraint of another service user, was indicated by him to have caused him particular upset and anger. Indeed, as he told his story he portrayed his anger and expressed his disrespect for the nurse involved.

In witnessing restraint, Rory’s asserted that, at times, service users were ill and needed a de-escalatory approach, more sensitive to their needs. Indeed, this is a central tenet of professional rhetoric around minimising the use of restraint (Price et al., 2017). In this respect, Rory deemed that staff’s actions in restraining service users highlighted a misunderstanding of their mental wellbeing and an inability to manage people when in distress. In a study by Carlson and Hall (2014), a barrier to restraint prevention for some staff was a lack of understanding about mental illness. Additionally, from a service user perspective, participants in Kontio et al.'s (2012) study found psychotic behaviour was believed to be the primary reason why restraint was used; yet a therapeutic approach could avoid restraint in such circumstances. Findings in these two studies correlate with Rory's perception of events, suggesting that staff fail to engage in alternatives to restraint and undertake a flawed assessment of the risks posed by individuals, such as those narrated in his story.

Risk assessment, however, can be inaccurate but is positioned as objective by staff, despite scientific reservations and limitations of evidence regarding its accuracy (Swanson, 2008). Staff are compelled to undertake assessments based on safety, and therefore this becomes legitimised practice; yet the ability to assess and monitor risks centres on professional competence and judgement (Coffey et al., 2016). In seeking to minimise risk, staff may unintentionally increase this in a cycle of compulsion and enforced treatment that damages trust, or by enforced compliance, that can destroy hope (Perkins & Repper, 2016). Although safety is important, risks are rarely discussed openly with service users, denying opportunities for service users to be involved in support that may manage or reduce risks or to achieve a degree of autonomy in managing their own risks (Coffey et al., 2016; Deering, Pawson, Summer, & Williams, 2019).

Last resort

All the four storytellers questioned the use of restraint as a last resort and alluded to restraint as a planned intervention. In sharing their stories, Rose, Jane and Rory positioned themselves as victims at times. Yet in doing so, resistance is also presented. Rory displayed his identity, as a fighter, but the power imbalance of one person fighting a big system was presented in his story and he was overpowered. Issues of Rory’s masculinity intersect with his resistance, as he discussed fighting back and putting up a good fight. In the end, the force of others was presented in having prevented him from resisting further. Tingleff, Hounsgaard, Bradley and Gilberg (2018) refer to this resistance as ‘overt protest’. In their study, service users reported fighting staff as they were surrounded, overpowered and held by the staff prior to mechanical restraint (Tingleff et al., 2018). As he is overpowered, on one occasion, Rory reported being intimately searched, whilst restrained, and he felt sexually violated. Here he positioned himself in an opposing identity, from that as a fighter to that as a victim of sexual violation, in which he questioned the morality of such an act. In this respect there is an implication that Rory is cast as a hero, holding on to what is right and wrong.

In another context**,** exploring how characters work in social movements, Young and Zuern (2018) advise how victims should take care to hold onto morality and to become heroes, rather than villains, or martyrs. In considering Rory’s victim identity further, his account of staffs’ actions, on occasions, suggest examples of inappropriate or abusive practice in their duty of care. This was demonstrated in Rory’s story as he walked away from a situation of potential conflict and thus felt he was not presenting a risk, yet restraint was undertaken.

This exercise of power is legitimised by policy and legislation, yet policies seek also to avoid restrictive interventions. Rory’s story contrasts in this respect with the public policy around restrictive interventions and the agenda for the avoidance of such practice in the United Kingdom (DH, 2014, 2015; NICE, 2015), as a ‘restrain first’ approach is noted.

It is relevant to consider the concept of violence inherent within mental health services here, which may impose violent responses from nursing staff. Holmes, Rudge, Perron and St-Pierre (2012) question the assumption that violence stems from service users in health care settings, proposing that violence is implicit within systems, enacted by staff upon service users. Gadsby (2018) considers violence to be inherent within the mental health system, which is seen by everything that is permitted under mental health legislation and other less visible forms of violence within this system. Yet within nursing literature regarding restraint, the illness model dominates as an effective treatment option, with the morality of legislation being largely unquestioned (Gadsby, 2018). Restraint and other forms of coercion are arguably mandated within mental health services operating within, and contributing to, wider systems of governance and control (Foucault, 2006; Rose, 1996). From this perspective, these often taken for granted practices reveal the implicit violence and power of psychiatric knowledge in organising and underpinning care and treatment regimes; understood latterly as epistemic violence (Fricker, 2007; Liegghio, 2013; Russo & Beresford, 2015).

Jane reported restraint being undertaken soon after admission to the ward to administer medication, which implies the unjustified use of coercion and is also in opposition to policy in this area (DH, 2014, 2015; NICE, 2015). Deveau and McDonnell (2009) propose how reliance on the ‘last resort’ principle is flawed, as it is an easily voiced rhetorical device yet is difficult to monitor or challenge. The pre-planned decision to form a team to administer medication, against the will of an individual, highlights inadequacies in using coercion, challenging the concept of ‘last resort’ (McKeown et al., 2019a). Findings from a service user perspective, have suggested that staff have been reliant on the use of restraint, without resort to de-escalation (Price et al., 2017).

It is relevant to consider Jane’s experiences prior to restraint being undertaken. In her story, fear was present, as she was admitted to the ward and separated from her son, indicating how Jane’s identity as a mother was compromised. In her story, like Rose’s experience in this respect, she reported being stripped of personal belongings when admitted onto the ward. Jane viewed that staff deemed these personal items to have been a risk to her safety. Jane’s initial experience of this is an example of Goffman’s (1961) ‘annihilation of self’, as Jane tells of being stripped of her personal belongings and a social distancing takes place. Jane reported that she attempted to seek support from nurses, as she wanted to know her son was safe, but nurses told her to go to bed. This distancing is then compounded by the encounter with the doctor later in the morning when she felt patronised. There was a disagreement with the doctor, and she felt this is the reason she was subsequently restrained.

Jane did not feel she was a risk to herself or others and made clear connections to the doctor having prompted restraint and felt the reasons for restraint to be punitive; indeed, she reported this to have been an abuse of authority on the part of the doctor. This suggests the power imbalance present in this aspect of Jane’s story. Jane’s depiction of restraint, as punitive, resonates with other research. In a study by Price et al. (2017) service users reported how restraint use was undertaken as a punishment or revenge on occasions. Jane suggested that nurses restrained her to medicate her. Resistance to medication can compel an individual to take on the identity of recalcitrant, although this term can be used negatively to describe resistance to care, so too can it be used positively to frame an individual’s dissent and reaction to restrictive practices (McKeown et al., 2019a).

In Jane’s story, she represented herself as not resisting restraint and complying with the procedure. She questioned this as a misuse of power, on the doctor’s part, in the forced medication and felt the doctor had orchestrated the whole procedure because she challenged him in her encounter with him earlier on that day. Other studies correlate with this, in that service users have reported their belief that staff have asserted power over them, via medication use (Kaminskiy, Ramont, & Morant, 2013; Knowles et al., 2015). In her story, Jane positioned herself as an innocent victim, in what she felt to be a violent response to her situation, as a newly admitted service user into a hostile ward environment. Interestingly, the concept of being newly admitted onto a mental health ward are mirrored in the stories of Rose and Finlay in their concerns about feeling vulnerable in this situation. Yet Jane presented further vulnerability as she discussed her experiences. Jane’s opening sentence prior to restraint, demonstrated her perception that she was not a risk: “*I was talking to some cleaners*”*.* Here she positions herself as unthreatening, not posing risks to herself or others, yet despite this, she was restrained. Reissman (2001) suggests that storytellers can position themselves as victims, as other characters in the story have the power to initiate action.

Although Jane’s initial reaction to being restrained was storied as compliant, she then reported her resistance to the act as she attempted to escape from the ward later in the day. This resistance persisted in Jane’s story, following her discharge from the hospital, in reporting the incident to the police, as an assault because of what she perceived to be unjustified restraint which was described by her as intense and excessive. Although Jane considered her experience of restraint unjustified, she also deliberated on how the use of restraint can be legitimate, as a last resort in certain circumstances. This highlights the perception that, although some service users object to coercion applied to themselves, they view it as warranted in its use with others, as a proportionate response to the risks posed (Dickens, Piccirillo & Alderman; Duxbury & Whittington, 2005).

From a nursing perspective, the view of restraint as a last resort is commonplace (Perkins, Prosser, Riley, & Whittington, 2012) with physical intervention seen as a justified part of the job when service users' aggression necessitates such a response (Moylan & Cullinan, 2011). Chapman (2010) argues that staff often legitimise and excuse their actions in restraining individuals; often revealing the moral nature of such discourse. Thus, agencies and individuals can be seen to engage in legitimation narratives concerning restrictive practices (Gadsby, 2018; Perkins et al., 2012). Negative emotions engendered in staff because of undertaking restraint are soothed within such justification processes; with staff reassuring each other that they have acted correctly and within professional and moral norms. Hence, a violent staff response, such as physical restraint, is placed within an acceptable moral order if this response is deemed to have been reasonable, fair and proportionate; judged in relation to the provoking violence posed by service users. This sense of 'procedural justice' allows for all concerned to adjust to any discomfort or revulsion at being party to violent actions (McKeown et al., 2019a). Debriefing processes, ostensibly designed to learn from restraint incidents, can serve to consolidate legitimisation tendencies; reproducing and reifying legitimation narratives, such as restraint as last resort, through telling and retelling these professional morality tales. As such, the narration within debriefing exercises risks defaulting to exculpatory, rather than explanatory reasoning (Chapman, 2010).

Rose’s story also positioned her as recalcitrant to some extent in her attempt to avoid medication. She talked of having previously signed an advance statement about her wishes not to take medication, yet she felt this was ignored and restraint was undertaken to medicate her. In a study by Haw et al. (2011) some participants reported that they had made an advance statement about restraint, yet neither case notes nor care plans showed any evidence of these. Service users have reported that co-produced plans to manage their behaviour when in crisis, help them to feel more in control of their mental health (Thornicroft at al., 2015).

Finlay’s story exposed his own portrayal of pre-planned restraint when he suggests people were removed from the room and a bed was placed in the middle of the room, which indicates restraint as a planned intervention. Yet, in this planned restraint, Finlay judged it to be justified for reasons of safety, indeed he expressed his anger towards staff who, in his view, were slow to restrain or have stated to him that they did not view themselves as “security guards”, which suggests nurses struggle with decisions to restrain individuals.

There is an international drive to reduce and possibly abolish the use of restraint (LeBel, Duxbury & Putkonen, 2014). Restraining individuals can cause ethical dilemmas for nurses working in all settings and within all service user groups, for example with children (Bray, Snodin, & Carter, 2015). However, these same dilemmas are felt by nurses working with adults and this can cause conflict for nurses. This has been referred to by some as the ‘conflicted nurse’ (Bigwood & Crowe, 2008; Marangos-Frost & Wells, 2000), whereby ethical values and safety need to be balanced when making decisions to restrain individuals (Bigwood & Crowe, 2008; Kontio et al., 2010; Marangos-Frost & Wells 2000).

In one study which looked at nurses' perspectives in use of restraint, fear for their own safety was reported regarding the elimination of restrictive practices, and nurses also reported how they felt blamed for the use of such practices (Muir-Cochrane, O'Kane & Oster, 2018). Yet, other studies have reported restraint to be part of the nurses' role (Moylan & Cullinan, 2011). Several studies have found that restraint to be explicitly linked to nurses' professional responsibility and accountability in providing a safe environment for staff and patients (McCain & Kornegay, 2005; Bigwood & Crowe, 2008; Perkins et al., 2012). Indeed, Perkins et al. (2012) reported how nurses viewed restraint as a 'necessary evil', suggesting a moral context. Other research from a nursing perspective has reported how restraint is believed to support safety (Bigwood & Crowe, 2008; Duxbury, 2002; Foster, Bowers & Nijman, 2007; Lemonidou et al., 2002; Perkins, Prosser, Riley, & Whittington; 2012; Riahi et al., 2016; Terpstra, Terpstra; Pettee, & Hunter, 2001); yet immediate risks to safety in these circumstances remains open to question as research has demonstrated success in restraint reduction rates (LeBel, et al., 2014; Madan et al., 2014; Wieman, Carmacho-Gonsalves; Huckshorn, & Leff, 2014). Furthermore, research has demonstrated that restraint reduction has not led to an increase in assaults (Smith, Ashbridge, Davis, & Steinmetz, 2015).

Physical pain and injury

Narratives of violence, power and control are presented by the storytellers in this thesis, excessive use of any of these may cause pain or injury. The physical impact of pain associated with restraint was presented in Jane, Rose and Rory’s story. Although Rory reported how the pain was bearable, he also told how the pain was very intense. He spoke of how he felt restraint placed other service users at risk of fractures, which is again in opposition to the United Kingdom’s policy surrounding restrictive interventions (DH, 2014, 2015; NICE, 2015). In describing his witnessing of restraint, Rory implied how service users did not always pose a significant threat and he inferred how staff could better manage service users’ presenting behaviour.

In this respect, Rory’s perception of the illness identity of other service users was presented in his story. This impression of illness identity was strengthened by Rory's perception of the service user’s compromised mental health, yet he was restrained. From Rory’s perspective, the response was disproportionate and restraint unjustified. Rory also positioned himself and others as victims, yet Rory’s depiction of himself also suggests his strong masculine identity as a fighter able to manage the pain, which conflicts with him being a victim, as he presents a narrative of masculinity.

All stories revealed their perceptions of the unsafe use of restraint for themselves and others; including unsafe positions and or excessive force during restraint. At stake here was service users’ perceptions of their safety and perhaps even, life. Studies have reported how physical harm can occur when excessive force and control is used during restraint, which can also result in serious injury (Brophy et al., 2016; Cusack et al., 2018; Knowles et al., 2015; Sequeira & Halstead, 2002; Wynn, 2004) and death (Aitken et al., 2011).

When Jane and Rose suggested the excessive force used during restraint caused pain, their reports of compliance during restraint questions the number of staff restraining them. Here their identities indicate their position as victims, as an excessive number of people are alleged to have been involved in restraining them, yet they tell of their lack of resistance. Although they disagreed to what was happening to them, both storytellers suggested how they wanted to avoid further pain. This has been referred to as ‘silent protest’ by Tingleff et al. (2018), as service users disagree to what is happening to them, yet they do not fight back for fear of more violence, which was a feature in both Jane and Rose’s story. Rose and Jane positioned themselves as victims of abuse from staff within their stories, indicating a doubled victimhood in aspects of their stories. Whilst Rose described being “*manhandled*” by staff, Jane reported on the physicality of staff who were aggressive. Additionally, both storytellers felt that the staff were using restraint to control them, which again indicates the power imbalance presented in their stories.

Rory, Finlay and Rose all spoke of restraint undertaken with service users in the prone position, for example when Rory was restrained following the rooftop protest, he reported that he was restrained by lots of staff in the prone position. Restraint in the prone position raises public policy concerns about this practice, as is potentially life-threatening (DH, 2014, 2015; NICE 2015; CQC, 2017; Mind, 2013). None of the storytellers referred to their knowledge of any serious risks associated with this position at the time of being restrained, yet at the time of telling their story they were all conversant that this position is discouraged in practice.

A different technique is indicated in Rory’s story in the potentially illegal way individuals were allegedly restrained in headlocks. This raises human rights concerns. From this context, there appears to be a contradiction under Article 3 of the European Convention on Human Rights (Council of Europe, 1950)**,** prohibiting torture, inhumane or degrading treatment or punishment, poor practice, including poor practice by staff undertaking physical restraint. Rory's, Jane's and Rose's stories reported several examples of practice around restraint that is contrary to the mantra around least restrictive practice (DH, 2014, 2015; NICE, 2015). Critical service users and practitioners have identified inconsistencies and contradictions in the reasoning that supports the continued use of restraint as exposing problems of legitimacy and procedural justice (see below).

Legitimacy: Restraint as a justified act

All storytellers questioned the justification for restraint use. Whilst Jane, Rose and Rory felt restraint had been unjustified, Finlay perceived this as mainly justified. From a staff perspective, coercion has been asserted to be a legitimate response to violence, caused by internal service user factors, yet service users have reported being driven to extreme behaviour, viewing coercion as excessive and unnecessary (Rose et al., 2015). It is relevant to consider procedural justice at this juncture. Procedural justice is when an individual, or any other reasonable observer, believes treatment is fair, including the application of restrictive practices (Wittouck & Vander Beken, 2019). In a more broadly cast care context, this sense of fairness would include being treated with respect and being listened to; characteristics of care that reasonably attend to the autonomy of individuals (Monahan, Hoge, Lidz, Roth, Bennett, Gardner, & Mulvey, 1995). A procedurally just approach is one in which recovery can be enabled, and any coercive interventions are justified within collectively acceptable moral parameters of fairness and justice; effectively this reduces to a consensus on a reasonable and proportionate response for any given circumstances (Wittouck & Vander Beken, 2019). When using a procedurally just approach with mentally disordered offenders, such as Rory, professionals can attempt to balance care and custody and address long-term consequences of stigma and trauma which can enhance an individual's self-esteem, agency and social identity (Wittouck & Vander Beken, 2019).

Finlay's story revealed his perception that restraint, regardless of its painful or excessive nature, was justified, as he viewed it as the only way to control him and it had saved his life. In Finlay's story, he expressed that he felt nurses could not afford to be kind, they needed to be professional. Finlay reported that he reacted positively to the stern words of a nurse, which he felt had helped him take control, yet stern communication can be part of an abusive culture in other contexts (see for example Flynn, 2012). In a different context, Young (1996) discusses how individuals from troubled family backgrounds, may unconsciously respond more positively to 'stern lawgivers' as substitute parental figures. Therefore, it could be seen that Finlay's appreciation of this directive response involved the nurses, psychosocially taking control of his distress at that point in time. Finlay suggested that he felt nurses needed to be professional because his behaviour warranted an immediate response, in his view this meant acting to restrain him as there were threats to the safety of himself and others.

As mentioned previously, the concept of safety has been seen to be an important consideration in undertaking restraint (Bigwood & Crowe, 2008; Duxbury, 2002; Foster, Bowers & Nijman, 2007; Lemonidou et al., 2002; Perkins, Prosser, Riley, & Whittington, 2012; Riahi et al., 2016; Terpstra et al., 2001); with nurses expressing concern about physical injury to all involved (Terpstra et al., 2001; Lemonidou et al., 2002). Although Finlay positioned himself within an illness identity, as others take control at times of distress, this identity can carry negative connotations. However, Finlay's story suggests a more positive recognition of illness, as he talks of managing his distress by allowing others to take control, yet staff have reported anger when services users bring about restraint purposely (Sequeira & Halstead, 2004).

Acknowledging illness and acting on this, may allow an individual to receive the support and enable recovery. Angermeyer & Matschinger (2003) propose how illness identity can be a resource for people in using use their experiences positively in recovery and can bring meaning to chaotic experiences. Ignoring an illness identity may lead to barriers in treatment and recovery (Yanos et al., 2010). Internalised stigma related to illness identity has the potential to be gradually reframed and revised, in doing so themes of agency and potential can come to predominate (Yanos et al., 2010). In this respect there was hope for Finlay in progressing from this identity. Other studies have found a minority of service users have viewed restraint as a positive intervention, as it is deemed to calm them and let others take control of their behaviour (Wynn, 2004; Haw et al., 2011). However, there are other choices in managing distress. An example of this being a focus on wards being a more healing environment. Wilson et al. (2018) found environments which focused on healing and recovery have been found to reduce incidents of physical restraint and are one way in which to manage distress.

An oxymoronic position presented itself in Finlay's story, in that he viewed restraint as a positive act that saved his life, yet his language suggested quite forceful use of restraint. A narrative of control was reversed in that Finlay suggested he brought about restraint to control his distress. This poses questions about the application of excessive control by nurses as reported in other studies (Brophy et al., 2016; Knowles et al., 2015; Sequeira & Halstead, 2002; Wynn, 2004).

Yet, for Finlay the problem of excessive force was not reported by him to be an issue, his illness and, on occasions, his physical build were problematic. Finlay suggested that his weight complicated restraint on one occasion, as he was placed in the prone position and was unable to breathe properly. This suggests how Finlay internalised his weight as being challenging and attributable to his difficulties in breathing as he was being restrained. Within his story, Finlay did not consider the breathing difficulties to be a consequence of inappropriate restraint techniques, yet the prone position appears to have challenged his breathing ability. This is particularly concerning as prone restraint is discouraged for individuals that are overweight (DH, 2014, 2015; NICE, 2015). Additionally, another study had reported that half of the participants reported that breathing would be improved if they were restrained whilst sitting up (Haw et al., 2011).

Finlay's suggested his concerns during this restraint, centred on his being believed by nurses regarding these breathing difficulties, rather than the positioning technique being dangerous. He alluded to how his diagnosis of a specific mental health condition rendered him untrustworthy[33] and his behaviour may have been interpreted by nurses, as attention-seeking. In a study by Haw et al. (2011), service users expressed concern about their experiences of

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[33] Interestingly, the whole notion of trust is a key element of professional mental health discourse and its critique. For the proponents of the idea of a psy-complex, psychiatry operates social functions of governance and control of deviant behaviour. The proscription of irrationality through diagnosis is a ready-made route to the denial of civil rights owing to rational beings, and the silencing of voice that accompanies this. From this perspective, coercive practices are an inevitable consequence of the adoption of this social control role by the psy-disciplines, such as nurses. It is not without irony that professional rhetoric privileges trust between service users and staff in a context of therapeutic alliances, but such trust is acutely vulnerable to disintegration in the face of restrictive practices (see Pilgrim et al., 2010).

breathing difficulties during restraint, blaming nurses’ poor practice, as opposed to any characteristics of service users.

Despite public policy discouraging its use, the CQC (2017) in an inspection of mental health services, highlighted continuing concern around the use of restraint, particularly prone restraint. Paterson et al. (2014) argue that although certain restraint positions are dangerous for individuals who are obese, banning intentional use of prone and other takedown positions in all circumstances, presents difficulties if safety is at risk. They go on to argue that banning prone and other takedown restraint, places employers attempting to enforce such guidance at risk of litigation, to health and safety requirements.

Dignity

In addition to the other consequences of restraint, the dignity of individuals was presented in all stories as restraint was undertaken. Rose cogitated on the connections with dignity and a sense of shame. She reported her experience of being left in urine-soaked clothing and feeling shame about this, but indicated she was unable to change her clothing as she has been injected with medication and was unable to move. Bonner et al. (2002) similarly reported evidence of an individual being left in urine-soaked clothing for three hours following restraint; feeling too ashamed to tell anyone. In the telling of her story, Rose located herself as a victim, suffering humiliation and disrespect. From a service user perspective, great importance has been placed in being treated with respect (Stewart et al., 2015).

Interestingly, both Finlay and Rose narrated their perception around inappropriate and undignified restraint practice by staff on specific shift patterns and the temporary nature of employment contracts of bank staff. Rose also suggested that much of poor practice occurred when night staff, were on duty. In a study by McKeown et al. (2019b) temporary staff were found to create discontinuities of care, with an associated lack of engagement with staff, service users and organisational policy.

All stories reported on the issue of restraint being undertaken in public spaces and here too, dignity was contemplated. Whilst Rose, Rory and Jane felt restraint in the presence of other service users to be undignified, Finlay indicated how he felt restraint behind closed doors evoked secrecy and by implication perhaps, a level of conspiracy; as staff "*get away*" with practice behind closed doors. The practice of restraint undertaken in an undignified way raises wider concerns about the treatment of individuals in a caring environment and appears to contravene Article 3 of the European Convention on Human Rights (1950)**,** prohibiting inhumane or degrading treatment.

Dignity is also presented within stories in the context of a lack of acknowledgement of service user preferences and needs, as a narrative of limited choice is also framed in this respect. Rose reported that she had written an advanced statement of her wishes yet alluded to how this had been in vain. As the advance statement is storied as either ignored by staff or lost, any sense of the service user voice or choice became invalidated. Advance statements have been defined in legislation via the MCA (2005), and it is deemed as best practice for service users to be fully involved in decisions about themselves as far as possible; yet Haw et al. (2011) reported that at times these requests have been ignored.

In developing the theme of choice, it becomes relevant to consider tensions in law, potential discrimination and equality of rights for mental health service users under two main aspects of adult law: the MHA (1983, amended 2007) and the MCA (2005). In respect of the MCA (2005), three of the statutory principles are relevant to the discussion here: A person must be assumed to have capacity unless it is established that he lacks capacity; A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success; A person is not to be treated as unable to make a decision merely because he makes an unwise decision. Irrespective of these principle and duties under capacity law, the administration of mental health treatments tends to invalidate service users' views (Rogers & Pilgrim, 2017). Mental health legislation, specifically section 63 of the Mental Health Act (1983, amended 2007), removes some of the rights for decision making for mental health service users (Senasinghe, 2017). The MCA (2005) allows adults with capacity to refuse treatment, even if the decision threatens their life, yet section 63 of the Mental Health Act (1983, amended 2007) can override such rights.

Senasinghe (2017) presented three cases where arbitrary use of section 63 of the MHA (1983, amended 2007) removed the rights of mental health service users and presented a paternalistic approach towards mental health service users.[34]In the first case B v Croydon Health Authority (1995) Fam 133, the court made a ruling that a young woman with borderline personality disorder could be force-fed under section 63 of the MHA (1983, amended 2007), so she could be kept alive and given treatment. This case raises fundamental ethical questions as to the sanctity of life doctrine (Kuhse, 1987) set against ethics of an

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[34] B v Croydon Health Authority (1995) Fam 133; Tameside and Glossop v CH (996) 1 FLR 762; and Nottinghamshire Healthcare NHS Trust v RC (2014) EWHC 1136 (COP) (2014) MHLO 20.

individual's right to autonomy, and the impact of trauma associated related to being force-fed (Senasinghe, 2017). In the case of Tameside and Glossop v CH (1996) 1 FLR 762, the court made a decision that would allow physical restraint to be undertaken, in the best interest of a woman with schizophrenia, to permit a caesarean section. This decision appears to ignore the negative impact that forced surgery may have on an individual's well-being (Senasinghe, 2017).

In Nottinghamshire Healthcare NHS Trust v RC (2014) EWHC 1136 (COP) (2014) MHLO 20, a man with self-harming behaviour who was also a Jehovah's witness, signed an advance decision when he had capacity, to refuse a blood transfusion. The court granted permission to undertake a blood transfusion as a medical treatment, should it be necessary. This means that psychiatric patients lose autonomy in such a situation, whereas the wishes of patients with physical conditions would not, as long the usual conditions[35] of the MCA (2005) are met (Senasinghe, 2017). This decision also breaches Human rights, as a Jehovah's witness, the individual in this case was observing his religion (Senasinghe, 2017). Everyone has a right to '*manifest his religious belief, in worship, teaching, practice and observance*' (ECHR art 9).

Advance decision-making is a form of self-determination and there are clear ethical, and legal reasons to question the division between physical and mental health (Owen et al., 2019). The law has determined that an adult with capacity to do so can make an advance decision to refuse treatment. The law also permits that an adult[36] could appoint a lasting power of attorney to make substitute health and welfare decisions[37] if at some future point they lose their

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[35] That the individual had the capacity to make the decision at the time of the advance decision and the advance decision was valid and applicable at the time of the proposed treatment.

[36] If the adult has capacity to at the time of making the LPA

[37] A separate LPA can also be made for Finance and property decisions

capacity to make decisions, this includes life-sustaining treatment. Amendments to mental health legislation in 2007, made clear that advance decision-making and substitute decision-making by an attorney, did not apply to compulsory treatment under the MHA (1983, amended 2007)[38]; however, prompted by the service user movement outside of the law, practice has developed for advance decision-making including crisis plans and advance care plans (Owen et al., 2019).

The concept of risk of harm to self and others features centrally in the MHA (1983, amended 2007) as criteria for treatment or assessment, and this concept also features widely in ethics and human rights[39]. Risk is also a feature within the MCA (2005), however, the risk of harm is focused on the individual concerned and does not relate to others. Therefore, the MCA (2005) allows an adult to specify what risks they consider as serious or significant (Owen et al., 2019)[40]. In addressing some of the inequality between medical and psychiatric service users, within the legislation, Owen et al. (2019) proposed mental health advance decision-making be incorporated within the review of the Mental Health Act 1983 (amended 2007). In terms of harm Rose positioned herself as not posing a risk to others, yet as I listened and later analysed Rose’s story, I was left with several questions from Rose’s account of events: Was Rose considered a risk to herself because of non-compliance? Was particular

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[38] Advance decision-making is allowed, with limits, for ECT and community treatment orders

[39] Owens et al. (2019) argue that although choice is important in contemporary medical ethics, is not purely about choice. Ethicists acknowledge the difference in a person’s decision-making capacity ability to make decisions for oneself and also to be accountable for it – and choices made without these abilities.

[40] Owens et al. (2019) state how there are likely to be public interest concerns around mental health advance decisions to refuse treatment, due to the possibility of a direction relationship between mental illness and harm to third parties. If a person refuses all anti-psychotic medication for example and then becomes violent related to their mental illness, this would raise notable public interest concerns (Solomon, O’Reilly, Gray and Nikoloc, 2008).

medication, with its profound side effects for Rose, the better outcome? Had staff tried other ways to engage with her about her choices? These questions appear fundamental to a treatment regime that is storied to have had a strong focus on compliance, yet as discussed above, there are wider issues about choice, rights and discrimination, which is legitimised by the state.

In addition to having one's wishes ignored, dignity can be compromised in other ways as staff were seen as patronising to storytellers. This was seen particularly in Rose's story as staff are reported as having used inappropriate language, such as telling Rose she was a "*good girl*"*.* From a service user perspective, some staff have been considered to have used patronising responses to aggression, without having engaged with the underlying causes (Price et al., 2017). In Rose's story, staff are alleged to have used such patronising tactics, potentially reinforcing power dynamics, hence sensitivity in communication was positioned as lacking here. Widespread use of infantilising language was similarly revealed in the Public Inquiry into abuses at Ashworth Hospital, with a terminology of endearment enmeshed with controlling power relations within the toxic culture which was commonplace in the hospital at that time (Blom-Cooper, Brown, Dolan & Murphy, 1992).

Occupational perspective: The mental health nurse

It is relevant to consider the nurses' perspective at this juncture as part of the caring profession, as all storytellers both explicitly and implicitly story the competing care and control roles of mental health nurses. Policy documents within health and social care provide a remit for managing violence and aggression, including supporting staff post-incident (DH, 2014; NICE, 2015; Skills for Care, 2015). Nurses have reported fear of impending danger to themselves, which had prompted their use of restraint (Bigwood & Crowe, 2008). From a staff perspective, nurses can also be affected by violence faced during their work. Rates of workplace violence against mental health staff are deemed as higher in comparison to other nursing disciplines (Camerino, Estryn-Behar, Conway, van Der Heijden, & Hasselhorn, 2008). Nearly one in five service users admitted to mental health wards have been deemed to be aggressive (Cornaggia et al., 2011; Iozzino, Ferrari, Large, Nielssen, & de Girolamo, 2015). It has been predicted that a nurses' lifetime risk of being the victim of such aggression is nearly 100% (Bowers et al., 2011).

Injuries to staff have been reported either because of direct service user assault or received during measures to manage behaviour, namely physical restraint (Renwick et al., 2016). In a survey of 1000 mental health nurses, 42% reported they had been the victim of violent attacks, and 36% reported that they had witnessed attacks in the past year (UNISON, 2017). Eighty-seven per cent of nurses in the same survey blamed staff shortages for the rise in violence and aggression, whilst 49% felt the overuse of agency staff were responsible for the increase in violence and aggression. Mental health services are beset with funding cuts, staff anxieties around job security and public/media demand that someone is held accountable when there are alleged failings within services (Randall & McKeown, 2014; McKeown & Foley, 2015).

Mental health nurses in one study reported their fear of violence and aggression on a personal level, was prompted by the risk of physical harm, this imminent danger triggering some self-preservative reactions (Bigwood & Crowe, 2008). The emotional impact on nurses undertaking physical restraint has been found to result in anxiety, anger, boredom, distress and crying (Sequeira & Halstead, 2004).

One study found a prevalence rate of between 9-10% of post-traumatic stress disorder amongst mental health staff following assaults from service users (Jacobowitz, 2013). Individuals who frequently witness violence or aggression may develop post-traumatic stress disorder (Richter & Berger, 2006), therefore the witnessing of violence to other staff can also be traumatic. In a study looking at nurses' experiences of witnessing violence, participants reported feeling fear during an incident, both for themselves and others, yet this fear was also reported post-incident impacting on their lives outside of work (Jeffrey & Fuller, 2016). In the same study, guilt and anger were also expressed because of witnessing violence, yet violence was also viewed by some participants as part of the job (Jeffrey & Fuller, 2016).

The paradoxical positioning of nurses

Though nurses may be victimised within conflictual mental health services, they are also legitimately empowered to perpetrate forms of violence and hence victimise others. The Mental Health Act (1983, amended 2007) legally codifies psychiatric systems of control. Mental health nurses caring for individuals in their care become part of the legitimation of the extraordinary powers within mental health legislation (Gadsby, 2018). Nurses are thus caught in the tension between espousing a caring role for the person yet actioning a controlling role for the state: in short, *'nice people doing nasty things'* (Gadsby, 2018, p.24). Nursing is seen as a caring profession. In the UK, nursing has adopted the six 'C's': care, compassion, competence, communication, courage, and commitment; which are deemed to encapsulate good nursing practice (NHS Commissioning Board 2012).

The notion of therapeutic alliance is seen as a cornerstone of care in professional nursing rhetoric (See for example Cabral & Carthy, 2017; Roche, Madigan, Lyne, Feeney, & O'Donoghue, 2014; Warne & McAndrew, 2004). Indeed, the Nursing and Midwifery Council (2014) promotes such relationships. However, mental health nurses have identified themselves as the enforcers of unpopular and coercive practices, which are distressing for themselves and service users (Felton & Stacey 2018). Similarly, McSherry (2018) proposes that psychiatry generates mental health nursing, as attendants for its purposes and tentatively suggests a name change from mental health nurse to 'social therapist' to reflect the importance of dialogue present in therapeutic nursing. However, contrary to such narratives of nursing values, conflicting narratives of power, control and violence are also relevant.

The concept of legitimatised power (Gadsby, 2018) is presented in nurses' use of restraint. Some mental health nurses avoid restraint and prefer others to carry this out (Gadsby, 2018), and Jane acknowledged a nurse who demonstrated caring by the act of sitting with her**.** This raises a question as to whether the nurse presented as consoling Jane in her story was there in an empathetic role or whether he was there to observe Jane. Jane felt the nurse was empathetic. Being empathic does not necessarily demand shared experience; it is possible to be imaginatively empathic. That said, mental distress being fairly ubiquitous, nurses can experience mental health difficulties and can become service users themselves, potentially as a result of vicarious trauma (McKeown, Wright & Gadsby, 2018). It is unclear as to whether the nurse in Jane's story had experienced such difficulties prior to or during their nursing career.

If the nurse’s primary objective was observation rather than expressing care, though these are not necessarily mutually exclusive, then the simple act of sitting with a person takes on more controlling overtones. Salzmann-Erikson & Erikson (2012), draw on Foucault's theory of 'panoptic power' as they note that observation is forced upon the nurse, as an agent of control. It is germane once again to make reference to Foucault’s (1982) suggestion of how individuals are *'made subjects to'* control and dependence by others. In this sense Jane may have been made a *subject to control* (Foucault,1982) with observation and monitoring. This is not confined to the aftermath of the incident, where it appears to be more explicit, but by being detained, observed and monitored under legislative powers.

However, it is relevant to also consider these noted tensions present nursing roles, paradoxically balancing care and control. As is true in all the stories within this thesis, it is pertinent to acknowledge once again how mental health nurses are placed in the frontline of managing restraint (Katsakou et al., 2012; Katsakou & Priebe, 2007; Sapey, 2013; Sibitz, et al., 2011) and perceived risk (Felton & Stacey, 2018). Trusting relationships become compromised by the power imbalance in traditional mental health care (Bladon, 2019; Fitzpatrick, 2014; Wheeler, 2011).

Certainly, in Jane’s story she presents a narrative of control from the nurses but felt that it was her encounter with the doctor which prompted restraint. She relates how this impacted on her trust with the nurses, yet the narrative of control is much wider, and modern psychiatric wards, with their routinely locked doors, are essentially spaces of containment rather than necessarily therapy.

All the storytellers spoke of the importance they felt about a positive therapeutic alliance, which is perhaps an over-idealised part of professional idiom. The coercive nature of their experiences calls into question whether such alliances are achievable or not within such environments. The extant power imbalances in mental health care thus suggest ideal-typical views of therapeutic relationships are problematic. For instance, the legal powers granted under the Mental Health Act (1983, amended 2007) to detain individuals with a mental health disorder, needing urgent treatment and deemed as a risk of harm to themselves or others clearly legitimate a use of force that appears antithetical to a simplistic conception of therapeutic alliance, and very real impediments to bringing such about in practice.

Returning to Smail (2005), individuals can be seen as being both conscious and unconscious of power. Smail (2005) states that individuals cannot resolve emotional distress at a personal level, because in addition to individuals seeing the need to change, they also need the power to change. Therefore, for Smail, an individual's proximal power is viewed in the context of distal forces and therefore personal distress is framed in a social and political context, distress is from the outside inwards, therefore people may need to develop external awareness rather than insight[41]. This then brings into question therapeutic relationships that rest on individual causes of distress, as opposed to looking at the wider social world. Smail (2005) proposed that a good relationship in therapeutic intervention is central, where service users are equal partners in

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[41] For Smail individuals have limited agency and willpower is a fiction. *The power to choose and act are not god given personal attributes, simply matters of will power but social acquisitions dependent on essentially material resources in the world outside our skins* (Smail, 2015, p. IX). Maloney (2013) also challenges the idea that success in life is due to 'personal will-power'. He links psychotherapy and extreme free-market capitalism. Maloney agrees with Smail in that a determinant in personal success is social background and a capitalist system prefers the 'personal will-power' concept as it justifies and permits inequality.

looking at the predicaments that cause distress. For Smail (2005) distress may not be cured by therapy, particularly if that therapy focuses on distress at a personal level. Maloney (2013), a clinical psychologist, agrees with many of Smail's arguments about therapy and suggests that a 'warm relationship' is more relevant in achieving positive outcomes for service users. Maloney (2013) is critical of traditional short-term therapy offered to individuals. This then raises an important question about the actuality of therapeutic alliances within nursing care and the way forward in supporting service users. In reality, nurses often find themselves in a custodial role, as they force compliance.

For mental health nursing, notions of empowerment and service users' rights are a feature of care (Fingfeld, 2004), yet nurses work within restrictive systems that are paternalistic in the western world, creating a libertarian paradox (Bladon, 2019). Amongst other commentators, Rogers & Pilgrim (2017) highlight how coercive practices remain prevalent, with restraint being a feature of contemporary mental health care, complicating therapeutic relations (see Duxbury, 2015; Wyder et al., 2013). This would appear to the case for Rose, as from her perspective there was a lost trust between herself and the nurses. She talked about her fear and retreating from contact with some nurses because of restraint.

Whilst mental health nurses are the staff at the sharp end of coercive practice, the social positioning and valuing of medical expertise means that nurses will remain oppressed and therefore attempts to promote social and psychological ways of dealing with distress may be limited (Felton & Stacey, 2018).

Narratives of violence were framed by Rory, Jane and Rose. One of the sets of 'stories' that is legitimated and has 'life' breathed into it in this regard is the story of control enacted by nurses, as part of the psy-profession. Grant (2018) argues that mental health nurses work with service users on the basis of 'confirmation bias'[42]. Nurses selectively attend to service users in response to what service users do and say, which then works to form theories about them. These theories tend to coincide with or are indeed informed by the functional diagnosis present within institutional psychiatry (Grant, 2018). Nurses can also act on the basis of 'fundamental attribution error', with presumptions about how service users act on the ward environment, is how they have always acted and perhaps will always act, confirming the institutional theories of who service users are (Grant, 2018). Additionally, Grant (2018) argues that nurses practise on the basis of 'actor-observer effect', tending to excuse their own behaviour, despite this being negative towards service users (Grant, 2018; Grant, Biley, & Walker, 2011). When nurses are annoyed by service users' behaviour, nurses explain this in accordance of the theory of who they are, who they have been and who they are likely to be, often based on non-existent mental illnesses (Grant, 2018; Grant, 2015; Smith & Grant, 2016). These theories are often overlain with moral judgements of a person's character which tend to label individuals, for example, a person being attention-seeking, or manipulative (Grant, 2018; Grant & Legh Phippard, 2014; Grant, Leigh-Phippard & Short, 2015; Short, 2011).

Bladon (2019) states that contemporary mental health nursing has evolved from the past history as a position of controlling and monitoring service users within large institutions. Beardshaw (1981) asserts how mental health nursing has developed into two strands- custodial and therapeutic. The explicit control function of mental health professionals, including nurses, has meant they have

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[42] Grant (2018) acknowledges that confirmation bias, fundamental attribution error and actor-observer effect are all seen in the classic experiments of Rosenberg et al. (1973).

been scrutinised and open to questions by other mental health workers and the public (Rogers & Pilgrim, 2017). The role of nurses as enforcers of moral and social order positions them within the ideals of a neo-liberal society (Szmukler & Rose, 2018). Although mental health practitioners are viewed as being part of a caring profession by the public, welfare professionals have been described as 'disabling' Illich (1977), with scandals such as Winterbourne View calling into question the professionalism of staff (Flynn, 2012). In looking at how professions are understood from a sociological perspective, it is relevant to note how the discipline is represented by contested areas of social inquiry[43] and it is not uncommon for sociologists to approach their work eclectically by drawing on more than one sociological framework (Rogers & Pilgrim, 2017). An important shift in social theory goes beyond this eclecticism (Rogers & Pilgrim, 2017), with one of its main intellectuals (Foucault) considering that social analysis involves examining a:

> *heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions- in short, the said as much as the unsaid* (Foucault, 1980, p.194).

For Foucauldians, power cannot be located in one elite group, whilst this may be bound up with a dominant group at any one time and place, power is not clear or stable (Rogers & Pilgrim, 2017). Ways in which the body and mind are described and constructed are key features in society; the medical profession has a central role in this with their interests in diagnosis, testing, assessment, treatment, management and surveillance of both sick and healthy within society

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[43] Rogers and Pilgrim (2017) point to four main sociological frameworks: Neo-Durkheimian; neo-Weberian; neo-Marxian; Eclecticism and post-structuralism)

(Rogers & Pilgrim, 2017). Burstow, LeFrançois and Diamond (2014) warn of the epistemological violence rooted in the diagnostic process of biomedical psychiatry, and how it erodes subjective experiences and denies entry of noncodified knowledge in the mental health care.

As has been discussed earlier, the post-structuralist framework in mental health, outlines the role of professionals in regulating the lives of service users (Donzelot, 1979), whist, Marxian tradition accentuates the enforced imposition of views of service users by professionals, as agents of the state (Rogers & Pilgrim, 2017. Apart from the controlling role of mental health nurses, there are other forms of power imbalances.

A further example of power imbalance within mental health nursing is the codification of thoughts into their own professionalised esoteric language (Bladon, 2019). Lakeman (2009) suggests that technical language serves to legitimise power and is potentially condescending to service users. Rogers & Pilgrim (2017) suggest that codified knowledge is self-serving and may function to maintain professional autonomy rather than seeking anything useful is relationships with service users. Several leading sociologists (see for example Foucault, 2006; Szasz, 2010), have viewed psychiatry as a system of control (Bladon, 2019).

Service users and critics have for a long time bemoaned a perception of distance, proximal and emotional, in their engagement with services (Grant, Biley, & Walker, 2011; McKeown & White, 2015; Newnes, Holmes, & Dunn; Rogers, Pilgrim, & Lacey, 1993). Nonetheless, nursing staff can also have their own vulnerabilities. Staff can experience vicarious trauma in caring for individuals who are traumatised with empathetic practitioners being more susceptible (Figley, 1995; Sabin-Farrell & Turpin 2003). Trauma uninformed services can themselves cause staff to experience vicarious trauma and organisation who rely on restraint to manage distress becomes harmful to both staff and service users (Sweeney et al., 2018).

Despite, the potentially oppressive nature of mental health care, there is optimism. Lively debate on the Critical Mental Health Nurses (2018), for example, has taken place from mental health nurses with specific reference to forced treatment questioning whether nurses should have a right to object to this on the grounds of personal/professional conscience and whether this right is safe for practitioners to make in refusing to participate. Other strategies such as The Power Threat and Meaning Framework (Johnstone, et al., 2018) present an alternative approach to the traditional diagnostic model of mental health care, for example, one of the ways suggested for engaging with service users is asking *'what happened to you'*, instead of '*what's wrong with you*?'

Therapeutic alliance

Having discussed the therapeutic alliance in a generalised way in the above section, it is relevant to address this relationship more specifically as a narrative of therapeutic alliances was presented in the stories, as storytellers suggested importance of positive relationships. It is pertinent to consider how this concept resonates with other available narratives in the social world. The therapeutic relationship is not easily defined (Welch, 2005; Norcoss, 2010). Peplau (1952; 1991) depicted this relationship has four phases: orientation, identification. exploitation and resolution. Trust is established in the orientation stage, which leads to a working phase where problems are identified and worked on collaboratively. The therapeutic relationship then terminates as independence is realised by the service user (Ramjan & Fogarty, 2019). Peplau (1991) regarded nursing as a *'significant, therapeutic, interpersonal process'* (p.16). Since Peplau, therapeutic alliances continue to be seen central to good nursing care (Cabral & Carthy, 2017; Roche, Madigan, Lyne, Feeney, & O'Donoghue, 2014; Warne & McAndrew, 2004) and the Nursing and Midwifery Council (2014) promotes such relationships. However, the therapeutic relationship creates competing roles for mental health nurses as demonstrated within each story. Staff are likely to have a view of their own and service users' realities that services users may not share and are also dismissive of the significance of service users' life stories (Grant et al., 2015).

Nurses are part of a wider profession. Rose (1985), drawing on Foucault's work, has defined, the development of a 'psychological complex' (Psy- complex)[44], referring to developments of disciplines like Psychology and Psychiatry which have perceived social problems in specific ways, producing new types of knowledge, which in turn legitimised the role of those professions in seeking to address those problems (Johnstone, et al., 2018). One of the notable aspects of this sort of knowledge is how social 'norms' become established; Rose et al., (1999, p.76) define a norm as that *'which is socially worthy, statistically average, scientifically healthy and personally desirable'*. Diversion from such norms may result in social shame as individuals engage in self-surveillance comparing themselves to implicit norms, across a varied range of behaviours, personal characteristics, wishes, and attainments categorising themselves as

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[44] The psy-complex also has a chronic surveillance role in relation to mental health service users, as it has been related to two types of discourse - the first is concerned with segregation and acting on the body, (physical treatments); the second involves construction of the self, via psychological accounts (Rogers & Pilgrim, 2017)

inadequate, deficient or pathological if they should deviate from these norms (Johnstone, et al., 2018). Such self-surveillance has huge consequences for psychological distress (Johnstone, et al., 2018). De Swann (1990) suggests that the public are encouraged through social contact with professionals and engagement with the media, to frame their difficulties in professional terms and coins this as 'proto-professionalization' he also suggests that people look to professionals to rescue and help them cope with distress. At the sharp end of distress, Finlay looked to nurses to help him cope with his troubling thoughts.

Hegarty and Brusasco (2020) argue that the use of compulsory treatment does not always result in poor therapeutic alliances and when utilised appropriately compulsory treatment may result in service users having a greater satisfaction with their care. However, it has been questioned whether restraint could ever be therapeutic (Huckshorn, 2004; Paterson & Duxbury, 2007), and the therapeutic alliance has been espoused by the storytellers within this study as a means to reduce restraint and noted as a casualty of the widespread use of restraint. It follows that the therapeutic relationship is one way to support service users and rebuild any lost identity. The nurses' role in allowing service users to gain control over their life and reconnect with aspects of the self, considered lost or damaged, is a fundamental aspect of the therapeutic alliance (Hutchinson & Lovell, 2013). The reconnection with a service user's self-identity, is a fundamental role in nursing (Hutchinson & Lovell, 2013).

Present in effective therapeutic relationships are positive engagement and good communication, recognised as preventative strategies helping to reduce restraint (Brophy et al., 2016; Jones & Kroese, 2006; Mielau et al., 2016: Olofsson & Norberg, 2001; Pulsford et al., 2012; Sequeira & Halstead, 2004; Wilson, Rouse, Rae, & Kar Ray, 2018; Wynn, 2004). The importance of the therapeutic alliance was presented in all four stories. When considering these relationships, all storytellers represented the importance they held in such relationships and they spoke reflectively and subjectively when doing so. Rose, Rory and Finlay, did so from their new-found perspective as educators, whilst Jane did this in relation to her identity in recovery, where she spoke of doing her own research about restraint reflecting her wider knowledge base.

There were both positive and negative examples of the therapeutic relationship in the stories. In Jane’s story, she told of a positive relationship with a nurse, yet also spoke of her view that some staff failed to engage with her positively. Indeed, in her first encounter with nurses, Jane reported she did not feel listened to when trying to express concerns for her son’s welfare. From a service user's perspective, great importance is attached to being listened to and treated fairly (Stewart et al., 2015).

In a more dramatic depiction, Jane’s perception about the violent nature of some nurses contradicts public perceptions of professionals in a caring role. Jane inferred how nurses lack compassion and any meaningful relationship between Jane and the nurses became damaged as she indicated they misused their power. This may connect with the lack of compassion shown by some health and social care staff, in reviews and inquiries within other institutions (see for example Flynn, 2012; Francis, 2013).

The observations of McKeown et al. (2019a) support the assertion that misuse of power breaks down trust between individuals and organisations. The therapeutic alliance is damaged as imbalances of power or the impact of staff's misuse of power obstruct the development of this relationship (Paterson et al., 2013). Yet Jane’s story also reported on her perception of a caring nurse. Jane positioned him as a protector, from an emotional perspective. Her use of words underlined this as she describes him as “*lovely”.* She felt he had sat with her to make sure she was supported; showing a caring individual. She reported how this staff member had been a previous service user and suggested he had some empathy and kindness, perhaps because of his own experiences as a service user. The nurse’s intentions were unclear, as his rationale for sitting with Jane was not totally confirmed in her story. The constructive use of ‘self’, as in one’s own experience of mental health, has been found to be a tool used by mental health nurses in enabling them to respond to and empathise with service users (Oates, Drey, & Jones, 2017). The judicious disclosure of personal experiences on the part of helping staff has been welcomed by service users but is not always encouraged within psychiatric services (McKeown, Roy, & Spandler, 2015).

Rose similarly reflected on the importance of a good staff-service user relationship. Again, the concept of trust is raised. In this context, it is relevant to consider obstacles that may impact on building trust for individuals who have experiences of previous trauma. Although Rose suggested she had lost trust with some nurses, she told that she had not lost trust with all nurses. From Rose’s perspective, the therapeutic alliance had not been a totally negative experience. Rose reported that some nurses had taken the time to review Rose's history and this inspired Rose to trust them. These nurses are positioned, by Rose, as good, having taken the time to get to know her, and in doing so were seen as being more understanding of her reasons for refusal of medication.

Despite the therapeutic alliance constituting a positive resource for mental health service users (Warne & McAndrew, 2004), there are obstacles in achieving this alliance. Rose was cognisant of such barriers. One example she reflected on was the low staffing levels within mental health wards, which has also been recognised in other studies as an issue preventing opportunities for therapeutic alliances (Baker & Pryjmuchuk, 2016; Wilson et al., 2018). Not necessarily independent of staffing concerns, high staff workloads have also compromised opportunities to build such alliances (Bee et al., 2008; McAndrew et al., 2014; UNISON, 2017). In the UNISON (2017) survey of 1000 mental health nurses, 60% of nurses felt they were unable to support service users properly and 74% felt stressed because of working conditions. Staffing levels and their impact on staff-service user engagement, were also reflected upon by Rory and Finlay. Rory shared his concerns about the reduction of therapeutic sessions within hospital trusts. In his view this meant there were lost opportunities to engage with service users with activities, such as playing cards, to build stronger relationships. Whilst Finlay reported his view that staff taking time to communicate with service users, reduces the need for restraint.

Furthermore, inadequate staffing may block attempts to change restraint practices. A recent multi-centre study aimed at reducing the use of restraint on wards found that staff and service users believed denuded staffing levels to be an impediment to realising the goals of the project (McKeown et al., 2019b). Nevertheless, ethnographic observations in the course of the same project showed that wards were often demarcated into separate staff and service user space, further limiting opportunities for therapeutic interaction and, perhaps, the sort of relational contact that might defuse discontent and avoid having to use restraint (McKeown et al., 2020).

Another barrier to building therapeutic alliances can be the willingness to build relationships following episodes of restraint, which is seen to be problematic from both service user and nursing perspectives and implicates the aforementioned traumatic impact of being involved in or witnessing restraint. Nurses have reported how witnessing violence has emotional consequences on their ability to build positive therapeutic alliances with service users who present with violence and aggression (Bimenyimana, Poggenpoel, Myburgh, & van Niekerk, 2009; Chapman, Perry, Styles, & Combs, 2009; Chen Wang Lew-Ting, Chiu, & Lin, 2007; Jeffrey & Fuller, 2016). Literature surrounding the staff-service user interaction is often framed within a 'them and us' context or within a framework of 'oppositional language' (Brunt & Rask, 2005; Dickens, Stubbs, Popham & Haw, 2005; Hörberg, Sjögren, & Dahlberg, 2012; Larkin, Clifton & de Visser, 2009; Tomlin, Bartlett, & Völlm, 2018). This theme is implicit within all stories, yet Rory was explicit in his attention to this, as he clearly expressed his perception of the 'otherness' of staff as they have meetings to plan restraint, having a '*pow-wow'* to discuss strategy. This sense of 'otherness' is different from findings which involve service users feeling alienated and 'othered' (Brophy et al., 2016; Wilson et al., 2017). In this context, Rory is positioning the staff as different.

It is relevant to consider the therapeutic alliance from the start of a service user's journey, as they are newly admitted to the ward. Finlay's, Rose's and Jane's stories reflected on the therapeutic relationship as people are admitted to wards. Rose considered the emotional experiences of newly admitted service users more generally in her story; whilst Jane and Finlay reported their personal experience in this context, feeling lost and frightened, needing care and compassion from the staff. From Jane's perspective, the staff, on computer games, failed to engage with her, therefore suggesting that opportunities for meaningful engagement were lost. Compassion and care are espoused as fundamental principles within the NHS Constitution (2015) and have become something of a policy mantra for nursing (McCaffrey, & McConnell, 2015). These principles should encompass care from the point of admission on the ward, and running through the journey, as cornerstones of care. As Jane was admitted onto the ward, she was separated from her son. This separation compromised her identity of a mother, yet nurses are viewed by her to have ignored her wishes to engage in conversation about her son's well-being. This is an example of the sort of encounter that Goffman (1961) highlighted in describing how culture and practice within psychiatric institutions lead to a mortification of self: Jane was distanced from her role as a mother, as staff are seen by her to fail to engage and therefore consider her needs fully. Finlay also reported on his view that administrative tasks were an obstacle in achieving a therapeutic relationship, exposing a gap between the rhetoric and reality of the espoused value of therapeutic alliance (Warne & McAndrew, 2004), with little time spent by nurses in communicating with service users (McAndrew, Chambers, Nolan, Thomas, & Watts, 2014).

In a recent study, staff and service users reported the need to take a whole system approach to training, which includes the service user perspective, confidence building, de-escalation, spirituality and interpersonal skills (Wilson et al., 2018). A whole systems approach would, interestingly, allow for concerted attention to the range of issues highlighted in this study, including matters of trust and therapeutic alliance. This would include listening to service users such as Jane, who feel lost and frightened when newly admitted to the ward.

The nurse's role is fundamental in supporting mental health service users to reconnect with identities other than those imposed by illness (Hutchinson & Lovell, 2013). Although all stories have presented a loss of self, as storytellers are admitted onto wards, it is relevant here to consider the setting in which Rory was placed during his admissions to mental health wards. Rory told that he had spent significant time in secure settings, where there may be additional difficulties in securing therapeutic alliances; as staff frequently need to manage safety issues (Burrow, 1991; Mason, Lovell, & Coyle, 2008; Knowles et al., 2015). Conversely, others would argue that spending time on a secure unit allows more opportunities to work on establishing therapeutic alliances (Chandley & Rouski, 2014). Yet from a service users' perspective, restraint has been reported as a means for staff to assert their power in such settings (Kaminskiy, et al., 2013; Knowles et al., 2015). The impact of staff misusing their personal power over service users in the use of restraint, in any setting, neglects the need to build a therapeutic relationship with service users (Paterson et al., 2013).

Narrative re-storying can offer an approach to recovery for both individuals and communities (Grant, et al., 2015) and may offer an opportunity to build alliances between staff and service users. Narrative re-storying is also a suggested intervention within the Power Threat and Meaning Framework (Johnstone, et al., 2018). Lived experience should be the major focus for mental health nurses to understand and support service users (Grant, 2015). Service users should be supported to story and re-story their experience avoiding the institutionalised narratives of psychiatry and also supported in challenging 'epistemic injustice'.[45]. The dialogue then becomes the basis for supporting the re-shaping of an individual's life based on a recovery relationship built on trust (Grant & Leigh

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[45] Fricker (2007) refers to two types of epistemic which both challenge lived experiences. Testimonial injustice occurs when prejudices cause a hearer to give a deflated level of credibility to the words of the speaker. Hermeneutic injustice occurs when individuals do not possess the interpretive resources to sufficiently make sense of their experiences.

Phippard, 2014; Grant at al., 2015; Johnstone, 2013). There is no ready-made model that nurses can use to support service user's in narrative re-storying, as its relationship with life events and is complex and relatively unpredictable (Grant et al., 2015). Nurses need to be supported to achieve narrative competence in absorbing, interpreting and responding appropriately to the stories of others and de-medicalising their language and approach when doing so with service users (Grant, 2015).

Person-centred care

From the perspectives of storytellers in this thesis, there is an implicit message in all the presented narratives pointing to, a lack of a person-centred approach, therefore it becomes relevant, to consider the grand narratives in society about this concept. Person-centred care in practice can take different forms, including shared decision-making, service user choice, self-management of care/conditions, co-production, and experts by experience. Immediately, it can be seen that conceiving of person-centred care is neatly compatible with a society and services which privilege the individual, this can be seen to operate at the nexus of biomedicine and neoliberal capitalism. Within this, notions of choice assume importance but also point to certain illusions within resource poor and conceptually limited systems. That said, such narratives are so powerful and far reaching, and certain alternatives unpalatable (who wants arbitrary care?), that most people see no problem with valuing person centred care.

Different labels have been assigned to person-centred care, including amongst other labels patient-centred and client centred care, yet as in the stories in this thesis, all these 'centred' approaches have responded to the disease-focused impersonal approach of biomedicine (Naldemiric et al., 2018). McCormack et al., (2012) identified two of the important antecedents of models in person-centredness from the work of Carl Rogers and Tim Kitwood. Rogers (1961) a psychologist, contested the knowledge and expertise of the therapist. He suggested that given the right support individuals should be able to find ways to become autonomous. The assumption about service users' capabilities to be autonomous beings resonates with the continuing concepts of contemporary person-centred care (Harding, Wait, & Scrutton, 2015). As noted previously, Smail (2015) suggested that people have limited agency and the power to choose relies on material resources in the world outside of ourselves. Service users may not be willing to, or as Smail suggested perhaps able to, employ their resources. Furthermore, the power to make choices is also dependent on a trusting relationship with health care professionals that are built on mutual understanding and cooperation (Naldemiric et al., 2018). Attributes such as autonomy and choice are promoted with a neo-liberalised society, however, the storytellers in this thesis reported challenges in achieving these 'ideals'. This begs the question as to how realistic the concepts of autonomy and choice are within coercive systems, where such 'attributes' are limited? A second model of person-centred care is Kitwood's (1997) concept of 'personhood', defined as being a *'standing or status that is bestowed upon one human being, in the context of relationship and social being'* (Kitwood, 1997, p.8), thus this definition goes beyond the notion of an individual endowed with rational reflective abilities (Naldemiric et al., 2018).

The narratives of person-centred care in the public sphere are well documented within formal government policy and planning documents. Amongst many policy documents that support person-centred care, the following are some examples:

Liberating the NHS: No decision about me without (DH, 2012): No Health without Mental Health (Department of Health & Social Care,2011); The NHS Constitution (DH, 2015). There is acceptance within health care policy that importance is afforded to the user perspective (Rogers & Pilgrim, 2017). In mental health care policy, the user voice can be seen in two specific ways: the introduction of the National Service Framework for mental health (DH/Home Office, 1999) and the National Institute of Mental health for England have incorporated the agenda for 'experts by experience' and invited service user input within a forum for discussion (Rogers & Pilgrim, 2017). Person-centred care is also outlined within legislation: Under section 11 of the Health and Social Care Act (2001), the Commission for Patient and Public Involvement in health was formed in 2003, with a duty on all NHS trusts related to user involvement. Similarly, the Health and Social Care Act (2012) places a legal duty for individuals to be involved in their care; whilst the Care Act (2014) outlines the importance of the individual nature of care. Pilgrim (2012) articulates the tension with person-centred policy within psychiatry:

> *‘Patient-centredness, now at the top of health policy agenda more widely, inherently focuses on voluntarism and mutually negotiated decision-making between patients and professionals. Such emphasis is on 'expressed need', whereas psychiatric decision-making, backed up by legislative powers and expectations, requires an emphasis on defined need; it is explicitly legitimised forms of parens patriae. Logically and pragmatically, it is not and cannot, be negotiation between equal citizens’* (Pilgrim, 2012a, p.73).

The use of such narratives in policy can serve to both to disguise barriers in achieving person-centeredness and promote its implementation. A paradoxical position for mental health service users is presented as the ideal of choice yet is affected by mental health legislation that enables psychiatrists to detain and treat people against their wishes. Compulsory detention under mental health legislation makes notions of free positive care tenuous (Rogers & Pilgrim, 2014). Psychiatry is biased towards drugs and ECT in treating mental distress, with service users on the receiving end of such treatments having little choice of alternatives, as these are legitimised by psychiatry with medication being encouraged by profit (Rogers & Pilgrim, 2017). Storytellers in this thesis positioned themselves to have limitations of choice/s. Indeed, Rose's story reported a narrative of limited choice, as noted in the discussion section about dignity, which highlighted the inequalities present in legislation; as one law (The MCA (2005) allows an adult to specify what risks they consider as serious or significant, hence they can refuse treatment, whilst another (The MHA 1983, amended 2007) can override choices in specific situations.

Choice is also reliant on what is deemed as responsible, for example, Rose (2014, p.17) highlights that, although goals in recovery are meant to be personal, '*certain goals are not permitted, you cannot decide to go to bed for a month*'. Goals relating to future opportunities outside of inpatient psychiatric care are also limited, which impacts on both current and future choices. Being diagnosed as mentally ill has wider social and economic consequences, with such labels allowing the opportunity for discrimination by present and prospective employers, thus people with such labels are at risk of a life of poverty (Rogers & Pilgrim, 2017). Similarly, educational opportunities are often curtailed, and social contact is fraught with difficulties, which affect rights and choices of citizenship (Rogers & Pilgrim, 2017). A further criticism of person-centred care is that the individual is assumed to be able to communicate their story in a coherent, structured way, however, as Pols (2005) suggests there is an assumption that service users perceive themselves as individuals and they can verbally communicate their perspective. Randall and McKeown (2014) argue that recent failures within health care, such as the failings at Mid-Staffordshire hospital (Francis, 2012), can be directly related to the liquidification of nursing. They point to Bauman (2000) in his description of a state of liquid modernity, a stage in the development of capitalism where uncertainty reigns and stability is eternally undermined. In contemporary nursing, the professional is fuelled by uncertainty in the job market and the functions of nurses become mechanistic, often in the name of quality improvement (Randall & McKeown, 2014). The impact of this leaves nurses dis-invested in service users, as such emancipatory practice is somewhat unachievable and perhaps for Bauman delusionary, with some nurses losing sight of the service users they are involved with (Randall & McKeown, 2014). However, the barriers to achieving person-centred care are not confined to nurses as studies have found that psychiatrists are also failing to fully develop person-centred care within their professional practice. Some psychiatrists may have attitudes that do not value working in a person-centred way, and for psychiatrists who are positive to working in this way, conflicting values around risk management and targets can prevent such practice (Boardman & Roberts, 2013). Burnout and fatigue are also factors that have been reported to prevent psychiatrists from embracing the concepts of person-centredness (Shanafelt et al., 2012). The lack of training in how to effectively work in a person-centred way has been reported to undermine person-centred practice (Moore, Britten, Lydahl, Naldemirci, Elam, & Wolf, 2016) and when training has been delivered there are reports that there has been a failure within such training to deliver on changes in attitude (Stead, Morant, & Moran, 2017).

Empowered identities

Frank (1997) refers to Brookes' (1994) work when exploring how experiences in illness can be a moral occasion and used to restore agency to individuals. Brookes (1994) proposes that experiences in illness can be a medium for the creation of new relationships with self or others. To a greater or lesser extent, in telling their stories all storytellers revealed a sense of their recovery. This was presented in the stories as individuals told of moving forward from institutionalised settings, where identity was threatened, towards more empowered identities. Empowerment in the mental health services context, involves the reframing of power relationships between service users and staff, communities and government (WHO, 2010)[46]. Acknowledging the limitations of control and choice discussed above, an international perspective frames empowerment as the level of choice and control and influence service users can assert over their lives (WHO, 2010). Empowerment is linked to recovery, yet recovery may have different meanings for individuals, making any measuring of recovery problematic. The WHO has defined the individual nature of recovery as follows:

> "*The meaning of recovery can be different for each person. For many people recovery is about regaining control of their identity and life, having*

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[46] Interestingly, despite a wealth of policy and professional rhetoric concerning empowerment, the field of mental health practice is relatively free of discussion of matters of power itself, how to make sense of the distribution of power, and how to address inequities. Critical commentators have not been slow to point this out (see Hopton, 1997, Cutcliffe & Happell, 2009), and most of the effective writing on power is located in external critique of psychiatry and mental health services.

> *hope for their life and living a life that has meaning for them whether that be through work, relationships, community engagement or some or all of these*" (WHO, 2017, p.15).

A definition of recovery influenced by the service user/survivor movement is offered by Anthony (1993, p.527) as a:

> '*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by the illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness. Recovery from mental illness involves much more than recovery from the illness itself.'*

This definition conflicts with the more conventional and clinical concept of recovery (Slade & Longden, 2015). For Anthony (1993) recovery is viewed as living a hopeful and satisfying life as defined by the person, in spite of the fluctuating nature caused by distress. Gadsby (2018) warns that staff working with service users to instil hope may neglect the power indifferences in society that assume a level playing field is present for individuals with mental health problems. In narratives of recovery, individuals are engaging in their life and find meaning through their own goals, in doing so their identity and social role is constructed or reclaimed (Slade, 2010). Recovery is thus a journey, not an outcome to be achieved (Perkins & Repper, 2003).

Narrating other key aspects of identity

Ethnicity

Rory's story differs from the other participants in narrating race as an influential construct and aspect of identity. A unique narrative is thus revealed in Rory's story. Rory shares a narrative of race without making explicit connections with ethnicity being an influencing factor on the use of restraint. However, it is pertinent to consider Rory's self-esteem at this juncture in the lack of a direct challenge from him as race being a potential contributing factor on restraint being undertaken. Hopton (1995) refers to Fanon's (1990) work on the damaging impact of oppression on the self-esteem of the oppressed and their view of the oppressor/s[47] under colonial regimes, with western ethnocentric psychiatry implicated as a tool of this oppression. Hopton (1995) suggests that Fanon's theory can be viewed through the lens of contemporary psychiatry. When an individual is distressed, they accept the psychiatrists' interpretations of their psychological and emotional experiences as being more valid than their own (Hopton, 1995). In doing so they become complicit in undermining their self-esteem (Hopton, 1995). Therefore, it is relevant to consider how race may have impacted on Rory's image of himself as a young black male, which is not mentioned by him as a contributing factor in his own experiences of restraint.

In Rory's witnessing of the restraint on a young black man he judged how no threat of imminent physical violence was present, yet told of how restraint was undertaken, which was suggestive of a culturally insensitive approach. Coercive practices have been found to be used more frequently on individuals from

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[47] Interestingly, Fanon also argues that this psychic damage is not limited to the oppressed, and that the oppressors themselves are damaged in this dehumanising dynamic.

ethnic minorities, especially young black men in the United Kingdom (McKeown et al., 2019a; Stowell-Smith, & McKeown, 2001). Although Rory's story did not explicitly mention his ethnicity to be a contributing factor to the use of restraint, an inference of cultural insensitive of staff is present. In these examples connections with any underlying racism appears to be underplayed by Rory. To paraphrase Frank (2010a), omission has made the silence significant, in that Rory, as the storyteller, left this part of the story imagined, as opposed to having been specified by him (Frank, 2010a).

For Rory, this storying of race also intersects with trauma[48] as he witnesses restraint as applied to another ethnic minority individual; with the implication that for this individual's restraint constituted a traumatic event imposed when he had not pose a threat. There is evidence that black and ethnic minority groups are more likely to experience such trauma (see for example Hatch, 2007) and are over-represented in the mental health system (McKeown et al., 2019a; Stowell-Smith, & McKeown, 2001; Sweeney et al., 2018). In considering the narrative of race, young Black males residing in urban areas within the United Kingdom have particularly high rates of being diagnosed with 'psychosis', including higher rates of 'paranoia', which might be accounted for by living at the intersection of multiple forms of disadvantage and discrimination (Johnstone et al., 2018).

Historically, the connection of 'schizophrenia' with Black males and with violence, hostility and ‘paranoia’ can be linked back to the Civil Rights Movement in North America in the 1960s when this stereotype started to emerge. However, this stereotype has survived as shown by the fact that both the public and professionals are likely to over-estimate the likelihood of young

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[48] Witnessing traumatic events within psychiatric settings can create trauma (Frueh et al., 2005; Palm, Polusny, & Follette, 2004; Clark, Ryan, Kawachi, Canner, Berkman, & Wright, 2008).

black men being violent (Johnstone et al., 2018). Horwitz (1983) noted that the tendency to label a person as mentally ill was influenced by the distance between the labelled and the labeller. In the aspect of labelling, it is relevant to consider the diagnostic model of mental distress used in psychiatry: The World Health Organisation's International Classification of Diseases (ICD) and the American Psychiatric Association's 'Diagnostic Statistical Manual' (DSM). As discussed in Chapter Two, one of the many criticisms of the diagnostic model in classifying mental distress is the euro-centric bias which embeds a Western world view of mental health (DCP, 2013). As a consequence of this bias, there is evidence of discrimination towards a wide range of groups and neglect in areas such as ethnicity, sexuality, gender, class, and culture (Bayer, 1987; Busfield, 1996; DCP, 2013; Fernando, 2010; Shaw & Procter, 2005). Rory was silent on the impact of his own ethnic and class status, however, for me this lies as an undercurrent in how he presents his story as a relatively young black man from what might be described by some as a ‘working-class’ environment. It has been noted that individuals subject to intersectional disadvantage often downplay or sometimes be oblivious to the influence of powerful wider narratives such as racism in their everyday lives (Harries, 2014).

In looking at some of the wider influences in mental health, Frederick (1991) identified several stress factors believed to lead to mental health problems for black people. These included problems coping with adolescence and the education system, which raises expectations, then dashes them; growing up in an environment which is deemed as hostile with few numbers of positive images of black people; and parental and British white cultural input with confusion and conflict with identity (Frederick, 1991). Black adult males are likelier to be compulsorily admitted to a psychiatric hospital and subject to other forms of coercive intervention (Johnstone et al., 2018; Rogers & Pilgrim, 2017). Noble and Rodger (1989) found that black people were reported to be more violent than their white counterparts. However, Rogers and Pilgrim (2017) question whether a 'spiral' of expectations is present, similar to those found in prison, in which black people are treated more coercively and are likelier to react to this discriminatory regime in a more aggressive way. Despite the over-representation of black people in psychiatric wards and more coercion, policy and strategies in addressing these issues have been slow to address this (Morgan, Mallett, Hutchinson & Leff, 2004). Fernando (1988) suggested that labels such as schizophrenia have been attached inappropriately to black 'patients', because of the imposition of western concepts with little attention to non-western culture. Fernando, Ndegwa, and Wilson (1998) argued that misdiagnosis is only part of the account as to why African-Caribbean over-representation. In their view, other factors need to be considered, such as institutional racism and the inadequacy of psychiatric knowledge in its totality. 'Paranoia' is similarly associated with being male, of low socioeconomic status, immigration, a member of a minority ethnic group, and being a refugee. Studies have associated 'paranoia' with feelings including shame, anger, worthlessness, humiliation, entrapment, disconnection, powerlessness and injustice (Johnstone et al., 2018), which has implications for Rory, who has been diagnosed with a label of paranoid schizophrenia. In Rory’s story the diagnosis of the other black individual is not revealed, however it is pertinent to consider how people are lost to diagnosis.

Links can be made between narratives of race and biomedicine. As Foucault (2006) argued as far back as 1965, we are pre-dispositioned to view madness as essentially 'other' to be segregated from society. In contemporary society, the narrative of loss and difference has been clearly expressed by Barham and Hayward (1991) who noted that individuals who receive a diagnosis are viewed as *'lost to the diagnosis'* (p.2). They become a stranger to themselves and others, in a sense they become alien[49]. The use of the English word 'alien' is used to describe an outsider or foreigner resonates with the phrase alienist, who was an expert in madness in the early nineteenth century (Rogers & Pilgrim, 2017). The notion of 'otherness' which characterises the discourse on psychosis is a good fit for this new type of racism, preoccupied with notions of who should be excluded or included within mainstream society (Rogers & Pilgrim, 2017).

Gender

Again, for Rory, matters of power and violence intersect with a narration of masculinity; another powerful construct that is sustained in wider social discourse. It is relevant to consider symbolic interactionism in presenting this narrative and the identity Rory assumed. Goffman (1969) highlighted the performance of social roles and identity within micro-social relations and coined the term dramaturgical analysis. For Goffman, social actors present themselves to others, attempting to control others' impressions to be seen positively (Goffman, 1969). In essence, this suggests that Rory gave a performance of his desirable self, to be viewed in a positive way, with his masculine identity intact. As Goffman (1974 p.508-509) eloquently suggested *'What talkers do is not to provide information to a recipient but to present dramas to an audience. Indeed, it seems we spend more of our time not engaged in giving information,*

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[49] The use of the English word 'alien' is used to describe an outsider or foreigner resonates with the phrase alienist, who was an expert in madness in the early nineteenth century (Rogers & Pilgrim, 2017).

but in giving shows'. Since Goffman, others have extended his work[50]. My analysis in this aspect of Rory's story was influenced by Goffman's ideas. In his story, Rory not only told me about his experiences, he performs significant moments and choses to dramatize these towards a socially approved masculinity. In this respect, the particular moments about his resistance in his use of key words/phrases, chime in with this masculine dramaturgy. I was his audience, and as such experienced the evolving of events with him, reliving episodes and experiences.

In organisations seen as more controlling, for example with a high priority on risk management, there is a significant impact of staff shaping and constructing and re-shaping service user's identity (Knight, 2015). Rory was in a secure mental health setting and he portrays the staff as controlling and using or indeed misusing their power. The use of power to manage presenting 'behaviour', can result in service users fearing and distrusting staff, particularly those who rely most heavily on power and control (Sweeney et al., 2018). Rory does display his mistrust of staff, he suggests this in different ways, for example in talking about feeling sexually assaulted by staff, or staff planning restraint. There is a definite sense of 'them and us' presented throughout the participants' stories.

Survivor

Again Goffman's (1969) dramaturgical theory can be seen to poignantly be relevant in the telling, listening and analysis of other participants' stories. Under this lens Rose's story, for example, has Rose offering a performance of her desirable self, to be viewed in a positive way, with her identity as a survivor

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[50] For example, Butler 1990 and Postlewait & Davis, 2003.

firmly anchored. In telling her story Rose dramatised events, for example making connections with the past and the impact of these events in her reactions. Rose told me about her experiences, whilst performing key moments, presenting drama. As her audience I experienced the unfolding of different episodes of drama with Rose as she dramatised particular moments with poignancy. She used key words, and symbols[51] in her story, which gave it a presence as I listened. In listening and also when analysing, I felt that I was reliving events with her. My first instinct was to care for and rescue the character in the story, for example when Rose presented herself as the young girl being horrendously abused. Frank (2010a) talks about suspense in stories requires listeners to care about the characters in the story.

Experts by experience

It is relevant to consider the narratives of expert by experience as identified in the stories by three storytellers. Some services have worked to select people with direct experience of mental health systems and experiences of distress, co-opting them as experts by experience into mental health assemblages (Voronka, 2016). As an expert by experience Voronka (2016) argues that being an expert by experiences can both legitimise and delegitimise a person's being. Voronka (2016) suggests that using one's identity and experience can help an individual gain entry into a system of power. However:

> *'As we work to privilege 'lived experience' as a commodity that can translate into inclusion within folds of power, we also have to think through our own agency, complicity, conflicts, and productivity within such ventures. Thus, we have to continue to name, trouble, and*

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[51] Frank (2010a) discusses how symbiotic meaning can give a story a tangible presence.

> *negotiate the power that we access when drawing on 'people with lived experience' both when individually and collectively asserted'* (Voronka, 2016, p.199).

For many years services have been provided by service users (Chamberlin 1988; Lindlow, 1994). The limitations of service users as providers in mental health are their willingness, or lack of it, to encroach upon on a role which is traditionally about care and social control (Rogers & Pilgrim, 2017). However, user-led services offer alternatives to care where traditional services have perhaps failed with some service users (Rogers & Pilgrim, 2017). In planning and delivery of care service users have been positioned as active citizens, not merely individual consumers of care (Bolzan & Gale, 2002). However, some critics have argued the rhetoric of partnership and involvement, in areas such as care coordination, has not entirely been mirrored by the responding involvement of users (Rose, Wykes, Leese, Bindman, & Fleischman, 2003). Service users have reported limited opportunities to express their care needs and what ought to be included in their care plan (Newman, O'Reilly, Lee, & Kennedy, 2015).

As biomedicine is such a dominant force within mental health care, an important question is posed on how we learn lessons from the lives of individuals who have been diagnosed, labelled, and 'treated' within the mental health system? As a consequence of the dominance of biomedicine, service users are positioned as less powerful than professionals caring for them. Fricker (2006, 2007) provides a relevant concept 'hermeneutical injustice' in contemplating the power dynamics present in such situations. Due to the uneven power relations, the shared meanings of less powerful groups may often reflect the lives of more powerful members, (in this context psychiatry), therefore there is a failure to properly capture the experiences of the less powerful (Fricker, 2006, 2007). This may result in members of less powerful groups being harmed by such disadvantage, resulting in 'hermeneutical injustice' (Fricker, 2006, 2007).

Rory, Rose and Finlay narrate how they have taken up the identity and role of expert by experience, as all three storytellers talk about drawing on their experiences to train staff. Service user movements have often criticised the top-down nature of knowledge production by psychiatry and psychology, which has tended to focus on objectivity, whilst marginalising subjectivity and meaning (Johnstone & et al., 2018). Rory and the others present themselves as making a difference in services in the role of educator, talking to nurses and doctors about their experiences. Although some critics, such as Fricker above, are sceptical about the engagement of people in this way, due to the power imbalances, other commentators have viewed the experiences from experts by experiences as an important resource, for example in supporting the teaching curriculum for students pursuing a career in health and social care (McKeown, et al., 2014). Inquiry into the reasons for service users' involvement reveals a desire to 'make a difference' to health and social care services (McKeown & Jones, 2012). This involvement does not stop at teaching, but also includes student selection, curriculum planning, course validation, and evaluation within higher education (see for example, Basset et al., 2006; Beresford et al.,2006; Brown & Young, 2008; Lathlean et al., 2006; McKeown et al., 2010; Morgan & Jones, 2009; Repper & Breeze, 2007; Towle et al., 2010). With regard to how such developments sit with wider social narratives, there is a growing critical literature that questions such user involvement practices on the basis of limited authenticity, democracy and impact, constraints on focus and ambition, and the danger of co-option within an over-arching neoliberal consumerism and biomedical frame (see Beresford, 2019; McKeown et al., 2014; Sapouna 2020).

All four stories presented changes to their identity by the storytellers. These were framed by storytellers as more empowered identities towards the end of their stories[52]. The strengthening of identity is viewed by some as an important aspect of recovery (Brown, & Kandirikirira, 2007). Three of the four storytellers discussed involvement within service user movements, suggesting this involvement has served to support them in more empowered identities. User involvement helps to demystify concepts of mental illness and raises awareness of individuals who have been socially excluded (Hutchinson & Lovell, 2013). Service user activism has enabled individual's experiences of mental illness to be used positively, indeed for some their own mental illness experience can be a social advantage in supporting others and giving individuals more empowered identities (Yanos et al., 2010).

Adler (2012) suggests that agency is associated with improvements in mental health. Yet it is argued that simplistic biomedical notions of recovering from symptoms of illness are outdated, and recovery is not about being cured (WHO, 2017). Furthermore, recovery within mental health services is deemed by some as an illusion, which masks the inequalities of power present in services, wherein coercion predominates and remains at odds with a sense of choice (Morgan, 2018). Such inequality of power is evident in all stories; indeed, the narratives of biomedicine, power and control have framed this inequality.
An example of change to identity is offered by Rory when he witnessed the restraint of others in hospital and he told of feeling unable to help. His identity

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[52] Acknowledging that stories are never finalised

changed to some extent in this aspect of his story, as a change in Rory's character is presented, against a backdrop of relatively impotent powerlessness. To paraphrase Frank (2010a, 2012) characters can change in stories to fit with the presenting circumstances. Here we see how Rory portrays himself as showing empathy and wanted to help other individuals. He told of wanting to rescue these individuals, perhaps suggestive of a hero character, no longer the victim being restrained. Towards the end of his story, Rory changed his identity further, no longer the service user who was positioned in his story as posing risks to others; he has changed his character to the wise sage in his story, suggesting he is able to help others through his experience. In this sense, the concept of recovery is perhaps represented more securely. Recovery in this aspect of Rory's story, chimes with the definition influenced by the service user survivor movement as proposed by Anthony (1993).

A narrative of redemption is presented by Rory, at the end of his story, which aligns firmly with a quest narrative. Rory has reinterpreted past experiences, which are framed as having made him, perhaps paradoxically, stronger, wiser and better equipped to 'give back' to others (Stone, 2016). The psychological aspects of redemption are important here, serving as a process for transforming the negative narratives of life, enabling more positive experiences to be acknowledged (McAdams, 2006). Redemption as a concept, is significant for individuals in forensic recovery, with its emphasis on atonement, reforming and acts of restitution (Ferito, Vetere, Adshead, & Moore, 2012). It may also be significant in a more mainstream context, escaping feelings of shame and stigma through a recovered identity (Horsfall, Cleary, & Hunt, 2010). Additional ways of making sense of having a mental illness include empowered identities and ones in which mental illness is irrelevant (Yanos et al., 2010); thus, the redemptive narrative identity suggests a more empowered resource for Rory, as he is not defined by a narrow notion of mental health. Narratives of redemption forecast a more purposeful future (Stone, 2016). Rory's role as an expert by experience suggests how he is still showing resistance, yet his combative identity is arguably channelled more constructively. As an expert by experience, Rory revealed his involvement in the training of nurses and doctors about restraint reduction. User involvement is central in helping to demystify mental illness and raise consciousness around what is really like to feel socially excluded and discredited (Hutchinson & Lovell, 2013).

Although not involved with any service user movement/organisations, Jane also positioned herself in a more empowered identity towards the end of her story. In reporting her experience of restraint as an assault to the police, she positions herself as reasserting some control, suggesting a greater sense of agency. The theme of agency is viewed by some as being concerned with an individual's ability to influence the course of one's life and in doing so connects with an individual's sense of meaning and purpose (Adler, 2012). It is suggested that a strong sense of agency has been found to be associated with psychological well-being (Adler, Harmeling, & Walder-Biesanz, 2013; Helgeson, 1994; McAdams, Hoffman, Mansfield, & Day, 1996; Woike & Polo, 2001).

Concurring with Archer's (2003) critical reframing of the relationship between structure and agency, the reflexive subjectivity of individuals can be an important element of seeking or realising social change. Jane's story suggests that she was able to exercise some control outside of the ward, which questions the limits of her control as an inpatient. Jane suggested that reporting the incident of restraint as an assault had helped her recovery. Indeed, in her referring to her experience as assault, she emphasises her perception of restraint as abusive practice. In a more empowered identity, Jane presents herself as taking some control back of a situation where she felt out of control in formally reporting this incident to the police.

Jane reported feeling relieved in telling her story as part of the study. In this sense, a further step in her recovery is at play. Woods, Hart and Spandler (2019) discuss the healing and transformative powers of sharing one's story. However, they also warn that the negative consequences of storytelling are often minimised; for example, the emotional labour involved in telling one's story can outweigh any therapeutic benefit (Woods et al., 2019). Although Jane suggested a therapeutic advantage in sharing her story, she also narrated how she may never feel that the experience in hospital will ever be totally resolved. She indicated that the restraint incident is something that she will not completely recover from. In her story, Jane expressed her hope for a future, for Jane this meant no longer taking her medication and her health is restored, which resonates with the concept of clinical recovery.

Rose's story also demonstrates her taking meaning from past experiences. Rose's own sense of agency can be observed in her role as a professional advocate and educator, as an expert by experience. Rose presents herself as having an empowered identity as she talks of her work in helping service users and staff, by sharing her stories. The sharing of her experiences in her professional capacity, as she travels the country to train staff, indicates that Rose is now placed in a more empowered identity. Furthermore, the act of re-storying also provides an opportunity to support recovery for Rose. Re-storying has the potential to help individuals both therapeutically and in moving forward (Grant et al., 2015).

In Finlay’s story, he presents his agency in two roles. His role within service user involvement practice, in which he positions himself in an empowered identity as he supports the training of future nurses and social workers. The second role being a student completing a degree. It could be argued that both roles support Finlay’s mental well-being. It is argued that an essential part of recovery is transforming undervalued identities, such as illness identities, with more empowered identities (Yanos et al., 2010), which resonates in Finlay's story. Finlay's role within a service user organisation reflects recovery in Anthony’s (1993) definition above, as Finlay presents his skills and role in educating others. Additionally, Finlay's story represents how his student identity had brought the added benefits of positive self-esteem and confidence, as he discussed how this had helped him to remain in the community. These roles both indicate empowered identities. Finlay offers suspense in his story “*if I wasn't a student I would have nowhere to go”*, which leaves a question open as to where Finlay will position himself once the student role ends.

Chapter conclusion

Having discussed the findings in specific detail, several relevant issues are revealed. These correlate to some extent with previous studies, strengthening the research base. The findings and subsequent discussion of this thesis has also raised new insights and provoked insights surrounding the lived experiences of service users who have experienced restraint. In considering the issues raised within this discussion, the next and final chapter will conclude the thesis by outlining the original contribution to knowledge, the strengths and limitations of the study and the implications for future practice.

CHAPTER SEVEN.
THESIS CONCLUSION

Having presented the findings and discussion, the final chapter provides details of my original contribution to knowledge, the strengths and limitations of this study and implications for practice, including suggestions for future research.

Original contribution to knowledge

When starting this study, I wanted to explore the stories of mental health service users regarding their experiences of physical restraint, in appreciation of their perspective. I believe I have contributed to the knowledge base in this area in several ways. Primarily there are limited published studies specifically exploring adult service users' experiences of physical restraint. Furthermore, this is the only study that uses a narrative approach to explore service users experience of physical restraint within published literature. I believe that first person narratives, co-created with me and a group of people, who have directly experienced restraint makes this unique. I consider the contribution of meaning from storytellers, challenges and suggests problems between different stories, including the master narratives 'out there' told and typically taken for granted about restraint. The approach of this study has highlighted the tensions in meta-stories about restraint. These tensions include: the implications of the diagnostic biomedical narrative; the contested nature of 'legitimised' restraint; the context of 'trauma' /traumatising environments/practices; the complexities of balancing care and control, in contexts of power and violence; compromised choices, including inequality in decision making; relational conflicts in building meaningful alliances; conflicts in concepts such as person-centred care; and the voices of service users, who feel marginalised and ‘storied’ about within the traditional mental health system. With respect to the latter, a strong sentiment shared by a storyteller in this study resonated with me which I feel captures this sense of ‘storying about’ a person:

> ‘*I had a phrase that I feel like I'm a library book where people just read me and then just put me back and I said on the ward I need people to get to know me’*

This study also takes a broad approach and is not limited to adults in one setting, rather the participants had been inpatients on different mental health wards, throughout England, which was consistent with the inclusion criteria of the study. Other studies have explored the impact of both restraint and seclusion (Brophy et al., 2016; Haw et al., 2011; Steinert et al, 2007), with several others which have examined the impact of physical restraint from a service user perspective (Bonner et al., 2002; Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002; Wynn et al., 2004). Whilst half of these studies have explored the impact of physical restraint from a service user perspective within secure mental health settings (Haw et al., 2011; Sequeira & Halstead, 2002; Wynn et al., 2004), the remaining studies have provided insights from other mental health inpatient settings (Knowles et al., 2015; Wilson et al., 2017; Wynn et al., 2004). This makes my study unique in its exploration of physical restraint from the perspectives of service users, in a variety of inpatient mental health settings across England.

On analysing the stories, each story is kept whole, which I believe adds authenticity to each narrative. This approach offers new insights and meaning from the perspectives of people who have experienced restraint, whilst avoids the fragmentation of stories as uniqueness and similarities are naturally revealed. Although not the aim of this study, the narrative identities of storytellers are highlighted, which is a novelty compared with previous studies exploring the impact of physical restraint for mental health service users. These identities are an important consideration and are not fixed, which corresponds with Frank's (2005a, 2010a, 2012) assertion of 'unfinalised' stories. It is proposed that an important aspect of nursing care is to support service users to identify with other identities, as opposed to those imposed by illness (Hutchinson & Lovell, 2013). I believe that finding ways of making sense of experiencing mental distress that attracts a mental illness diagnosis and moving to more empowered identities where mental illness is irrelevant (Yanos et al., 2010), helps with recovery, and this is revealed by the storytellers here.

As storytellers in this study journey through their stories, aspects of identity are revealed. Each storyteller narrated their transition from a vulnerable identity, in which they position themselves during their experiences of restraint, to more empowered identities. Choosing four stories for focused attention reveals strong, separate stories, albeit with some commonalities: the story of resistance; the story of injustice, the story of trauma; and the story of saving life because of physical restraint. The stories given voice to by participants in this study may reflect various meta-narratives, some differed but many were similar. These included narratives of trauma; power; control; violence; race; masculinity; biomedicine; illness and labelling; limited choice; therapeutic alliances; and expert by experience. These narratives specifically resonate with other available narratives at large in the social world. In this respect I was able to address the broader social and narrative context in which these stories were given voice. The participants' stories were situated within other people's stories and the grander narratives in society which influence their and my own stories. In other words, any one story exists within the inter-relationships with all other the stories, as these influence our knowledge of the world and sense of self**.** My analytic treatment of the participants' stories discussed with reference to these wider social narratives brings an original contribution in the context of understanding the social function of mental health care beyond the immediate dimensions of physical containment or aspects of individual need, help and support. I have attempted to navigate a theoretical standpoint that acknowledges the power of neoliberal and bio-psychiatric meta-narratives but remains optimistic for the potential for change and respectful of the agentic resistances contained within participant accounts.

Frank (2010a, 2013) suggests that the past relates to the present and the present relates to a future. Storytellers have reported a position of past disempowerment; their positions are then rebalanced in the present and the future is perhaps open to possibilities. Storytellers present more enabled identities, as characterised through their involvement in planning and supporting services and other individuals within the mental health community.

Physical harm became a dominant representation within the stories of this study, yet a more complex outcome is articulated as storytellers tell of the psychological impact of restraint, which appears to have resonated across all stories. Using a narrative approach allows for this complexity to be exposed in an unrestricted way. At times storytellers reported about the punitive use of restraint. At a micro level, the use of restraint is also seen by storytellers, to damage opportunities for building a therapeutic relationship. This is similar to findings in other studies (Brophy et al., 2016; Haw et al., 2011; Knowles et al., 2015; Sequeira & Halstead, 2002, 2004; Wilson et al., 2018; Wynn, 2004), so is worthy of consideration in terms of mental health practice.

The narratives do not cease with pointing out shortcomings, and storytellers suggest ideas for improving the quality of care. At both a micro and meso level, this involves their suggestions for improving the therapeutic alliance within organisations. At a macro level, storytellers question the adequacy of staffing levels within the mental health system. As a consequence of the latter, storytellers view engagement between staff and services users as being compromised leading to more restraint, as service users are left relatively unsupported. Critical commentators, however, argue that mental health environments are implicitly and explicitly violent; by their very nature legitimating and institutionalising coercion (Gadsby, 2018; Holmes et al., 2012; Liegghio, 2013; McKeown et al., 2019a). Storytellers do not propose ‘no restraint’ environments and acknowledge how staff are called upon to manage risks, yet their own experiences of being restrained are mainly deemed by them as unjustified.

Finally, the study provides experiences from a service user perspective of the importance of strengthening relationships with staff. My study provides the perspectives and meanings from service users, who are experts by their experience by virtue of the very particular fact they have experienced restraint, which were co-created and considered in the context of grand narratives. As such, they offer suggestions for future practice, in conjunction with revealing the impact of being physically restrained, from a personal and storied perspective. I believe this is important in its relevance to the future practice of mental health nurses, as well as other allied professionals.

Narrative research can be criticised for reproducing unsubstantiated claims of storytellers. Indeed, this may be the case in any qualitative methodology, as the researcher is reliant on what the participant shares with them and what is shared may also be influenced by the participant’s favoured views or values. I was mindful, however, to be true to Frank’s (2010b) assertion of how ethics come first. Anything that is deemed as ethical emanates from the stories that participants know. Actions that are deemed good or bad, legitimate or illegitimate, derive from stories that people know, thus moral views of the actions of others are influenced by stories that people have grown up with, to a greater or lesser extent (Frank, 2010b).

Participants revealed stories of what they felt was justified or not, based on their ideas of right or wrong. It was, therefore, relevant to appreciate the stories as told through the lens of the teller. Yet, I was also cognisant of appreciating other individuals in the story, including their potential position. An example of this is when a storyteller reported hitting a staff member with a kettle. Within my interpretation, I was mindful not to neglect the scenario from the staff’s perspective, faced with what was storied as facing the imminent risks of being attacked. Any story, even one from a singular voice and from the perspective of one person, can open up consideration of other perspectives. The presentation of traditional qualitative data is always an organising, a storying of, the material offered. Within the analysis, the findings and the discussion, I considered the narrative of violence and all the complexities involved. In doing so I drew attention to competing roles of staff when faced with issues of violence. I was mindful of the fact that I was ultimately answerable to the storyteller in my analysis of their story (Frank, 2010b).

Strengths and Limitations

When undertaking this study, I sought to maintain rigour, credibility and confidence in the process and the related findings. As with all studies, there are strengths and limitations in the design, which will now be discussed.

Strengths

A key strength of this study is the use of a qualitative approach to explore service users’ experiences of physical restraint. Many studies that have explored restraint to date investigated this as part of a broader study of multiple forms of restraint, including seclusion. Furthermore, there remains limited evidence from a service user perspective on the specific impact of physical restraint, with no published papers exploring this using narrative inquiry. Using a narrative approach allowed me, in this study, to listen to service users’ experiences of this issue and gain perspectives from individuals who had encountered restraint. Using unstructured interviews has allowed participants to talk about their experiences without the influence of a researcher setting fixed questions to fit in with a set agenda. I also believe that the opportunity for participants to talk freely, allowed them to control the story without interruption. In doing so, I believe they were at ease and comfortable in discussing their experiences.

The decision to participate in the research was motivated by participants who came forward at the recruitment stage. They had not been initially approached directly by me, as the researcher; rather their interest in telling their story was motivated at this point by their desire to participate in the study. I also believe that enabling participants to choose their preferred environment for the interview, gave them more control and helped establish a more relaxed environment during interviews. Some participants chose to be interviewed in person, whilst others wanted to be interviewed by telephone. I believe that interviews for the participants interviewed by telephone were not negatively impacted upon by this medium. This is perhaps due to the efforts made before the interview to get to know the participant, and for them to get to know me, rather than going into an interview without any previous communication. I had also held mock interviews with colleagues before commencement and feedback from this was helpful when I started interviews with participants.

The involvement of a member of my supervisory team within the analysis, included their listening to the interview recordings and meeting to ensure that I had not missed any major concepts in my interpretation of the stories. This added credibility to interpretation, as they have relevant experience in research analysis and the study of restrictive practice. The stories could have had several interpretations, yet it was important not to finalise the stories, nor control them, as interpretation involved retelling the stories in varied forms to create connections within the stories (Frank, 2010a). All steps of the process were recorded in an audit trail, including noting decisions made.

Reflexivity was central to this study and allowed me to consider my impact on the research, including my own experiences and values which may have influenced the process. Although it could be said that in any qualitative study there are limitations and potential for bias, for example, analysis being overly influenced by the researcher's prior values and experience; there are also potential strengths to be gained from the declared subjectivity or positioning of the researcher. Thus, some relevant experience and affinity for the subject matter can assist in forming an insightful interpretation of data; including insights that may elude a subject-naïve reading of the data.

I refer here to Lincoln and Guba (1989, p.83) in proposing that the researcher-participant relationship *"is subjective iterative and inter-dependent".* The researcher's values are present in all aspects of the research as findings are to some extent, co-constructed between the researcher and participant, yet this is not in a vacuum as we are also influenced by other stories 'out there'. In keeping a diary of my thoughts and feelings, I was able to reflect on and consider my thoughts and feelings during the study. In this sense, 'co-construction' involved my interpretive impact upon stories told, whilst attempting to be true to the story in line with Frank's (2010a) approach to dialogical analysis. The diary entries were also shared and discussed with my supervisory team, which helped focus my reflections on the impact of my subjectivity. I had concerns that my interpretation of the stories may be perceived as inaccurate, however, in my analysis I believe I interpreted the stories openly and honestly. Frank (2010a) warns that interpretation should not seek to control stories, but to be responsible in response to the story. Interpretation becomes responsible when it opens stories, rather than closes them; making links to more stories and asks why some stories affect judgements, rather than others (Frank, 2010a).

I consider that credibility was strengthened by adopting this reflexive approach throughout the whole of the study. In doing so, I have declared information about myself, my background and my positioning on key matters relevant to the subject of the study; including my prior beliefs were about restraint, coercion, and storytelling.

Choosing four stories for focused attention may be deemed as a limitation by some yet choosing a selection of stories allowed me to look in-depth at each story included in the thesis and kept the stories whole and authentic. This was in line with Frank's methodological approach for a selection of a small number of stories for focused attention (Frank, 2012). The stories were not chosen for representativeness, but because of their clarity concerning the phenomenon being explored (Blix et al., 2013; Frank 2012). In selecting stories for focused attention, I believe avoided fragmentation of stories, in line with Frank's (2012) suggestion of keeping the stories intact. The selected stories were each narratively diverse, yet this does not exclude the stories that were not selected having had shared features.

Limitations

Whilst there were significant strengths to this study, there were also some limitations. Using a third party to transcribe interviews meant that it is possible that not all interactions between words and gestures were captured (Reissman, 2008). This could be a limitation, however, to defend against this, on receipt of the transcripts I meticulously checked each interview for its content and the precision in transcription. In doing so, I was able to amend any misunderstandings in transcription. Transcription was undertaken in a short period after the interviews, which enabled me to recall what had been revealed in the interview. I found few errors in transcription and the transcriber had highlighted sections of text within the interview where they had been unsure about what they had heard; this was useful in focusing on specific areas within the digital recordings to ensure that I was able to add the relevant text to any missing script.

Whilst previously arguing that subjectivity was a strength within this study, it may be argued that this introduces a degree of bias. I took practical steps to acknowledge this, which served as a vehicle for reflection of my impact on the research. Keeping a research diary was a major resource in this respect.

Overall, however, I felt this subjectivity was more of a strength in the research process, as opposed to a limitation. Keeping a diary and having adopted a reflexive approach supports credibility and confirmability within this study. I believe I have been aware and honest about my impact, beliefs and assumptions.

It could be suggested that a limitation in this study was the selection of participants. The participants were self-selected, allowing those who wished to be involved in the study to take part without any undue influence from myself. This gave me access to participants on a national basis, rather than from a defined population within a locality. The limitations of this are that only people who were able to take part, or possibly those who might have had grievances about their experiences of physical restraint, may have offered to be involved. That said, although some storytellers aired grievances, not all participants told wholly negative stories, as complex and diverse stories were revealed. Furthermore, in choosing the sample for this study, I was influenced by Flyvbjerg's (1996) argument that atypical or extreme cases may reveal richer information, as they may activate more actors and basic mechanisms in the study. The implications for practice will now be explored, as part of a wider agenda for improvement, as influenced by models of good practice.

As discussed in the thesis, I did not return the final stories to participants as part of the interpretive process and acknowledge this and I realise this could be open to criticism. and be seen as a limitation. I offered my reasons for not doing so in the methods section. I acknowledge that my interpretations could have been discussed with participants and this could have been included in the analysis. The participants' responses could have generated new discussion and steered the analysis further.

Implications for Practice

Having considered the strengths and limitations of the study, I shall now discuss the implications for practice based on my findings.

Therapeutic alliance

Throughout all stories, the theme of therapeutic alliances was reported as an important aspect of care by storytellers. It is suggested that the therapeutic alliance is a fundamental element of mental health care (Roche et al., 2014; Warne & McAndrew, 2004). It is argued that the therapeutic relationship may be unachievable in secure mental health settings, with conflicting roles of security maintenance and the provision of a therapeutic milieu (Knowles et al., 2015). As has been presented in this thesis such relationships are complicated by the controlling role within mental health wards, authorised by detention under the Mental Health Act (1983, amended 2007). The power issues present in such contexts, means that mental health nurses, by default, have privileged views over what is meant by 'recovery' (Grant et al., 2015). Policy about good information provided to service users about choices of intervention, are in conflict with the contrasting views between workers and users (Grant et al., 2015).

Having looked at the problematic nature of building therapeutic alliances in the context of 'care versus control', I am not suggesting that therapeutic alliances are unachievable, rather that this territory is complicated; arguably indelibly complicated by the highlighted contradictions between idealised professional rhetoric and the realities of discursively operating limitations which drive and sustain anti-therapeutic coercion. Indeed, Johnstone et al. (2018) suggest one of the important aspects of therapeutic interventions is to support recovery and find different ways to engage with service users. From a dialogical perspective, nurses can be socialised to the institutionalised narrative of psychiatry (Grant, Leigh-Phippard & Short, 2015); however, it is important to find other narratives, which may point one way in achieving therapeutic alliances built on trust chiming with what Maloney (2013) describes as being built on ‘warm relationships’.

In consideration of this therapeutic relationship, it is relevant to consider initiatives to reduce restraint, whilst investigating ways to make their enactment real and not derailed by problems, such as staffing levels. In a study by Putkonen et al. (2013) a restraint reduction initiative was evaluated in a secure setting and a reduction in both restraint and seclusion was found. I propose that it is relevant for agencies to consider restraint reduction initiatives, as a means of achieving ways in which to manage hostility, reduce the potential for violence and improve experiences for staff and service users. These recommendations are supportive of other trends towards an emphasis on relational security as an alternative, or complement to, dimensions of physical security (Deacon, 2004).

Restraint reduction programmes

Although the policy in the United Kingdom regarding restraint reduction for adults and children (DH 2014; NICE 2015) is seen as best practice, detailed guidance on the best way to achieve this is lacking (Wilson, Rouse, Rae, Jones, & Kar Ray, 2015) and, arguably, even the most successful interventions do not challenge the legitimation of restraint and psychiatric power (Fabris 2011). Whilst critical commentators like Fabris may be correct, other authors writing from a critical perspective make a case for continued efforts at reform in the interests of currently detained patients, for whom the existence of an external critique of oppressive power, whilst important, may be scant or pyrrhic consolation when subject to ongoing restraint in clinical settings in the present (McKeown et al. 2019a).

The government has recently produced best practice guidance for the reduction of restraint on children and young people with learning disabilities, autistic spectrum disorder and mental health difficulties (Her Majesty's Government, 2019). However, in all settings, regardless of the population or setting, leadership is needed in seeking ways to reduce restraint and manage violence (Lebel et al., 2014). Although there have been international studies on interventions to reduce mechanical restraint, there remains a lack of studies regarding other forms of restraint (Wilson et al., 2015). This leaves the United Kingdom with an insufficient evidence base, as mechanical restraint is not routinely employed (Wilson et al., 2015). However, there are some fairly recent initiatives, which are based on a trauma-informed approach and are relevant for consideration. The uptake of these initiatives is varied within the United Kingdom; however, these will now be discussed in the next part of this thesis.

Storytellers did not advocate a no restraint environment. Having undertaken this study, I have some reservations about a full implementation of this model of care in current care settings within the United Kingdom. The question remains open, as to whether aggression and violence would disappear in using such a model, or whether the existing settings in the United Kingdom, which legitimise restraint encourage a violent response from service users. Without addressing the latter, in how mental health care is organised, the prospect of a no restraint environment would appear to be idealistic or even utopian, and might be hard to achieve. Initiatives such as the Trieste model, incorporating a broader approach to mental health centred on the whole person and their social background, might point the way forward.

Programmes such as the REsTRAIN YOURSELF and The Safewards model as discussed in Chapter Two, provide frameworks which seek to improve staff-service user relationships, with less reliance on restraint, which may improve ward environments and the therapeutic alliance (Cabral & Carthy, 2017). It is argued that strategies such as Safewards can support the achievement of a therapeutic milieu including strengthened interactions between staff, service users, family and friends, as well as improvements in the physical ward environment (Bowers, 2014). Whilst the REsTRAIN YOURSELF attempts to achieve such with a focus on leadership towards organisational change

Organisational culture

Many health services are characterised by the low status of staff, operating under rigid professional hierarchies, with the predominance of particular forms of knowledge, such as biomedicine and less regard paid to the social perspective (Paterson et al., 2013). It is suggested that when staff feel disempowered, conformity with organisational rules and procedures including the use of coercion can become part of the care provided (Wardhaugh & Wilding, 1993). Staff may seek to regain self-esteem by misusing the power they have at work and may seek to restrain service users, negating the need to build a therapeutic alliance with them (Paterson et al., 2013). Narratives of biomedicine, power, control and violence are represented in the stories of this thesis and chime with the above. Weak leadership and inappropriate training, which fails to emphasise preventative approaches to reduce restraint, can often be a feature of organisations in which the use of restraint is misused (Paterson et al., 2013). The organisational culture is also central to other initiatives, such as the aforementioned REsTRAIN YOURSELF Programme. Such initiatives suggest practical ways forward for services to address restraint reduction, as part of a wider initiative to improve care.

Co-Production/expert by experience

Co-production needs to be considered as part of a whole systems approach, with consideration at macro-level which may present barriers. An example of this is the problem of loss in welfare benefits for some service users when involved in co-production (Boyle & Harris, 2009).

At a macro-level, organisations have a central role to play as frontline staff are pivotal to the success of co-production. Staff morale is as important as service user morale in achieving less fixed delivery-led services, therefore staff need more facilitative interpersonal skills (Needham & Carr, 2009). Asking people to step outside their comfort zones to share power can lead to an element of discomfort (National Development Team for Inclusion, 2016). Co-production is an area of practice which is considered in its widest context from the planning of policy and services, through to individualised care. This means that experts by experience have a voice, that power is shared with health care professionals and the potential for co-option of critical voices is resisted.

A strong presentation across all stories in this study was a presented narrative of expert by experience, as individual storytellers positioned themselves within empowered identities as their stories ended. Three of the four storytellers told of being involved as service user activists in paid capacities working within the healthcare system. All three reported supporting others as advocates and delivering training to health professionals. These identities would appear to be central to their continued recovery. These three storytellers describe themselves as experts by experience.

It is relevant to consider their positions in the context of co-production, where the benefits of lived experience are central to planning, supporting and delivering care. Furthermore, individuals offering expertise about their lived experiences support teaching of future nurses and other allied professionals (McKeown, et al., 2014). However, there is a risk that these role in services can be tokenistic, thus services should embrace the lived experiences of individuals and not see this as a ‘tick box’ exercise.

Narrative re-storying

The intersection between the individual narratives of participants and wider powerful discourses in society implies certain important recommendations. Most obviously, progressive change would appear to require conscious awareness of the role of such narratives in maintaining the status quo. At the macro social and professional level, it would be helpful for practitioner education and socialisation into caring roles to more fully address the inter-relationships between such narratives and how power is distributed in services and society. At the individual and micro-level of care relationships, narrative re-storying might be one way to build therapeutic alliances between service users and staff and might also be one way to develop support for individuals and communities (Grant, et al., 2015). The technological paradigm favours medication and psychological interventions to fit in with medicalised notions of mental health (Grant, 2015). The narratives of service users, with lived experience, is frequently viewed as anecdotal and/or diagnostically symptomatic, and as such irrelevant to traditional institutional psychiatric treatment (Grant, 2015; Johnstone, 2014; Thomas, 2014). Mental health professionals are socialised to a powerful expert narrative of individual deficit and medical illness (Johnstone, et al., 2018). The medical 'illness' narrative continues to be used by mental health professionals, yet it should not be another story that a service user is offered concerning their emotional distress or troubled/troubling behaviour (Johnstone, et al., 2018).

Lived experience knowledge should be a primary focus in understanding and helping people, within mental health nursing and a basis for a relationship which aims to support recovery (Grant, 2015). Mental health professionals need to cultivate more sophisticated levels of understanding and working with narrative in the work of recovery with service users (Grant, 2015). Nurses with the skills and willingness to develop narrative competence[53] may be an exception within services (Grant & Leigh-Phippard, 2014; Grant, Leigh-Phippard, & Short 2015). By sensitively focusing on the context, nuance and difference within and between an individual's experiences of distress, narratively competent practice becomes valuable for engaging service users in a recovery process as they are enabled to re-story their lives' (Grant, 2015).

Power, Threat, Meaning Framework

The Power, Threat, Meaning Framework is of interest because it explicitly attempts to inform care, help and support by foregrounding matters of power and deleterious life experiences in the course and amelioration of mental distress. It is beyond the scope of this thesis to give a detailed account of this

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[53] This term is in reference to the capacity for people to deeply absorb, interpret, and appropriately respond to the stories of others. Such practice facilitates ways in which to address service users' existential issues around inner hurt, despair, hope (Grant, 2015)

framework, and in part, this was introduced in Chapter Two and referred to in Chapters Five and Six. The framework offers a foundational document setting out a conceptual and empirical basis for working with a wide range of models, practices and theoretical/philosophical traditions (Johnstone et al., 2018). The framework looks at how power operates in people's lives and how that power affects a person (Johnstone et al., 2018). Additionally, the framework questions the meaning of experiences/situations and what a person has to do to survive (Johnstone et al., 2018). The framework recognises that mental health service are a source of negative power and threat, frequently traumatising and re-traumatising individuals (Grant & Gadsby, 2018).

The framework suggests several initiatives for working with individuals including the use of more hopeful narratives about their lives than those offered by psychiatric narratives (Johnstone et al., 2018). The framework also looks at the impact of social factors in mental health, such as poverty and inequality and offers ways to move forward, including therapy, standard interventions, per support, resources and community activism (Johnstone et al., 2018).

Moral and epistemic challenges

Teasing out practical remedies may only be part of the answer of what to do about physical restraint and its potentially damaging effects. Consideration of broader, more intangible questions, that are also prompted by the stories in this study and how they interact with wider literature. This could involve professionals directly confronting the more epistemic challenges that have been raised. These deeper moral, political and philosophical questions regarding the purpose of psychiatry as a container for social 'deviance', and how this renders practice purposively coercive in nature. A pessimistic stance might result in perpetually alienated staff, forever estranged from their preferred selfhood as caring, helpful practitioners; beset by the reflexive question, how can we ever get over this? Efforts to minimise restrictive practices, from this perspective, are perpetually doomed to scratching the surface and leaving the edifice of legitimated coercion intact. Yet, possibilities for much less coercive, more consensual services do exist, and the Trieste model is one example.

Critical commentators, including those following previous seminal authors such as Peter Sedgwick (Sedgwick 1982; Spandler, Moth, McKeown, & Greener, 2016), or coming from the emergent mad studies tendency (Russo & Beresford, 2014), have argued for the co-creation of newer, non-coercive forms (see Russo & Sweeney 2016). Such alternatives, whilst small-scale, may serve to prefigure, or show the way, for more substantial cultural shifts in the mainstream or a means of scaling up the alternatives. Notwithstanding there being no ready-made blueprint or roadmap to get to absolutely non-coercive mental health care. Attending to the stories offered by service users, such as exemplified in this study, may be part of a pointing towards more values-based, or moral, turn in services.

Proposals for future research

In undertaking this study, it is evident that published research studies from this service user perspective in this topic area are scarce. This study is unique in its narrative approach in this area and builds on the small body of available evidence. However, calls for further attention to the service user perspective in a variety of settings is needed.

Future narrative research with health care professionals could determine whether narrative evidence might improve outcomes for all involved with mental health care, including formal carers. There is published research around the nursing perspective on physical restraint, yet this is limited concerning the physical and emotional harm caused to nurses in undertaking restraint, with no studies published using a narrative approach.

Another under-researched group of individuals are informal carers of people who have been restrained. During recruitment, the mother of a service user contacted me and told of the devastating impact of physical restraint on her son. As a mother, she was clearly upset by her son's experiences and asserted that she too had a story to tell. The carer in question was motivated to talk about this topic. She relayed that her son was recently discharged from hospital and expressed concern about his involvement in this study, in fear of a deterioration in his mental health. During the literature review for this study, it became apparent that carers voices are silenced in this area of research. I am aware of only one study that has included informal carers as participants (Brophy et al., 2016) and they were not a distinct participant group, as participants also included service users.

What the study's stories teach healthcare professionals and others

From my perspective, in undertaking this narrative study and using interviews to collect data, service users were comfortable in telling their stories. Furthermore, one participant reported a therapeutic element in telling her story. Findings from the selected stories are presented in this thesis. I suggest that the most positive aspect throughout the stories is the reports of empowered identities and hope in attaining fulfilled lives. The stories of empowered identities and journeys should provide encouragement to others. These amazing people told stories of difficult times and storied their disempowered identities. They have come through these experiences and to a greater or lesser extent, found some positivity from their experiences. The stories teach all those working in health about the impact of physical restraint from a service user perspective. These stories reveal experiences that are emotionally challenging at times. It is appropriate that the perception of experiences such as those in this study, are heard by those delivering care to improve support to individuals and examine the role of power within institutions, which can be used both positively and negatively.

Arguably, the twin powerful narratives of neoliberalism and biomedicine, in particular, have exerted their influence throughout the conceiving and telling of these stories and I have needed to be alert to this in my analysis and discussion. The most obvious effect is the potential for such intertwined meta-narratives to constrain the discursive means by which individuals can make sense of their experiences and in turn give voice to them in the course of telling their story. One way of thinking about this is to question whether any one individual’s story does wholly belong to them.

If a person conceives of important aspects of their life and, particularly, psychic and emotional experiences as ‘illness’, then this may be a consequence of the normative social function of the overarching biomedical narrative; operating to close down alternate means of thinking and speaking about such experiences. In tandem with this can be a tacit acceptance, or even deference, to biomedical treatments as the only show in town. Similarly constraining is the intersection of neoliberal consumerism and psychiatric practice that legitimates the individual as the appropriate subject for intervention. So, for all the supposed informative value of the participants’ stories as told and interpreted in this thesis, there can be no absolute confidence that these stories are free of such constraints. From this perspective, we can only ‘know’ what we think we know; in effect, what we are allowed to know within the prevailing order of things.

That said, as Foucault himself reminds us, even the most powerful discourses inevitably potentiate discursive resistance. Here there is perhaps a more nuanced set of reflections possible, as to the value of aspects of the participants’ stories, and their expressed actions, for constituting or promoting change within mental health services. To some extent this involves an intellectual appraisal of the capacity for individual’s motivations to contribute to change, and their chosen strategies for achieving this, largely via enrolment in various user involvement and staff training initiatives, to escape a neutering, hegemonic pull into futile co-option. To a degree, such questions can be answered with recourse to appreciation, and corollary critique, of the power of hegemony.

In this vein, proponents and critics of the concept of hegemony identify various traps into which progressive activists might fall; in our case radical staff or service users attempting to escape the hegemonic constraints of biomedicine intertwined with neoliberalism. With regard to the narration of change within the individual life-journeys of the participant storytellers in this study, on the face of it most of them offer examples of personal resistance to and possible transcendence of the power of bio-psychiatry to define their experiences in a totalising fashion. Rory, for example, describes literally fighting the system; first physically and then at a more intellectual level with regard to involvement in staff training. Two of the other storytellers have also become involved in such institutionally sponsored programmes oriented to educative change. Within these tales can be glimpsed significant aspects of personal growth or even aspects of lives redeemed.

Beyond a surface appraisal of such efforts to make change, however, is a relatively easily made judgement that real transformations are denied within an overarching hegemonic pull to incorporation. Nevertheless, it is also worth noting that pointing out such a denial to these participants who have viscerally lived through the sharp end of psychiatric power and come out the other side willing to offer further pragmatic challenges may represent a somewhat choice irony. In this regard, an overly prescriptive emphasis on the power of discourse might actually serve to downplay the material and tangible reality of personally experiencing psychiatric power through coercive practices, such as restraint, and equally downplay the importance of available, if mundane, resistances. Arguably, for them, the opportunities to get involved in teaching staff from a service user perspective opens up one set of discursive spaces within which, however subtly or incrementally, dominant discourses can be undermined or subverted.

Working with anarchist and post-structuralist ideas, the Marxist notion of hegemony is critiqued for a perceived self-defeating impact and implications for individuals' personal goals, tactics and, ultimately, their hope and optimism that the better state of affairs they seek is indeed realisable. First, a reformist agenda is doomed to fail precisely because reforms can never escape co-option into the prevailing hegemony. In this sense, the 'Recovering our Stories' campaign (Costa et al. 2012: 85), organised within Canadian mad studies activist circles, is a 'small act of resistance' to the co-option of patients' stories under bio-psychiatric hegemony. Second, the enmeshment of psychiatric and state hegemonies further complicates aspirations for transformational change. If hegemony is, correctly, identified with state power, then arguably revolutionary ambitions to overthrow the state (or psychiatry) and replace it with another supposedly more benign version are doomed to reproduce similar failings of hegemonic power, albeit with an altered hegemony.

Interestingly, mad studies and associated place-based activism may have the potential to further resist hegemony in ways that involve neither rupture nor reform, offering possibilities for the prefiguration of situated alternatives or so-called autonomous zones, which may arise and survive, however fleetingly, to show different ways are possible. This is possible because even though hegemonic power is by definition oppressively constraining of counter-hegemonic resistance this may not, after all, be omnipresent or omnipotent. There will always be gaps, spaces and interstices wherein alternatives can be formed and worked with.

The aforementioned Sedgwick synthesised strands of Marxism and European anarchism to make the case for just such prefigurative tactics, whilst not losing sight of aspirations for larger transformations and the need for mental health support on a societal scale. A tentative case can be made that Frank's selective affinities for key writings from Foucault and Bakhtin, alongside his optimism for the power of stories to play a part in realising social change, locates him in a position broadly allied to Sedgwick and others' advocacy for the micro-social, relational politics of prefiguration. In this sense, the stories identified in my study and the actions narrated, at the point that they intersect with critique of the system and tactics for change, are criticisable for their largely reformist content and vulnerability to co-option. They, may also, however, be conceived as constituting their own small capacity for resistance or exist in the relational realm as minor inspirations or provocations to further resistance on the part of readers or listeners to the stories. I prefer to conclude my thesis by offering an optimistic view that alternatives can prevail in spite of a powerfully constraining hegemony.

Confirming Frank's aphorism that the story is never finalised, it never ends.

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APPENDICES

Appendix One

Link to published paper for integrative review

https://onlinelibrary.wiley.com/doi/epdf/10.1111/inm.12432

International Journal of
Mental Health Nursing

ORIGINAL ARTICLE

An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings

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Appendix Two

Sample of reflective diary entries

17/11/17

I met X today, I was a little apprehensive about talking to him, in part due to my fear of the unknown. He was relaying how he was in a high secure unit and talked of some of the background to this. I found this a little scary if I am honest. I will need to be mindful not to let this impede the interview. It did not appear to impact on the discussion we had about the research, so hopefully all will go well. I arranged to interview him next week

20/11/17

It was good speaking to… today as she is so clearly an inspiration for anyone who has been through the system. I was struck by her strength and insight. I find her very reflective, so perhaps therefore we got on so well. I feel she will be able to narrate her story in a powerful way. I could spend hours listening to her

22/11/17

I am starting to get a bit panicky about recruitment. I have just sufficient numbers who expressed an interest. Yet 2 have not got back to me about setting a date for interview and one has re-arranged his interview. I cannot decide what to do for the best. I do not want to harass people. Will this impact on my interview? I must try and relax around this issue, which is out of my control to some extent. I spoke to my thesis supervisor, who tells me this is normal.

14/12/17

I was able to undertake the fifth interview yesterday. Several preliminary thoughts are coming to mind about what people are telling me. Some issues about the survivor movement and the strength of this in people who come forward. Most are involved in training or jobs related to the lived experience of people who have were involved with the mental health system. Another issue is that restraint does not seem to be preceded by violence. So, this questions the idea that it is used in an emergency or when someone is at serious risk of harm. The other is the misuse of power and the associated shame people feel following restraint. A participant put it well yesterday. I am in hospital because I am ill, but I am informed I am badly behaved, which caused the restraint. So, which is it, am I ill or bad? The importance of language has also been in my thoughts recently. I was reading a post of a Facebook page, where the person did not find the term mental illness helpful. This led me to do a little research around his area. One of the areas that I looked at was the terms mental illness or mental disorder. Some people prefer other means of referring to people who have used the mental health system at some point in their life, others valued a diagnosis based on mental disorder. There is an argument to be had about the medicalisation of conditions. This also made think about the use of the term 'service user'- is it better to use client or consumer? Interesting areas for further thought.

9/1/17

Reflecting on the interview yesterday with a participant. I feel I did not quite connect with this participant. He made a comment about wanting to drive into *staff who restrained him, when he sees them at the bus stop. I felt he had a very macho approach, for example he said he attacked a patient and restrained another patient at the request of the staff because he was asked to help. I am conscious that this may be bravado, but his comments were quite upsetting, and I am aware that I need to reflect on this and not allow this to contaminate my analysis. I also discussed this in academic supervision, which was useful in helping to take a balanced view.*

Appendix Three

Potential agencies for recruitment

Mind Lancashire

Rethink

National Survivor User Network

Comensus

Mind (Manchester)

Appendix Four

Recruitment Poster

University of Central Lancashire

Research as part of a Professional Doctorate Degree study

Research

Physical Restraint

Listening to people's stories

Have you been Physically restrained* in a hospital Mental health ward ?

Are you over 18 ?

Would you be interested in taking part in a research project?

*experienced direct physical contact from a mental health professional to intentionally reduce your movement

If the answer is yes to these questions, I would like to hear from you.

Please contact: Pauline Cusack E mail pcusack@uclan.ac.uk or Tel: 01772 895112

Appendix Five

Blog

Research from university of Central Lancashire into the use of Physical Restraint

Hello all,

My name is Pauline Cusack and I am a lecturer at the University of Central Lancashire. As part of my Doctorate study, I am interested to interview service users in the UK about their experiences of physical restraint, whilst they were patients on a mental health ward This is to gain a patient perspective about how and why physical restraint has been used. I am interested in what impact this has had on patients before, during and after the physical restraint. I hope to use these findings to help improve practice on mental health wards.

There is some concern about the potential harm to individuals caused by physical restraint. It has the potential to cause both physical and psychological harm. There are particular concerns about physical restraint being used when an individual is placed face-down on a surface and is physically prevented from moving from this position, which can cause breathing difficulties and can be life threatening.

Physical restraint is undertaken by staff to prevent imminent harm to the patient or others. In the UK, there is Guidance by the Department of Health in 2014, which sets the policy in the UK to minimise interventions such as this.

I have already done a lot of reading about physical restraint and have written this up. I have also gained ethical approval to make sure that my research is done properly and within the right guidelines. The next part of the process is to ask people who have been physically restrained by staff, if they want to be involved in my research. This would involve people telling their story and me listening to them. This will be in the form of a one to one meeting, either in person, by Skype or over the phone. People who have told their stories would remain anonymous. Involvement is voluntary, so I would gain consent to be involved, from people who have expressed an interest in being involved

If you would like to be interviewed, please contact me at the following e mail address pcusack@uclan.ac.uk or telephone on 01772895112.

Thank you for taking the time to read this

Appendix Six

Participant Information Sheet

Title: Stories of service users and professionals regarding physical restraint

AN INVITATION TO TAKE PART IN A RESEARCH STUDY

My name is Pauline Cusack. I am a lecturer at the University of Central Lancashire. As part of my Professional Doctorate study, I am undertaking research about people's experiences of physical restraint within mental health wards. I want to find out about your experiences of physical restraint, which is when someone deliberately restricts a person's movements, liberty and/or freedom to act independently. If you feel able to talk to about your experiences of this, I would like to invite you to participate in the study.

Before deciding if you would like to participate or not, please take time to read the rest of this leaflet. If you wish to discuss taking part in this research with the researcher, please feel free to do so. I will be happy to answer any questions that you have before deciding if you wish to participate.

WHAT IS THIS STUDY ABOUT?

It is about finding out about your experiences of being physically restrained when you were an inpatient on an inpatient mental health ward.

WHAT IS THIS PURPOSE OF THIS STUDY?

To interview people who have had experience of physical restraint and hear about their experience. This will develop a better understanding of the impact of restraint on the lives of those who have experienced it. The findings will be used to inform and improve future care for service users on mental health wards.

WHO WILL BE INCLUDED IN THIS STUDY?

This will be adults over 18, who have experience of being physically restrained, whilst an inpatient. If you were involved in on-going legal action about the physical restraint, you would be unable to participate, as this may harm your case.

DO I HAVE TO TAKE PART?

No, you do not have to take part. If you decide that this is not for you. Your right to access services will not be affected.

BEFORE PARTICIPATING IN THE RESEARCH

You will be given information as to what you will be expected to do if you decide to participate in the research. Once you have read this information sheet, there will be opportunity for you to contact me to ask questions about the research.

If you are happy to participate, you can inform me directly. If you decide to participate, we can agree a convenient time and date for the interview to take place.

As stated above, any care that you are receiving will not be affected in any way should you not wish to participate.

WHAT WILL HAPPEN DURING THE RESEARCH?

Before participating, you will be asked to sign a consent form. If you wish, the form will be explained to you so that you are clear about what you are agreeing to do. If you agree to be interviewed this will take place at the University of Central Lancashire, or at local Rethink offices. Individuals who live some distance away from the North-West will be offered an interview by phone/Skype. We will agree a different name for you for the interview to protect your confidentiality. During the interview, you will be asked about your experiences about physical restraint whilst you were an inpatient on a mental health ward. The researcher is interested in what you have to say and your views about what you believe went well and what you think could be improved. With your permission, the interview will be audio-recorded. If you prefer not to have your interview, audio-recorded, written notes can be taken instead. The interview will last up to 60 minutes and what is said will remain confidential (please see below about confidentiality). At the end of the interview, the audio recording device will be turned off and there will be some time for you to talk about any aspects of the interview you found upsetting or difficult. This information will not be included in the research.

THE RIGHT TO WITHDRAW

You will be free to terminate the interview at any time. If you do decide to do so, the information you have given will be destroyed and not used in the research. Your participation is voluntary and you are free to withdraw, without giving a reason. Once the data is collected, however, it would not be possible to withdraw your interview responses.

WHAT HAPPENS AFTER THE INTERVIEW?

Once the interviews are complete any audio recordings will be transcribed, as explained above, and we will have changed your name to protect your confidentiality. I will analyse what has been said during the interview and will look across all the transcripts to see what the similarities and difference are. Once this work is complete I will write a report and all information in the report will be anonymised.

CONFIDENTIALITY

What is said will remain confidential between you and the researchers, (myself and my research supervisor). All locations, names and any identifiable information, which could breach your confidentiality, would be removed, for the purposes of the research. I must highlight that if you do tell me anything that is illegal, or suggests risk to self or others, I am duty bound to report it to the appropriate authorities.

WHAT ARE THE BENEFITS OF PARTICPATING IN THE RESEARCH?

The interviews will provide insights into whether physical restraint has any effects on people's physical or mental wellbeing. By talking about your experiences of physical restraint, it is hoped that practitioners will be better informed as to the impact of restraint. This will help develop a better understanding of the impact of physical restraint on the lives of those who have experienced it and use these experiences in helping to gain greater awareness from a service user perspective. It is not unusual for people to feel their contribution might help practice by telling their stories, in this case about physical restraint use.

WHAT ARE THE DRAWBACKS TO PARTICIPATING IN THE RESEARCH?

I do not expect there to be any disadvantages or risks to you during the study. I do however accept that being interviewed can, at times, be upsetting. The interview will only focus on your experience of physical restraint and at the end of the interview the opportunity to talk about anything you found uncomfortable to talk about, would not be part of the research. If you feel that you would like further support, I will be able to signpost you to additional help.

MAKING A COMPLAINT

If you wish to make a complaint about the research, you can contact the University Officer for Ethics (OfficerforEthics@uclan.ac.uk).

WHAT WILL HAPPEN TO THE RESULTS OF THE RESEARCH STUDY?

Findings will also be shared with people who have been participated in this research

It is the intention that the research findings will be written up as a research report and be also published in a journal. Names of participants will not be identified and confidentiality will be protected at all times.

SOURCES OF EMOTIONAL SUPPORT SHOULD YOU NEED THESE

Samaritans

Offering emotional support 24 hours a day

Tel: 116 123

Email: jo@samaritans.org

Web: www.samaritans.org

Sane Line

Offering specialist mental health emotional support 6-11pm every day.

You can also email through their website.

Tel: 0845 767 8000

Web: www.sane.org.uk

Mind

Lines are open 9am to 6pm, Monday to Friday (except for bank holidays).

0300 123 3393
info@mind.org.uk
Text: 86463

WHAT NEXT?

- If you would like to take part, contact details are available at the bottom of this sheet, so please contact me to confirm this. If you wish to ask any questions, please do not hesitate to contact me
- If you are unsure you may wish to talk to someone, you trust and feel will be able to help you make a decision as to whether or not to participate.

Researcher's name: Pauline Cusack

Phone number: 01772 89 5112

E-mail: pcusack@uclan.ac.uk

Thank you for taking time to read this leaflet

Appendix Seven

Consent form

University of Central Lancashire

CONSENT FORM

Full title of Project: **Title:** Stories of service users and professionals regarding physical restraint (Research as part of a Professional Doctorate Degree study).

Name, and position Researcher: Pauline Cusack, Professional Doctorate Student & Senior Lecturer.

Participant contact details……………………………………………………………….

Please read the following statements and initial the boxes to indicate your agreement

Please initial box

I confirm that I have read and understand the information sheet, dated ………….. for the above study and have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I understand that once the data is collected, it would not be possible to withdraw. Only if the interview is incomplete will data be destroyed ☐

I agree to take part in the above study. ☐

I agree that my data gathered in this study may be stored (after it has been anonymised) in a locked office on a computer with password protection, which is only known by the researcher. ☐

I understand that it will not be possible to withdraw my data once it has been collected. ☐

I agree to the interview being audio recorded (If you prefer not to have your interview audio recorded the researcher can make notes). ☐

I agree to the use of anonymised quotes in publications. ☐

I understand that the summary of findings is available to me as a participant should I wish to see these and details of participants will be anonymised. If I should want a copy I can write to Pauline Cusack at The School of Community Health and Midwifery, Room 217, Brook Building, Preston, PR12HE. ☐

______________________	______________	______________________
Name of Participant	Date	Signature
______________________	______________	______________________
Name of Researcher	Date	Signature

Appendix Eight

Socio-demographics of participants

Participant	**Age**	**Ethnicity**
Rory	39	Black British
Jane	41	White British
Finlay	43	White British
Rose	60	White British
Saul	25	Pakistani
Tom	44	White British
Mel	26	White British
Leonard	49	White British
Charlotte	53	White British
Jasmine	51	Greek
Cissie	36	White British

Appendix Nine

Interview Guide- Unstructured interview

Introduction

Background to project

Explain the purpose of interview

Check the participant understands the nature of the study

Obtain Consent-Consent forms completed- any questions about confidentiality or other aspects of research

Promote relaxed atmosphere by making conversation

Warm-up

Neutral, unthreatening questions

Factual information

General question

- Can you tell me about your experiences of being physically restrained on a mental health ward?

Follow up questions if necessary (following participant's ideas)

- What happened then?
- Can you tell me more about that?
- Who else was involved?

It is important to note that these questions are questions that aim to facilitate the telling.

Wind down

To finish with

Anything else that participant wants to add?

De-brief- How do you feel now having discussed your experiences

Check out what the participant knows what will happen with data

Thank the participant

Appendix Ten

Extract From interview transcript

I: Have you done these before?

R: Ages ago, yeah

I: Right ok, so we should be recording now. Firstly, it’s nice to meet you again and I wanted to say thank you for coming to the interview. So first of all, just to explain what we are going to do, I’m going to ask you a question, what I might do when you are speaking is I might make some notes but I won’t be asking lots of questions or interrupting. The idea is that you tell me your story. If you say something that I find interesting I’ll jot it down which is why you might see me jotting down notes and I might want you to expand on that, tell me more about it. So, first of all before we start with the interview question, can you tell me a little bit about yourself? Interests, hobbies, things like that?

R: I like football, I’ve got a good sense of humour, sometimes I can be a little abrupt and I don’t know I’m being abrupt. I can come across that way to other people. My sense of humour can be a little dark, I like watching films. I don’t drink, I don’t smoke. I like getting new clothes, stuff like that.

I: Yeah, what sort of films do you like watching?

R: All kinds really, I do like gangster films, but you have got to be in the right mind to watch films like that because they are a little negative. I like my comedies if they are good.

I: Me too.

R: I like my sci-fi, I liked Avatar.

I: Yeah.

R: It was a really good film.

I: Have you got a favourite film? What would that be?

R: It’s a good question, favourite film, do you know what I wouldn’t say I have got a favourite film I just like all different types of films for different reasons.

I: OK

R: No hang on, Jungle Book, the old one.

I: Yeah, I might be watching that tonight.

R: And the old Yellow Brick Road.

I; Yeah, yeah, yeah, Wizard of OZ, Yeah, yeah, good films.

R: They are really old, but they just have something about them.

I: I’m having my grand-daughter over tonight and looking after her, she is only four and I’ll be watching Jungle Book, because I thought what can we do? So, I got the old Jungle Book, I’ve got it from when my son was younger so yeah, so that we’ll be watching tonight. What about other interests for you? Do you support a particular team?

R: Yeah, I support Liverpool and England.

I: Not (Town)

R: No, not yet anyway, I haven’t been here long enough.

I: OK. So, do you go and watch Liverpool?

R: No, I don’t go and watch.

I: No, no it’s expensive isn’t it?

R: It’s not just that I’ve spent a lot of time locked up and sitting in a crowd of 60,000 people would give me a bit of a meltdown to be truthful.

I: Oh, right so crowds can be….

R: I’m not amazing with crowds, I can walk through a town centre when there’s crowds I’m fine, if it gets too many people I’m not good.

I: Like black Friday today?

R: Basically, yeah.

I: You keep out, I wouldn't blame you. I don't like crowds either. OK, so I know you told me we met before that've been on a few mental health wards, so I just wanted to know about your experiences of physical restraint. I am now going to ask you the interview question. So, can you tell me about your experience of being physically restrained on a mental health ward?

R: OK, well, I've been restrained at a place called (name of hospital).

I: Right.

R: I was unwell when I came in, I'd been in there about a week. I was having an argument with the staff. I don't remember what over. He's got in my space so there was a kettle on the side, I went to hit him with the kettle and then they just all jumped on me, restrained me, I'm shouting at them and screaming at them. They weren't hurting me too bad; it was hurting but nothing like getting beat up. So, they incapacitated my arms and my legs by holding them, so the only thing I had left was my head, so I was just smashing my head off the floor and they restrained me by pushing my head to the ground. They was shouting commands what they wanted me to do but I couldn't hear them cos he was pushing my head down to the ground, he had my ears blocked, so eventually they carried me into the strip cell. Chickened me up, which basically means my hands gone from locks to behind my back, they crossed my legs and then one person can control or restrain then cos they hold your arms and he is sitting on your legs crossed and then they shout all clear and they all ran out and slammed the door on me. I was in seclusion for three days. Immediately after the seclusion I had a sore throat cos of the screaming I was doing. My eyes were stinging cos I'd been crying, cos that's what you do. Not out of fear or it wasn't at that time I was just crying out of frustration. And yeah that's about it really, I was restrained there a couple of times in (hospital). They have got a shop you can go to, to buy stuff, it is still within the grounds and they said to me next week if you are good you'll be able to go yourself and buy your own stuff. That came and they wouldn't let me go they pulled me in an interview room and said you can't go. I said, why? They said because someone asked you what you was in (hospital) for and you told them, and you are not allowed to talk about your offences in here. So, I’ve walked out the interview room, slammed the door behind me, and I was walking down the corridor to my door and they just jumped on me. We ended up halfway down the corridor. I was trying to punch them when they grabbed my arms and put me on the floor, so I was kicking them and then one of the staff, big member of staff, has bear hugged my legs. Obviously I don’t think you’ve been restrained before but once someone takes control of your legs, see cos when you are fighting with people when you are getting restrained you sort of use your legs for leverages and strength to push in that direction or push in that direction but once your legs have been taken out the game there is not much you can do. So, I was trying to bite their hands and they were sort of, they don’t hurt you like they do in prisons, but they still hurt you. It’s like if you are in a lock and you try to maybe he has got your hand here in a lock and you try and bite his hand, like try and bite it or something, and they’ll pull your arm away and pull them self away but while he’s doing that it’s really hurting your arms and they are screaming at you to calm down and all this stuff. Yeah, so that restraint, I ended up in seclusion after that for about three weeks but immediately after when they put me in seclusion they’ve stripped me clothes off me, left me with a unrippable blanket. I think the first few times I was restrained in prison I’ve had my clothes taken off me and at first it feels a little bit indecent, but you sort of get used to it. It still feels indecent cos the first thing you do once they let you go in the strip cell and they’ve shut the door is try and wrap yourself up in in the blanket cos you’ve got unrippable blankets, but it’s still degrading. Another time I was restrained in (name) hospital I got on the roof, the wards, I don’t know there is about twenty wards there low secure, medium secure, super high and the wards are in L shapes. It’s two wards together in a L shape or a V shape however and this is when I was on the induction ward still. It was a couple of months after I’d had that fight over while being restrained in the canteen and I ended up getting on the roof. Because the wards are joined so you had the induction ward for mental health, which I was on (name of ward) and you had the induction ward for people with personality disorders, we called it the (name) ward. So, when I’ve got on the roof I’ve started smashing, I ripped the thing off like that and I’m smashing the windows, leaning over and smashing them. They were toughened glass, but it was working when I was smashing them, and they had to evacuate two wards. I caused over a quarter of a million pounds worth of damage, I'm not proud of it, I'm just reciting the build-up. So, I was up there a few hours, I self-harmed while I was up there and then the staff have got a negotiator to talk to me and he said if I come down no one is going to hurt me. So, I said ok so about half an hour later I decided to come down so I've hung off the roof, dropped to the floor and then they just shouted stay facing the wall so they've come up behind me, they all had riot gear on. They've put me in locks but kept me upright, bought me to the strip cell. Take into account they'd evacuated people of both of the wards, the two wards, so I'm the only person on this bloody ward. They've bought me into the strip cells, cut my clothes off me, didn't strip me, just cut them off me, then they've let go of my legs. So, my legs are long ways, and someone has come up behind me, I don't know who cos they all had riot gear on. I couldn't tell who what and he was put his hands on my bum and parted my arse cheeks to make sure, well I'm assuming, to make sure I didn't have no weapons or glass secreted on me. But in all the restraints I've had I have never had no one do that to me and even though I was unwell at the time. It still sticks out in my mind as, even to this day I feel like I was indecently assaulted. I feel like I was touched up in some way, it was just so. I've been battered in other restraints in other places and they feel horrible and they stick with me and I feel like it wasn't justified, but the restraint at (hospital) where he's parted me bum cheeks it's just the weird feeling that goes with it. I can't, like I've been touched up or something. I'd rather be battered by the police all day than go through that again. I think what added to it is the point that I was helpless I was restrained down on the bed I couldn't move and that's what they did before they came out of my cell and as usual eyes stinging through crying, sore throat through shouting and my arms, you know if you go to the gym and the next day you are aching all over, well that's what you get after restraint if you've been fighting them. Because it's basically like a workout you are pulling against them and pushing against them. I was aching, my arms were aching, my back was aching.

Appendix Eleven

Extract from a working example of analysis document

What does the story make narratable?

Victims can make victimisation narratable (and thus empowering)

The visible and compelling claims of experiences

How does the story change people's sense of what is possible, what is permitted and what is responsible or irresponsible?

The perception of resistance and a fight. (Characters-Here the storyteller is the protagonist, who justifies his action of hitting someone with a kettle, as a staff member got in his way when he was ill and not accountable of his actions) The staff members perhaps are seen as villains here as they *jumped on him*. In fact, Rory's use of language is interesting- *they all jumped on me*. He perceives himself as fighting back. At one stage in the story on of the nurses appear to be protecting his head as he smashed it in the floor, *I was just smashing my head off the floor and they restrained me by pushing my head to the ground,* this protective action appears to not be acknowledged, in this section on the story, but later when coming back to this, Rory saw this as protective.

He's got in my space so there was a kettle on the side, I went to hit him with the kettle and then they just all jumped on me, restrained me, I'm shouting at them and screaming at them. They weren't hurting me too bad; it was hurting but nothing like getting beat up. So, they incapacitated my arms and my legs by holding them

Here Rory, as the protagonist appears to see himself as victim to the unfairness of the nursing staff, again the language of fight, is repeated as staff are perceived to have ‘jumped on’ Rory.

On another occasion Rory seems himself as rendered helpless by the staff numbers and noted is the size of the staff member who he talked of having had bear hugged his legs- described as a ‘big’ staff member., perhaps an expression of clear motives to render Rory helpless. Here Rory is a pugilist who fights back, although outnumbered, but eventually resistance is futile. What is possible in his fighting back? Power at play here. Force has rendered him helpless. Violence present- is violence present in the system ? Trouble- is present for the storyteller as an action where he sought to avoid trouble; brings trouble and the storyteller struggles to make sense of this hostile response on behalf of staff. Suspense is at play as both the storyteller questions why this happened- it is left unanswered, as the voices of staff are silent in Rory’s telling of this story .A sense of irresponsibility- power at play.

they have got a shop you can go to, to buy stuff, it is still within the grounds and they said to me next week if you are good you’ll be able to go yourself and buy your own stuff………… so I’ve walked out the interview room, slammed the door behind me, and I was walking down the corridor to my door and they just jumped on me.

We ended up halfway down the corridor, I was trying to punch them when they grabbed my arms and put me on the floor, so I was kicking them and then one of the staff, big member of staff, has bear hugged my legs

In this sense: in reliving this event, the unjustness is presented by Rory. Staff response is a fight, their response is presented as irresponsible . He develops the story. Trouble is at play on both sides- again he is outnumbered (masculine identity). Rory develops this part of his story and presents the fight continuing down the corridor. *when I've started fighting with them and the corridors about the length of this corridor with loads of bedrooms on.* There is violence – as an agent of violence, but also recipient - restraint/care is violent, but legitimised.

And others are presented at having witnessed the fight (this character is another service user, who witnessed the event, perhaps positioned by Rory as an independent on looker, but still part of the 'group' of service users, to whom they both belonged. There was added drama to the extent that the restraint went on, underscoring the extent of the fight- all the way down the corridor, Rory again seeing himself as victim in this conversation with a group member- *"Don't even ask man they jumped me, I had my back to them and they jumped me".*

Rory perceived a lack of basic human rights (Character- Rory sees himself as being punished after restraint by indecency *it feels a little bit indecent* being stripped naked by staff, who are referred to as '*they' put me in seclusion*, stripping him of clothes, and perhaps dignity). There is a blanket provided by staff, which is used to protect decency/give warmth (Yet Rory sees it -*but it's still degrading)*. The staff may be viewed by Rory as slightly uncaring and perhaps this act is perceived as abusive as basic dignity is challenged by their actions. Care versus control – here staff are perceived as controlling. Trouble- dignity is threatened as the storyteller is stripped bare, presumably for his protection, the trouble for the staff is silenced- their intentions were presumably to prevent harm (i.e. hanging) to Rory. Slight suspense presented here as we can only guess at the motives of the staff were protective).

A sense of violation and sexual assault presented in Rory's story. (Character- here Rory, following an act of resistance on the roof- causing lots of damage, changes from being a fighter to a victim and the act of searching during restraint is seen as sexually abusive, trauma presented, with the faceless and nameless staff member- masked in riot gear - being the perpetrator of this abuse. Rory assumes motives were for searching for weapons yet feels violated and sees this as indecent. Rory talks of being unwell, but able to recall this event, as it was so dramatic for him; Trouble- this is deeply troubling to Rory and this incident comes back and forth in different ways throughout the story; this trouble has not gone away, as the Rory discussed sexually indecency *I was indecently assaulted. I feel like I was touched up in some way*. The staff members voices are silent here, where they troubled by weapon concealment? Morals- are also present here- the act is deeply immoral and disturbing for Rory *it still sticks out in my mind*. Suspense is at play- the listener may question the motives of staff- where they abusive; where they looking for weapons? This remains unanswered by the silence of the staff's story.

After this event, Rory talked of being moved to a different ward and not being updated where he was going (Character- here Rory sees himself further as victimised by staff- being told by staff that he was moving, but not informed to where. Is this a power issue? The staff's motives may have been to move him an environment that was more aligned to his needs at that time, but this is not presented as such. This causes some anxiety for Rory as he assumes he is going to prison, yet staff are presented to maintain the veil of secrecy until he arrives at a high security ward. Trouble- the act of silence on the part of staff is deeply troublesome as the storyteller does not know where he is going and experiences anxiety and some anger about the secrecy of the destination- fearing the worst.

Staff were silent on why just keep repeating- *We 're putting you on the van we're moving you* Was this an attempt to minimise further violence or a display of power? Rory restrained on the transport to the new facility. Morals- truth is challenged, Rory perceived this action to be against what should happen and staff ought to be open and have told him where he is going. Suspense- for the listener there are unanswered questions- where staff afraid of repercussions? Where they deliberately using a veil of concealment as a means of punishment /asserting power?

Feeling violated but looking back and suggesting that he was ill (illness narrative-has this been influenced from the outside in? Not responsible message) and may have misunderstood, the reasons for the staff's action, yet again there is mention of the time when on another occasion the perception of violation was real and not due to his illness. Illness label – why is this seen as misunderstanding? (Character – the story is told in the present when Rory is out of hospital, so the motives of staff as potential abusers changes, as there is suggestion from Rory now that his illness made see events differently, however the recollection of the incident following the roof ordeal is still visibly seen as abusive. My understanding here-This caused trouble at the time- to the extent of rioting on the roof. Is there an imposition of a professional narrative of 'illness' and impact of a bio-medical perception of illness. How has this impacted on Rory's experiences? Has this limited who Rory is or can be?

From Rory's perspective, the pain due to restraint was visible and was compared to other forms of pain that Rory storyteller has experienced when not being restrained. Note: staff are referred not by their names or roles (is this a case of them and us??). The pain is described as intense and Rory feels victim to this pain because of many incidents of restraint as staff's actions are framed as violent. (Trouble- this appears to cause some resentment for Rory, who sees this as a *nightmare*, *it's the pain of it, it's a dull, it's not sharp it's a dull, just like a bad toothache but in your wrist.* Morally- For Rory, pain in a therapeutic environment is wrong. Is there an issue about therapeutic milieu? Care versus control. Restraint is legitimised. Mental health care framed as violent. Power issues visible, whilst at other times they are presented, but less visible.

Restraint is seen as unjustified not only for Rory personally, but as witness, (Characters- So here the main character is the other service user, note how he is referred to by name- does this indicate group belonging? The main character here is vulnerable, due to his illness, so has a sick role. The staff are perceived by Rory as uncaring- with threats- '*stop or else'*. The fact that he was black is referred to here; perhaps to outline the ridiculousness of calling himself a monkey *he's running round doing monkey noises saying I'm a monkey I'm a monkey, he was a black lad* - this outlines his character as ill and distressed. Racism is not referred to. Is silence significant here? Staff are again not referred to by name or role- is this reflecting an impersonal view of staff? Staff are referred to by Rory has having *jumped on* the service user, injustice is inferred to at the end, witnessing this causes trouble for the Rory as he wants to stop it, he shows himself to display empathy, he knew the service user was unwell *he wasn't well*. Violence is presented in the witnessing of restraint. Trouble is at play for the service user, who is told as being unwell and may be challenging services by his actions? However, a strong response is questioned by Rory in how he tells this aspect of the story *they could've just grabbed him by his arm and said come on we've told you you're going in your room, but they ended up jumping on him*. Morally – he appears to question the staffs' actions in their approach. The suspense for the listener of the story- the visibility of Rory's story is presented in a way that makes claims by Rory in his experience of violence and trauma, questioning practice

In another witnessing, the main character is another service user, who again described as ill (Rory sees this as therefore not accountable perhaps for his racist language -*black bastard* -towards a staff member). Note- this is the first and only time the storyteller has used the staff members name in the whole story telling. Is this significant? Here the staff member is seen as *'getting a bee in his bonnet'* and lacking sensitivity to the patient's illness. The story from the staff perspective is absent here, but staff are storied to have *jumped* on this service user, which questions whether this was down to genuine concern about potential violence or whether it is a violent response from staff, or in defence of a staff member who was confronted with racist reference? The element of suspense here again lies in the actions of the staff- was this over-reactive, were there untold elements.

Signs that restraint is about to happen *a bell will be pushed* (Characters- staff are perhaps viewed by Rory, as heavy handed and reactive- all staff jumping on someone, or acting with a hint of conspiracy and planning- going away discussing tactics, taking action, The bell is storied as a sign of trouble to come for all, provoking anxiety and perhaps fear; visual prompts also are seen as an indicator that that something is going to happen- *may take their jumpers off so they've just got their t-shirts on and then they'll come out and you know there is going to be a restraint.* Suspense for the listener- I can almost put myself in the situation- the bell sounds, the jumpers come off- the audio and visual cues raise anxiety.

Restraints as planned in different locations (again characters are storied as using a plan of attack). A *pow wow* is an interesting expression and is suggestive of native American culture, does Rory teller perceive staff a distinct group? The number of staff increase as the story is told, is this done to elaborate a point? or is this how this has been witnessed? Again, the trouble here and closely connected to morals- is the sheer number of staff to patient in a restraint episode, as well as the approach that staff are perceived to taking- being jumped).

Does Rory's story tell of being judged and not engaged with? (Character Here the storyteller is a misunderstood character and uses a metaphor to powerfully explain this position to people)

I had a phrase that I feel like I'm a library book where people just read me and then just put me back and I said on the ward I need people to get to know me

From 'victim' to 'rescuer' (Character- here the character sees himself as wanting to come to the rescue- being the hero. He refers to people who have not been on wards as 'normal', so again does the bio-medical concept of illness play a part here? Rory makes connections with his showing empathy, wanting to help, but being intimated, which further victims the storyteller as witness. Not helping, perhaps feeling compelled to act/help and wanting to, but not doing so- was this an indication of perceiving boundaries? *you feel really bad for them, you don't know whether to go up and start shouting, and try and help them, all these emotions come with it.*

As Rory's storytelling concludes: not finalised, he changes his role from 'patient' to teacher, there is some empowerment present in the language and perception of self present (Character- here the storyteller has changed his role- he is fighting the system still, but through education and less hostile routes. He sees himself as the expert and staff are the ones who need to learn- they ask advice. Staff are storied here to acknowledge the incorrect approach- staff coming running out, everyone gets irate- *like a football match fight- is this a good idea?* In the discussion with staff about them running out of the office when the bell sounded- the staff themselves were troubled about this, questioning the morals or anxiety/distress of such violent action. Staff are storied as not happy with restraint this as they raise this looking to Rory, the expert by experience for advice. Aa sense of what is possible for Rory is presented as he uses his experiences to support change – the narrative of expert by experience. How far can experience help an individual gain entry into a system of power. How do power imbalances impact on this? Do experiences from experts by experiences impact change? In Rory's story he sees this as doing so. Staff ask: *do you think it's a good idea when loads of staff come running on and it makes everybody else feel irate and it turns into a football match fight? I said no it's not a good idea.*

Appendix Twelve

Ethical Approval

University of Central Lancashire

Date 7 June 2017

Joy Duxbury / Pauline
Cusack School of
Nursing
University of Central

Lancashire Dear Joy /

Pauline

Re: STEMH Ethics Committee Application Unique Reference Number: STEMH 619

The STEMH ethics committee has granted approval of your proposal application 'Stories of service users regarding physical restraint'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Additionally, STEMH Ethics Committee has listed the following recommendation(s) which it would prefer to be addressed. Please note, however, that the above decision will not be affected should you decide not to address any of these recommendation(s).

Should you decide to make any of these recommended amendments, please forward the amended documentation to roffice@uclan.ac.uk for its records and indicate, by completing the attached grid, which recommendations you have adopted. Please do not resubmit any documentation which you have **not** amended.

Yours sincerely

Ambreen
Chohan
Chair
STEMH Ethics Committee

* for research degree students this will be the final lapse date
NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

Response to STEMH Application Reference No (STEMH 619) Version No (1)

Recommendation	Applicant Response
1. Please consider revising point 2 on the consent form to make it clear that only if the interview is incomplete will data be destroyed.	Changed
2. Is the capacity to consent screening info not needed to prove individuals had this?	Changed
3. It is suggested on the consent form the address box may be more appropriate moved next to the statement that relates to whether they want a copy of the results.	Changed as per recommendation

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