Nurses’ Discourses of Challenging Behaviour in Inpatient Mental Health Services

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A thesis submitted in partial fulfilment of the requirements of the University of Lincoln for the degree of Doctor of Clinical Psychology

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Nurses working in acute mental health services are vulnerable to occupational stress. One main stressor identified has been the challenging behaviour of some service-users (Jenkins & Elliott, 2004). The impact of challenging behaviour is far reaching. It affects the health and safety of staff, service-users and carers, negatively impacts the overall experience of care (Beech & Leather, 2005; NICE, 2014; 2015) and can increase risk of abuse, isolation and neglect of service-users and increase stress and strain amongst caregivers (Emerson, Robertson, Gregory, Hatton, Kessissoglou, Hallam, & Hillery, 2000; Rose, Nelson, & Hardiman, 2016). Challenging behaviours, in particular incidents of violence and aggression, are a complex manifestation of a combination of characteristics. Challenging behaviour has been found to be the term most often cited as the reason for the use of restrictive interventions on incident forms (Ryan & Bowers, 2006). The use of unnecessary restrictive interventions has been widely criticised, particularly following the Winterbourne View Inquest (DoH, 2012) and national guidance states that it should only be used as a last resort to manage imminent risk (NICE, 2015a). A number of political drivers have attempted to end the use of unnecessary restrictive interventions (Mind, 2013). However, a Freedom Of Information request (FOI) made by Norman Lamb MP has found that the use of physical restraint on inpatient wards remains high. The central aim of this research was to explore how qualified mental health nurses construct the challenging behaviours they experience on the wards, and how they talk about its management.

A number of studies have explored how staff account for their treatment decisions and have shown how dominant practices are enabled and maintained through language (Harper, 1995; Parker, Gergaaca, Harper, McLoughlin & Stowell-Smith, 1995).

This research is informed by a critical realist stance. Semi-structured interviews were used to elicit talk about challenging behaviour and its management with seven voluntary participants, all inpatient mental health nurses recruited from the acute and PICU Wards of two NHS mental health
hospitals. Interviews were analysed using discourse analysis, informed by both discursive psychology (Potter & Wetherell, 1995) and Foucauldian discourse analysis (Foucault, 1979) approaches.

It was found that staff drew on a dominant biomedical discourse which acted to legitimise restrictive interventions and marginalise psychosocial and emotional constructs and approaches. Systemic discourses were also drawn on to both justify and criticise the use of coercive approaches and to position both staff and service-users as disempowered. Thus, challenging behaviour and restrictive interventions could be argued to represent tools for both groups to recover control.
Acknowledgements

I would like to thank my supervisors for their guidance and input throughout the process of this project, with particular thanks to Dr Anna Tickle and Dr Hanne Jakobsen.

I would like to thank my participants for their input and time given to talk to me, and all of those people who have shared with me their life stories, and experiences of inpatient mental health care during my work in this field.

I would like to thank my family and the Peaches (my second family) for all of their love, support, nurturing and inspirational conversations. I am very lucky to have two such wonderful families.

Finally, I would like to give special thanks to Sam Peach for all of his proof reading, encouragement and cups of tea. Most of all, I would like to thank him for his incredible and unlimited support that somehow manages to transcend the miles, time zones and limited access to communications often put between us.
Statement of Contribution

I, Amy Mellow, declare that this research is the product of my own work, conducted as part of the Trent Doctorate in Clinical Psychology. This research was developed in consultation with my research supervisors, Dr. Anna Tickle and Dr. Mark Gresswell, with early supervisory input from Dr. Mike Rennoldson and Dr. Simon Clarke, and my field supervisor Dr Hanne Jakobsen. I have been the sole researcher for this project, responsible for obtaining ethical approval, the collection and analysis of data and the write up of this thesis, with appropriate recognition given to others throughout.
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Systematic Review
Qualitative Systematic Literature Review: The Experience of Being in Seclusion for Adults with Mental Health Difficulties?¹

A systematic literature review of the lived experience of seclusion for adults with mental health difficulties.

Authors: Amy Mellow, Dr Mike Rennoldson, Dr Anna Tickle

Correspondence:

Conflict of Interest statement: This paper was written as a part of the Doctorate in Clinical Psychology. There are no conflicts of interest.

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Abstract

Aims: To conduct a systematic search of the peer-reviewed qualitative literature investigating the lived experience of seclusion for adults with mental health difficulties, to appraise the quality of the existing literature and synthesise findings. Background: Seclusion is a controversial intervention for the short-term management of unsafe behaviours in inpatient mental health services. There has been some sporadic interest in the service-users’ experiences of this. Design: Systematic literature review and meta-synthesis. Data Sources: Databases MEDLINE, EMBASE, CINAHL and PSYCHINFO were searched in July 2015. Review Methods: The JBI QARI tools for critical appraisal and data extraction were used to review papers and synthesise findings. Results: A small number of papers were found of mixed quality. Conclusions: Although most participants from the existing research described seclusion as mostly negative with the potential for causing iatrogenic harm, some described more positive experiences, often in the context of compassionate interactions with staff.

Summary Statement:

A systematic literature review and meta-synthesis of the existing qualitative literature investigating the lived experience of seclusion for adults with mental health difficulties was conducted. It was found that seclusion has the potential to cause iatrogenic harm, particularly where staff interactions are not experienced as compassionate.

Key Words

Qualitative, Systematic Review, Meta-Synthesis, Experience, Seclusion

Introduction

Seclusion, also known as supervised-confinement, is one of the oldest interventions still in use for those with mental health difficulties, but despite its common use it is considered controversial by many (McCoy & Garrtison 1983). Seclusion practices vary internationally and there is no clear, consistent definition (Happell & Harrow 2010). Common amongst these practices is the placement of the individual alone in a locked room for their
own protection and that of their environment with the aim of controlling unsafe and aggressive behaviours and allowing nursing and treatment interventions (Lendemeijer & Shortridge-Baggett 1997; Sailas & Fenton 2012; Happell & Harrow 2010). Despite controversies surrounding its use and policies stipulating it be used only as a last resort, seclusion continues to be a commonly used intervention on inpatient mental health units. In the UK an average of 21% of service-users admitted to wards were secluded, many on multiple occasions (van der Merwe et al. 2009). Parallels between isolation imposed for therapeutic reasons during seclusion and the isolation imposed as punishment in solitary confinement (Farrell & Dares 1996) and research exploring experiences within inpatient mental health settings have found seclusion to be harmful for many (Frueh et al. 2005).

Background

The proposed rationale for seclusion is that it provides three important elements to help the individual feel safe from external stimuli that may have led to disruptive behaviour; these are containment, isolation and a reduction in sensory stimulation (Gutheil 1978). This is based on the assumptions that increased sensitivity to sensory stimulation may be present in psychosis, and that those with a heightened sensitivity to environmental stimuli may be unable to tolerate competing sensory demands of an inpatient mental health unit (Wells 1972; Rosen & DiGiacomo 1978). However, the theoretical underpinnings of seclusion have received little investigative attention since and there has been little development to better understand this (Alty & Mason 1994). Current debate questions whether the use of seclusion is a therapeutic intervention, a form of emergency containment or punishment (Mason 1993).

Despite ethical dilemmas, guidance and protocols for the use of seclusion vary within the UK and are outlined by specific NHS or other hospital trusts (NICE 2015; NICE 2005). However, most recent UK national guidance stipulates seclusion must only be used on individual’s detained under the Mental Health Act, used only as a last resort and in accordance with core procedural standards and that the dignity of the individual must be upheld.
(NICE 2015). It is likely that there will be further differences in the use of seclusion internationally.

Research investigating the effectiveness of seclusion is contradictory. Some reviews have concluded that seclusion is an effective intervention in preventing violence and self-harm (Fisher 1994; Lendemeijer & Shortridge-Baggett 1997). However, a more recent systematic literature review concluded that there is no good quality evidence in support of this (Sailas & Fenton 2000). This is likely due to the impossibility of conducting randomised controlled trials ethically for such phenomenon. Another systematic review, including qualitative as well as quantitative research has concluded that due to the poor quality of existing literature, there is insufficient evidence on the effectiveness or safety of seclusion as a short-term intervention for the management of violence in adult inpatient mental health units (Nelstrop et al. 2006). Of note, seclusion has been found to have the potential to increase rather than reduce aggressive behaviour (Donat 2005). Interestingly, the reduction in use and elimination of seclusion has been found not to lead to an increase in staff injury (Ashcraft & Anthony 2008; Martin et al. 2008). Furthermore, a smaller recovery-oriented crisis service, found elimination of seclusion resulted in a decrease of yearly staff injuries from fifteen to five (Ashcraft & Anthony 2008).

For such a controversial intervention, it is vital to understand how it is experienced by those involved. Some studies have found that nurses are distressed by and dissatisfied with restrictive interventions such as seclusion (Moran et al. 2009; Duxbury & Whittington 2005). A review of the literature has concluded that most nurses view seclusion as a necessary intervention in the management of violence and aggression (Happell & Harrow 2010), and refer to strict protocols for the use of seclusion to appease ethical concerns (Muir-Cochrane 1996). Interest in service users’ experiences of seclusion has been sporadic, but as yet there has been no synthesis of these findings. It was considered timely to synthesise the published peer-reviewed research on the lived experience of seclusion for adults with mental health difficulties, to
further inform public policy and future research on the experience of seclusion.

The Review

Aims

There were three aims of this review: i) to conduct a systematic search of the existing peer-reviewed literature investigating the lived experience of seclusion for adults with mental health difficulties. ii) To critically appraise the quality of the existing literature. iii) To produce a synthesis of research findings.

Design

A systematic literature review of qualitative literature and meta-synthesis of findings was conducted. This followed the protocol outlined by the Joanna Briggs Institute (JBI: The Joanna Briggs Institute, 2009). A systematic search of the literature was carried out according to predefined inclusion and exclusion criteria. Papers that were selected for inclusion based on these criteria were then subjected to quality appraisal using the QARI quality appraisal checklist published by the JBI. The checklist for the assessment of quality in the QARI quality appraisal tool can be found as headings on Table 2. Findings from each paper were then extracted using the JBI QARI data extraction tool. Findings were then synthesised.

Search Method

Electronic searches of four academic and research databases in July 2015: Medline, EMBASE, Psychinfo and CINAHL. The following search terms were used: service user*, patient*, or client* and mental health, psychiatric or inpatient and experience*, perception*, perceive, attitude, impact*, describe*, description*, opinion* or feel* about and seclusion, patient seclusion, seclusion room, supervised confinement, confined, coercion, coercive intervention*, restrictive intervention*, physical restrain, restricted, segregat*, confinement or contain*. In addition, further studies were sought by hand search of the reference lists of all included studies and literature reviews found.
Inclusion Criteria

Qualitative research from peer-review journals was included if i) they focused on adult service-users’ experience of seclusion ii) they presented original data iii) the study participants had first-hand experience of being placed in seclusion.

Exclusion Criteria

Papers were excluded if they i) used quantitative analysis ii) did not focus on adult service-users’ first had experiences of seclusion iii) they did not present original data iv) it was not possible to disaggregate data of adults with mental health difficulties’ first hand experiences of being in seclusion.

Search Outcome

The search outcome and included studies are illustrated in the QUOROM Diagram (figure 1.) and the table of included studies (Table 1.) below:
Papers retrieved from database searches (MEDLINE, PSYCHINFO, EMBASE and CINAHL) (n=3656)

Articles selected for title/abstract review (n=237)

Articles excluded: Not about seclusion, not about experience of seclusion, not adult participants, not qualitative studies

Potentially eligible articles, full copy accessed (n=32)

Articles excluded: Not about the experience of seclusion, not adults, quantitative analysis, not original data, not service users’ experiences

Full text articles considered for inclusion (n=24)

Articles excluded: Not about the experience of seclusion, not adults, not original data, not qualitative analysis, not adults, not service users’ experiences, not possible to disaggregate data from adult service users on the experience of seclusion.

Hand Search (n=13)

Articles excluded: Not English language, quantitative analysis, not original data, not possible to disaggregate data from adult participants.

Articles included for review (n=11)
Table 1. Table of included studies

Key findings are presented as the themes presented in each paper.

<table>
<thead>
<tr>
<th>Paper Number</th>
<th>Author (Year)</th>
<th>Setting</th>
<th>Participants</th>
<th>Data Collection Method and analysis</th>
<th>Key Findings (Themes)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Wadeson &amp; Carpenter (1976)</td>
<td>1 inpatient clinical research unit, USA</td>
<td>n=62, Age 18-60</td>
<td>Drawings and comments during art therapy. Analysis not stated.</td>
<td>Hallucinations during seclusion, delusions during seclusion, intense affect and attending staff members.</td>
</tr>
<tr>
<td>2</td>
<td>Meehan et al. (2000)</td>
<td>2 inpatient units, Australia</td>
<td>n=12, Age 18-52</td>
<td>Semi-structured interviews. Meaning categorisation</td>
<td>Use of seclusion, emotional impact, sensory deprivation, maintaining control and staff-patient interaction</td>
</tr>
<tr>
<td>3</td>
<td>Kontio et al. (2012)</td>
<td>6 inpatient units (2 hospitals), Finland</td>
<td>n=30, Age 20-64</td>
<td>Focused interviews with open-ended questions. Inductive content analysis.</td>
<td>Not enough information regarding their situation, dissatisfaction with treatment by staff, emotional experiences during seclusion, problems relating to basic needs, lack of meaningful activities, positive experiences of communication, experiences after seclusion and suggestions for improvements.</td>
</tr>
<tr>
<td>4</td>
<td>El-Badri &amp; Mellsop (2008)</td>
<td>Out-patient clinics, New Zealand</td>
<td>n=56 (patients who had been secluded)</td>
<td>Questionnaires with closed ended questions and a section for qualitative comments. Content analysis</td>
<td>Negative emotional impact and positive effects.</td>
</tr>
<tr>
<td>6</td>
<td>Faschingbauer et al. (2013)</td>
<td>Inpatient unit, USA</td>
<td>n=12, Age 18-50</td>
<td>In-depth unstructured interviews. Phenomenological analysis.</td>
<td>Hope for respect and open communication, emotional response, insight into behaviour and positive coping skills.</td>
</tr>
<tr>
<td>7</td>
<td>Sambrano &amp; Cox (2013)</td>
<td>Outpatient setting, Australia</td>
<td>n=3, Age over 18 Indigenous Australians</td>
<td>In-depth unstructured interviews. Phenomenological analysis.</td>
<td>Police involvement and criminalisation of clients, experience of being punished, use of force, resistance and power dynamics and dehumanising effects.</td>
</tr>
<tr>
<td></td>
<td>Norris &amp; Kennedy (1992)</td>
<td>2 inpatient units, USA</td>
<td>n=20 Age 15-55</td>
<td>Questionnaires with face-to-face clarification interviews. Descriptive.</td>
<td>The seclusion room environment, events of seclusion, staff members, reasons for seclusion, feelings in and after seclusion, behaviour in seclusion and suggestions for improvements.</td>
</tr>
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</tr>
<tr>
<td>9</td>
<td>Thibeault et al. (2010)</td>
<td>1 inpatient unit, Canada</td>
<td>n=6 Age 20-75</td>
<td>Semi-structured interviews. Interpretive phenomenological analysis</td>
<td>Feelings</td>
</tr>
<tr>
<td>10</td>
<td>Richardson (1987)</td>
<td>4 inpatient units, USA</td>
<td>n=52 Age 19-67</td>
<td>Semi-structured interviews. Grid analysis.</td>
<td>Reasons for seclusion, negative and positive interactions, after seclusion, positive and negative change</td>
</tr>
<tr>
<td>11</td>
<td>Larue et al. (2013)</td>
<td>5 inpatient units, Canada</td>
<td>n=50 Age not stated</td>
<td>Structured interviews with closed and open-ended questions.</td>
<td>No alternatives offered, feeling protection from the outside world, loss of freedom and objects and proposed alternatives.</td>
</tr>
</tbody>
</table>

**Quality Appraisal**

The JBI Quality Appraisal and Review Instrument (QARI) tool was used to assess the quality of included studies. The QARI is a systematic tool for the quality appraisal of qualitative literature, it forms part of the JBI manual for systematic reviews and is advocated by the Journal of Advanced Nursing. However, a criticism of this tool is that criteria are rated in yes or no terms and the degree to which a criterion is met cannot be accounted for. For example, many of the papers included in this study, met criterion to varying levels. Further, a number of papers discussed ethical issues without stating obtainment of ethical approval but this cannot be accounted for if the QARI tool is followed strictly. A final criticism of the QARI tool is that it does not account for potential bias in participant selection, for example many papers stated that ward staff identified ‘appropriate’ participants.

The QARI tool assesses quality on ten criteria:

i) Whether there is a stated philosophical perspective of the research and whether this is congruent with the research methodology.

ii) Whether the research methodology is congruent or appropriate for the research questions.
iii) Whether the methods used for data-collection are congruent with or appropriate for the research methodology.

iv) Whether the representation and analysis of data are congruent with or appropriate for the research methodology.

v) Whether the results are interpreted in a way that is congruent with or appropriate to the methodology.

vi) Whether the potential influence of the researchers’ theoretical or cultural beliefs and values on the study are declared.

vii) Whether there is potential for the researcher to influence the research, or vice-versa. For example, does the researcher acknowledge their own role and relationship to participants in data collection or how they responded to events as they arose.

viii) Whether participants and their voices are represented, for example are findings illustrated with examples from the data.

ix) Whether the study is ethical, with a statement acknowledging ethical approval.

x) Whether conclusions drawn flow from the analysis of data.

The papers identified were characterised as a series of small-scale qualitative studies of mixed quality. Poorer quality papers, such as Richardson (1987) and Larue et al. (2013) did not adequately represent the participants’ voices, giving few quotations to illustrate their findings. Table 2 below illustrates the assessed quality of each of the included studies.
<table>
<thead>
<tr>
<th>Paper Number</th>
<th>Author</th>
<th>Congruity between philosophical perspective and research methodology</th>
<th>Congruity between research methodology and research questions</th>
<th>Congruity between research methodology and methods used to collect data</th>
<th>Congruity between research methodology and representation and analysis of data</th>
<th>Congruity between research methodology and the interpretation of results</th>
<th>Statement locating the researcher culturally or theoretically</th>
<th>The influence of the researcher is addressed</th>
<th>Participants and their voices are adequately represented</th>
<th>Conclusions drawn from the report flow from the analysis or interpretation of data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Wadeson &amp; Carpenter</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>2</td>
<td>Meehan et al.</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>3</td>
<td>Kontio et al.</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>4</td>
<td>El-Badri &amp; Melsop</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>5</td>
<td>Hoekstra et al.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>6</td>
<td>Faschingbauser et al.</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>7</td>
<td>Sambrano &amp; Cox</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>8</td>
<td>Norris &amp; Kennedy</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>9</td>
<td>Thibeault et al.</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td><strong>Not stated</strong></td>
</tr>
<tr>
<td>10</td>
<td>Richardson</td>
<td>✗ Not stated</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
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Data Abstraction

Data was extracted from all 11 papers using the QARI tool. Where possible themes were extracted as described by the authors with illustrative quotations from their participants. A criticism of the JBI QARI data extraction tool is that it restricts the extraction of data to clearly defined themes when used strictly. Therefore it was used flexibly in this synthesis to allow for the extraction of poorly defined themes.
Synthesis

The inductive approach to synthesise the extracted data is illustrated in Table 3 below. Themes were identified and extracted from the included papers and same themes were merged into one theme, a total of 25 themes were identified. An inductive approach was then used to synthesise these themes, they were initially grouped together based on similarity forming eleven subcategories. Subcategories were then reviewed and grouped together where they described a common process or experience forming five categories and leading to an overall synthesis of the literature. The five categories identified were i) Emotional Impact of Seclusion, ii) Environmental Experience of Seclusion, iii) Cognitive and Behavioural Responses to Being in Seclusion, iv) Making Sense of the Seclusion Experience and v) Role of staff, these and the overall synthesis of the literature are explored below. Table 3 below illustrates the inductive process of synthesis.
Table 3. Table to Illustrate the Inductive Synthesis Process

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subcategories</th>
<th>Categories</th>
<th>Synthesis</th>
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<tbody>
<tr>
<td>Negative Emotional Response (papers 1, 2, 3, 4, 5, 6, 8, 9, 10, 11)</td>
<td>Negative Emotional Experience</td>
<td>Emotional Impact of Seclusion</td>
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<tr>
<td>Positive effects (paper 4)</td>
<td>Positive Emotions</td>
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<td>The Seclusion Room Environment (papers 2, 3, 8)</td>
<td>Environmental Experience of Seclusion</td>
<td>Environmental Experience of Seclusion</td>
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<td>The Events of the Seclusion Process (paper 8)</td>
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<td>Delusions in Seclusion (paper 1)</td>
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<td>Hallucinations in Seclusion (paper 1)</td>
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<td>Behaviour in Seclusion (papers 8, 11,)</td>
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<td>Sensory Deprivation (paper 2)</td>
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<td>Maintaining Control (papers 2, 9)</td>
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<td>Resistance (paper 7)</td>
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<td>Need for Seclusion for Safety (paper 10)</td>
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<td>Coping (paper 5)</td>
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<td>Experience of Being Punished (papers 7, 2, 11, 4)</td>
<td>Perception of Being Punished</td>
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<td>Police Involvement in the Seclusion Process and the Criminalization of Clients (paper 7)</td>
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<td>Use of Force (paper 7)</td>
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<td>Autonomy (papers 5, 9)</td>
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<td>Problems Relating to Basic Needs (paper 3, 6)</td>
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<td>Power Dynamics and Dehumanising Effects of Treatment, Abuse and Neglect (papers 7, 4)</td>
<td>Dehumanising Effects of Seclusion</td>
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<td>Experiences Following Seclusion (papers 3,8, 10)</td>
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<td>Reasons for Seclusion (paper 8)</td>
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<td>Patient Insight into Behaviour and the Importance of Coping Skills (paper 6)</td>
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<td>Patient Hope for Respect and Open Communication (paper 6)</td>
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<td>Suggestions for Improvements (papers 3, 8)</td>
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<td>Positive Interactions with Staff (papers 1, 3, 8, 10, 11)</td>
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<td>Negative Interactions with Staff (papers 1, 2, 3, 5, 8, 10, 11)</td>
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<td>Seclusion has the potential to cause iatrogenic harm to adults with mental health difficulties when they are not adequately informed about seclusion (e.g. when and how it is used). The role of staff in the seclusion process is be vital, as positive descriptions of seclusion were experienced in the context of clear, open and compassionate communication and support throughout, including at debrief.</td>
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</table>
The Emotional Impact of Seclusion

Ten of the eleven included papers identified the emotional impact of seclusion as an important theme. All of these found that participants reported negative emotional experiences in seclusion. Two papers also found that some participants also reported positive effects of the seclusion experience (El-Badri & Mellsop 2008; Richardson 1987).

i) Negative Emotional Response

All papers reviewed, other than Sambrano and Cox (2013), identified themes of negative emotional responses to seclusion. These themes came under the titles of intense affect, emotional impact, emotional experiences, loneliness, autonomy, patient emotional response to the seclusion process and feelings. In common, participants from the included papers described feelings of fear, anger, frustration, powerlessness and sadness. For example:

…I was feeling very low, I couldn't have felt any lower I thought, until they put me in seclusion and then I realized you could go lower. But by then there was nothing I could do about it. They even take away your option to try and change your circumstances to try and lift your mood (Meehan et al. 2000 p. 373).

…I felt fear and anger, especially towards those who put me into the seclusion room. Nurses and physicians used power and authority over patients. I didn't know where I was and how long it lasted, it was terrible…. (Kontio et al. 2012 p. 19).

Another strong negative emotion that participants described experiencing both during the seclusion but also afterwards in lack of understanding from others.

I've talked about it with my dad and with my sister too. Somehow I feel it may even be incredible, in a way. As if what you feel and what you experience at such a time that this to other people is… that other people cannot fully live this experience (Hoekstra et al. 2004 p.180).
The only paper not to describe a theme for negative emotional responses was Sambrano and Cox (2013), but the anger participants felt when recounting their experiences comes across in their narratives:

…They would just take me to seclusion and just give me the injection! And they just leave me for the night let me out in the morning. You know? And when I’m there, and, Ahhh!! [Peter yells in anger]
(Sambrano and Cox 2013 p.525).

ii) Positive Emotions

Two of the papers, El-Badri and Mellsop (2008) and Richardson (1987) also described positive emotions in relation to the seclusion experience, under the theme of positive effects. One participant in their study commented on feeling ‘relieved I’m in good secure hands so I can get some sleep’ (p. 251). It is important to note that El-Badri and Mellsop (2008) used a questionnaire with closed ended questions and a space for qualitative comments. The ten closed ended questions in the questionnaire are not described in the paper. Further Richardson (1987) gives little evidence from the data to support her findings.

The Environmental Experience of Seclusion

Four of the included papers reported on the environmental experiences of seclusion, either the physical experience of the seclusion room itself or the events of the seclusion process. Other papers also described these aspects of the participants’ experiences of seclusion under different themes.

i) The Seclusion Room Environment

Three of the included papers explored the theme of the seclusion room environment under the titles the seclusion room environment, sensory deprivation and descriptions of problems relating to basic needs. However, other papers explored the environmental experience of seclusion under other themes such as suggestions for improvements, loss of freedom and objects and punishment. Participants from studies described the sense of being
‘…locked up with all my problems and bewilderment’ (Wadeson & Carpenter 1976 p. 322). Most striking were consistent reports about the lack of access to facilities to meet basic needs:

…I kicked the door a long time so that they could understand my need to get to the toilet. Once I relieved myself on the porridge plate and put two sandwiches on it to prevent the smell…’ (Kontio et al. 2012 p. 19).

…I was dirty, I sweated all the time. They washed my hair once a week and I didn’t have a chance to brush my teeth. I was thirsty and I peed into the floor-drain… (Kontio et al. 2012 p. 19).

ii) The Events of Seclusion

One paper, Norris and Kennedy (1992) described how participants reported that the physical events of seclusion, such as disrobing and the locking of the door were experienced to be ‘frightening’, ‘humiliating’ and ‘dehumanizing’ (Norris & Kennedy 1992 p. 10), this is echoed by other papers under different themes, such as Emotional Impact:

It’s humiliating, having male staff seeing me naked and you’ve got to face them… Yeah, there was females ere too, but they don’t care if there’s male staff watching while you’re naked, couldn’t care less (Meehan et al. 2000 p. 373).

The Cognitive and Behavioural Responses to Being in Seclusion

Seven papers discussed how participants responded cognitively and behaviourally to their experiences in seclusion. In particular was the impact of seclusion on psychological symptoms and how they coped with seclusion.

i) Effects of Seclusion on Psychological Symptoms

Four papers explored the effects of seclusion on psychological symptoms, such as agitation, hallucinations, delusions and the effects of sensory deprivation. These are symptoms that are described by participants as a direct response to or amplified by the experience of being placed in seclusion, but are perceived as signs of illness or reasons for needing seclusion by stuff.
Such experiences, other than hallucinations, were consistently distressing for the participants involved:

*I was locked in a gas chamber – behind bars. I was afraid of punishment but I don’t remember for what. The room looked the same, but it was a gas chamber. I was waiting for the gas. There were strange odors and heat… Other patients had written obscenities on the wall. They were there for me – that’s what my friends thought of me* (Wadeson & Carpenter 1976 p. 322).

*…the silence starts to drive you mad except for that blowing sound [fan in the ceiling] so you start talking to yourself, trying to keep yourself, you know, sane* (Meehan et al. 2000 p. 374).

In contrast, Wadeson and Carpenter (1976) described how positive experiences of hallucinations in seclusion outweighed the negatives. Positive hallucinations were described as uplifting and reassuring; there is a possibility that these were a coping mechanism for those participants:

*He [Mao Tse Tung] told me in Chinese to keep peace in the world. It was a surprising psychic communication… I felt important* (Wadeson & Carpenter 1976 p. 320).

**ii) Coping**

Four papers illustrated how participants coped with their experiences in seclusion. For example through comforting hallucinations, but also by maintaining control by talking to themselves, singing and resistance. Others described submission as a form of coping:

*I just paced around, sung to myself, talked to myself did all these stupid little things that you do when you’ve got nothing else to do and you can’t go no where else* (Meehan et al. 2000 p. 374).

*I just became so distressed that I didn’t speak and stopped talking and just stopped moving and just thought maybe if I just keep still enough they’d come in and let me go out I didn’t dare talk to anyone or do
Making Sense of the Seclusion Experience

The way in which participants made sense of their seclusion experience was identified in all eleven of the included papers. Many made sense of their seclusion experience as a form of punishment and described it as a dehumanising experience. Participants’ reflections on their understanding, or lack of understanding about seclusion were also identified. Participants from the papers were able to reflect on their experiences and suggest improvements.

i) Perception of Being Punished

Four of the included papers described themes where participants perceived their experiences in seclusion as punishment or made sense of the experience as coercive and punishing. This was described under themes of the experience of being punished, the involvement of police in the seclusion process and the criminalisation of clients and the use of force. Feelings of punishment are also described as a part of other themes, such as delusions in seclusion and the emotional impact of the seclusion experience:

*Or something just to show, don’t mess with them. Don’t mess with their standards and all that kind of stuff coz you get locked up* (Sambrano & Cox 2013 p. 525).

One participant described feeling like a ‘prisoner without having done anything criminal’ (El-Badri & Mellsop 2008 p. 250).

ii) Dehumanising Effects of Seclusion

Eight of the included papers described how participants made sense of their seclusion experience as dehumanising and humiliating. This came under themes of punishment, autonomy and problems relating to basic needs and was echoed in themes describing the emotional experience of seclusion and a sense of a loss of dignity and basic human rights:

*anything, you know cause I was frightened I’d go back in* (Meehan et al. 2000 p. 374).
...terrified not being told why I had been locked in this dark room on a mattress on the floor. I felt like a caged animal… (El-Badri & Mellsop 2008 p. 250).

I don’t ever have a problem urinating myself, never. I could use the bathroom just fine, I can talk just fine, I can walk just fine. But to urinate myself and do that just because I was not given the chance to go to the bathroom. They refused to give me a pillow. They refused everything. All my rights were gone (Faschingbauer et al. 2013 p. 36).

iii) Understanding of Seclusion

Two of the included papers illustrated themes of participants not being informed of or understanding the reasons for their placement in seclusion. A lack of prior knowledge of the use and process of seclusion was also identified:

…I didn’t understand why they put me into the seclusion room and I never got information on this. The staff was reluctant to provide information on why, and how long, what next… (Kontio et al. 2012).

However, some participants described understanding the experience to be more positive and helpful, particularly following debrief:

…They told me how aggressive and unpredictable I was before seclusion. I understood that this was the only alternative and a part of my treatment… (Kontio et al. 2012 p.20).

iv) Suggestions for Improvements

Many participants in the papers were able to reflect on their experiences of seclusion and volunteer suggested improvements. These were for more sensory stimulation in the seclusion room itself and for more interpersonal support from staff:

I reckon they should have paintings on the walls or on the roof or something... I don’t know, anything to keep your mind occupied… I think it was worse for me in a way because I was so bored… (Meehan et al 2000).
Talk about it – talk through the feelings and offer some kind of touching that would be reassuring (Norris & Kennedy 1992 p. 12).

The Role of Staff

All but one of the included papers (El-Badri & Mellsop 2008) presented themes exploring the role of staff as an important aspect of the experience of seclusion. The role of staff was important, not just in terms of positive and negative interactions with participants when they were in seclusion, but also in terms of their understanding of that individual and their provision or lack of provision of support in understanding the seclusion process and making sense of the experience.

i) Interactions with Staff

Participants discussed their interactions with staff in eight of the papers. Both positive and negative aspects of participants' interactions with staff were reported. Staff members attending the seclusion room were either described as 'compassionate' or 'the silent guard' (Wadeson & Carpenter 1976 p. 324). Positive aspects of interactions with staff, where clear communication, support and understanding were shown, was described in five papers:

*For me I remember that I was about to start screaming but that this nurse stroked my hair and I thought that was such a sweet thing to do. I was deeply moved, and then I calmed down completely and the urge to scream was over. Just that little gesture of stroking my hair. Yes I thought it was very sweet* (Hoekstra et al. 2004).

In contrast the negative aspects were about poor quality interactions and a lack of communication or concern was identified in seven papers:

*…the staff is for patients. I did not like it that two nurses stood indifferently near me in the seclusion room and talked by themselves…* (Kontio et al. 2012 p. 20).

ii) Understanding and Knowledge
The role of staff in understanding and knowing the individual key. Participants from two papers described how if staff had better understood them or had known about their backgrounds and treatment plans they would not have been secluded:

*I feel that if they’d have known that I was claustrophobic and a little of my background, the outcome could have been different. I mean being cooped up in one floor, you can’t really exercise. And that’s how I was trying; normally I would blow off steam that away*… (Faschingbauer et al 2013).

The overall synthesis of the existing qualitative literature on the lived experience of seclusion for adults with mental health is that seclusion has the potential to cause iatrogenic harm. The role that staff members play in seclusion is key to whether the experience of seclusion is to be harmful or helpful. Clear, open and compassionate interactions and support from staff, including during debrief were described in the context of more positive experiences. Harmful experiences were described in the context of uncompassionate care, inadequate support, information and inattention to basic human needs.

**Discussion**

This paper set out to conduct a systematic search of the existing literature on the first-hand experiences of seclusion for adults with mental health difficulties, to appraise the literature and synthesise findings. A small number of small-scale qualitative studies of varying quality were found. These explored the experience of seclusion using questionnaires and interviews conducted in Australia, New Zealand, Finland, The Netherlands, Canada and USA and dated from 1976 to 2013. Interestingly, no qualitative research investigating the lived experience of being placed in seclusion was found from UK.

Seclusion is a controversial treatment used on inpatient mental health units for the short-term management of potentially dangerous behaviour. Guidelines stipulate that it must only be used as a last resort and measures should be taken to ensure that the dignity of service users is upheld.
throughout the seclusion process. Despite controversy, there is very little scientific research investigating the underlying theoretical principles proposing the use of seclusion.

Although NICE only recently revised their guidelines for the use of seclusion in the UK this year, previous guidelines had stipulated that seclusion was only to be used as a last resort in the short term management for violent or aggressive behaviour (NICE 2005). This is echoed by guidelines for the use of seclusion in other western countries, such as the USA, Australia, and Canada (El-Badri & Mellsop 2008; Faschingbauer et al. 2013; Larue et al. 2013). Experiences recounted by participants suggest that these guidelines may not always be followed in clinical practice. The studies included in this review were conducted across different geographical regions with a wide temporal range dating from 1976 to 2013. A criticism of the JBI review method is that it does not account for potential cultural differences. However, unexpectedly this review found that findings about the experience of seclusion were consistent across countries and time periods and did not reflect these cultural differences. This finding may indicate cause for concern if the experience of seclusion does not change in line with changes in guidelines and attitudes towards those with mental health difficulties. It is inexcusable that in the 21st century individuals are exposed to situations where treatment is experienced as punishing, or where they do not have access to facilities in order to attend to their basic needs, such as going to the toilet. Further research is needed to explore why this might be. However, positive experiences also illustrated the importance of clear and open communication from staff and the importance of compassionate care and working to understand the person and to support them in learning from their own behaviour. It is important staff are made aware of the potential seclusion holds for causing iatrogenic harm and how their own individual actions may contribute to or prevent that.

Evidence on the effectiveness of seclusion is lacking, with some reviews reporting that it is an effective intervention for the short-management of aggression, others highlighting the poor quality of such research and potential biases. One of the findings identified in this systematic literature review was
the participants described that the seclusion process led them to become submissive and hopeless. This is an important observation that needs to be acknowledged. It raises the question whether the use of seclusion aims to help individuals manage their distress or aims to coerce individuals to behave in a more desirable manner.

Gutheil (1978) described observations on the theoretical underpinnings of seclusion. He described that seclusion works on the basis of containment, isolation and reduced sensory input. Whilst some participants in the existing literature described how containment, being restricted to a safe place where they were unable to harm themselves or others was helpful, many described the experiences that contradict the theoretical propositions of seclusion. For example, this synthesis identified that for many reduced sensory stimulation had the opposite effect to what would be expected from Gutheil’s observations of isolation in seclusion and therapeutic aims of seclusion. Participants from the existing literature described negative effects of sensory stimulation, and described ways of coping such as singing or becoming more agitated to cope with this. These coping behaviours in response to the unusual experience of being placed in seclusion run the risk of being interpreted by staff as pathological. Therefore it is vital that staff members are able to understand how individuals may express and cope with distress. Gutheil’s observations on isolation are again contradicted. Those participants who described more positive experiences of seclusion often did so in the context of compassionate interactions with staff and knowing that they were not alone. Many described that the experience of feeling alone increased their distress. Further research investigating the positive experiences of seclusion is necessary. It is clear from the synthesis that the role of staff and the quality of their communication, relationship and interactions with the individual is very important.

Conclusion

The overall synthesis of findings concluded that seclusion has the potential to cause iatrogenic harm to adults with mental health difficulties. The role of staff is key to whether the experience is recounted as positive or negative. If this is
true, then there are indications for staff to understand and be sensitive to how their interactions may minimise or maximise iatrogenic harm. It must be clear to all how, when and why seclusion may be used. Staff must be compassionate towards the individuals’ distress throughout the seclusion process. There must be a debrief to allow the individual time to talk about their feelings and reflect on their experiences following seclusion. Further research is needed to identify a theoretical basis and better understand those processes that lead to it becoming a helpful or harmful intervention in order to eliminate the risk of iatrogenic harm.

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Journal Paper
Nurses’ Discourses of Challenging Behaviour in Inpatient Mental Health Services

1. Abstract

Nurses working in acute mental health services are vulnerable to occupational stress. One stressor identified is the challenging behaviour of some service-users (Jenkins & Elliott, 2004). The present study is concerned with the discourses drawn on by nurses to understand challenging behaviour and talk about its management. Nurses working on acute and psychiatric intensive care (PICU) wards were interviewed and data was analysed using Discourse Analysis. Biomedical and systemic discourses were found to be dominant. Alternative psychosocial and emotional discourses were drawn on by some participants but marginalised by the dominant biomedical construction of challenging behaviour.

Key Words

Discourse analysis, challenging behaviour, inpatient, mental health, qualitative, restraint, seclusion

2. Background

Nurses working in acute mental health services are a group of health care professionals particularly vulnerable to occupational stress and burnout, with key stressors identified as a lack of adequate staffing levels and “physically threatening, difficult or demeaning patients” (Jenkins & Elliott, 2004 p. 627). Between 2013 and 2014 more than 5% of those who spent time admitted to inpatient mental health services were subject to at least one incident of physical restraint, and 1% were subject to more than five incidents of restraint. (Health & Social Care Information Centre, 2015). A further 4% were subjected to at least one episode of seclusion (Care Quality Commission (CQC), 2010). These figures indicate restrictive interventions are frequently used to manage behaviour in inpatient mental health services and an ethnographic study has identified that challenging behaviour and the use of restrictive interventions represent a struggle for control between staff and service-users in inpatient

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mental health services (Breeze & Repper, 1998). Challenging behaviour (CB) is a term adopted from the learning disabilities literature where evidence-based alternatives to restrictive interventions, such as Positive Behaviour Support (PBS), aim to reduce CBs by promoting wellbeing (Brown, Shawe-Taylor, & Swan, 2017). In particular, PBS is considered to hold potential for improving practice in mental health services (Brown et al., 2017).

The risk of assault for mental health nurses is high (National Institute for Clinical Excellence (NICE), 2014 Robinson & Grant, 2017; Wright et al., 2005) and the impact of all CB is far reaching. It affects the health and safety of staff, service-users and carers and is associated with a negative experience of care (Beech & Leather, 2005; NICE, 2014; 2015). Further, it can increase risk of abuse, isolation and neglect of service-users and stress and strain amongst caregivers (Emerson, et al., 2000). This is particularly relevant to inpatient settings for vulnerable people, including those with mental health difficulties, where systemic pressures are high and there is a reliance on low paid and often undervalued workers. This has been demonstrated in a number of public inquiries, most infamously the inquiry into Winterbourne View (Department of Health (DoH), 2012). CBs, in particular violence and aggression, are a complex manifestation of a combination of characteristics. These are not limited to the aggressor’s disposition but, importantly, include attitudes of surrounding people, such as staff members, and the physical environment, particularly those that limit the service-user’s freedom, like the inpatient mental health ward (Farrell, Shaffei, & Salmon, 2010; NICE, 2014). The experience or threat of aggression is likely to influence nurses’ attitudes towards their work with service-users and has negative effects on staff wellbeing and the quality of care delivered (Arnetz & Arnetz, 2001; Stanko, 2002). Attributions of aggressive behaviour can influence a team’s subsequent response to it (Collins, 1994; Whittington & Higgins, 2002).

Weiner’s (1972) theory of attributions proposes that our attitude towards a behaviour depends on how much control we believe the person to have over their behaviour and its outcome, and whether we believe it is capable of changing. Nurses’ attributions of behaviour has been found to differ depending on the diagnostic label the person has been given, with those
labelled with personality disorders considered to be more in control of their behaviour than others (Markham & Trower, 2003).

Staff and service-users hold different views on the precursors of incidents of violent or aggressive behaviour. One study identified that service users perceive the main precursors to be poor communication and environmental conditions whilst staff named the main reason to be the service-user's mental illness (Duxbury & Whittington, 2005). It has also been found that a large proportion of staff see a person's behaviour to be intentional and that this increases the likeliness of inappropriate responses (Hastings, Reed & Watts, 1997). However, during interviews, Duxbury and Whittington (2005) found nurses and service-users expressed dissatisfaction with the under-resourced and restrictive services provided.

Behavioural theories propose the environment, including other people, is key in the understanding of CB and that CBs are functional and maintained by their consequences (Skinner, 1974). In contrast, a biomedical view would propose that such behaviours in mental illness have a physiological basis and require medication (Double, 2002; 2013; Engel, 1977).

Training that aims to enable prevention, de-escalation and management of challenging behaviours is now mandatory for all NHS Staff working in inpatient mental health settings (NHS Security Management Service, 2005). However, the evidence-base for the effectiveness of such training is questionable (Lee et al., 2001; Rogers, Ghroum, Benson, Forward, & Gournay, 2006; Rogers, et al., 2007). Guidelines stipulate this training must emphasise prevention and that non-physical interventions, such as verbal de-escalation, are used as a first response. Restrictive interventions, which include physical interventions such as restraint and seclusion, must only be used as a last resort (NHS Security Management Service, 2005).

Service-users have reported that they believe restrictive interventions are not only used as a last resort (Fish & Culshaw, 2005). Further, some services that claim so, did this without adequate exploration of the root-cause of the behaviour (Paterson & Duxbury, 2007). Menzies-Lyth (1960) proposed that healthcare institutions organise themselves to defend against staff anxiety,
triggered by caring for people in distress, and that this could lead to practices that are contrary to guidelines.

The psychological and physical risks of restrictive interventions are serious, including injuries for both staff and service-users (Lancaster, Whittington, Lane, Riley & Meehan, 2008) and links to a number of service-user deaths (Mind, 2013; Paterson, et al., 2003). The experience of restrictive interventions has been found to be distressing for staff and service-users alike (Bonner, Lowe, Racliffe, & Wellman, 2002). Psychologically for service-users, the experience of being restrained is distressing, disempowering and retraumatising, leading to feelings of fear, frustration and anger, thus increasing risk of further aggression (Bonner et al., 2002; Fish & Culshaw, 2005; Mind, 2013; Sequiera & Halstead, 2002). Likewise, the experience of seclusion has been found to have the potential for iatrogenic harm (Frueh, et al., 2005; Mellow, Tickle & Rennoldson, 2017). This counters the aim of supporting people to recover from mental health difficulties.

Consequently, political drivers aim to reduce restrictive interventions (Mind, 2013; NICE, 2014; NHS Security Management Service, 2005). Previous attempts at this have had little impact on staff attitudes towards them over time (Sailas & Wahlbeck, 2005). Further, research in learning disability settings has found that staff have difficulty applying individualised guidelines for the management of CB. This is due to staff inconsistency, limited knowledge, and time to discuss guidelines and staff attributions of the behaviour as deliberate (McKenzie, McLean, Megson & Reid, 2005).

However, there is an absence in the literature as to the barriers of implementing broader guidelines, and training interventions to resolve this have been found ineffective (Hahn, Needham, Abderhalden, Duxbury, & Halfens, 2006).

Research has found guidelines for the use of restrictive intervention only as a last resort are not necessarily translated into practice. Fewer than half of staff working on psychiatric intensive care units (PICUs) across England and Wales rated verbal de-escalation as one of their three most used techniques (Lee et al., 2001; Wright et al., 2005). Decisions to use restrictive
interventions are reported to be influenced by contextual demands, a reported lack of alternatives, perceptions of risk and the escalatory effects of restrictive interventions themselves (Perkins, Prosser, Riley, & Whittington, 2012). Further, restrictive interventions have been found to be used for the management of incidents other than violence and aggression, the term ‘challenging behaviour’ has been found to be the most often cited reason for the use of restrictive interventions on incident forms (Ryan & Bowers, 2006). A review by Stewart, Bowers, Simpson, Ryan and Tziggili (2009) demonstrated that more robust studies point to a range of behaviours, including attempts to abscond and noncompliance.

Wider management of CB in inpatient mental health settings is a topic that attracts ambivalence. Conflict arises in the competing demands of delivering care and needing to remain in control where there are high levels of distress and crisis, with aspects of care involving containment to manage risks (Mind, 2013; Vassilev & Pilgrim, 2009). The heterogeneity of behaviours and the disorders presenting in inpatient mental health services make CB difficult to define. This study adopts Emerson’s (2001) broad definition that incorporates behaviour other than violence and aggression as indicated by existing research (Stewart et al., 2009; Farrell et al., 2010):

   Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities (Emerson, 1995; cited in Emerson, 2001).

Estimation of the prevalence of CB is also difficult. However, one study found that 75% of men and 53% of women during their first admission presented with aggressive or self-harming behaviours (Steinart, Weibe, & Gebhardt, 1999).

Nurse attributions of CB for those with mental health difficulties differ dependant on diagnosis; with more negative causal attributions and less empathy for those with diagnoses of personality disorder than, for example, those with a diagnosis of Schizophrenia (Markham & Trower, 2003).
Existing studies have not considered how language might be used to socially construct mental health services, in particular the concept of CB and its management in this setting. Understanding this is key to making sense of the culture in order to lead a reduction in the use of restrictive interventions.

Discourse analysis (DA) differs from other qualitative methodologies as it does not take language at face value and can hold and reflect on inconsistencies and broader discourses. The discourses drawn on are considered to be reflective of wider routinised discourses and thus allows greater opportunity for interpretation of the sociocultural contexts at play (Willig, 2015).

2.1 Research Question

What are the discourses drawn on by inpatient mental health nurses in talking about CB and its management?

3. Method

3.1 Design

Epistemologically, this research subscribes to a critical realist position, where it is assumed that an objective world exists but is mediated by our senses, and by social constructions such as power and culture (Nightingale & Cromby, 1999). Therefore, DA was considered to be the most appropriate method. Interviews were conducted with registered mental health nurses (nurses) working on inpatient acute mental health wards and psychiatric intensive care units (PICU).
3.2 Participants

Seven participants (one male and six female) were recruited from one NHS trust based in the South-East of England. All but one completed their nurse training in the UK and length of experience working as a registered mental health nurse ranged from three months to eleven years, with a mean of four years.

3.3 Procedure

This study gained approval from the University of Lincoln, School of Psychology Research Ethics Committee and the Health Research Authority. RMNs from inpatient acute and PICU wards across three hospital sites within the NHS Trust were contacted with information about the study via their work email and flyers were placed in staff areas on the wards. Nine potential participants responded and agreed to participate. One did not attend the interview and one interview was excluded as they did not meet the inclusion criteria of being a registered mental health nurse. Participants were given a £10 voucher for an online retailer as a token of appreciation for their time.

Semi-structured interviews were conducted and lasted between 23 and 45 minutes (mean 33 minutes). Interviews were audio recorded and transcribed verbatim with linguistic and paralinguistic features included in accordance with the Jefferson-lite style of transcription (Potter, & Wetherell, 1987).

3.4 Analytic Approach

Data was analysed in accordance with a mixed discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis (FDA: Willig, 2008) approach as advocated for by Wetherell (1998) and Alvesson & Karreman (2000). This analysis was weighted towards the FDA approach as the research question was more concerned with the social constructions that dominate and limit available discourses and thus available actions. The mixed approach enabled the analysis to attend to both the local and detailed interactional talk (the interview discourse) and also the broader social and institutional discourses.
Analysis followed the steps outlined in Willig (2015). First, audio-recordings of interviews were listened to alongside the first reading of transcripts to generate a greater sense of the linguistic detail of the interviews. Each transcript was read twice before coding to experience linguistic features of the text and consider what impact the transcript has as a reader. Transcripts were coded in light of the research question, with all aspects implicitly or explicitly relating to CB or its management selected for analysis (MacNaughten, 1993). The function and linguistic details of these were broadly noted to consider what was being accomplished through the particular use of words, phrases and metaphors (Willig, 2008) and how the participant positioned themselves and service-users (Frosh, Pheonix, & Pattman, 2003; Whetherell, 1998).

Analysis of the transcripts followed eight stages, which were: i) initial reading; ii) coding; iii) broadly noting linguistic detail and discursive devices; iv) analysis of broader discourses and consideration of the following; v) action orientation; vi) subject positioning (Davies & Harre, 1999); vii) impact on practice and viii) subjectivity.

4. Analysis

Participants described “a multitude of challenging behaviours” (Jessica³, p.6;19⁴), ranging from making “demands” (Christina) and “medication non-compliance” (Samira) to acts of “violence” (James).

4.1 Overview of the analysis

The analysis indicated four key discourses drawn on by nurses to construct behaviour they viewed as challenging. The biomedical discourse was dominant across transcripts. Whilst alternative psychosocial and emotional discourses also featured their influence was limited by discursive constructions of the system. No assumptions of statistical representativeness are made in this analysis, which presents one interpretation of the data.

³ All participants have been given aliases to protect their anonymity.
⁴ Page and line number from analysed transcript
4.2 Biomedical discourses

The dominant construction of CB drew on the lived ideology of the biomedical discourses.

All participants talked about service-users being “unwell” (Toni) in relation to CB with frequent references to “mental illness” (Christina) or “diagnosis” (James):

some people will behave that way because they are genuinely unwell, they have a mental illness and they might be hearing voices telling them, you know, not to take medication because it’s poison or whatever hh er:m, or to assault, hu-hurt other people because they’re going to either hurt(.) you know them, and then in response to their voices, they might hurt other people. .. I’ve known people to attack, ..., it falls back to, you know, them being unwell (Samira, p.11;43- p.12;6).

Here, Samira uses the discursive strategy of a three-part list (Jefferson, 1990), based on illness to emphasise the biomedical construction. Alternative explanations are marginalised by the phrase “you know” which present biomedical discourses as common-sense. She positions service-users as “attacking” in response to threat, the source of which is attributed to illness, quashing alternative constructions, limiting opportunities to prevent risk behaviour and restricting management to medication.

Medication refusal was constructed by some as a response to “voices”, positioning service-users as voiceless victims of their illness who do not understand their own needs: “she doesn’t fully understand her diagnosis” (Jane). However, another participant constructed valid reasons for medication refusal:

you can get people who, even cultural reasons, don’t like to take medication. So when you’re forcing meds on them, “that’s a huge, huge, huge, yeh, I think it’s really a huge thing (Denise, p.10; 26-29).

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5 Please see extended paper section 3.1 in the extended paper for an explanation of lived ideologies.
6 Please see extended paper section 3.3.ii for a definition.
Denise positioned herself as advocating for service-users, acknowledging the impact of “forcing meds”. However, the qualifier “I think” presents this as her opinion, rather than policy. She draws on wider discourses of valuing diversity to present an argument that is hard to challenge. Side-effects, perhaps a more common reason to refuse medication, are not mentioned, indicating an ideological dilemma for nurses when confronted with the discourse of side-effects (Billig, et al., 1988).

Despite its prevalence, the biomedical construction was shown to limit understanding of CB: “someone who’s psychotic and you can (.) you can see (1.5) them becoming mo:re agitated because of psychotic reasons” (James, p.9; 3-5). This exemplifies the tautological argument for which the biomedical model is often critiqued (Cohen, 1993; Engel, 1977). James recognises the emotional state but attributes this to illness, constructing agitation as a response to intrapsychic rather than contextual events.

The biomedical construction acts to split service-users into two groups and leads to attributional discourses where those with diagnoses treatable with medication. For example, “bipolar affective disorder” (Jane) and “Psychosis” (James), are positioned as victims of illness, unable to control the reason for their behaviour, its outcome and able to recover. Participants described finding it easier to tolerate CB from this group, echoing the “insanity defence” (De Fabrique, 2011): “if somebody’s challenging but they have a psychotic illness I can excuse that somehow?” (Jessica, p.8; 34-38). In contrast, understanding is limited for those labelled with “personality disorder” (Christina): “I don’t know what, what diagnosis is that? … is that just an antisocial (2), antisocial personality disorder?” (James, p.15; 32-34).

Attributional discourses for this group position them as antisocial, in control of their behaviour and its outcome, and unlikely to change. Discourses of morality are implicated by the word “antisocial” (Foucault, 1967) which acts to limit and reduce empathy for this group who are positioned as “just nasty” (James), and victimising rather than victims: “they’ll target .h and victimise” (Samira) and they “should be dealt with by the police” (James). This echoes the existing literature on attitudes towards those with the personality disorder
label (Bodner, Cohen-Fidel, & Lancu, 2011; Markham & Trower, 2003; Westwood & Barker, 2010; Woollaston & Hixenbaugh, 2008).

Discourses of medico-legal constructs, the Mental Capacity Act and Mental Health Act, confirm this. Those who are not “sectioned” (Samira) and deemed to have “capacity” (Samira) are positioned as deliberate and vengeful:

there are other time when (. ) patients are at full capacity and they attack a particular member of staff they want to attack because they’ve been targeting that member of staff because that member of staff might have (. ) refused them something (Samira, p. 12; 10-15).

Interpersonal constructions of CB are alluded to but dismissed, therefore opportunities for action to reduce risk are marginalised. Some participants constructed CB as unpredictable and ward environments as “dangerous” through language that positioned nurses as disempowered and failed to endorse interventions:

I think, (2) because a lot of PICU staff have been so battered and bruised… they just fear, fear the worst .hh all the time... I used to go to work thinking (. ) that (. ) some, like every day, something awful is going to happen to me today (. ) something terrible will happen to me today .hh and I know a lot of people feel like that (Jessica, p. 10;46- p.11; 7).

The phrase “battered and bruised” presents staff as victims and parallels discourses of domestic violence (Towns & Adams, 2009). Jessica uses rhetorical devices of repetition, personal experience and certainty (“I know”) to construct the high-risk environment as common knowledge and positions staff as fearful and vulnerable. The experience or threat of violence has been found to influence nurses’ attitudes towards their work and to impact on staff wellbeing and the quality of care delivered (Arnetz & Arnetz, 2001; Stanko, 2002). This discourse acts to perpetuate the real sense of threat experienced by nurses.

This is confirmed by participants’ use of militaristic language, “commandeered” (James), “frontline” (Jessica), which constructs mental
health nursing as a high-risk but disempowered profession existing to enforce the actions of those in authority: “You’re kind of the frontline… the doctors and the (AMPHS) have sectioned them, it’s you that gets the crap every day… you’re the one enforcing medication…” (Jessica, p. 8; 2-7).

Practice is limited by the biomedical construction to an “overuse of medication” (Jessica) and the use of coercive and restrictive interventions which are legitimised by this and discourses of heightened risk: “we have to manage their medication. Isolating people… but medicating them, often oral medication and if they refuse, then, you know… doing, the erm, you know, administering IM injections.” (Samira, p. 13; 8-18).

Samira’s hesitation in talking about forced medication and the technical phrase “IM injections” enables her to avoid talking directly about coercive interventions that could lead to iatrogenic harm (Bonner et al., 2002; Fish & Culshaw, 2005; Lancaster et al., 2008; Mind, 2013; Paterson et al., 2003; Sequiera & Halstead, 2002). This illustrates the ideological dilemma of mental-health nursing. Participants managed this dilemma by positioning themselves as empathic, constructing restraint as “not something that anyone would ever want to do” (Jane). However, some critiqued the biomedical model as unjust and disempowering for service-users, highlighting the issue of moral distress:

if someone was in an accident and needed their leg amputated, we wouldn’t hold them down and amputate their leg if they had said they don’t want their leg amputated. But it’s kind of like, with mental health, they can say no, and because they have a mental health problem, we override that, say they don’t have capacity and do it anyway (Denise, p.11; 10-16).

For those invested in the biomedical construction, alternative approaches to care were undermined or dismissed by the attribution of change to medication: “Some patients do report. I’m feeling better because I’m, so and so drug and it’s helped me, I understand myself more … talking will not help a person who is very distressed?” (Christina, p. 21; 9-19).
It is of note to this interpretation that participants described an abundance of medics on the wards “a psychiatrist…SPRs… junior doctors… GP trainees” (Samira, p.9; 40-42) and a scarcity of psychologists: “there’s not a psychologist for this ward” (Denise, p.5; 43). Arguably, the wards were set up to promote and maintain the biomedical construction.

4.3 Alternative discourses

Despite the biomedical dominance, alternatives such as emotional and psychosocial discourses were present. Emotional discourses were drawn to construct CB as a response to “fear” (Jane), anger – “E:::rm (.) because they’re angry?” (Jessica) – or “frustration” (Denise) and to talk about its impact on staff.

The discourse of fear constructs CB as a response to feeling afraid and unable to act autonomously:

there was a fire on the ward, so patients started lashing out … because they were frightened…they were scared… there were fear … they didn’t know what to do… (Jane, p.5;39- p.6; 2).

Jane uses a three-part list to construct “lashing out” as a response to environmental threat in a context where they are positioned as disempowered and unable to act autonomously in response to danger.

Anger was also drawn on to construct the behaviour as understandable: “she expressed why she was angry. And it did turn out that she had asked for certain things quite repetitively and it wasn’t done… we ended up having to apologise to her” (Toni, p.10;46 – p.11;1). Here the service-user’s anger is validated and staff are positioned as holding responsibility, highlighting the interpersonal context. Recognition of this allows for reflection and promotes understanding rather than blame. This shared responsibility acts to unite staff and service-users: “We’re not saying aggressive is acceptable but we are saying we can understand why it happened … go to them and say look I know we had a bad day yesterday … can we start afresh today” (Toni, p.13;1-6).

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7 Please see extended paper 3.3.iii for a definition
These alternative constructions lead to attributional discourses that see behaviour as transient and in response to events outside of the service-user’s control. Understanding is presented as an interpersonal management strategy inviting all parties to consider responsibility and collaborate to avoid recurrence. Toni uses emotional discourses to question the problem of the behaviour, positioning the interpersonal context as culprit, using rhetorical questions as a device to strengthen her argument: “Is this really challenging behaviour (.) or somebody upset because (.) they’ve been neglected or… shoved aside continuously?” (Toni, p.13; 23-25).

In contrast, other participants positioned service-users as vengeful and nurses as naïve to their potential role: “she was not happy about a record that was given (.) about her, blah, blah, blah, so she attacked, attacked a member of staff… so you see she’s planning it … this patient’s got that type of history” (Christina, p.13;37-41).

The service-user’s distress is minimised and she is disempowered by the label “that type of history”. This acts to stigmatise and dismiss the service-user’s experience. The interpersonal trigger is dismissed with “blah, blah, blah” whilst repetition of “attacked” emphasises the severity of the behaviour, acting to close off opportunities for compassion towards the service-user along with opportunities for reflection and learning from the incident.

Interpersonal accounts act to highlight the importance of communication and collaboration to reduce CB. For example, where behaviour is constructed as a response to “not told enough information… not involved in their care enough” (Jessica, p.8;45-48), practices such as “having a good chat” (Jessica) and collaborating on a “kind of a behaviour contract” (Jessica) are indicated.

For some participants, psychosocial management meant attending more to that individual’s needs: “if the patient is difficult … give that person more of your time than what you would probably give the other person” (Christina, p.10;45-p.11;6). This draws on a relational discourse and constructs CB as a tool for service-users to get their needs met where they might otherwise go unmet. Without formulation of the behaviour, this runs the risk of leaving service-users, who “are never a bother” (Toni) “neglected” (Toni) and risks
iatrogenic consequences by reinforcing CB through meeting needs reactively rather than proactively: "you end up with people either: then developing learnt behaviour ...> if I bang on there shout at the nurse I get what I want<" (Toni, p.12;38-40).

Some participants drew on psychosocial discourses to place responsibility for treatment on other professionals. Therefore, these discourses are marginalised amongst the core nursing team, limiting opportunities for action: “So it’s psychological (. ) you understand? ... she needs that deep therapy about her psychological: (. ) upbringing... all these things outside us that were not dealt with” (Christina, p. 14;32 – p.15;4).

Interviews also drew out strong emotional discourses regarding the personal impact of CB on staff. Examples where staff had suffered life-changing injuries were drawn on to construct their work as perilous: “He immediately went out and punched a (. ) nurse, fell down, hit his head and has permanent brain damage” (James, p.16;2-4).

Participants positioned themselves as “brave”, a word more traditionally associated with professions such as firefighting and the armed forces, when talking about the emotional impact of their work: “you’re not fine, you’re just bra:ve” (Jessica). These discourses act to justify the bias of attending to the needs of “difficult” (Christina) rather than “quiet” (Toni) service-users, in the pursuit of a “risk-free shift” (Jessica). In light of this, it may be that the agenda to reduce the use of restrictive interventions is considered to be counterintuitive where psychosocial discourses of CB and its management are marginalised.

The construct of nurses’ as “stressed and tired” (Jessica), “burnt out” (Denise) and “hurt” (Toni) served to present the inpatient ward as “emotionally draining” (Samira). Only one participant considered the impact on service-users, in that staff “just can’t seem to: communicate” (Jessica, p.9;3-4). However, emotions were stigmatised by the biomedical dominance. For nurses, they were positioned as having to be “strong” (Samira) and “cope” (Christina) as “part of the job” (Christina). For service-users, emotions are constructed as something to be medicated: “medicate them... to calm them down” (Christina, p.18;1).
Despite their availability, strategies endorsed by alternative discourses to prevent or manage CB appear restricted by the dominance of biomedical discourse and systemic discourses.

4.4 Systemic discourses

Systemic discourses relate to the wider systemic and political context of NHS mental health care. Participants drew on systemic discourses of their immediate and wider systems to justify and criticise common practices.

The system was constructed as unboundaried, in terms of diagnostic categories - “it’s supposed to be psychosis ...we have some people with, you know, degenerative, erm (3) dementia” (James, p.6;15-17) and the number of admissions and use of facilities: “it should be an eighteen bedded unit with a de-escalation room however the de-escalation room has been commandeered as a permanent bedroom” (James, p.5;45-p.6;1).

The militaristic word “commandeered” positions nurses as disempowered, having to face the real-term consequences of another’s orders. Other participants positioned nurses as “unable to manage” (Jane) as the boundaries between services become “blurred” (Jane): “like a rollercoaster... you don’t know the risk, you don’t know the diagnosis, you don’t know what the patients are coming in with” (Samira).

Mullen, Admiraal, and Traverna (2008) described mental health nursing as having fallen into a defensive and reactive mode of practicing as a product of working in an acute environment. Participants described their role as defensive; “doing damage control (Jane) rather than “actual nursing care” (Jane). Their opportunity to care was constructed as “a conveyor belt...just offering medication” (Denise) with the same service-users “revolving round and round” (Denise). Discourses of evidence-based practice and clinical guidelines were drawn on to criticise current practice and the limitations of the biomedical construct, alluding to moral distress: “Even when we go to evidence-based practice, it says, psychological treatments with medication” (Denise, p.14;29-31).

Please see extended paper section 3.3.iii for a description of this.
Political discourses of “cuts” (Jane) and closures, “another unit closed” (Christina), allow practice that is nonconcordant with guidelines, in a system constructed as withholding of vital resources: “really, poor resources… makes your job challenging” (Denise, p.16;13-14), and makes CB unmanageable: “challenging behaviour =is manageable with good resources in place. Yeh, like if you have enough staff” (Christina, p.20;30-31).

Limited time further justifies the “overuse of medication” (Jessica) and constraints on the use of alternative interventions that “takes time” (Christina): “I don’t think staff feel they have enough time to kind of sit and (.) e:rm (.) deescalate properly… there’s a feeling that there’s no time for that… things are risky .h we need to contain, let’s medicate” (Jessica, p.10;32-39).

Further, participants constructed services as not giving them time to engage with support or psychologically informed practice or provide the quality of care expected of them:

they do now have a reflective practice group. However, I missed the last one ‘cause we’re too busy? That’s, a lot of the time we miss things because we’re too busy? It’s hard to write a decent care plan because you’re too busy? (James, p.16;37-43).

This acts to maintain the biomedical dominance and restricts implementation of best practice guidelines. James draws on the discourse of paperwork with his reference to care plans, in a system reported to prioritise “too much paperwork” (Denise) over delivering care: “there’s just … too, too much ((laughs)) paperwork… to actually talk to the person the paperwork’s about” (James, p.17;15-16).

Likewise, discourses of control, “kind of systematic things like rules” (Jessica, p.9;6-7), were positioned as disempowering for service-users who are “turned into children again” (Jessica). This mirrors nurses own position of disempowerment. The control of blanket rules is constructed as an “injustice” (Jessica) that restricts autonomy and choice and act to trigger CB:

on a day to day basis, er:m the biggest issue we have… we’re all non-smoking, and that does bring a lot of challenging behaviour… Err,
people abusing you, like verbally… I’ve seen like people getting physically assaulted as well (Samira, p.10;16-21).

Here, enforcement of the “non-smoking” “blanket rule” is positioned as putting staff at risk of abuse because of its enforcement, which acts to challenge its value.

A lack of stimulation and boredom of the “four walls” (Toni) were also drawn on to construct CB, indicating activities as preventive: “we all know a bit of yoga for an hour would keep you calm for (.) the next few hours (.) it gives the nurses a break… not to have any activities would be a bit of a nightmare” (Toni, p.6;40-43).

However, the systemic construct of austerity and funding acts to curtail this practice: “that funding’s coming to an end” (Toni). Whilst participants constructed wards as risky and dangerous, they positioned the system they work for as creating “added stress and pressure” (Denise), not recognising the risk staff face at or listening when concerns are first raised: “maybe how the wards on the NHS works, but (.) something has to happen before (.) something can be done… Even though people will report certain things” (Jane, p.4;43-p.5;1).

The system is constructed as dismissive of employees’ experience: “they (.) don’t really consider (.) =the impact that it’s having on staff… it’s burning people out a lot quicker” (Denise, p.14;6-8). Participants positioned themselves as unsupported having to “just get on with it ◦like you know and everybody everybody’s fi:ne◦” (Toni, p.8;7-9), accepting risk and stress as “part of the job” (Christina).

Participants talked about a counselling service, but did so tentatively, presenting a culture that limits access to it, either through a lack of knowledge, “they also have the counselling… I think … I don’t know” (Jane, p.9; 14-20), or a sense that they are not deserving of it: “I was like ◦I don’t need this, there’s people worse off than me◦… I’m sitting here moaning about like, my job’s hard. And I chose this job… I didn’t deserve it” (Jessica, p.12;22-28).
Similarly, participants positioned the system as leaving them ill-equipped to manage CB, giving them only “hands on, erm (.) physical violence and aggression training” (Jane, p.7;19-20), “we don’t…actually learn more about de-escalation techniques” (Jane, p.7;43-45). This positions staff as disempowered, and endorses the dominance of the biomedical model, with medication, rules and restrictive interventions as its main tools.

Participants positioned themselves as “human” (Denise), allowing their emotional response to CB to influence their practice: “Some of them are not very professional these debriefs… it’s understandable because emotions are high and people are feeling hurt (.) they probably say things they don’t mean... that’s why we have our debriefs away from the patient” (Toni, p.8;12-17).

This along with “the pressure” (Denise) acts to create conflict within the staff team, with those advocating for alternatives as a minority: “it’s hard when you’ve got the rest of the team saying one thing and you think maybe that that’s too severe” (Jessica, p.11;16-17). The systemic discourse functions to manage issues of responsibility and accountability, justifying poor practices and absolving moral distress by externalising accountability to the institutional structures. It works to create empathy for nurses who position themselves as “burnt out” (Jessica).

This discourse perpetuates defensive and reactive practices, with issues of responsibility and irresponsibility appear to be passed up and down the hierarchical chain; from nurses to management systems and service-users and by management systems to nurses.

5. Discussion

Numerous national initiatives aim to reduce the use of restrictive interventions in inpatient mental health care. It has been found that despite guidance and wider assumptions that restrictive interventions are only used as a last resort, only in the management of violence and aggression, this has not always been the case (Ryan & Bowers, 2006; Stewart et al., 2009) and the use of restrictive interventions remains high (Mind, 2015) and training interventions in isolation have not been effective (Hahn et al., 2006). This research set out
to explore the discourses inpatient mental health nurses draw on to construct CB and its management.

Dominant biomedical and systemic constructions were found to act in ways that marginalise alternative emotional and psychosocial discourses in the absence of a full multidisciplinary team (MDT). Attributional discourses of illness were drawn on for behaviours by those who are given diagnostic labels such as psychosis, allowing empathy for this group. However, attributional discourses of control and being “nasty” were drawn on for those given diagnostic labels of personality disorder, stigmatising this group. This acted to perpetuate dominant biomedical constructions and marginalise the psychosocial, absolving individual accountability for nurses and maintaining the lived ideology. This echoes previous studies that have found staff assign responsibility and blame for the cause of aggression to service-users, without considering the context, particularly for those diagnosed with personality disorders (Cutcliffe & Riahi, 2013; Markham & Trower, 2003).

Participants positioned themselves as a group disempowered by the dominant constructions that lead to reliance on medication and rules as a method of control. Likewise, they positioned service-users as disempowered, voiceless and without autonomy. This frames CB as a coercive strategy used by some service-users to re-gain control from a place of disempowerment and restrictive interventions a tool for nurses to regain control, supporting earlier findings (Breeze & Repper, 1998).

Discourses of risk and burnout constructed inpatient work as perilous, with the practical goal being a “risk free shift” (Jessica). Through the biomedical lens, the agenda to reduce the use of restrictive interventions is at odds with this goal. The dominant biomedical construction of CB acts to legitimise the use of coercive interventions and systemic discourses manage the issue of personal accountability by positioning this on the service-user and institution.

Menzies-Lyth (1960) argues that organisations respond to the anxieties of delivering care by structuring themselves, and nursing tasks, in ways that act as a defence. From this perspective, the biomedical dominance could serve as a defence to protect against the proximity of distress to our own
experiences. It has been highlighted that mental health nursing has fallen into a mode of defensive practice in the existing literature (Mullen et al., 2008; Mullen, 2009). This acts to further manage the issue of individual accountability and protect against anxiety (Menzies-Lyth, 1988). Participants presented ideological dilemmas of mental health nursing in their talk about the ethical quandaries and moral distress that they face in their work. For example, their roles in forcing medication against a person’s will, the side-effects of medication they dispense, and their use of physical restraint. The biomedical and systemic discourses resolve this dilemma by justifying such treatment and placing the accountability for it within the service-user or system rather than the individual staff members.

The systemic discourses highlighted parallels between treatment of staff by the wider organisation and treatment of service-users by staff. Both were positioned as disempowered, not listened to and in a position where “something has to happen before (.) something can be done” (Jane). Likewise, the use of militaristic language and phrases that parallel discourses of domestic violence raise questions of the treatment of nurses by the organisation in which they work. Such issues of NHS culture were highlighted by the Francis Report (2013). In particular, disengagement between management and the “frontline”, target-driven priorities, a lack of candour and low-staff morale were cultural issues identified by the Francis Report and echoed some of the issues raised by participants in the systemic discourses they drew upon.

This research proposes that such cultures are maintained by the lived ideologies and dominant discourses that perpetuate them. The implications are that a system-wide cultural shift is required to openly promote alternative discourses that are able make sense of CB and clarify the links between this and proactive psychosocial approaches. Clinical psychologists are well placed to foster discussion on the constructs of CB and how these relate to the dominant discourses. It is recommended that such practitioners have a good knowledge of the system and socio-political context and are able to both support and challenge their co-workers (Christofides, Johnstone, & Musa, 2012). Provision of space to reflect on ambiguities of the construction of CB
and explore alternative conceptualisations that map onto professional identities, values and the goal of reducing risk could be helpful to promote an alternative to the biomedical construction and support nurses to feel empowered in their work. However, it is important that the system provides safety and support for this to be accessed.

Further research could investigate the impact of such a reflective space on the use of psychosocial and restrictive interventions in inpatient mental health care. Likewise, the impact of interventions to reduce staff stress and burnout on discourses would also be of interest. DA could also be applied to written documents, such as care plans, policies and core training materials accessed by nurses to further examine the discourses of CB and its management.

Limitations of this research are considered. Firstly, there has been debate and critique over the appropriateness of interview data for DA studies, with a preference for naturally occurring data (Potter & Hepburn, 2005). However, the collection of naturally occurring talk within inpatient mental health wards would pose ethical dilemmas, and counter-arguments propose that due to the limited number of discourses available to speakers, interviews allow for routinised discourses to be reproduced, and thus hold ethnographic relevance (Griffin, 2007; Wetherell, 2007). Social desirability bias of interviews is not overlooked, and DA allowed for participants’ use of language to manage the interviews to be accounted for to some degree. Only qualified mental health nurses were interviewed in this research and it is likely that other disciplines working on inpatient mental health wards may draw on different dominant discourses to construct CB.

DA studies aim to present a challenge to common approaches and aim to initiate change (Morgan, 2010). Menzies-Lyth (1982) proposes that to identify cultural practices and influence change a “fresh look” where one sets aside “habitual ways of looking at things” is required. A strength of this research is its attempt to put aside “common sense” and dominant beliefs about CB and its management, with a focus on the discursive constructions behind these.
In conclusion, the finding that biomedical discourses were dominant in nurses’ constructions of CB and talk about its management is at odds with current guidelines that emphasise a holistic approach (NICE, 2015a; NICE 2015b). The biomedical and systemic discourses drawn on managed issues of individual accountability, but also disempowered nurses and service-users alike. CB and restrictive interventions could be perceived as ways of regaining control. To empower the agenda of reducing the use of restrictive interventions, alternative psychosocial and emotional discourses need to be brought from the margins to the main page, with clear connections made to the values and safety of nurses and service-users alike.
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Extended Paper
1. Extended Background

1.1 Terminology

It is important to first note the use of language for this thesis. The term ‘service-user’ refers to someone who accesses health care services and it is most commonly used for mental health services. This is the term adopted due to its common usage and links to movements such as service-user involvement. It is however acknowledged that individual preferences are important in the use of terminology and service-user has not been found to be a consistently preferred term by those to whom it relates (Simmons, Hawley, Gale & Sivakumaran, 2010; Speed, 2006).

The way in which we typically understand other people’s behaviour depends on cultural norms and values, and our expectations for a situation (Burton, 2001). The term challenging behaviour is most commonly used in learning disability services. Use of the term challenging behaviour (CB) aims to emphasise the social construction and sociocultural contexts of behaviours that are considered challenging. This study adopts Emerson’s (2001) broad definition:

Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to ordinary community facilities (Emerson, 1995; cited in Emerson, 2001).

This definition includes a broad range of behaviour beyond violence and aggression and positions the problem of the behaviour in its consequences. Where forms of challenging behaviour vary widely, they consistently have a negative outcome for the individual’s quality of life (Lloyd & Kennedy, 2014). In particular, it has been documented to increase the risk of experiencing chemical and physical restraint (Robertson et al., 2004), restrictive interventions which, in contrast to current guidelines (NICE, 2015b), are still commonly used in the management of challenging behaviour for those with
learning disabilities and mental health difficulties (Heyvaert, Saenen, Maes & Onghena, 2014; Mind, 2013).

The term challenging behaviour was first used in the UK by Blunden and Allen (1987). It was adopted as an attempt to replace terms such as “problem” and “disordered” behaviour with the aim to emphasise that these behaviours are not intrinsic to or defining of the person. The aim of moving towards the use of the term challenging behaviour was to open up understanding of the behaviour and the challenges it poses to services and people that support them:

*We have decided to adopt the term challenging behaviour rather than problem behaviour or severe problem behaviour since it emphasises that such behaviours represent challenges to services rather than problems with individuals… in some way carry round with them* (Blunden & Allen, 1987; p.14).

This is applicable to all populations where such behaviours may present, including adult mental health services. Although the term challenging behaviour has rarely been used in mental health research, which has typically focussed on aggression and violence, it is commonly used in clinical practice. Studies have identified that challenging behaviour is the term most often cited as the reason for the use of restrictive interventions on incident forms in inpatient mental health settings (Ryans & Bowers, 2006).

It is of note that over time, the term challenging behaviour has taken on the old meaning of “problem” and “disordered” behaviour and is sometimes used as if it were a diagnosis (Burton, 2001). It has been noted that the introduction of new language alone may not be sufficient for change in practice. Rather, without deconstruction of the dominant constructs there remains the risk that old practices may be maintained. (Parker, Georgaca, Harper, McLaughlin & Stowell Smith, 1995). Despite this, the term challenging behaviour, based on Emerson’s definition above, has been adopted for this research, based on the intentions of its initial introduction and for the purpose of familiarity of the term with participants.
A number of studies exploring staff attributions of challenging behaviour (CB) in learning disability and accident and emergency settings have found that where the behaviour is attributed as controllable, independent and stable, staff are more likely to have a negative response and are less likely to help (Stanley & Standen, 2000; McKay & Barrowclough, 2005). Likewise, judgements of responsibility have been found to be predictive of carers’ responses to challenging behaviour in learning disability settings (Dagnan & Cairns, 2005).

However, staff attitudes towards and attributions of CB have not been found to be consistent (Hare, Durand, Hendy & Wittowski, 2012). This is partly due to the severity of the service-users’ impairment (Tynan & Allen, 2002; Williams, Dagan, Rodgers & Freeston, 2015). Tynan and Allen (2002) found that the severity of the service-user’s learning disability impacted on how staff perceive their behaviour. They found that a service-user with mild learning disabilities was perceived to have more control over factors causing aggressive behaviour than those with severe learning disabilities. Behaviour from the service-user with severe learning disabilities were however considered significantly more challenging. It was found that participants considered the biomedical model more appropriate in understanding the service-user with severe learning disabilities. They favoured theories of learned behaviour and emotional causal models in explaining the behaviour, and were less likely to consider the physical environment.

It has been found that competing demands on staff are likely to influence their attributions of behaviour. Increased competing demands on staff in a dementia setting were found to significantly impair staff members’ ability to use situational information to form attributions of internality and controllability of challenging behaviour (Parker, Clarke, Moniz-Cooke & Gardiner, 2012). Such competing demands have also been considered to impact on stress for the nursing profession (Menzies-Lyth, 1988).

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9 Please see sections 1.8 and 1.9 for a review of factors influencing nurses’ attitudes towards their work with service-users and a broader consideration of societal attitudes to those who are different.
This contradicts findings and guidelines that emphasise the importance of considering an interplay of factors, that include the people involved – staff, service-users and others – and the situation in which the behaviour occurs, including the service culture and physical environment, in understanding challenging behaviour (Farrell, Shaffei & Salmon, 2010; NICE, 2015b; Department of Health, 2012). It has been found that in a non-naturalistic setting, staff were able to identify situational factors which could be more likely to lead to incidents of challenging behaviour. For example, crowding, noise, boredom and strong negative emotions (McGill, Teer, Ryes & Hughes, 2003). This highlights the importance of other factors which influence staff’s attributions in the real-life context.

As per its definition, challenging behaviour has a significant impact on those supporting the person exhibiting the behaviour. It has been positively correlated with carer stress and burnout, particularly where there is risk of potential physical assault (Rose, Nelson & Hardman, 2016; Mills & Rose, 2011; Rose & Cleary, 2007). Carers identified as experiencing burnout have been found to be less willing to help (Todd & Watts, 2005), this has the potential to develop into vicious cycles of increasing levels of challenging behaviours in service-users and burnout in staff.

Research into challenging behaviour in mental health care has had a stronger focus on behaviour of aggression and violence. Some research found that staff are disproportionately more likely to attribute the cause of an aggressive incident to the service-user but evidence shows that this is only the case for a small proportion of incidents (Cutchliffe, & Riahi, 2013). This is important as nurses’ attitudes regarding the causes of aggression can influence their choice of intervention (Dickens, Piccirillo, & Alderman, 2013).

The focus on aggression and violence perhaps reflects the risk posed to mental health nurses. However, nurses working in learning disability settings are also at significant risk but there is a broader consideration of challenging behaviours for this population. In 2011, 69% of the 60,000 recorded assaults against NHS staff took place in mental health and learning disability settings (NICE, 2014). Recent reports in mainstream news indicate that the number of
assaults on mental health staff in the UK remains high (Robinson & Grant, 2017), and older research has concluded that a mental health nurse is likely to be assaulted at least six times over the course of their career (Wright et al., 2005). However, despite these figures, it is important to note that the majority of people with mental health difficulties, including those who access inpatient services, are not and will not become violent or aggressive (NHS Security Management Service, 2005).

1.2 Inpatient Mental Health Care

During the financial year 2015/16, 63,622 people were detained in hospitals under The Mental Health Act (1983), an increase of 9% from the previous year (NHS Digital, 2016). In recent years, a number of official inquiries have focused on the use and abuse of physical restraint in mental health and learning disability services, such as the Mid Staffordshire NHS Foundation Trust Public Inquiry (2013) and the Winterbourne View public enquiry (Department of Health, 2012). As a response, socio-political drivers have aimed to reduce the use of physical restraint and, in particular, to end the use of physical restraint in the prone position (Mind, 2013), as has been reflected in current clinical guidelines (NICE, 2015a). However, guidance and training interventions on their own have been ineffective in initiating this change (Hahn, et al., 2006).

In August 2015, in England alone, there were 9600 recorded incidents of restraint, of which 16.5% used the prone position (Mind, 2015). A Freedom of Information (FOI) request made by former DoH minister, Norman Lamb (MP) revealed that between 2014/2015 and the first half of 2015/2016 the reported use of restraint rose by 7403. The same FOI request found that in the same period, the number of injuries to service-users caused by restraint stayed fairly constant (from 1512 to 1548). However, the injuries suffered by staff increased by almost 10% (Lamb, 2016). This demonstrates that, despite the guidelines, the rate of restraint has increased.

Another restrictive intervention commonly used in inpatient mental health services is seclusion. In August 2015 there were 1671 recorded incidents of seclusion (Mind, 2015) and a national census of mental health inpatient
service-users found that 4% of adult service-users had experienced one of more episodes of seclusion (Care Quality Commission (CQC), 2010). It is however important to note that in this census and the five previous, that there are significant differences between ethnic groups, with white British individuals experiencing a 9% lower than average rate of seclusion (CQC, 2010). Research evaluating the effectiveness of seclusion has been contradictory. Some reviews have found that it is an effective intervention in the prevention of violence and self-harm (Fisher, 1994; Lendemiejor & Shortridge-Baggett, 1997) and others concluded that there is not enough good quality evidence to support this (Sailas & Fenton, 2012). Further, seclusion has been found to potentially increase aggressive behaviour (Donat, 2003) and programmes adopted to reduce or eliminate the use of seclusion have not been found to lead to an increase in staff injury (Martin, Kreif, Eposito, Stubble, & Cardona, 2008). One study found that elimination of seclusion in a small recovery-oriented crisis service resulted in a 10% decrease in annual staff injuries (Ashcraft & Anthony, 2008). Despite this, most nurses view seclusion as necessary in the management of violence and aggression (Happell & Harrow, 2010).

A meta-synthesis of qualitative literature into the experience of having been placed in seclusion found a small number of small-scale studies of mixed quality. The meta-synthesis concluded that, overall, seclusion has the potential to cause iatrogenic harm and that the role of compassionate staff interactions were key to mitigate the potential for harm (Mellow, Tickle & Rennoldson, 2017). A large-scale study of 136 NHS acute inpatient mental health wards in England found, high levels of aggression associated with high proportions of service-users detained under The Mental Health Act, a high turnover of service-users, alcohol use by service-users and locked doors. This suggests that restrictive practices and environments may exacerbate the problem of violence on inpatient mental health wards (Bowers, et al., 2009).

1.3 Multidisciplinary Teams (MDTs)
The concept of MDT working is unclear despite its apparent commonality. Terms such as “multidisciplinary” and “interdisciplinary” are often used interchangeably (Mental Health Commission, 2005).

Multidisciplinary work has been described as a core mechanism to ensure holistic care and a seamless service for patients across the trajectory of their illness (Jeffries & Chan, 2004). In contrast, interdisciplinary work has been described as the sharing of knowledge and authority between different professionals to best meet the needs of clients (Carrier & Kendall, 1995). When MDT work is referred to in this report it relates to the latter definition.

MDT work is considered to “maximise clinical effectiveness” (Junor, Hole & Gillis, 1994) and the literature on MDT working has highlighted a number of benefits of this approach. These include being able to effectively meet the complex needs of service-users, delivering planned and coordinated care, and increasing a sense of responsibility, job satisfaction and personal achievement amongst staff (Mental Health Commission, 2005). However, it has been noted that MDT working is not always well implemented and therefore not always effective (Mental Health Commission, 2005). Despite MDT working being proposed as best practice (Mental Health Commission 2005), at present there do not appear to be any clear guidelines on who should make up the MDT on an acute or PICU inpatient mental health ward for adults.

Clinical psychologists form part of a full MDT. As a profession, the core conduct of clinical psychologists involves the skills, knowledge and values to work effectively with complex systems, including teams, and to hold a high level of skills in critical reflection and supervision.

1.4 The Francis Report and Winterbourne View

The Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry: Francis, 2013)

In 2008 the healthcare commission commenced an investigation into the operation of Stafford Hospital, following alerts of high mortality rates and in 2010 a full public inquiry commenced.
The first inquiry report was published in 2010 and criticised the care provided by the Trust and drew the following conclusions:

- There was a lack of basic care.
- The culture was not conducive to providing good care or providing a supportive working environment for staff. There was an atmosphere of fear of adverse repercussions and low morale amongst staff members.
- A high priority was placed on achieving targets and managing financial pressures prioritising trust status over the quality of care.
- Likewise, there was a preference for statistics and reports that focused on systems over outcomes, neglecting patient experience data.
- There was a lack of openness, an acceptance of poor standards and lack of internal and external transparency with regards to problems in the Trust.
- The consultant body was dissociated from management.
- The board’s approach to problems lacked urgency.
- The Trust lacked effective clinical governance.

The report made 290 recommendations. Some key recommendations are listed below:

- A culture share by all in the service of putting the patient first should be fostered.
- A set of fundamental standards should be developed that is easily understood and accepted by patients, the public and healthcare staff. A breach of these should not be tolerated.
- Professionally endorsed and evidence-based means of compliance to these fundamental standards should be adopted.
- Openness, transparency and candour about matters of concern should be held throughout the system.
- Individuals and organisations should be properly accountable for what they do and should ensure that the public are protected, with a proper degree of accountability for senior managers and leaders.
• The recruitment, education, training and support to key contributors, particularly nurses and those in leadership positions, should be enhanced to integrate those essential shared values.

The number of recommendations made in the report highlight the scale of the failings and the importance of the improvement of standards. However, the sheer number of recommendations for health care organisations to follow may have the adverse effect of hindering change and progress or resulting in key messages for change being lost. Menzies-Lyth (1988) has reported on the impact the multiple tasks can have on performance and wellbeing of staff in institutions where there is not a single, clearly defined primary task. She wrote:

Unless the members of the institution know what it is they are supposed to be doing, there is little hope of their doing it effectively and getting adequate psychosocial satisfactions from this. Lack of such definition is likely to lead to personal confusion in members of the institution, to interpersonal and intergroup conflict and to other undesirable institutional phenomena (Menzies-Lyth, 1988, pp. 222-223).

This provides a framework of understanding for how it may have come to be that the important recommendations from the Francis Report have been difficult to implement. In particular within in the context of mental health hospitals were tasks are difficult to define due to competing biological and psychosocial schools of thought. This results in a lack of a clear, coherent and consistent understanding of some of the problems that staff face.

Transforming Care: A National Response to Winterbourne View Hospital
Department of Health Review Final Report (Department of Health (DoH), 2012)

Following a BBC Panorama television documentary that brought to light abuse and mistreatment of residents at Winterbourne View Hospital, the DoH issued a report that focused on the need to change. The report recognised that examples of good practice demonstrate that such changes are achievable and should be the expected standard of care. The report
responded to the failings identified in the Winterbourne View scandal and went beyond the conviction of individual staff members. For example, it highlighted weaknesses in the system’s ability to hold leaders of organisations to account.

The DoH report is concerned with the wider issue of how those with learning disabilities, autism, mental health conditions and with behaviours described as challenging, are cared for. It sets out how services should be, with the individual at the centre of their care with individualised and person-centred support. Services should be provided by skilled workers and focus on improving quality of care and quality of life in maintaining individual dignity and human rights.

1.5 Current Guidelines

NICE (2015a) Violence and Aggression: Short-Term Management in Mental Health, Health and Community Settings

NICE advise that these guidelines are applied in conjunction with their guidelines regarding service-user experiences in adult mental health services (NICE, 2011) that identifies how service-users should be able to experience services. For example, that those detained under The Mental Health Act are routinely involved in decisions about their care, have daily one-to-one contact with professionals known to them, regularly see other members of the care team, and have access to meaningful activities every day. Most relevant for this research is the statement that “People in hospital for mental health care are confident that control and restraint, and compulsory treatment including rapid tranquilisation, will be used competently, safely and only as a last resort with minimum force” (NICE, 2011).

The guidance for short-term management of violence and aggression (NICE, 2015a) states that all services that use restrictive interventions, should have a restrictive intervention reduction programme with measured outcomes. These programmes should ensure effective service leadership and address environmental factors that are likely to increase or decrease the need for restrictive interventions. Service-users and their carers should be involved and empowered in the process, and meaningful activities, including physical
exercise, should be available. Guidance stipulates that restrictive interventions should only be used as a last resort where alternatives have failed, that it is done in the least restrictive way and, when used, should be followed by a post-incident debrief and review.

Further guidance, specifically for prevention of and interventions for challenging behaviour in learning disability services (NICE, 2015b), advises that the severity of the person’s learning disability and their developmental stage, including any difficulties with communication or physical or mental health problems, are considered. Professionals should aim to provide support and interventions in the least restrictive settings and should aim to prevent, reduce or halt the development of future episodes of challenging behaviour. Such interventions should aim to improve quality of life for the service-user, with the focus on improving their support and increasing their skills, rather than aiming to change the person. Guidance recommends that evidence-based models, such as positive behavioural support (PBS), should be used and be a part of the service culture (NICE, 2015b).

**Mental Health Crisis Care: Physical Restraint in Crisis (Mind, 2013).**
In 2013, the national mental health charity Mind issued a report highlighting the problem of overuse of physical restraint in mental health services and the harmful impact that this can have on service users. The report called for action to reduce the use of unnecessary physical restraint and eliminate the use of prone restraint, which had been linked to a number of deaths in services.

In 2015, Mind issued a follow-up report reviewing the impact of this. The report highlighted issues that needed to be addressed, such as improved information, support, better staffing, training and attitudes. It also recommended creating an improved culture that values and is sensitive to the individual, including cultural, needs of service-users, and better responsiveness at the organisation level, in the reduction of restrictive interventions. It further highlighted five good practice initiatives outlined below:
i. PROMISE (PROactive Management of Integrated Services and Environments)
PROMISE is an initiative based in Cambridge where staff and service-users work towards eliminating mental health services’ reliance on force on a global scale.

ii. RESPECT
RESPECT is a training approach based on supportive de-escalation, empowerment and physical interventions that do not cause harm (pain or panic). It is supervised by the Lincolnshire social enterprise NAViGO Health and Social Care.

iii. Restraint Reduction Network™
Restraint Reduction Network aims to bring together and support organisations to make meaningful changes to their services, to work towards restraint free services. They work to minimise the use of coercive and restrictive practices and prevent the misuse and abuse of restraint.

iv. REsTRAIN YOURSELF
ReSTRAIN YOURSELF is a UK adaptation of an approach developed in the US: Six Core Strategies©. It is based on the evidence, that often the use of seclusion and restraint could have been prevented if issues such as ward design, staffing levels, and poor staff communication and behaviour are addressed. It is currently being trialled in the North West of England.

v. Safewards
Safewards provides a framework that aims to make wards safer for staff and service-users alike. It includes evidence-based resources such as advice for staff on how they can talk in ways that foster collaboration as an alternative to confrontation, how to talk in ways to calm someone down and calming equipment that can be kept on wards, for example scented pillows, blankets, music, massage balls and ear plugs.
Positive and Proactive Care: Reducing the Need for Restrictive Interventions (Department of Health, 2014).

As a response to Winterbourne View (DoH, 2012), the Francis Report (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) and the Mind report (Mind, 2013), the DoH (2014) published Positive and Proactive Care: Reducing the Need for Restrictive Interventions. This aimed to provide a framework for health and social care services to develop cultures where restrictive interventions are only ever used as a last resort; and when used, only for the shortest possible time. It aimed to eliminate the use of unnecessary restrictive interventions across health and social care services and identified ways in which services should better meet people’s needs to enhance their quality of life, thus reducing the need for restrictive interventions. The document sets out that services should ensure accountability for these improvements, and that this includes effective governance, transparency and monitoring.

The document recognised evidence-based approaches that should be used, such as Positive Behaviour Support (PBS) (Allen, Evans, Hawkins & Jenkins, 2005) and indicates key actions and principles to be introduced by services, some of which echo the key underpinnings of PBS:

- People should not be deliberately restrained in a way that may impact on their airway, breathing or circulation. This includes face down or prone restraint on any surface.
- Restrictive interventions must never include the deliberate application of pain.
- When restrictive interventions have to be used, it must be done in the least restrictive way to meet the immediate need.
- Seclusion can only be used for people detained under The Mental Health Act (1983).
- Service-users, their families and carers must be involved in planning, reviewing and evaluating all aspects of their care and support.
• All people who use services and are known to be at risk of exposure to restrictive interventions must have individualised support plans that include behavioural support plans.

• Recovery-based approaches, including PBS planning and reducing restrictive interventions should have a board level lead and boards must maintain and be accountable for overarching programmes to reduce the use of restrictive interventions.

• Executive boards must approve increased PBS planning and restrictive intervention reduction be taught to their staff.

• Governance structures and transparent policies around the use of restrictive interventions must be established by organisations. These should be clear, available and accessible to service-users and their carers.

• The use of restrictive interventions should be reported to service commissioners who must monitor their use and act in the event of concerns.

• Boards must receive and develop action plans in response to annual audits of behaviour support plans.

• Post-incident reviews and debriefs should be planned to allow lessons to be learned from incidents where restrictive interventions have had to be used.

• Service-providers must be transparent and record and report data on the incidence of restrictive interventions.

• The CQC will monitor and inspect the use of restrictive interventions and review organisational progress against restrictive intervention reduction programmes.

• The CQC will scrutinise behavioural support plans, particularly where these include the use of restrictive interventions.

1.6 Positive Behavioural Support (PBS)

PBS has been identified as the approach of choice in the support of people with learning disabilities presenting with behaviours that challenge (DoH, 2012; 2014). It is a proactive, multi-component model that evolved from an
integration of applied behaviour analysis, social valorisation and person-centred values that draw on both educational and systemic models to improve the individual’s quality of life whilst reducing challenging behaviour (Allen, Evans, Hawkins & Jenkins, 2005; Goore et al, 2013; Noone & Chaplin, 2017). PBS is a multi-disciplinary service approach that needs consistent adherence from all staff and carers, rather than a specific intervention by a clinical psychologist. It is based on an ethical responsibility to promote understanding of people, that moves past a tendency to use “interpretation before description” (Skinner, 1953). However, it has faced criticism, as the behaviour analytic component is sometimes misunderstood and considered controlling and manipulative (Noone & Chaplin, 2017).

Functional analysis, a core component of PBS, is about understanding the behaviour in context and has demonstrated effectiveness in achieving positive outcomes (Scotti, Evans, Meyer, & Walker, 1991). However, over time, protocols that have been developed, have begun to rely more on descriptive assessments than intensive assessment procedures, which serves to be easier to use in clinical settings, but reduces internal validity of the approach (Noone & Chaplin, 2017).

PBS and functional analysis differ from behavioural modification programmes that label the individual behaving in ways that challenge as the “problem”. Instead, behaviour is considered in its context, and the social construction (Goldiamond, 1974) of this is not ignored (Noone & Chaplin, 2017).

Despite its evidence base and recommendation of its use in NICE guidelines (NICE, 2014; 2015), there is the risk that it may be poorly represented in clinical service, for example where there is a lack of competence-based training in those who undertake the analysis or where general models of formulation-based assessment, such as the 5Ps are used (Ingham, 2015; Noone & Chaplin, 2017). Further, Holmes & Murray (2011) critique the use of traditional behaviour modification programmes as used in a Canadian inpatient forensic setting as coercive and based on promoting adherence to service needs and values rather than the individual’s needs and values. However, this setting used traditional behavioural modification programmes
that are based only on the principle of operant conditioning. These differ to PBS which aims to foremost improve quality of life for the individual and in turn reduce the need for them to behave in ways that challenge. PBS does this by drawing on educational and systemic models to provide normalisation, social role valorisation and person-centred values (Gore, et al., 2013).

Whilst most of the literature focuses on the use of PBS for those with learning disabilities, the principles of PBS have value for other services where challenging behaviour may present. For example, in inpatient mental health services and in the support of people with a diagnosis of personality disorder (Brown, Shawe-Taylor & Swan, 2017).

1.7 Mandatory Training

NICE (2015) identify in their guidance for the short-term management of violence and aggression in health and social care settings that:

- Organisations should train staff in psychosocial methods to minimise the use of restrictive interventions.
- Stipulate that this training should enable staff to develop person-centred and values based approaches to care.
- Therapeutic relationships underpin the understanding of the relationships between mental health problems and the risk of violence and aggression.
- Staff should be trained to develop the skills to assess why behaviour is likely to escalate, including personal, constitutional mental, physical, environmental, social, communications, functional and behavioural factors.
- Staff are trained to develop skills and techniques to reduce imminent violence and defuse aggression, for example verbal de-escalation.
- Staff should be taught to undertake restrictive interventions safely, only when these are necessary, and to undertake immediate post-incident debrief following this
- Formal external post-incident reviews should take place in collaboration with experienced service users who are not currently using the service.
Despite widespread mandatory staff training in the safe management of potentially dangerous events, either by breaking away from the aggressor or using restrictive interventions, there is a lack of evidence evaluating the effectiveness of such training (Stewart, Bowers, Simpson, Ryan and Tziggili, 2009; Zarola & Leather, 2006; Rogers et al., 2006). Historically, training has been provided by a number of different bodies, following different models and without proper regulation (Rogers et al., 2006; NHS Security Management Service, 2005). A national survey of training found that such training varies from half a day to 21 days (Lee, et al., 2001). One audit study, in which role play has been safely used to evaluate the effectiveness of such training, found that in pseudo life threatening scenarios 40% of trained staff were unable to breakaway within ten seconds and a further 60% did not employ the right technique (Rogers, Ghroum, Benson, Forward, & Gournay, 2006). A review of the training delivered at Broadmoor High Secure Hospital identified that staff were expected to learn 21 techniques, involving 104 component parts in just seven and a half hours (Rogers et al. 2007).

National guidelines stipulate that restrictive interventions should only be used as a last resort. Despite this, one study found that only half of trained nurses working on psychiatric intensive care units (PICU) across England and Wales were asked to rate techniques they personally use most in practice. They rated verbal de-escalation as one of their three most used techniques (Lee, et al., 2001). A further study asked nurses about the techniques most frequently used on the wards where they worked and found that verbal de-escalation techniques did not make the top three, whilst 21% of those asked reported taking the person to the floor in prone restraint as one of the most frequently used techniques learnt in mandatory training for managing challenging scenarios (Wright, et al., 2005). This indicates that there is a discrepancy between the national guidelines and clinical practice. One study found that the decision to use restrictive interventions was influenced by contextual demands, a reported lack of alternatives, perceptions of risk and the escalatory effects of restrictive interventions themselves (Perkins, Prosser, Riley, & Whittington, 2012).
There is an assumption in the literature that restrictive interventions are used to manage violent incidents, but some studies have found that ‘challenging behaviour’ is the term most often cited as the reason for the use of physical interventions on incident forms (Ryan & Bowers, 2006). Furthermore, a review by Stewart, Bowers, Simpson, Ryan and Tziggili (2009) demonstrated that more robust studies point to a range of behaviours, including attempts to abscond, refusal to take medication or comply with instructions and agitation, resulted in the use of restrictive interventions.

1.8 Staff Stress and Burnout

Despite the terms being widely used, the concepts of staff stress and burnout are not clearly defined. To the lay population, stress is typically viewed as a harmful and unwanted emotional and physiological response to excessive pressures and demands. However, under some conditions, benefits of short-term stress have been identified, for example increasing motivation and active learning (Amabile, Barsade, Mueller & Straw, 2005; Seligman & Csikzentmihalyi, 2000).

Formal definitions of stress have taken different forms over time. Typically, definitions and theories of stress have built on the Yerkes-Dodson Law (1908; Cited in Cooper, Cooper & Eaker, 1988). This defines stress as a parabolic equation, where performance increases with arousal to an optimum point, from which further increases in arousal lead to a reduction in performance.

Selye, a biologist often regarded as the pioneer of stress research, defined stress as a nonspecific biological response (arousal) to any demand following three physiological stages of alarm, resistance and exhaustion (Selye, 1956). This acute stress response can become maladaptive under continuous activation, as in the case of chronic stress (Selye, 1950). In turn, this can take a physiological toll on the body; for example, chronically elevated blood pressure can damage arteries and lead to formation of plaque, whilst elevated levels of stress hormones affect cytokine profiles and may suppress the immune system and may thus lead to a vulnerability to viral infections (Schneiderman, Ironson & Siegel, 2005). Paradoxically, elevated levels of stress hormones have also been found to lead to excessive inflammation and
autoimmune reactions (Schneiderman, Ironson, & Siegel, 2005). Although this model is able to account for the effects of chronic stress, it has been critiqued for its over-emphasis on physiological factors and under-emphasis on psychological factors (Lazarus & Folkman, 1984).

More modern theories of stress take an interactional approach, viewing the stress response as an interaction between individual and environmental factors (Derogatis & Coon, 1993). Lazarus and Folkman (1999) proposed that there are three components involved in a stress reaction, an internal or external event (the “stressor”), the individual’s appraisal of the stressor and the individual’s evaluation of their resources to cope with the stressor. Coping is another commonly used concept that is difficult to define, and is typically considered to be a balance of demands and resources to manage those demands (Rodney, 2000).

This interactional approach forms the basis of the concepts of occupational stress. Occupational stress is another concept with competing definitions. At their core they consider occupational stress to result from a mismatch in demands made on the individual and their ability to manage these demands based on their level of personal control and resources to cope (Karasek, 1979; French, Caplan & Van Harrisson, 1982; Osipow & Spokane, 1984).

A number of adverse effects of occupational stress have been identified. These include a loss of morale, reduction in productivity, poor working relationships and unsafe working practices (Health & Safety Executive (HSE), 1995). At its extreme, work-related stress has been termed “burnout”, a label in itself that forms a powerful metaphor to describe an employee as fully consumed with no resources left. As a concept, burnout has been described as “a state of physical and emotional depletion” resulting from “prolonged exposure to stressful working environments” (Khamisa, Oldenburg, Peltzer & Ilic, 2015 p.653). A review of the existing literature identified that between 21 and 48% of mental health workers have reported experiences of burnout (Morse, Salyers, Rollins, Monroe-DeVita & Pfhaler, 2012). However, despite common usage of the term, it is not clearly defined.
Three dimensions have been identified in the conceptualisation of burnout: emotional exhaustion, depersonalisation of service-users and a reduced feeling of personal accomplishment (Jackson & Leiter, 1996; Maslach, Jackson & Leiter, 1996). However, this has been critiqued for its circular nature, as it is arguable that emotional exhaustion, depersonalisation of service-users and a reduced feeling of personal accomplishment could be both consequences of and factors leading to burnout (Kristensen, Borritz, Villadsen & Christensen, 2005).

The high-stress environment in which nurses work has been well documented (Humpel & Caputi, 2001; Tully, 2004). The level of occupational stress experienced by nurses, and other healthcare professionals, working across the NHS’ physical and mental healthcare services is higher than other comparable professions (Bamber, 2006; Edwards & Burnard, 2003; Williams, Michie, & Pattani, 1998). Wide scale studies of staff from across the NHS, twenty years ago, found that over a quarter of nurses were experiencing minor mental health difficulties such as anxiety and depression, compared with less than a fifth of the general population (Borrill, Wall & West, 1996; Wall et al., 1997). Similarly, higher levels of general fatigue and psychological distress were experienced by NHS staff, particularly nursing staff, compared to figures from the general population (Hardy, Shapiro & Borrill, 1997). Mental health nurses are a professional group that are identified as being at risk of burn-out and stress due to the nature of their work (Jenkins, & Elliott, 2004; Klifedder, Power, & Wells, 2001). In particular, work in inpatient and residential settings, where there are increased risks of incidents of challenging behaviour, has been associated with an increased risk of burnout in staff (Jenkins, Rose & Lovell, 1997).

Jenkins and Elliott (2004) aimed to explore burn-out and stress for nurses working on inpatient mental health wards. They found that approximately half of all nursing staff showed signs of burnout in terms of emotional exhaustion. Stressors included inadequate staffing levels, workload stress, “physically threatening, difficult or demanding” service-users and positively correlated with depersonalisation and emotional exhaustion. Qualitative research has identified that employment insecurity, inadequate resources, aggressive
behaviour from service-users, lack of value for nurses and service-users, physical and emotional constraints of the work setting and relationships with colleagues, including doctors and other nurses, to be sources of work-related stress for mental health nurses (Taylor & Barling, 2004). Kindy, Petersen & Parkhurst (2005) conducted a phenomenological study where nurses interviewed, constructed their work as “perilous” and reported physical and psychological risks of violence and aggression. This influenced how they then acted in their role as nurses to manage their own distress. Further, a national survey of nurses in inpatient mental health services found 73% of nurses reported having been assaulted at work at least once, with a mean of 6.7 assaults over the course of their career (Wright et al., 2005).

Practical factors such as too much paperwork, staff shortages, unsupportive communication, unsupportive management, injuries and verbal aggression have also been associated with an increased risk of burnout in nurses (Bowers & Flood, 2008; Farrell & Doves, 1999; Sullivan, 1998; Flannery, Farley, Rego & Walker, 2007). Within an NHS context, workloads, self-doubt and relationships with both other professionals and service-users have also been associated with burnout (Tyler & Lushway, 1992). Menzies-Lyth (1988) identified further causes of stress for nurses across all healthcare settings. These include the daily confrontation of suffering and pain; working with people who are ill and under stress; the heavy demands placed on nurses to provide pity, compassion and sympathy to others; the impossible demands placed on nurses for comfort and cure; physical contact with service-users that may be overstimulating and disturbing; feelings of irritability and resentment towards service-users which leads to feelings of guilt and anxiety; and tasks that “by ordinary standards” are considered “disgusting, distasteful and frightening” (Menzies-Lyth, 1988, p. 101).

Moral distress (Jameton, 1993) refers to the painful feelings as a result of the dilemma of believing one knows the right thing to do, but being unable to do this. For example, co-worker disagreement or institutional boundaries may not allow this. In the nursing context institutional boundaries could include a lack of time, lack of supervisory support and institutional policy. Moral distress
leads to internal conflict and a reduced sense of personal accomplishment and is therefore associated with stress and burnout.

The experience of burnout itself has been associated with low optimism, negative responses to challenging behaviour and less willingness to help in a study of staff responses to challenging behaviour in a dementia setting (Todd & Watts, 2004). In mental health workers, burnout has been associated with an increase in rejecting attitudes towards service-users (Holmqvist & Jeanneau, 2006) and can lead to a milieu that facilitates abusive practices (White, Holland, Marsland & Oakes, 2003). It has been found that mental health nursing has fallen into a defensive and reactive mode of practice, which could be considered to be a by-product of working in an acute environment and an attempt by nurses to protect themselves from burnout (Mullen, Admiraal, & Trevera, 2008).

The NHS, which has faced continual waves of increasingly contentious and radical changes since the 1970s (Litwienko & Cooper, 1997; Savage, 1993), is conducive to occupational stress. This has led to problems in recruitment and retention of nursing staff within the NHS, particularly within mental health settings (Williams, Michie, & Pattani, 1998).

1.9 A Review of Factors Influencing Mental Health Nurses’ Attitudes to Their Work With Service-Users

The concept of an attitude relates to a “relatively enduring organisation of beliefs, feelings and behavioural tendencies towards socially significant objects, groups, events or symbols” (Hogg & Vaughn, 2005, p.150). They function to allow us to know or predict what is likely to happen, to express ourselves and assert our identity, protect our self-esteem, for example by justifying actions that make us feel guilty and to promote social acceptance (Katz, 1960). However, it is important to note that attitudes have not been found to always influence behaviour (LaPiere, 1934).

Although to date, little to no research has specifically investigated factors that influence mental health nurses’ attitudes to their work with clients. However, the limited research available has identified some factors likely to hold some
influence. For example, stigma, diagnostic labels, moral distress, burnout, and experience.

As discussed in section 1.7 staff stress and burnout influence attitudes (Holmqvist & Jeanneau, 2006; Kindy et al., 2005). Menzies-Lyth (1988) formulated how this stress not only influences attitudes but also affects practice as it leads to an organisation of nurses that acts to defend against anxiety. From a literature review, a number of other factors that have been identified as influencing nurses’ attitudes to work with users of mental health services have been identified. However, it is important to note that in general these could be mediated by stress or societal processes of stigma.

Stigmatising attitudes are likely to influence attitudes of mental health nurses towards their work with service-users. Nordt, Rössler, & Lauber (2006) found that mental health professionals do not typically have less stigmatising attitudes towards those with mental health difficulties. In particular, they identified that psychiatrists demonstrated more negative stereotypes than the general public and there was no significant difference in measures of social distance for mental health professionals as a group and the general public. However, mental health professionals, as a group, were less likely to condone restrictions for those with mental health difficulties. However, the response rate for mental health professionals was low and it is of note that these attitudes do not necessarily translate to real life behaviours. However, a different study by the same authors did not have consistent findings with this (Lauber, Nordt, Braunschweig, & Rössler, 2006).

The type of diagnosis a service-user is given has been found to influence nurses attitudes towards those service-users, particularly for those with Borderline Personality Disorder (BPD), a group of service-users who appear to be particularly vulnerable to stigma. In a systematic review of the literature, Westwood and Barker (2010) found that registered mental health nurses demonstrated more negative attitudes towards those with BPD and their behaviour than those with other diagnostic labels such as Schizophrenia and Depression. These include greater social rejection leading to increased social distance and perceiving those with BPD as more dangerous than other
service users exhibiting similar behaviours. It is considered by the authors of the papers reviewed that this is likely to be in response to unpleasant interactions with those service-users and a perceived inability, or lack of skills and knowledge in how to work with and help this group (Westwood, & Barker, 2010; Woollaston & Hixenbaugh, 2008). More recent studies have supported these findings. For example Bodner, Cohen-Fridel & Lancu (2011) found that those diagnosed with BPD elicited antagonistic judgements amongst mental health professionals. In particular, mental health nurses were found to show less empathy towards this group than psychiatrists and psychologists. The perceived difficulty in treating these patients and challenging behaviours, for example self-harm and suicidality, exhibited were found to influence these attitudes. All professional groups reported they were interested in learning more about how to “treat” those with BPD.

Markham and Trower (2003) identified that nursing staff perceived those with a diagnosis of BPD to be more in control of their challenging behaviour than those with schizophrenia or depression and thus felt less sympathy for this group. They drew on Weiner’s (1972) model of attributions to interpret their findings. Further linked to the dimension of stability in Weiner’s (1972) theory of attributions Hugo (2001) found that professionals tended to base their attitudes about prognosis and long term consequences for those with mental health difficulties. Compared with other professional groups, mental health nurses were found to have more optimistic attitudes.

Munro and Baker (2007) proposed that attitudes are reflective of values and that the difficulties in recruitment and retention, poor environmental conditions and continuing lack of MDT input into inpatient mental health services suggests that this is an area that is not highly valued. However, they do not make the relationship between attitudes and values clear, nor do they specify whether this is an area not highly valued by inpatient mental health nurses as well as society more generally. However, these are all factors that influence staff stress and burnout.

Whittington (2002) found that more experienced staff working in community mental health care were more tolerant of aggression and that this was
associated with lower levels of burnout compared to staff with less reported
tolerance of aggression. However, it is unclear of the nature of this
relationship, whether it is tolerance that acts as a protective mechanism
against burnout or higher levels of burnout reducing tolerance. It is plausible
that recent involvement in an incident may also influence both tolerance and
burnout.

Likewise, Austin, Bergum & Goldberg (2003) found that mental health nurses
experience moral distress where lack of resource (time, staff) leads to
dispiritedness, absence of recognition and a lack of respect between nurses
and their service-users, which in turn led to poorer quality of care. The authors
reported on how nurses described colleagues who would switch off from their
patients’ distress and then would feel subsequently feel isolated in their work
when trying to do the best they could, but that this was hard to sustain.

The experience, or threat, of aggression and violence is another factor likely
to influence nurses' attitudes towards their work with service-users. Patient
aggression has been found to have negative effects on staff wellbeing, job
motivation and the quality of care delivered (Stanko, 2002; Arnetz & Arnetz,
2001). It has been noted that nurses' attitudes about the reasons for
aggression might influence their responses (Whittington & Higgins, 2002;
Collins, 1994). Key to this research is the finding from Breeze and Repper’s
(1998) ethnographic study, where staff and service-users are considered to
be “struggling for control” (p. 1307) through cycles of challenging behaviour
and restrictive interventions.

Ethnicity may play a role in mental health nurses’ attitudes towards their work
with clients. The CQC has found that inpatient service-users from non-white
British ethnic groups were significantly more likely to be detained under the
Mental Health Act and placed in seclusion (CQC. 2010). Further, those from
minority ethnic groups have reported some of the worst experiences of mental
health services (CQC, 2014). However, reasons for this have not yet been
investigated.

Three modes of attitudes have been proposed for nurses’ attitudes, towards
service-user aggression, that maps loosely onto Weiner’s (1972) model of
attributions: Internal, external and situational/interactional. The internal attitude is where inherent characteristics are considered to be the aggression and is underpinned by the biomedical model. This attitude has been found to be prevalent amongst mental health nurses (Outlaw & Lowery, 1994; Duxbury, 1999; 2002), and acts to free the individual from responsibility, placing that solely within the service-user (Poster, 1996; Duxbury, 1999). In contrast, the external attitude is one that focuses on the environmental factors that contribute to aggression, such as the ward atmosphere (Morrison, 1998) and staff characteristics including their interactions with service-users (Whittington & Wyke, 1994). Finally, the situation/interactional attitude combines elements from the internal and external model, but prioritise the interpersonal context, with the staff – service-user interaction as integral (Whittington & Wykes, 1994; Duxbury, 1999; 2002).

Hahn, Needham, Abderhalden, Duxbury & Halfens (2006) found that such attitudes remain stable despite training aimed at altering this perspective and changing the management of violence and aggression in mental health. The authors concluded that in isolation such training is not sufficient for change.

Some research has been conducted into general nurses’ attitudes towards those with mental health difficulties. Van der Kluit & Gossens (2011) identified that general nurses’ attitudes towards those with comorbid mental health difficulties were influenced by a number of professional, organisational and personal characteristics that may be transferrable to mental health nurses. In terms of professional characteristics, they found that those with more knowledge and skills in mental health and those with a higher level of education had more positive attitudes towards these service-users. More experience in caring for those with comorbid mental health difficulties was also associated with more positive attitudes. Those reporting greater satisfaction at work were more likely to report more positive attitudes.

In terms of organisational characteristics, having less time led to less positive attitudes to this group and less support from management also led to less positive attitudes. In terms of personal characteristics, those who reported having friends and relatives who have experienced mental health difficulties
reported more positive attitudes. However, those with a more authoritarian style were less positive.

1.10 Attitudes Towards People Who are Different

Social Identity Theory (Tajfel & Turner, 1979)

Social Identity Theory (Tajfel & Turner, 1979) proposes that group membership gives people a sense of social identity and is a source of self-esteem. To increase our own self-image and to enhance the status of the groups to which we belong (ingroups) we act by discriminating or being prejudiced against other groups (outgroups). This separates us into groups of “us” and “them”, allowing one group to identify and accept their own social identity and discriminate against others (Widdicombe & Wooffitt, 1990).

Tajfel (1978) proposed that we stereotype as a normal cognitive process based on this and in doing this we exaggerate the similarities of the ingroup and the differences between this and other groups. Behaviour is then defined by reference to the norms of the group. This can lead to discrimination and stigma against those who are considered to be different. From a discourse analysis perspective, this acts to legitimise one’s social identity and authentic group membership (Widdicombe & Wooffitt, 1990).

Stigma

Stigma is a process within the social construction of identity. Those people who become associated with a stigmatised status become “discredited” in their social status (Yang, et al., 2000) hypothesised that signals of mental illness, for example people acting in ways or saying things that could be considered odd, leads to stereotyping which in turn can lead to behavioural interactions from others that include discrimination. Corrigan suggested that signals of dangerousness lead directly to a fear response which in turn leads to avoidance and discrimination (Corrigan, 2003).

Foucault (1970) reflected how “madmen” as a group are vulnerable to stigmatisation, particularly since the industrial revolution. The most frequent
contact that the general population knowingly has with those with mental illness, or indeed other differences, is through the media which frequently presents them as unpredictable, violent and dangerous, despite this representing only a minority (Arboleda-Florez, 2008). This means that despite their numbers, people with mental illness are positioned as disempowered by society (Arboleda-Florez, 2008). However, it is likely that the general population unknowingly has daily contact with people who have mental health difficulties but do not fit this profile.

Stigma is the socio-cultural process in which particular groups are devalued, rejected and excluded on the basis of a particular characteristic which positions them as in a “different” societal group to the majority (Weiss, Ramakrishna and Somma, 2006). In considering the conceptualisation of stigma, the etymology of the word “stigma” itself is important. “Stigma” as a term originated in Ancient Greece and was used to describe the branding or tattooing of the skin of slaves and criminals to visibly mark them so that other people would know how to interact with them as a devalued person (Arboleda-Florez, 2008).

Jones, et al. (1984) conceptualised stigma towards those with physical and mental health conditions as having six separate dimensions: (i) Concealability: How detectable characteristics are and the concealment of these attempted by the stigmatised person in order to avoid negative social consequences. (ii) Course: Whether the “stigmatised condition” is considered reversible, with irreversibility or “hard to see changes” leading to increased negative attitudes towards the person. (iii) Disruptiveness: The degree to which the “stigmatised condition” strains or obstructs interpersonal interactions. (iv) Aesthetics: The extent to which a characteristic is perceived as pleasing or leading to concerns that elicit disgust, with less pleasing characteristics leading to an increased risk of rejection. (v) Origin: How the condition is perceived to have developed, with perceptions of the person being responsible for it leading to increased risk of discrimination. (iv) Peril: The extent to which the condition is associated with actual or perceived physical threats to others or perceived feelings of discomfort. These concepts broadly map onto the dimensions of Weiner’s (1972) theory of attribution, in that those that are more likely to be
stigmatised are perceived as being more in control of their actions and the consequences of these actions, more in control of the origins of their difference and unlikely to be able to change. The concept of peril is key to understanding how nurses’ attitudes to their work in inpatient mental health services, as they have been identified to construct their work as “perilous” in response to risks of violence and aggression (Kindy et al., 2005).

Jones et al.’s (1984) model, along with other earlier models of stigma have been criticised for their location of stigma as being somehow within the stigmatised individual (Arboleda-Florez, 2008). Link and Phelan (2001) offered a broader definition of the social conditions under which stigma can occur: “when elements of labelling, stereotyping, separatus, status loss and discrimination co-occur in a power situation that allow them to unfold” (Link & Phelan, 2001, p. 367). This has since been expanded to include emotional responses (Link, Yang, Phelan & Collins, 2004). All of which are arguably applicable to inpatient service-users.

Stigma manifests at three levels: (i) Within the self; in the negative feelings one holds towards themselves and maladaptive behaviours that may endorse stereotypes in response to experiences, perceptions and expectations of others’ negative social interactions. (ii) Socially; in the process of larger social groups acting in ways that endorse discrimination and stereotyping of a stigmatised group, (iii) Structurally; in the rules, policies and procedures of institutions that restrict the rights and opportunities for those members of groups that have been stigmatised (Corrigan, Kerr & Knudson, 2005; Herek, 2007; Herek, Gillis & Cogan, 2009). All of which is largely socially constructed through language.

**Social Role Valorisation (SRV)**

SRV attempts to provide a different view where people of “difference”, such as those with physical or learning disabilities, mental health difficulties and illness, are likely to be negatively perceived and thus devalued and stigmatised by society. This in turn is considered to lead to segregation, reduce the likeliness of their needs being met and a reduction in opportunities (Wolfensberger, 1987). However, SRV argues that needs can be met and
stigma reduced where environments and relationship are tailored to maximise valued perceptions of the person (Wolfensberger & Thomas, 1983).

1.11 Psychological Theories That Have Informed This Research

A number of psychological theories account for why people act in ways that are contrary to how they believe they should. Rotter’s theory of locus of control (Rotter, 1954) states that people act in accordance with how much they believe they have control over the outcome of a particular event. These loci of control are considered to be socially learned and can be either internal (the person believes that they can control the outcome) or external (the person believes that they cannot control the outcome which is controlled by outside factors that they cannot influence). For example, a person with an internal locus of control is likely to blame or praise themselves for an outcome, whilst a person with an external locus of control would blame or praise other factors. This could correspond with how nurses account for their interactions with others. For example, if they had an internal locus of control, they may be more likely to blame themselves for a negative response from the person with whom they are interacting. In contrast, if they have an external locus of control, they are more likely to attribute blame to the other person and not consider their potential role within the interaction. This may contradict how they would expect to respond in a given situation.

Locus of control has been shown to predict outcomes such as job satisfaction and job performance, with internal loci of control associated with greater job satisfaction and performance (Judge, Locke & Durham, 1997). Further, an internal locus of control has been found to be a predictive variable for behaviour change and has informed the development of the theory of planned behaviour, which provides a framework to understand why people do not always act in ways that they intend to (Ajzen, 2002).

Weiner’s attributions theory (Weiner, 1972), builds on the theory of locus of control, by proposing that the attributions we make of our own and others’ behaviour are based on three dimensions: (i)Locus of control: How much control we perceive the person to have over the outcome of their behaviour,
Stability: Whether we believe the person’s behaviour is static or capable of changing over time and (iii) Controllability: How much we perceive the person to be in control of their behaviour, for example having a particular set of skills or responding to an uncontrollable cause such as someone else’s actions.

It has been found that the care staff working with people with learning disabilities are more likely to help when they attribute challenging behaviours to be external, unstable and uncontrollable for the service user (Stanley and Standen, 2000). However, not all studies have been consistent in this finding (Bailey, Hare, Hatton, and Limb, 2006).

An alternative theory as to why people may act in ways that they do not believe are right, is Milgram’s theory of Obedience to authority (Milgram, 1967). Milgram found that ordinary people will follow orders from an authority figure who they perceive to have some sort of moral or legal authority. He proposed in his agency theory that people can either behave in an autonomous state where they see themselves as directly responsible for their own actions and the results of these, or an agentic state, where they allow others to direct their actions and pass on responsibility for the consequences of these to the person in authority. To enter into this agentic state, the person in authority must be perceived as legitimate and qualified to direct another’s behaviour, and it must be believed that they will accept responsibility for the outcome of this action (Milgram, 1974). However, it is of note that Milgram’s theory is based on experiments conducted in a controlled laboratory setting, and although findings were consistent with replication studies (Packer, 2008), other factors may act as mediators in real world settings. It is of note that in manipulations of Milgram’s study where participants have been required to physically administer the shock themselves, they have been significantly less compliant (Packer, 2008).

Milgram conducted his research in response to the atrocities of the second world war. His research relates to the defence of superior orders, often referred to as the Nuremberg defence, that was drawn on by Nazi defendants during the Nuremberg trials. It was during these trials that it was ruled that this
defence does not absolve the individual of responsibility for their actions (King, 2002).

Hofling (1966) studied this social phenomenon in a hospital setting where a doctor (stooge) told nurses to administer twice the maximum dose of a drug (placebo) and that he would sign the authorisation form later. Ninety-five percent of nurses did so, despite this meaning that they would have broken three hospital rules: That they were not allowed to accept instructions over the phone, that it was double the maximum dose and that the medicine itself was not authorised. This demonstrates that people are unwilling to question “authority” even when they have good reasons to do so. However, findings from other studies on a similar topic have not always been consistent. For example, Rank and Jacobsen (1977) found that all but two of nurses asked to administer a known drug above its recommended limits did not comply. However, in a survey study, Krackow and Blass (1995) found that nurses typically reported being obedient, relinquishing responsibility to doctors.

Further, Asch’s (1951) theory of social conformity implies that people will conform with a majority’s opinion if they believe the group is better informed than they are, an informational influence, or if they want to fit in with the group and avoid ridicule, a normative influence. Dominant discourses could arguably lead to conformity through both normative and informational influences, particularly where discourses are led by authority figures, such as doctors.

Festinger’s (1957) theory of cognitive dissonance explains that people find it uncomfortable when they experience inconsistency, or dissonance, between attitudes or beliefs and behaviour. When this occurs, we exert cognitive effort to minimise the dissonance, by changing the attitude so that the behaviour can be accommodated. Festinger argued that this can be achieved in three ways: By reducing the importance of the inconsistent belief, by looking for more beliefs that are consonant to the behaviour so that these outweigh the inconsistent belief or by changing the inconsistent belief so that it is no longer dissonant.

The theory of cognitive dissonance may explain how alternative discourses become marginalised by nurses who work in environments where they are
required to work in accordance with the dominant biomedical discourse. For example, attributional and stigmatising discourses of service-users with challenging behaviour may be drawn on to neutralise dissonance and accommodate the limited range of management strategies allowed by the Biomedical discourse. Lewin’s (1935) approach- avoidance conflict can further account for why staff may find it difficult to introduce proactive rather than reactive strategies in the management of challenging behaviour. Approach-avoidance conflict (Lewin, 1935) proposes that we experience conflict when a goal is simultaneously experienced as both desirable and undesirable due to it having both positive and negative valence. Lewin proposed that there are three factors that could lead us to approach or avoid a goal. These are the tension created by need, the magnitude of the valence and the psychological distance from the goal.

A goal that may be held by nurses in the inpatient mental health setting is to deliver care and containment without being harmed. Conflicting demands of wanting to show care and build relationships, whilst not wanting to get close to people who might pose some risk to them leads to tension when managing risk, with the stronger valence toward avoiding harm. Psychological distance can be achieved through focus on other tasks demanded of them that do not involve contact with service-users (and likely to have negative consequences if not completed). This allows the nurses to put boundaries in place, avoiding building relationships with service-users in order to minimise opportunities of risk events. However, this acts against person-centred, proactive care approaches and runs the risk of needs going unmet, and thus increases of challenging behaviour as a result.

Menzies-Lyth (1960; 1988) conducted detailed observations and interviews with staff at a teaching hospital that was having significant problems with retention and morale of nurses. She identified a number of stressors experienced by nurses working in physical health care. This included constant contact with illness and injury; uncertain recovery; the reality of suffering and tasks that are considered distasteful, disgusting or frightening. Many of these are relevant for those working in mental health care. Menzies-Lyth (1960)
formulates that this can lead to strong and conflicting feelings of pity, compassion, disgust, guilt, anxiety, resentment and envy. These are amplified by having to meet and manage other people’s complex feelings towards the hospital setting, e.g. those of service-users and relatives. In order to protect themselves from the anxiety elicited by their work, Menzies-Lyth identified a number of defences that nurses engage in. These include focusing on clinical tasks to reduce the anxiety elicited by relating to service-users; depersonalising the service-user and denying the significance of their individualism; detaching from and denying difficult feelings elicited by nursing; standardising nursing procedures to eliminate decision making; and by assigning responsibility and irresponsibility to other groups – service-users, superiors and subordinates or other groups of professionals. Menzies-Lyth also argued that nurses are resistant to change as this threatens their defences against anxiety.

However, the nursing system in the hospital where Menzies-Lyth undertook her research resisted her findings, insisting that the problem was due to the hospital being “incompetently run”. Menzies-Lyth considered this to be an example of the resistance to change that she had highlighted (Menzies-Lyth, 1988). Despite this resistance to change being a common challenge, organisational learning based on such consideration of maladaptive social defences is considered seminal and has been, successfully achieved in other cases (Bain, 1998; Brown, Crawford, & Darong Karma, 2000; Corely, 2002).

1.12 Reflections

The motivation behind this research came from my personal experience, particularly that of working as health care assistant and then an activities coordinator on a PICU for women. There, I experienced as a staff member, how restrictive and coercive practices, not just the use of rapid tranquillisation, seclusion and restraint but also things like blanket rules and a lack of the individual’s involvement in their care were common. It was my experience that not enough thought went into understanding the behaviour and proactive

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10 A reflective journal was kept for the duration of this project and has been consulted in the writing of these reflective sections found throughout the extended paper.
approaches to its prevention. I felt that alternatives were rarely used and often restrictive interventions were the first, rather than the last resort. Whilst I could appreciate the pressures on staff, I felt there was a distinct lack of awareness, or openness, to psychosocial approaches and an over-reliance on the biomedical model and use of medication, often when service-users articulated preferences against medication, or particular medications or when they had voiced preference for psychosocial interventions. This ward had limited input from a highly motivated and experienced Clinical Psychologist, but who was the only psychologist across all six of the inpatient acute and PICU wards at that hospital site.

In my role as activities coordinator, I was able to demonstrate to my colleagues that meaningful engagement could reduce the risk of incidents. Challenging practices of restrictive interventions, however, was more difficult as there was a biomedical view to the behaviours that challenged and a sense of fear and risk that aggression and violence was inevitable and often unpredictable and so restrictive interventions and medication were considered the only way to maintain control and order. At times I had a sense that seclusion was at times used as a punishment. I wanted to understand why my colleagues, and friends, were unable to share my perspective despite being caring and compassionate people who wanted to help our service-users. Conversations with service-users who shared with me their distressing experiences of being restrained, placed in seclusion or witnessing this happen to others motivated me to question and challenge these practices. The Mind Report (Mind, 2013) was published shortly before I left the PICU and validated my concerns and motivation to understand what was happening in staff-teams on these wards to, hopefully, facilitate change. Further whilst I was conducting the interviews, in September 2016, there were widespread news reports regarding the inquest following the death of Chris Brennan. Chris Brennan asphyxiated after swallowing a foreign object on an inpatient mental health ward. The coroner found that despite a care meeting days before the incident, there had been no discussion about his escalating behaviours of concern and that staff had become “desensitised” towards self-harm due to frequency of
incidents. They also concluded that the ward had been struggling to maintain basic functions due to staffing issues and low morale (BBC, 2016).

More recently, publications where service-users have shared their experiences of restrictive interventions during inpatient care have demonstrated that this continues to be a problem in some areas. With progress led by campaigns, policy and guidelines than had been hoped, and in some areas met with barriers (Anonymous, 2017; Mind, 2013; 2015 and O’Brien, 2017).

Service-user involvement was sought in the design and planning of this research. I met with a member of the service-user and carer panels that support the course through which I am training as a clinical psychologist. Although this member had not personally experienced physical restraint, they had witnessed it during their inpatient experience and shared their experiences with me where, at times, staff had been experienced as bullying. They told me that they felt that this would be an important research project and recommended that I also interview health care assistants, as they are often involved in incidents of restraint. This was considered carefully in supervision, but due to the scope and time frame of the project it was decided to focus on just one professional group. I also have some friends who have experienced inpatient mental health care in different parts of the UK and have shared with me, informally, their thoughts on my plans for this research.

Throughout the process of this research project, I was aware of my motivations behind it and the emotional experiences that have motivated and fuelled it. I was keen for these not to skew the perspective of this research and have carefully considered my motivation, and emotions, and their potential input.

2. Extended Methodology

2.1 Epistemological Considerations

Epistemological positions are important as a framework for making sense of the knowledge produced through research (Riley & Reason, 2015). In the history of science exploring human mental life, much attention has been given
to the development of rigorous specifications and procedures to measure phenomena and forming quantitative methodologies that are only able give an indication of the magnitude of that phenomenon (Werts, et al., 2011). In contrast, there has been relatively little attention given to the field of qualitative research that aims to investigate what a subject of interest is, in all of its real-world complexity (Werts et al., 2011). This is true in my experience of studying psychology, where there has been an emphasis on positivist stance, empiricism and the view that there is a discoverable ‘truth’ to be found by researchers through the employment of carefully designed experiments. For example, the emphasis on randomised controlled trials to evaluate the effectiveness of a psychological therapy.

The converse of a positivist stance is social constructionism, which essentially subscribes to a position that realities in the social world are constructed through language and discourse, rather than there being an underlying ‘truth’ to discover (Andrews, 2012).

On the bridge between positivism and social constructionism spans the spectrum of critical realism. Critical realism acknowledges that to be and see in the world is mediated through social constructions provided by language, though they are grounded in material structures such as institutions and their practices (Nightingale & Crombie, 1999). This approach was considered a good match to the aims of this research, to explore the discourses of challenging behaviour and its management, drawn on by RMNs working on inpatient mental health wards. This position also reflects my personal viewpoint and the view of discourse analysts, that discursive constructions have 'real' effects in the work place (Willig, 2008). This thesis subscribes to a critical realist position that is weighted towards social constructionism.

2.2 Methodological Considerations

Different qualitative methodologies were considered for the research questions, including interpretative phenomenological analysis (IPA), grounded theory (GT) and discourse analysis (DA).
2.2.1 Interpretative Phenomenological Analysis

IPA is an approach that is specifically concerned with the personal meaning and lived experience, to get close to the participant’s personal world, or ‘insider’s perspective’ (Conrad, 1987). It is widely used in psychology and related disciplines to explore in detail the personal meaning that participants hold for particular experiences and events rather than the experiences or events themselves (Smith & Osborn, 2015). IPA assumes a chain between talking and thinking and works to interpret the person’s emotional and mental state from what they say. Therefore, IPA is a cognitivist methodology. However, it does not eschew generalisations, rather it is interested in lived experiences from the personal perception of the individual. From here it works cautiously to make tentative claims that are more general. IPA is primarily concerned with the individual’s account of their experience (Smith & Osborn, 2015).

As a methodology it is able to ask critical questions of the data, such as “what is the participant trying to achieve through this?” and can consider whether something is coming through that was unintended to interpret the mental and emotional state that underlie what is said (Smith & Osborn, 2015). Typically research questions that would adopt an IPA approach would be interested in the individual and the cognitive sense making process of a particular experience, rather than the social context. For example, IPA might ask questions such as “what is it like to experience aggression at work?”.

2.2ii Grounded Theory

GT is an inductive method that aims to study the external world, and generate theory from data, flexibly exploring general questions related to a topic of interest (Charmaz, 2015). GT works in converse to traditional quantitative methods that aim to generate data to test a hypothesis (Charmaz, 2015). Instead it consists of an open-ended and flexible methodological approach that aims to build theories from inductive data and contains both positivistic and interpretive elements (Charmaz, 2015). Although originally a positivist methodology, GT has adapted over time and can be used from a constuctivist stance by adopting a pragmatist emphasis on language meaning and action.
GT differs from IPA as it is concerned with investigating experiences and events themselves, rather than the individuals’ interpretations of these. For example, a GT approach may be used to answer research questions such as “what is the impact of aggressive confrontations at work on the nurse identity?”.

2.2.iii Discourse Analysis

DA is a methodology that subscribes to the social constructionist belief that language is not unambiguous and descriptive, but an active tool that constructs versions of social reality and that the way people talk, tells us something about what they are using the tool of language for, such as disclaiming, persuading, justifying and excusing, rather than using words as a representation of a cognitive structure, as in IPA (Willig, 2015). However, DA also fits with a critical realist position through which it is argued that the nature of people, institutions and power relations flow from an overarching ideological context, rather than from individuals’ attitudes and motivations (Parker, 1992). DA is concerned in studying the meaning and meaning making where it occurs, in language. Not because this is considered to provide a direct relation to universal truths, but because it is through language that meaning making and action taking are constructed or contested in the social world (Dunn & Neumann, 2016). Discourses provide a framework for understanding the world, within which they represent the constructed “regimes of truth” and “knowledge” and how these open and close opportunities for action (Willig, 2015; Dunn & Neumann, 2016). It is considered that “discourses make intelligible some of the ways of being in and acting towards the world and operationalising a particular “regime of truth” while excluding other possible modes of identity and action” (Miliken, 1999; cited in Dunn & Neumann, 2016) and therefore acts to both enable and constrain.

Culture is a way of collectively “knowing” in a social world (Bruner, 1993). This shared knowledge constructs a set of everyday practices (Scriber & Cole, 1981). Key to culture is the construction of shared meaning which acts as a lens through which we see the world (Jahoda, 1992). Dominant discourses and narratives act to form this lens, and so to understand the social
construction of a phenomenon it is important to investigate those dominant discourses that construct that shared meaning. The concept of culture represents something that is deeply socially ingrained and difficult to change, and is akin to the regimes of truth and lived ideologies of DA. It has further been cited as a factor in a number of inquiries investigating serious incidents in health care (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013; DoH, 2012) and other industries in which lives depend on the actions of others in control, such as aviation (Haddon-Cave, 2009).

The aims of this research are concerned with the discourse, social context and available ways of constructing challenging behaviour and acting in response to this. It is of note that although FDA is concerned with language and the role that language plays in social and psychological life (Willig, 2008), its focus goes beyond the immediate interpersonal context of language. FDA’s concern sits with the “regimes of truth” and the relationship between available discourses, and how this facilitates and limits what can be said and known (Parker, 1992). It is argued that as we confront social structures, particularly where there is unintentional resistance to change, there is a need to reflect on why the existence of alternative discourses does not necessarily equate to alternative social practices (Parker, 1992). Such discourses have ideological effects, and reproduce and maintain power relations (Parker, 1992).

In the context of inpatient mental health services, discourses exist in a variety of texts, such as talk, training, resources, books, medical notes and care plans. Parker (1992) proposes that much of the time, people are not aware of the discourses that form the architecture of our society, as such “it is not possible to say we create a society, rather we must either reproduce or transform it” (Parker, 1992 p. 37). Deconstruction of lived ideologies through recognition and reflection on the existing discourses, from a critical realist perspective has the potential to lead to prospects of change (Parker, 1992). It was therefore considered that DA was the most appropriate method to address the research question of what are nurses’ discourses of challenging behaviour in inpatient mental health services?

11 Please see section 3.1 for discussion of these terms.
Broadly speaking, there are two main schools of DA; discursive psychology (DP) and Foucauldian discourse analysis (FDA). These two types of DA are explored below.

**Discursive Psychology**

DP is concerned with the performative qualities of discourse, in particular “what are participants doing with their talk?” (Willig, 2015). DP prioritises the fluidity and variability of language as the primary site for meaning making (Stokoe & Wiggins, 2005; Willig, 2015). It takes a social constructionist stance where questions about “reality” are put to one side to consider how they are talked into being (Willig, 2008). The DP approach is interested in understanding the local interaction of talk and is not typically concerned with wider socio-cultural discourses (Willig, 2008; 2015).

**Foucauldian Discourse Analysis**

FDA was developed from the principles and writings of philosopher Michel Foucault. It is concerned with the way in which language constructs versions of reality that then become rationalised and legitimised (Parker, 1997). It is concerned with the broader socio-cultural discursive resources and power and is interested in the discourses people draw on to talk about a subject and the implications that these have (Willig, 2015). It assumes that although mediated socio-culturally through language, meanings to some degree are durable and standardised (Willig, 2008). These socio-cultural accounts are powerful and can enable or disable the available ways to construct versions of events and ways of acting (Willig, 2008). The term “subject position” refers to the location of people into certain positions through the way that they are talked about, or talk about themselves (Willig, 2008). The freedom to position oneself is reliant on access to power (Parker, 1992).

In FDA, power and language are considered inseparable (Willig, 2008; Dunn & Neumann, 2016). The availability of dominant discourses support and validate some positions but marginalise others, producing understandings that over time become taken for granted and treated as “common sense” and “truth” (Alvesson & Karreman, 2000; Dunn & Neumann, 2016).
Foucault (1969, trans. 2002) wrote about how the things that must be questioned are those that appear most immediately and are presented in a certain manner. He considered how as closer inspection of these “truths” occurs, the difficulties they pose become apparent. He reflected that every discourse rests not only on what has already been said, but also on the unsaid.

Therefore, Discourse Analysis, taking a mixed approach weighted towards FDA, was the most suitable methodology to explore the research question: What are the discourses drawn on by inpatient mental health nurses in talking about challenging behaviour and its management.

Combining DP and FDA

Whilst DP has criticised FDA for failing to take seriously certain aspects of language, such as the power negotiations during an ongoing interaction, FDA has argued that DP is reductionist (Alvesson & Karreman, 2000). It has been proposed that a combination of the two approaches is best practice for DA (Alvesson & Karreman, 2000). Therefore, this is the approach that has been taken for the analysis. Steps set out for both DP and FDA in Willig (2015) were combined and followed, in the analysis of the data, with a stronger focus on FDA12.

Existing Research

DA has been used to explore other psychiatric interventions, such as electroconvulsive therapy (ECT) (Johnstone & Frith, 2005) and how professionals talk about psychiatric diagnoses (Harper, 1994; 1995; O’Key, 2014). Johnstone and Frith (2005) conducted a discourse analysis of an influential paper presenting service-users’ experiences of ECT. They identified that where service-users refused to participate in the study or were critical of ECT, they were constructed as hostile, uncooperative, ignorant and unreliable. In contrast, those who reported neutral or positive experiences were constructed as passive, compliant and unquestioning. The authors concluded that this DA deconstructs the paper’s conclusions that ECT is

12 Please see Appendix 11.
helpful and not frightening and might serve to purpose the original authors’ own interests.

Benson, et al. (2003) have previously found that staff and service-users both presented themselves as “good people” and the “victim” in talk about incidents of violence and aggression, but staff drew on discourses of blame and personality whilst service-users drew on discourses of injustice in explaining the incidents. A number of studies have shown how dominant clinical practices are enabled and maintained through language (Harper, 1995; Parker, Georgaca, Harper, McLaughlin, & Stowell-Smith, 1995). Holmes and Murray (2011) conducted a DA study of documents regarding behavioural modification programmes in a Canadian secure hospital and found that they were more reflective of what staff valued and needed rather than service-users.

Hamilton and Manias (2006) reviewed ethnographic and discourse analytic research of mental health nurses’ use of language in acute inpatient settings. They reviewed studies that analysed spoken language and documentation. Identifying that discourses of moral judgement, common sense, objectification and empathy were drawn on. The authors also identified that there was a dominance of biomedical language and discourses of the organisation and bureaucracy. However, this research did not focus on the discourses drawn on in talking about challenging behaviour or nursing interventions.

2.3 Interviews

The use of interviews in DA research has been a topic of debate, with a preference raised for naturally occurring text and talk, particularly for DP (Potter & Hepburn, 2005). This is because DP is concerned with how people manage issues of accountability and stake during social interactions (Willig, 2015). Such data would include recordings of neutrally occurring conversations in “real world” formal (e.g. MDT meetings and handovers) and informal (e.g. conversations between colleagues and service-users on the ward). However, there are ethical and practical difficulties in collecting such data and so many discourse analysts have turned to the use of semi-structured interviews. It has been argued that such interview data will allow for
the production of routinised discourses and therefore holds ethnographic relevance.

The semi-structured interviews of this study aimed to create an interview that was as close to a naturalistic conversation between the researcher and participant as possible. A semi-structured interview schedule was provided as a topic list of key questions and potential follow up questions to cover in the interview. The interviews started with ice-breaker questions that aimed to put participants at ease.

It is of note that although interviews took place outside of participants shifts and off the main ward environment, some interviews were held close to the wards. Interviews were often interrupted either by telephone calls or other staff asking clinical questions of the interviewee. This was felt to be indicative of the level of pressure and demand placed on nursing staff.

Interviews were transcribed by a professional transcription company who signed a confidentiality agreement. Unfortunately, they were unable to transcribe in accordance with the conventions of the Jefferson-Lite method (Potter & Wetherell, 1987) and so paralinguistic details, for example changes in speed, pitch, and pauses were added afterwards by the author.

The first interview is included in the data, but was used as a pilot. This interview was listened to and reflected on in research supervision to help build on interviewing skills and identify important follow-up questions that may have been missed.

One interview was excluded as the participant was a health care assistant and not a qualified nurse, which was not identified until the interview had started. After consideration, it was felt that this error may have been due to the research not being clear enough on the differentiation between a qualified nurse.

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13 Please see Appendix 7 for the semi-structured interview schedule.
14 See Appendix 3 for a copy of the confidentiality agreement for the professional transcription company.
15 See Appendix 10 for a template of the Jefferson-Lite (Potter and Wetherell, 1987) transcription conventions used.
and unqualified nurse. The interview was completed and after careful consideration and discussion in supervision, it was excluded as it did not meet the inclusion criteria.

Most participants reported having worked in mental health services before undertaking their nurse training and their level of experience ranged, in time from 3 months to 11 years and in seniority, from newly qualified to ward manager.

Qualified mental health nurses were chosen for this research as they are responsible for leading and managing shifts on the wards, including leading responses to incidents of patient behaviour that is challenging to manage. Therefore, they were considered leaders of discourse amongst those who have the most contact with service-users.

2.4 Ethical Considerations

This research gained a favourable opinion from the University of Lincoln, School of Psychology Research Ethics Committee, the Health Research Authority and also complied with the British Psychological Society’s Code of Ethics and Conduct.

2.4.1 Confidentiality

Careful consideration was given to protecting the confidentiality and anonymity of service users, within the limits set out clearly in the participant information and consent sheets. These limits mirror those of clinical practice which participants, as qualified mental health nurses, will have been familiar with and were made clear.

All raw data collected (both recordings of interviews and transcripts) were fully anonymised and kept securely at the University of Lincoln to protect confidentiality. A separate reference sheet was kept separately and securely to identify data should a participant wish to withdraw from the study. Names of any service-users or other staff members, wards or hospitals mentioned in interviews were changed or redacted during transcription to protect confidentiality and anonymity.
2.4.ii Informed Consent

Participants for this study were members of nursing staff with the capacity to give informed consent. They were recruited via posters, emails and researcher attendance to staff meetings to promote the study. Participants were fully informed of the research aims, what their participation involves and their rights, before being asked if they consented to participate. Please see appendices 4 to 6 for the participant information, consent and debrief sheets. The right to withdraw and the limitations of this (for example up until the point of analysis, which would be two weeks after the date of the interview) were made clear and there was no impairment to the participants' autonomy. The limits of confidentiality were also made clear.

2.4.iii Risk of Harm

The interviews explored how nurses talk about ‘difficult to manage’ presentations and behaviours and how these are managed. It was not intended to cause any distress, but it was recognised that there was a possibility that participants may recall distressing events and become upset. The primary investigator was trained to work with people in distress as part of their role as a trainee clinical psychologist. As such, their role as researcher, not therapist, was made clear in the interviews, but they were in a position to contain, comfort and signpost the participant to find further support. For example, employee wellbeing and counselling services, The Samaritans or through a GP referral. Participants were also given, in a written format, details of the Trust’s staff wellbeing and counselling services available to them as employees.

No participants became distressed during the interviews but consideration was given to what would have happened in such circumstances. Should a participant have become upset, they would have been asked if they wish to terminate the interview or take a break. Should they have wished to terminate the interview they would have been asked if they wanted to withdraw consent to use the data collected so far. If a participant should have become too distressed, the researcher would have taken the decision to terminate the
interview. Respect for the individual’s autonomy and dignity was upheld at all times.

Following the interview, there was a debrief where the purpose of the study was explained and again, details of the Trust’s Department of Occupational Health and Wellbeing, should patients wish to access counselling. Participants were given the chance to raise any questions or concerns at the start (during the information and ‘consent giving’ part of the interview) and again at the end (during the debrief) of the interview.

No safeguarding issues or concerns that would merit a breach of confidentiality occurred. In planning the study, however, careful consideration was given to what would happen should a participant disclose anything that may be a cause for safeguarding concerns, such as abuse on the wards. The researcher would have a duty of care to report this. Therefore, the limits of confidentiality were made clear both at the start of the interview and on the participant information sheet that, should such an incident occur, the Ward Manager (or whoever is Acting Ward Manager in their absence) would have been informed immediately and that they will have been responsible for taking appropriate action. Should there have been a need for escalation, then the Clinical Lead for inpatient acute wards or psychiatric intensive care units would have been contacted. The field supervisor was also available to provide support in making appropriate safeguarding and incident reports according to the Trust’s policies and procedures, should this have been required. In such an instance, the participant would have been made aware of what was happening and kept informed. They would have been given the opportunity to discuss their concerns with the researcher and be asked if they still consented to their data being used in the study or whether they wished to withdraw.

It was believed that the risk of harm incurred by taking part in this study was no greater than the risks faced day-to-day. As interviews took place outside of shift hours participants were given an Amazon gift voucher as a small token of appreciation, and compensation, for their time. This was given before the interview commenced so that it would not be perceived as an incentive to continue with the interview should they wish to withdraw or stop. It was made
clear to participants that should they wish to stop or withdraw then they would still keep the voucher.

It is felt that this research would be of benefit to both service-users accessing and clinical teams working in inpatient acute mental health wards, to better understand challenging events that occur on these wards.

2.5 Sample Rationale

Based on previous research (Mason, 2010; Stevens & Harper, 2007; Benson et al., 2003), similar studies have used between three and ten participants. Therefore, seven interviews were deemed to provide sufficient data to explore the discourses drawn on by inpatient mental health nurses in their talk about challenging behaviour and its management on the wards. Originally, it had been proposed that the aim would be to conduct ten to twelve interviews, however, following delays to the project due to changes in supervisor and the Health Research Authority approval processes (see reflections for further exploration of this), this was reconsidered and it was decided that based on previous research seven participants would give enough data.

Due to the small sample size, demographics are presented across the group rather than individually to minimise the risk of identification of participants (Stevens & Harper, 2007). Of the seven participants, six were female and one was male. One participant completed their training as a nurse in Australia and all others completed their training in the UK.

2.6 Recruitment

Participants were recruited via emails and flyers (please see appendices 8 and 9). Initial recruitment emails were forwarded to staff members by the field supervisor who worked giving input to the wards. This was to protect staff members’ personally identifiable information. Nurses who wished to contact the researcher for more information or to participate in the study were able to do so directly.

The primary researcher was introduced to staff members on the wards and able to place flyers in nursing stations with the field supervisor’s support. The head of nursing for the acute and PICU wards volunteered to support the
primary researcher by forwarding the same email promoting the study to service-leads and ward managers to disseminate to their teams.

Three ward managers invited the primary researcher to attend team meetings to promote the study. However, one ward manager did not attend the meeting themselves, nor make clear arrangements for those there, about this. This is explored further in the reflection section.

2.7 Quality Control

The Joanna Briggs Institute's (JBI) Qualitative Assessment and Review Instrument (QARI) was used to ensure that this research was of sound quality (JBI, 2014).

The QARI appraises research based on the following criteria:

- **Congruity between philosophical perspective and research methodology:** The critical realist position that leans towards social constructionism is a congruent epistemology with the DA methodology which is typically social constructionist.

- **Congruity between research methodology and research questions:** DA is the best approach to answer the research question “what are the discourses drawn on by inpatient mental health nurses in talking about challenging behaviour and its management?” As a methodology, DA’s primary concern is discourse and how this constructs lived ideologies and limits alternatives. Please see section 2.2 for methodological considerations.

- **Congruity between research methodology and methods used to collect data:** Please see section 2.3 for discussion on the use of interviews for data in discourse analysis. Interviews were transcribed using the Jefferson-Lite conventions as per general guidance for the use of discourse analysis (Wetherell, Taylor & Yates, 2001 p.62).

- **Congruity between research methodology and representation and analysis of data:** Data is represented in terms of the key discourses, giving voice to participants with broader discourses explored, as per the FDA methodology, and some consideration has also been given to
the local discursive devices presented in participants’ talk in light of this, as per the combined DA methodology adopted for this research.

- **Congruity between research methodology and interpretation of results:** The data is interpreted in relation to the dominant constructions of challenging behaviour as per the analysis which has considered issues of power, the action orientation of the subject positioning, practice and subjectivity of the discourses present in the data.

- **A statement locating the researcher culturally or theoretically:**
  Please see section 2.1 for a discussion on the researcher's epistemological position.

- **The influence of the researcher is addressed:** Please see section 4.3.iii for a consideration of the researcher's influence. The influence of the researcher is addressed throughout using reflective notes present throughout the extended paper. These notes were based on a reflective journal that was kept throughout the project. The researcher’s influence was also considered and reflected upon during supervision. Care has been taken for this paper to be transparent with steps of analysis, an analysed transcript and photographs taken of the analysis process included in appendices.

- **Participants and their voices are adequately represented:**
  Quotations from participant's interviews are present throughout the analysis section. Effort has been taken to keep them as full as possible, only cutting out words due to pressures from the word limit and with great care to stay true to the participant’s voice.

- **The research is ethical:** Please see section 2.4 for ethical considerations.

- **Conclusions drawn from the research flow from the analysis or interpretation of data:** The conclusions of this research flow from the analysis, drawing on existing literature and psychological theory to place the findings in context. The conclusions may appear tentative and this is consistent with the methodology. Implications for future research and clinical practice also flow from the analysis and
interpretations of the data.

(JBI, 2014)

It is believed that this research meets all of the above criteria. A paper written by Antaki, Billig, Edwards and Potter (2003) that highlights “common pitfalls” of DA was also considered in ensuring that this research was of good quality. The common pitfalls identified by Antaki et al. (2003) are:

- Under-analysis through summary
- Under-analysis through taking sides
- Under-analysis through over quotation or the use of isolated quotations
- Circular identification of discourses and mental constructs
- False survey, where it is reported that findings are true for all members of a categorical group, e.g. mental health nurses
- Analysis that consists of simply spotting features

It is believed that this research has not fallen into any of the “common pitfalls” listed above. Analysis has not summarised or taken sides, nor has there been an over use of quotation leaving little room for analysis and quotations have not been isolated. There has been no circular identification of discourses and mental constructs. Reported findings have not made sweeping generalisations to all mental health nurses and inconsistencies and contradictions have been reported. The analysis has not consisted of simply spotting features, but has considered the role of psychological theories, existing literature and provided consideration of the function of features that have been reported.

2.8 Reflections

The process of understanding DA and planning the methodology was personally challenging and particularly difficult. DA was the best approach to address the research questions. Further, I felt inspired by talking to Air Chief Marshal Sir Stuart Peach about the best approach to diplomatic negotiations with other nations, which echoed what I feel are the key principles behind discourse analysis (S. Peach, personal communication, February, 2016). However, my journey with DA occurred in the context of multiple changes in
supervisor due to maternity leave and then two secondary supervisors leaving. After the resident specialist in DA left, external tutorials had been arranged with a specialist in DA. Unfortunately, changes to the HRA process delayed my need for this, by which time that person had also taken planned time off for several months. These challenges tested me, and at times left me feeling isolated and overwhelmed in trying to get to grips with DA and resolving practical difficulties.

My primary supervisor was supportive in finding a workshop held on DA that we attended together. However, this was focused on DA from a linguist’s perspective, and due to the nuances of DA and the approach taken for this research, was not as helpful as I had hoped. This is perhaps one of the problems in choosing a methodology with a broad range of distinctive approaches. Overall, I feel that I have risen to the challenges presented, although this did limit my consideration of the types of DA in this write up.

Starting recruitment was a relief. I felt the process in some ways reflected how staff may have engaged with their work on the wards. My visits to the wards to give flyers to staff or present in team meetings were often met with enthusiasm, with many nurses saying they would like to participate. However, few subsequently made contact or responded to emails. This is considered to reflect motivation to improve practice and engage with service users positively, and thus reduce the need for restrictive interventions, that would then be quashed by other demands of the job. My own experience of working on this thesis alongside other clinical and academic demands mirrored this when the project, and with it my motivation, had to be repeatedly side-lined to meet other demands and deadlines from the course.

Of interest was one meeting attended on a ward at the invitation of the ward manager, who did not turn up. This meant I was left waiting as other staff had not been briefed. Eventually, a charge nurse acknowledged that this had been written in the ward diary, apologised and agreed to call the qualified nurses to a brief meeting to present the research proposal and invite participation. As with all meetings, I had brought sweets as a token of appreciation for their meeting with me and to win staff over. Whilst this had been positively received
by other wards, here this simple act came under attack for being “childish” (although I noticed there were no sweets left at the end). Staff members of this ward were hostile to the invitation to be involved in research. This was interesting and posed the question of what was happening systemically for that ward. Time was spent, with my field supervisor, reflecting on this and considering whether, as a team, they had been let down by visitors to the ward before or felt criticised and under attack themselves. One staff member volunteered to participate. Unfortunately, it became apparent during the interview that this staff member was not a qualified nurse and so their interview was not included in the analysis. It was felt during that interview, however, that his agenda was to convince me that restrictive interventions were not used on the ward, except in extreme circumstances. I wondered if perhaps he, and other staff, had assumed the purpose was to expose or chastise them in some way. This was reflected on with my field supervisor at the time.

3. Extended Analysis

DA is not a cognitivist methodology. The aims of DA are to identify and reflect on the dominant discourses and lived ideologies that socially construct practices rather than making assumptions of internal processes. There are no strict set of guidelines to follow, with multiple and varying guides available, on how to conduct DA (Parker, 1992; Wickham & Kendall, 1999, Willig, 2015). For this research, analysis followed a set of eight steps brought together from Willig’s brief guidelines on conducting DA using DP and FDA (Willig, 2015). This led to seven steps, that aim to broadly attend to the broad discursive devices used by participants (DP) and focus on identifying how nurses construct challenging behaviour on the wards and the way it is managed (FDA). Each transcript was analysed individually following the eight steps outlined below (Willig, 2015):

- **Stage 1**: Initial reading of the transcript and noting my initial response to it as a reader (DP) and asking “what features of the text made me read it this way?”
• **Stage 2**: Coding, by selecting all parts of the transcript that are directly or indirectly relevant to the research questions for analysis.

• **Stage 3**: Re-reading the transcript and noting for each passage “what features of the text produce this reading?” In particular, looking at how discursive objects are constructed.

• **Stage 4**: Identifying dominant discourses at play in each passage of the text and considering other discourses that are being marginalised.

• **Stage 5**: Considering the action orientation of the discourses “what is gained by constructing the object in this way?” and the function of the specific discourse as it relates to other constructions.

• **Stage 6**: “How are the speaker and other people within the text positioned?” Subject positioning refers to positions from which the speaker can speak and act: “a location for persons within the structure of rights and duties for those who use the repertoire” (Davies & Harre, 1999; cited in Willig, 2015).

• **Stage 7**: “How do these discourses allow or limit opportunities for action in practice?”

• **Stage 8**: Tracing the consequence of taking up subject positions from and considering the subjective experience of these positions, in terms of what can be felt and experienced from there.

In working through these stages, the following questions, drawn from existing literature, were posed:

• How are staff accounting for challenging behaviour?
  - What discourses are available to and drawn on by participants?
  - Do the way that dominant discourses are talked about, rebut or marginalise potential alternatives (Frith & Kitzinger, 2001)?
  - Who does this advantage or disadvantage and how (Parker, 1999)?

• How are staff accounting for the ways in which challenging behaviour is managed on the ward?
  - What discourses are available to and drawn on by them (Willig, 2001)?
- Do the way that dominant discourses are talked about rebut or marginalise, potential alternatives (Frith & Kitzinger, 2001)?
- Who does this advantage or disadvantage and how (Parker, 1999)?

- What positions do participants place themselves and others in?
- What are the implications of this for rights, responsibilities and power (Parker, 1999)?

Following this, the key discourses were brought together and the action orientation, positioning, practice and subjectivity mapped. Throughout analysis, close attention was paid to the construction of power (Dunn & Neumann, 2016). See appendices 13 and 14 for images of discursive maps.

Power is considered the practice of knowledge as a socially constructed system, from which representations of “truth” can be enacted (Dunn & Neumann, 2016). Thus, there is an intrinsic relationship between discourse and power, as “discourses are understood to work to define and to enable and also to silence and to exclude”. Thus, a certain common sense is endorsed, whilst other modes of “categorising and judging” are made “meaningless, impracticable, inadequate or otherwise disqualified” (Miliken, 1999). Lukes’ (1974) approach to making sense of positions of power specifies that one person, or group, “A”, influences another, “B” in a way that contradicts B’s interests. Foucault’s stance on power is that “A” does not act intentionally, but from a position where this action is considered to be “normal” (Dunn & Neumann, 2016).

It was reflected, that despite the intention of this research being to challenge social injustice, it perhaps colludes with the power dynamics at play. This is as nurses were interviewed, allowing them to speak, but not service-users.

3.1 Discursive Devices

The main concern of DP is the detail of talk, how it is used to manage a given interaction to build credibility or discredit others (Edney, 2001). As this paper uses a mixed DA approach, although weighted towards FDA, it is helpful to consider discursive devices previously identified in the literature and which have informed the analysis of this study.
More broadly, lived ideologies are considered to be the taken for granted regimes of truth that construct our versions of reality. In other words, they are the condensed wisdom or knowledge held by a particular society that holds interwoven contradictions and inconsistencies that allow them to be used flexibly for social interactions and everyday sense making (Billig et al., 1998). Interpretive repertoires are the “terms and metaphors drawn upon to characterize and evaluate actions and events” and which provide the patterns through which we talk and maintain lived ideologies (Potter & Wetherell, 1987, p. 138). These repertoires often hold a number of techniques that are consciously or unconsciously used by the speaker to manage the interaction.

A number of discursive techniques have been identified in the existing literature, particularly in studies using a discursive psychology approach, some of which are described below. Discourse analysis does not treat narratives as a means to find out about an objective world, indeed DA would argue that such a world does not exist. Instead DA is interested in that world that is actively constructed through social narratives.

Institutions, such as the inpatient mental health ward are likely to hold a particular lived ideology and set of routinised discourses. Institutional talk is considered different from everyday conversational talk in that participants are with the institution and thus their talk is concerned with specific tasks connected to its “business” and their identities in relation to this (Heritage, 1997). It is proposed that within institutional talk there are constraints around what is considered an appropriate or inappropriate thing to say and the institutions practice shapes the inferences of the interaction (Heritage, 1997).

When encountering or producing discourse, we all become reconstituted as subjects (Walkerdine, 1990) and our identity is constructed based on where we are positioned in the available discourse (Hall, 1988). This is known as subject positioning, which actively plays out issues of power (Dunn & Neumann, 2016). Further, it allows the speaker to manage issues of personal accountability and exoneration which Edwards and Potter (1992) have explored in relation to examining courtroom testimony, where they considered how the reporting of events carry attributional implications (Edwards & Potter, 1992).
Ideological dilemmas can also be identified in discourse and refer to the
dilemmas that we face when confronted with everyday normalised actions that
are at odds with our core values or identity (Billig et al., 1988), for example
when participants described being confronted by tensions between care and
compassion, and forcing medication. These dilemmas are explored through
the analysis of what people say when talking about key topics, e.g. health
care. Billig et al. (1988) argue that, when reflected on and brought into light,
ideological dilemmas can be enabling and support people to think
meaningfully about how they are in the world.

Looking in detail at the text, rhetorical devises such as metaphors, lists, the
inclusive use of “us” and “we”, fence-sitting accounts and extreme case
formulation play a role in the “insidious exercise of power” to persuade others
to agree and marginalise alternatives (Lukes, 1974 p.23). However, there is
no definitive list of such devices and each paper differs. Further devices that
were identified and considered important in the interpretation of the data
include jargon and biomedical terminology and rhetorical questions. All of
these are explored below in detail:

Metaphors involve understanding a concept in terms of another concept, often
drawing on experiential and emotional elements, such as warfare, to
strengthen an argument (Lakoff and Johnson, 1980). Listing is another
commonly used rhetoric device drawn on to strengthen an argument. Lists of
three are commonly used in advertising and rhetoric to give an implied sense
of completeness. Where two examples might seem unconvincing, three is
considered to seem intuitively comprehensive (Atkinson, 1984). This is
famously demonstrated in Tony Blair’s 1997 winning political speech which
demonstrated the power not only of a three-part list but also in repeating a
single word three times: “Our top priority was, is and always will be education,
education, education” (Tony Blair, 1997). Likewise, Edwards and Potter
(1992) have argued that five-part lists are used to effectively construct factual
accounts.

The use of inclusive terms such as “us” and “we”, and “you know”, open up
accountability and responsibility to more than the individual. By positioning the
speaker as not alone in what they are saying, and making an assumption that the receiver of the discourse is a part of it, they open up the issue of accountability and responsibility to the team, the profession or even society as a whole and present the discourse as a shared common knowledge (Edwards, 1997). Whilst, in contrast, qualifiers such as “I think” may act to position the speaker as thoughtful and open minded on one hand with a vagueness and ambiguity that could protect them from personal accountability, but leaves them open to ambiguity and criticism on the other.

Similar to the use of qualifiers, fence-sitting accounts where there is an assumption that all points of view are useful are hard to defend against criticism and thus maintain the status quo (Billig, 1987). Harper (1999) argued that such accounts may act to maintain the dominant construction of mental health difficulties resulting from a biomedical causation, pushing alternatives to the side-line. Whilst similar to the use of inclusive terms, Pomerantz (1986) reported on instances where the object of evaluation is taken to its extreme limits through use of phrases such as “everyone” or “only one”. This is termed extreme case formulation. Another device, disclaimers, are used to ward off potential obnoxious assumptions, such as “I’m not sexist but…” (Herwitt & Stokes, 1975).

One device frequently drawn on by participants was the use of jargon and biomedical terminology. For example: “.Hhhh Someone who:se got, erm, like the American Axis 2 .h traits… =the European standards .hh or erm W-World Health Organisation Standards” (James, p.9;12-15). This served participants as a way to position themselves as experts, holding specialist knowledge.

Another device used was rhetorical questions, particularly when coupled with the phrase “you know”, which interpreted to reinforce “common sense” notions or build an argument against these. “Is this really challenging behaviour (.) or somebody upset because (.) they’ve been neglected or (.) they’ve been (.) you know (.) sh-shoved aside continuously?” (Toni, p.17; 24-26). Here, Toni uses the phrase “you know” to create a common-sense notion that challenges the biomedical discourse in her argument against it. Interestingly, she uses the term challenging behaviour as a diagnostic category, something within the
person, indicating that this may be how this term is often used, or understood, on the wards.

In terms of the interaction of live discourse, Jefferson (1989) has suggested that pauses of 0.8 to 1.2 seconds fall within a “tolerance interval” but pauses that are longer than this indicate that there is some form of “trouble” in the conversation. In her study, she highlights interpersonal ruptures in the live conversation. However, longer pauses in the interviews conducted for this research indicated taking space for careful thought or a sign of resignation or sadness:

Interviewer: Why do you think people behave that way when they’re on the wards?

Jessica: .hhh E::rm, (.) because they’re angry:? E:rr, because (3) ((sigh)) for some people they’re so unwell… (Jessica, p.8; 22-26).

Jessica starts by using an emotional discourse to explain the behaviour, but then after her pause returns to the dominant biomedical discourse. This resignation may have been well rehearsed.

The internal conflict experienced when everyday discourse and normalised actions are at odds with our core values or identity shown in discourse through ideological dilemmas that are explored through the analysis of what people say when talking about key topics, such as healthcare (Billig et al., 1988). For example, when confronted by tensions between care and compassion, and forcing medication. Billig et al. (1988) argue that, when reflected on and brought into light, ideological dilemmas can be enabling and support people to think meaningfully about how they are in the world.

It is of note that participants, questions and write up of this project use the word “management” when talking about challenging behaviour. This word is deeply embedded in this research and for the participants in their interviews. It implies that the behaviours of certain adults are other’s (staff’s) job to manage and bears reflection.
3.2 Overview of the analysis

The biomedical discourse was considered dominant across the transcripts, in nurses’ talk about challenging behaviour and how it is managed. Alternatives, such as psychosocial and emotional discourses also featured, but the influence of these were limited by discursive constructions of the system. It is important to note that no assumptions of statistical representativeness are made in this analysis. To do so would be at odds with the social constructionist epistemological stance of this research. Therefore, this analysis presents one of many interpretations of the data.

3.3 The Analysis

3.3.1 Challenging Behaviour

Before presenting the analysis, it is recognised that nurses described “a multitude of challenging behaviours” (Jessica, page 6 line 19), in line with existing literature (Stewart et al., 2009). A list of those reported and alluded to by nurses during the interviews are presented below:

- Verbal aggression, including threats, hostility, racist remarks, sexual references, criticism and insults
- Physical violence and aggression
- Medication refusal
- Stealing from other patients
- Making demands
- Making allegations against staff
- Arguing and fighting
- Self-harm and suicide
- Self-neglect

Erm (. ) err, there’s a multitude of challenging behaviours ((laughter)). Erm, I think the things that I find most challenging, erm, especially (. ) on the male wards, (. ) are erm kind of sexual aggression? I find that quite challenging. Quite a lot of kind of abusive language I don’t really even hear anymore I don’t think (. ) erm but when it becomes (. ) kind of, e:rm, like
references to rape or kind of invading personal space or things like that, I find that very challenging.

>>I also find<< (. ) kind of ( , ) erm, if there’s a lot of sexist remarks, I find that incredibly challenging, not to challenge that ((laughter)) and to pick my battles at the same time, (. ) E:rm, there’s a lot of kind of ( , ) comments about racism, I find very difficult, being accused of being racist a lot. ((sniff)) And then you’ve got your kind of ( , ) your usual kind of physical aggression, threatening behaviour (. ) if you don’t do this I’m going to do that, what are you going to do about it? ((sniff)) Erm (. ) what else is there? (. ) All sorts of stuff.” (Jessica, p.6; 19-37).

This quotation summarises that broad range of challenging behaviours experienced by staff on the wards. Here Jessica’s talk is tentative and her use of the first person, “I find”, makes it clear that this is her experience and opinion and that she is not speaking for all staff. She constructs the ward as a threatening environment. References to rape is an example of particular interest as it echoes discourses of power and disempowerment that parallels discourses of abuse (Towns and Adams, 2009). Her statement “I find that very challenging” echoes the social construction of challenging behaviour, but also could be interpreted as self-chastising, as though finding these things challenging is stigmatised.

Jessica uses a military metaphor, “pick my battles” to construct the ward as a relentless battlefield. Referring to “abusive language I don’t really even hear anymore” positions nurses as desensitised to behaviours they face frequently. She conveys herself as upset at accusations of racism and this echoes Denise’s use of the cultural example for why some people might refuse medication. This constructs a problem of cultural conflict in mental health services. She positions physical aggression as “the usual”, again indicating its frequency and she switches to take on the aggressor’s voice and could be interpreted as her reliving a traumatic experience. However, her use of “this” and “that” in the example is interpreted as either being indicative of the commonality of such behaviour on the wards, that she no longer hears the
threats, or as having been deliberately omitted and thus too awful, or triggering, to repeat.

3.3.ii Biomedical discourses

The dominant construction of challenging behaviour drew on biomedical discourses. Here, the term “biomedical” is defined as the application of biological science, to understand and explain mental illness from a positivist stance (Double, 2006). A biomedical model implies medication can be seen as a panacea (Deacon, 2013; Double, 2002; Engel, 1977).

All participants talked about service-users as being “unwell” or “mentally ill”, in relation to their challenging behaviour. It was considered that from the high prevalence of references made to “mental illness” or “diagnosis” when explaining the reason for challenging behaviour on the wards, that this was the dominant discourse drawn on to construct it.

hhhh I would say some people will behave that way because they are genuinely unwell, they have a mental illness and they might be hearing voices telling them, you know, not to take medication because it’s poison or whatever hh er:mm, or to assault, hu-hurt other people because they’re going to either hurt (..) you know them, and then in response to their voices, they might hurt other people. .. I’ve known people to attack, or people are sort of paranoid or, you know, so again, it falls back to, you know, them being unwell. (Samira, p. 11;43- p.12;16).

This quotation illustrates how the biomedical discourse may be interpreted to marginalise or quash alternative explanations. For example, here the choice not to take medication is one made because of “voices” and the service-user is positioned as powerless and voiceless, a victim of their illness and not given a chance to explain their decisions. Pertinent to this is the use of the word “whatever”, which is interpreted as a dismissal of potential reasons for refusing medication, the biomedical construction sees these as unimportant. Elsewhere participants were positioned as not knowing what is (or has been deemed) best for them or what they need, because they are unwell: “It may
be due to their mental state, where they don’t understand” (Denise, p.6; 24-25).

Samira’s quotation above indicates that service-users might attack others because they feel threatened. However, opportunities to reduce potential sources of threat in the environment are denied as it is dismissed as “voices” and other possible discursive constructions are marginalised. This is one of the ways in which service-users are positioned as disempowered.

The following quotation demonstrates the tautological argument posed by the biomedical construction in attempt to explain challenging behaviours: “so, OK, someone who’s psychotic and you can (.) you can see (1.5) them becoming mo:re agitated because of psychotic reasons” (James p.9; 3-5). Here, recognition is given to the emotional state, but the alternative emotional discourse is interpreted to be undermined by the primacy of the biomedical discourse with the cause for agitation being within the service-user, ‘psychotic’, rather than contextual.

This biomedical dominance splits service-users into two groups. Those who are “genuinely unwell” and those who are labelled as having personality disorder. The ‘genuinely unwell’ category are constructed as those who can be treated with medication. By placing the responsibility for the behaviour in an illness, one is not seen as “bad” or accountable, but as “different” to those who are not ill, for example staff. This provides a protective mechanism of distancing for staff. However, it positions those who are not treatable with medication, those diagnosed with personality disorder, as threatening to staff. They are instead positioned as solely responsible for their behaviour, which is considered deliberate. The attributional discourses, informed by Weiner’s (1972) theory of attributions, as described in the journal paper act to construct and perpetuate stigma towards those labelled with personality disorder. This acts to limit empathy and their behaviour is seen as harder to tolerate. These service-users are presented to be misplaced in health services rather than the criminal justice system “.hh If he attacks anyone it should be dealt with by the police” (James, p. 11;29-30). Samira positions these service-users as deliberate: “patients are at full capacity and they attack a particular member of
staff they want to attack because they’ve been targeting that member of staff because that member of staff might have (.) refused them something (Samira, p.12; 10-15).

Here Samira uses definite language “they want” in talking about the attack, she uses uncertain language in talking about the service-user’s experience “might have” trivialising and devaluing their experience and perpetuating stigmatic discourses. The context of being refused something too is of note and appears to neglect the inpatient experience where basic rights such as autonomy and freedom, are often refused. Interestingly, The Mental Capacity Act and The Mental Health Act is used here to highlight the difference in “type of patient”, which is at odds with the definition of The Mental Health Act (1983), which does not make such a distinction between diagnostic labels.

Participants could be critical of, but resigned to, the biomedical dominance:

Yes, definitely, that’s why you will write care plans (.) with them. But, at the end of the day (.) your decision and your, your (.2) clinical treatment, I guess, is down to your RC, which is, you know, we’re still working on a medical model, so: it’s about curing a disease. So (.) you can write care plans and you try and do that to kind of, to help and, but (.4) yeh ‘we work under the medical model’ (Denise, p.11; 25-31).

Here, Denise refers to current practices being down to the RC (responsible clinician), usually a consultant psychiatrist, implying that it may be the biomedical emphasis, led by those in power, that disables best practice. Thus they positioned both themselves and service-users as disempowered by the biomedical dominance of mental health. Denise positions herself as coerced to act in ways they would not have otherwise done, to coerce or force service-users to take medication, by the doctor who she positions as powerful, building a Nuremberg defence:

the doctors were adamant they had to have their depot today? … but they were insistent that they had to have that depot and they had to have it today? And so this patient, who is adamant they don’t want it, you’re having to call a team and forcibly (.) inject someone, medicate somebody, you know, it’s it’s a bit (.) I think that’s that went it doesn’t
go so well… You know, if they were ever to get unwell, to me, they they would run for the hills, rather than coming back to hospital. Even if that depot had got them well, they would remember that experience of having to be held down or restrained by staff in order to have something injected. (Denise, p10; 5-40).

Here, Denise signals her moral distress and describes an unnecessary use of physical intervention, the restraining of someone for regular medication, directly against clinical guidelines (DoH, 2014; NICE, 2015a). Her use of emphasis, positions her as angry with doctors and uncomfortable with the incident, that she constructs as causing iatrogenic harm. Her intonation for the word “today” suggests that she is challenging the immediacy of the need. Her use of medicalised language, “unwell” and “well”, is interpreted to represent the dominance of the biomedical construction of mental health, and challenging behaviour, as being so ingrained in everyday nurse speak that its language is used even when the construction itself is challenged. Here she positions psychiatrists at the top of the hierarchy and nurses “on the frontline” (Jessica).

Both Jessica and Denise describe how nurses are expected to do as they are told, for example “enforcing medication” (Jessica), even when that produces a negative personal outcome for them as nurses: “it’s you that gets the crap every day” (Jessica). Neither participant talked about challenging or refusing to follow the instruction and their compliance to the doctors is in line with Milgram’s (1967) theory of obedience to authority and building a discourse that echoes the Nuremburg defence.

This may serve to undermine the challenge of the biomedical dominance. Particularly, where those who bought into the biomedical dominance attribute successful care to medication: “Anything therapeutic? Yeh, the drugs are therapeutic. Some patients do report .hh I’m feeling better because I’m, so and so dru:g and it’s helped me, I understand myself more .hh you know” (Christina, p. 21;9-11).

Christina dismisses alternative contributions to recovery, giving voice to service-users, but with what are interpreted to be her own words to strengthen
her own argument that is incoherent. Where it is plausible, medication might help someone to feel better but there is no mechanism for medication to aid self-reflection and personal understanding.

3.3.iii Other Constructions: Psychosocial, Emotional and Systemic Discourses

These featured in all participants’ interviews, but in different ways. Some participants drew on psychosocial and emotional constructions of challenging behaviours and the impact that it has on them, whilst others drew on them by dismissing or overlooking them. Here, “psychosocial” relates to wider psychological and social influences contributing to the aetiology of mental health and recovery, including intra- and inter-personal process (Kinderman, 2005). Participants also drew on systemic discourses to talk about challenging behaviour and justify their own actions as a group. Here, systemic discourses related to the wider systemic and political context of the NHS. Systemic theories construct problems as within the relationships of this wider context, rather than within individuals (Vetere & Dallos, 2003). It is of particular note that this research took place within the NHS during a political period of “austerity”. The psychosocial and emotional constructions were considered to be marginalised by the more dominant biomedical and systemic discourses. The absence of environmental discourse, such as noise, crowding and facilities, in the interviews of this study is interesting.

Toni demonstrates this by immediately defending her argument in a rehearsed discourse indicating that she is used to confrontative disagreement when she presents a non-dominant approach: “We’re not saying aggressive is acceptable but we are saying we can understand why it happened…” (Toni, p.10; 46-47). Equally, Toni demonstrates that she is also rehearsed in questioning the utility of the construct of challenging behaviour: “Is this really challenging behaviour (.) or somebody upset because (.) they’ve been neglected or … shoved aside continuously?” (Toni, p.13; 23-25).

This highlights how the introduction of the term challenging behaviour to highlight its social construction and the social context has not been successful and has instead become synonymous with the terms it had aimed to replace.
The marginalisation of the alternative discourses is further demonstrated in the following quotation: “We’ve got this new system at the moment called DASA Scoring. So you try and erm deescalate the situations before it gets to the point where we have to now, it’s an immi-imminent risk” (Samira, p.12; 33-39). Here Samira refers to the Dynamic Appraisal of Situational Aggression (DASA: Ogloff & Daffern, 2006) which is a checklist tool developed to assess the likelihood of a service-user becoming aggressive based on observable characteristics, such as “irritability” and “easily angered when requests are denied”. Opportunities for reflection and learning are replaced with a checklist.

The DASA’s clinical utility has been critiqued for having potential to overestimate the likelihood of aggression (Griffith, Daffern, & Godber, 2013). The checklist items, as with the biomedical model, overlook contextual and environmental influences on behaviour and make no attempt to understand or remedy triggers for it. Lantta, Konto, Daffern, Adams & Valimaki (2016) found that not only was the DASA time consuming and perceived as upsetting and disrespectful by service-users, there were also concerns that negative attitudes towards a service-user were likely to influence scores. This approach is in contrast to behavioural monitoring charts that aim to understand the function of the behaviour would be used in a psychosocial approach such as PBS.

Such risk assessment tools have been criticised more broadly as being unthinking tick-box exercises (Reid, 2003). This is interpreted as an example of biomedical dominance undermining the potential for useful non-biomedical approaches. Further, a checklist to recognise aggression echoes other participants’ discourses of excessive paperwork drawn on in the construction of challenging behaviour: “there’s just (1.5) too many screening tools, too many (3) too, too much ((laughs)) paperwork .hh to actually engage with the patient as much as (1) as would be beneficial for them… to actually talk to the person that the paperwork’s about” (James, p.17; 14-22).

Participants constructed their work environment as one that is of high risk for staff stress and burnout. They highlighted experiences and risk of assault, verbal aggression, loss of autonomy, reduced opportunities for a sense of
personal accomplishment through the lack of a poorly defined primary task; a lack of resources, including staff shortages; and too much paperwork (Bowers & Flood, 2008; Farrell & Doves, 1999; Flannery et al., 2007; Kindy et al., 2005; Menzies-Lyth, 1988; Sullivan, 1998).

3.4 Reflections

The process of analysis was particularly hard. I was very aware of my emotional response when reading the transcriptions. I had expected to feel angry on behalf of service-users. However, I found myself also feeling angry at the system on behalf of staff. Narratives, that echoed literature on domestic violence, were particularly pertinent to me and I felt that nurses too were subject to social injustice. During the interviews, it felt as though participants had little opportunity to talk about the behaviours they face on the wards and the personal impact that this has on them. One participant contacted me following the interview, to inform me that she had found it helpful to talk about these things and had made contact with the Trust Occupational Health service for support. She informed me that from this she has received a diagnosis of PTSD following a serious incident that had been aimed at her. Although not a part of the research, I felt that this epitomised the military metaphor of the mental health ward as constructed by participants.

I managed these emotions by taking regular breaks during the process of analysis. For example, going for walks to calm down and actively looking at data from a different perspective. I also asked my supervisor to look over my comments on analysed transcripts to encourage me to think about things from other perspectives and ensure my interpretations were rational rather than emotional.

Despite the small number of interviews, the amount of data felt overwhelming and progress was slow. I constantly felt uncertain as to whether I had approached analysis in the right way, as there is no definitive text or guidance on how to conduct discourse analysis. I managed these difficulties by ensuring that this research met the criteria outlined on the QARI (JBI, 2014) and being mindful of the common pitfalls of discourse analysis outlined by Antaki, Billig, Edwards and Potter (2003).
My emotional reactions to some transcripts were significantly different to my reactions during the interview. For example, I struggled to feel empathy for James during his interview and found myself feeling irritated by some of his comments. However, I found myself more drawn to his sense of feeling burnt out and that the system had taken from him the job that he “used to love”, with his chance to witness recovery lost in the systemic pressures. I wondered if this difference was perhaps because he was an hour late for the interview and I had struggled to put this annoyance aside. I also wondered if perhaps mannerism or intonation, that were not picked up on in transcription, may have led me to focus on different parts of his narrative in the interview. However, I also wondered if perhaps this was a strength of working from transcripts, in that I was able to attune to things that I may have otherwise missed.

This was similar for Samira. I really enjoyed the interview with her. I noted that she was smiley and engaging, and came across as kind and compassionate. However, during the analysis I found myself drawn to aspects of her transcript that left me feeling annoyed and judgemental. For example, it was more noticeable in the transcript that she frequently referred to pressing charges, or wanting to press charges, against service-users in the absence of motivation to understand why incidents had occurred. This is not to say that I disagree with pressing charges following assault, more that it felt her talk about this in the transcript came across to me as cold. I managed this by looking for examples of warmth in her transcript to contrast this.

The process of making amendments to these findings was a challenge. Although theory was drawn on to inform the analysis, it was difficult to respond to these mostly positivist theories through the findings in a way that remained true to the discourse analysis methodology which does not attempt to draw conclusions on cognitive or individualistic processes (Parker, 1992).
4. Extended Discussion

This study explored how inpatient mental health nurses conceptualise challenging behaviour and their responses to this when talking in an interview context. The process of any qualitative interview research represents an interaction between the researcher and participant. A methodological strength of DA is that it allows for research to interpret this. Whilst the use of interviews has been criticised in favour of naturalistic data (Potter & Hepburn, 2005), it is believed that interview data can hold ethnographic relevance as they allow for the reproduction of routinised discourses (Griffin, 2007; Wetherell, 2007).

Although this research stops short of making generalised claims about subjective realities (Alvesson & Karreman, 2000), it encourages consideration of how the ways of talking available to nurses can enable and disable practice. The exploration of staff talk reveals how staff practices that might counter research are culturally and professionally legitimised and may help us to understand the findings of the Francis Report (2013) and Winterbourne View (DoH, 2012) inquiries.

The key finding of this research is that a dominant biomedical discourse was drawn on by nurses to conceptualise challenging behaviour and their responses to it. This acted to legitimise coercive interventions but disabled proactive and interpersonal responses. This counters current guidelines (NICE, 2015a; NICE 2015b) and what is considered best practice (DoH, 2014), which rely on alternative psychological and social constructions. Previous DA studies have identified biomedical, objectifying and systemic discourses by nurses in their talk and written records about service-users (Hamilton & Manias, 2006) and the findings of this research build on this.

Harper (1995) stated that: “a discourse analysis that does not have any implications for the practical organisation of mental health services in an impotent one… However it would be a mistake to assume that such research is straight forwardly applicable” (Harper, 1995 p.353-354).

The implications of this research are that the inpatient mental health ward is organised by the lived ideology of the biomedical discourse, which restricts positive practices and opportunities for change in relation to challenging
behaviour. The biomedical model is unable to recognise the psychosocial precipitants to the behaviour. This acts to manage issues of accountability for nurses, but conversely limits opportunity for change. Efforts to lead change need to focus on reflection and promoting alternative discourses, at all levels, as a core aspect of everyday business.

An alternative, psychosocial approach to working with challenging behaviour is PBS, an evidence based whole system care approach from the learning disabilities literature. This aims to reduce the frequency, intensity and duration of challenging behaviours over time, by promoting a better quality of life for the individual (Allen et al., 2005; NICE, 2015). PBS aims to achieve this by understanding the function and reinforcement of the behaviour to ensure needs are met, whilst promoting a better quality of life for the individual (Allen et al., 2005). It has been proposed that a similar approach would be of benefit for staff and service-users in mental health services (Bown, Shawe-Taylor & Swan, 2017). Whilst it has been considered that there is a need for multiple interventions to reduce the chance of incidents of violence and aggression occurring (Cutcliffe, 2013), multimodal interventions such a PBS could play an important role. Cutcliffe and Riahi (2013) identified systemic, environmental and interpersonal phenomena as key in the risk of incidents and advocate for a multi-modal systemic approach to address this. The present study would support this, and the impact of introducing such an approach on discourses would be of interest. However, as mentioned before, for alternative interventions to be effectively introduced, the discourses that construct and support them need to dominate and training based interventions alone are unlikely to be effective (Hahn et al., 2006). It is of note that the burnout and systemic difficulties reported by nurses could further pose barriers to change. Perkins et al. (2012) have previously identified that such contextual demands can influence the use of restrictive interventions. In order for change to be effective, support to tolerate, rather than defences against, anxiety is important (Menzies-Lyth, 1988).

The findings of this study are supported by a number of psychological theories. It was found that participants drew on the Nuremberg discourse, where one claims to have done something because they were ordered to by
an authority figure, in talking about their use of restrictive interventions for reasons other than as a last resort to manage violence and aggression. This is consistent with Milgram’s theory of obedience (Milgram, 1974). This is important to recognise, as it highlights the importance for change to occur at all levels for the drive to reduce the use of restrictive interventions in line with current policy and guidelines to succeed. Further, it indicates a real need for a reflective space where staff can consider ethical dilemmas and social constructions related to their work, as well as their clinical practice and emotional responses to this.

Attributions theory (Weiner, 1972) also plays a role in interpreting these findings and implicates the recommendation for reflective practice. Participants drew on attributional discourses of behaviour, that mirrored theoretical concepts of stigma (Jones et al., 1984). For example, attributions of stability and controllability where drawn on when talking about incidents of challenging behaviour, particularly for those service-users with a label of personality disorder. Perceptions of stability and controllability are dimensions that form part of Jones et al.’s (1984) model of stigma. Again, space to reflect on the attributions made for behaviour, to consider different ways of understanding the behaviour and factors which influence attributions and actions would also be beneficial in clinical practice.

Reflective practice would also allow for staff to reflect on organisational defences against anxiety that may lead to milieus where service-users become depersonalised and the focus of nursing becomes individual tasks, rather than person-centred care (Menzies-Lyth, 1960; 1982). Not only would a reflective space allow alternative discourses to challenge the lived ideology, it would also allow for consideration of the role of cognitive dissonance and for inpatient mental health nursing to therefore move from a defensive to a reflective practice.

Barriers to change have however been recognised. Participants drew on systemic discourses, talking specifically about austerity and the lack of resources and time to prioritise important processes such as reflective practice groups: “a lot of the time we miss things because we're too busy?”
This represents some of the negative valence associated with the goal of reducing reliance on restrictive interventions in inpatient mental health services. Approach-avoidance conflict (Lewin, 1935) can explain such barriers to change, where the positive valence towards the goal does not outweigh the negative valence and psychological distance. Whilst the biomedical discourse limits alternative practices, a reflective space that draws on psychosocial discourses could make those links that increase positive valence and a sense of need for change, whilst reducing the psychological distance and negative valence of the goal to reduce the reliance on restrictive interventions in inpatient mental health services. In order to effectively reduce the negative valence associated with change, staff need to feel supported in their work and a whole-systems approach to change is required, with a focus on reflective rather than defensive practice.

Clinical psychologists are well placed to lead in reflective practice (Division of Clinical Psychology(DCP), 2010). This is as a professional group who are expected to have a good knowledge of systemic and socio-political contexts that can both support and challenge co-workers (Christofides et al., 2012). However, the wider system must provide the safety and support for this to be effectively accessed.

Further research could explore discourses of challenging behaviour and interventions in written documents, such as policies, care plans and key textbooks used by nurses in their practice. The discourses of challenging behaviour and interventions, as in mandatory training, would also be of interest. Existing literature has applied DA to discourses drawn on by professionals and service-users in their about mental health and how nurses write about it in health care records (Harper, 1995). DA has also been applied to analyse the discourses drawn on in the writings of influential journal articles (Johnstone & Frith, 2005). As with the current study, these found a biomedical dominance and discourses that disempowered service-users and undermined their autonomy.

As with all studies, this one is subject to a number of limitations. Although DA assumes a limited number of discourses which will be reproduced in the
interview (Griffin, 2007; Wetherell, 2007), the small number of voluntary participants, from one NHS hospital trust is considered a limitation. Issues of sample bias and social desirability bias are not ignored, however, close attention to language and the function of talk was able to manage this to some extent. The method of DA considers meaning and meaning making to be a fluid rather than fixed process. This implies that this study may not hold temporal stability (Morgan, 2010). However, discourse analytic studies aim to present a challenge to common approaches to policy and practice, and the aim is to initiate change.

4.1 Reflections

Whilst the disruptive and deconstructive approach of discourse analysis (Burman & Parker, 2005) is considered a strength of the methodology, it does not lend itself to easy dissemination back to staff teams. I speculate that it may be uncomfortable for those participants who requested a copy of the written report to see their talk deconstructed. However, I hope that I have made every effort to represent their voices fairly and accurately. Research on how staff respond to challenging behaviour, could run the risk of positioning staff as blamed and the research as critical. Particularly in the light of the Francis Report (2013) and Winterbourne View (DoH, 2012). The approach of DA placing the discourses in the system rather than the individual, is hoped to mediate this risk and provide a more useful interpretation of the problem at hand.

4.1.i Terminology

It is noted that the term “service-user” is used throughout this report and is not a term that I am particularly comfortable with. I will always remember an angry “patient” shouting at staff in a community meeting about the use of the word “service-user” and insisting that if she required treatment in a hospital she should be referred to as a “patient”, as she would be in a general hospital or other medical setting.

I am also aware that from the inception of this project, I have used the word “manage” to talk about how the responses or interventions of staff towards challenging behaviour. The word manage was chosen to reflect how we all
“manage” interpersonal events, including their impact on us. I am however aware, that it can also be interpreted as placing responsibility on nurses to act to “manage” another person’s behaviour, particularly where challenging behaviour has not been conceptualised as an interpersonal phenomena.

4.1.ii Tensions: Issues of Stake

It was difficult to balance my focus between the implications for staff and the implications for service-users. I tried to strike a balance by focusing on the system rather than individuals in an attempt to avoid blaming or shaming. This evoked strong feelings of empathy in me towards both groups and the anger I had felt at some staff members for their actions, when I worked in that environment, was redirected towards the organisation.

Participants talked at length about the organisational pressures they face and how they find themselves coerced and “embarrassed” (Jessica) by the organisation they represent.

4.1.iii Researcher Influence

It is important to be aware of how I was positioned in the research process. One of the participants I knew well and two others I was well acquainted with from my work as an activities coordinator at one of the hospitals. I expect this was likely to influence the interview process in that they knew I had shared some of their experiences on these wards, but also in that they are likely aware of my position towards the excessive use of restrictive interventions on the wards.

Other participants, who did not know me were unaware of my experiences working on a PICU and I was aware that they may have felt I would not be able to understand the fear and anxiety that can be felt working in such an environment. Despite this, participants that both knew and did not know me relaxed into the interview process. It is noted that participants who knew me were more likely to consider psychosocial and emotional discourses that the other participants.

As a clinical psychologist in training, I was also aware that this “role” may have led participants to consider that I would have a different stance towards
challenging behaviour than them. What I did notice was that it was those participants who knew me who were more inclined to draw on the alternative psychosocial and emotional discourses. I considered not only the social desirability bias of interviews in interpreting this, but also the specific role I had when they knew me, in promoting culture change and different ways of thinking about behaviour and meaningful activities. However, I got a sense from the interviews that staff were burnt out and under pressure and just wanted to talk. I feel this is clear from the transcripts where a one line question could generate a page long answer and I found that during the interview process I was required to only provide minimal input.

4.1.iv Ethics

I found myself questioning the ethics of this analytic approach even though participants gave informed consent and were not deceived in the process of this research. Participants consented to take part in research, that was interested in the service-user presentations, particularly the behaviours they found difficult to manage and how they managed these. However, the explicit deconstructive nature of the methodology was not made clear. I often wondered about how they would or will feel when they read the report.
5. Extended References


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NICE (2015a). *Violence And Aggression: The Short-Term Management In Mental Health, Health And Community Settings*, London: NICE.


The UK. The Results Of A Preliminary Survey. *Journal Of Psychiatric And Mental Health Nursing*, 10(1); 3-15.


Hospital: ‘When I Go Home, It’s Then That I Think About It’. *The British Journal Of Forensic Practice*, 6(1); 3-15.


Van Der Kluit, M. J., & Goossens, P. J. (2011). Factors Influencing Attitudes Of Nurses In General Health Care Toward Patients With Comorbid Mental Illness: An Integrative Literature Review. *Issues In Mental Health Nursing*, 32(8); 519-527.


Appendices
Appendix 1. University of Lincoln Research Ethics Committee
Documentation

SCHOOL OF PSYCHOLOGY ETHICAL APPROVAL FORM
FOR HUMAN PARTICIPANTS

Tick relevant  □ STAFF Project  □ POSTGRADUATE Project  □ TRACK A

boxes:  □ UNDERGRADUATE Project  □ TRACK B

□ ROUTINE EXTENSION TO STUDY

Title Of Project: What are Nurses' Discourses of Challenging Behaviour on Acute Inpatient Mental Health Wards?
Name of researcher(s): Amy Mellow
Name of supervisor (for student research): Dr Anna Tickle / Dr Simon Clarke Date: 19/03/16

<table>
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<tr>
<th></th>
<th>YES</th>
<th>NO</th>
<th>N/A</th>
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<tr>
<td>1</td>
<td>✓</td>
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<tr>
<td>2</td>
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<td>3</td>
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<td>5</td>
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Will you describe the main procedures to participants in advance, so that they are informed in advance about what to expect?
Will you tell participants that their participation is voluntary?
Will you obtain written consent for participation?
If the research is observational, will you ask participants for their consent to being observed / taped?
Will you tell participants that they may withdraw themselves or their data from the research at any time, that no reason needs to be given, and that they can do so without losing any rewards (if applicable)?
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<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>6</td>
<td>Will you give participants the option of declining to give information they do not want to give (e.g., not filling out all questions in a questionnaire)?</td>
<td>✓</td>
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<tr>
<td>7</td>
<td>Will you tell participants that their data will be treated with full confidentiality, and stored securely (for 7 years at the minimum) and that, if published, it will not be identifiable as theirs?</td>
<td>✓</td>
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<td>8</td>
<td>Will you debrief participants at the end of their participation (i.e. give them a brief explanation of the study)?</td>
<td>✓</td>
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If you have ticked No to any of Q1-8, but have ticked box A overleaf, please give any explanation on a separate sheet. (Note: N/A = not applicable)

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<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>9</td>
<td>Will your project involve deliberately misleading participants in any way?</td>
<td>✓</td>
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<tr>
<td>10</td>
<td>Is there a realistic risk of any participants experiencing either physical or psychological distress or discomfort? If Yes, give details on a separate sheet and state what you will tell them to do if they should experience any problems (e.g. who they can contact for help).</td>
<td>✓</td>
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</table>

If you have ticked Yes to 9 or 10 you should normally tick box B overleaf; if not, please give a full explanation on a separate sheet.

<table>
<thead>
<tr>
<th></th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
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<tr>
<td>11</td>
<td>Do participants fall into any of the following special groups? If they do, please refer to the appropriate BPS guidelines, and tick box B overleaf.</td>
<td>School children (under 18 years of age)</td>
<td>✓</td>
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<tr>
<td></td>
<td></td>
<td>People with learning or communication difficulties</td>
<td>✓</td>
<td></td>
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<td></td>
<td></td>
<td>Patients</td>
<td>✓</td>
<td></td>
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<td></td>
<td></td>
<td>Those at risk of psychological distress or otherwise vulnerable</td>
<td>✓</td>
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<td></td>
<td></td>
<td>People in custody</td>
<td>✓</td>
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<td></td>
<td></td>
<td>People engaged in illegal activities (e.g. drug taking)</td>
<td>✓</td>
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Please note that you may also need to gain satisfactory CRB clearance or equivalent for overseas participants.
There is an obligation on the lead researcher to bring to the attention of the School’s Ethics Committee projects with ethical implications not clearly covered by the above checklist.

PLEASE TICK EITHER BOX A or BOX B BELOW AND PROVIDE THE DETAILS REQUIRED IN SUPPORT OF YOUR APPLICATION, THEN SIGN THE FORM.

Please tick:

A. I consider that this project has no significant ethical implications to be brought before the Departmental Ethics Committee.

In less than 150 words, provide details of the study including the rational, the number and type of participants, methods and tests to be used (i.e. the procedure).

This form (and any attachments) should be submitted to the school’s Ethics Committee where it will be considered by the Chair before it can be approved.

B. I consider that this project may have ethical implications that should be brought before the Departmental Ethics Committee, and /or it will be carried out with children or other vulnerable populations.

Please provide details of the project on an EA2 University Ethics for Human Participants, taking account the following advice:

1. Be clear about the purpose of the project and its academic rationale.
2. Briefly describe the methods / measurements and parties involved / affected.
3. Be clear about recruitment methods, numbers used, age, gender, exclusion/inclusion criteria, handling procedures for field experiments, etc.
4. Include concise statements of the ethical considerations raised by the project (including care and aftercare) and how you intend to deal with them.
5. Include all relevant materials, such as consent form, participant information form, debrief, questionnaire / stimulus materials, letters /posters to recruit, etc.

This form should be submitted to the School’s Ethics Committee for consideration. 
If any of the above information is missing, your application will be returned to you.

I am familiar with the BPS Guidelines for ethical practices in psychological research, and the University Regulations for Ethical Research (and have discussed them with other researchers involved in the project or my supervisor)

Signed………………………………………….…………
Print Name: Amy Mellow
Date 19/03/16
(UG/PG Researcher(s), if applicable)   Email: ________________________________

Signed……………………………………………………
Print Name: Dr Anna Tickle
Date…………..
(Lead Researcher or Supervisor)   Email: ________________________________

STATEMENT OF ETHICAL APPROVAL

This project has been considered using agreed Departmental procedures and is now approved.

Signed…………………………………………………Print
Name……………………………………………………Date………………..
(Chair, Departmental Ethics Committee)
Ethical Approval Form: Human Research Projects

Please word-process this form, handwritten applications will not be accepted

This form must be completed for each piece of research activity whether conducted by academic staff, research staff, graduate students or undergraduates. The completed form must be approved by the designated authority within the Faculty.

Please complete all sections. If a section is not applicable, write N/A.

<table>
<thead>
<tr>
<th>1 Name of Applicant</th>
<th>Amy Mellow</th>
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<tbody>
<tr>
<td>Department:</td>
<td>School of Psychology</td>
</tr>
<tr>
<td>Faculty:</td>
<td>College of Social Sciences</td>
</tr>
<tr>
<td>2 Position in the University</td>
<td>Student (DClinPsy Candidate)</td>
</tr>
<tr>
<td>3 Role in relation to this research</td>
<td>Primary researcher for project which is the thesis in accordance with the Trent Doctorate in Clinical Psychology.</td>
</tr>
<tr>
<td>4 Brief statement of main Research Question</td>
<td>The title of the study is What Are Nurses’ Discourses of Difficult to Manage Behaviour on Acute Inpatient Mental Health Wards? Although this is likely to change to include a quotation from transcripts following analysis. The main research questions are: 1. What discourses do inpatient mental health nurses draw on to understand and respond to difficult to manage presentations and behaviours on the ward? 2. What subject positions do inpatient mental health nurses take when discussing their responses to difficult to manage behaviour and the use of physical intervention on the wards?</td>
</tr>
<tr>
<td>5 Brief Description of Project</td>
<td>The study will be a discourse analysis of how mental health nurses, working on acute inpatient mental health wards, talk about difficult to manage presentations and how these are managed. The following research questions will be explored: 1. What discourses do inpatient mental health nurses draw on to understand and respond to difficult to manage presentations and behaviours on the ward? 2. What subject positions do inpatient mental health nurses take when discussing their responses to difficult to manage behaviour and the use of physical intervention on the wards? The data analysed will be collected from semi-structured interviews with approximately 10 (8-12) inpatient qualified mental health nurses currently working on inpatient acute or intensive care mental health wards. The</td>
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Interviews will be conducted by the principal investigator. The interviews will be recorded, transcribed using Jefferson system of transcription notation and then coded and analysed using Discourse Analysis, following guidance from Taylor (2001).

<table>
<thead>
<tr>
<th>Approximate Start Date:</th>
<th>April 2016</th>
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<tr>
<td>Approximate End Date:</td>
<td>January 2017</td>
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**6 Name of Principal Investigator or Supervisor**

<table>
<thead>
<tr>
<th>Principle investigator - Amy Mellow (D ClinPsy Candidate)</th>
</tr>
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<tr>
<td>Email address:</td>
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<tr>
<td>Telephone:</td>
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</table>

**7 Names of other researchers or student investigators involved**

1. Dr Anna Tickle, University of Nottingham (first research supervisor)
2. Dr Simon Clarke, University of Lincoln (second research supervisor)
3. Dr Hanne Jakobsen, South London and Maudsley NHS Foundation Trust (field supervisor)
4. 

**8 Location(s) at which project is to be carried out**

<table>
<thead>
<tr>
<th>Lincoln University</th>
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<tr>
<td>South London and Maudsley NHS Foundation Trust</td>
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<tr>
<td>9 Statement of the ethical issues involved and how they are to be addressed – including a risk assessment of the project based on the vulnerability of participants, the extent to which it is likely to be harmful and whether there will be significant discomfort.</td>
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</table>

Participants for this study will be members of nursing staff with the capacity to give informed consent should they wish to participate. They will be recruited via posters, emails and researcher attendance of staff meetings to promote the study. Participants will be fully informed of the research aims, what their participation involves and their rights before being asked if they consent to participate. Participants will not be deceived. The right to withdraw and the limitations of this (for example up until the point of analysis, which will be two weeks after the date of the interview) will be made clear and there will be no impairment to the participants’ autonomy.

All raw data collected (both recordings of interviews and transcripts) will be fully anonymised and kept securely at the University of Lincoln to protect confidentiality. A separate reference sheet will be kept separately and securely to identify data should a participant wish to withdraw from the study. Names of any service-users or other staff members mentioned in interviews will be changed or redacted during transcription to protect confidentiality and anonymity.

The interviews will explore how nurses talk about difficult to manage presentations and behaviours, and how these are managed. It is not intended to cause any distress, but it is recognised that there is a possibility that participants may recall distressing events and become upset. The primary investigator is trained to work with people in distress as part of their role as a trainee clinical psychologist. As such, their role as researcher not therapist will be clear in the interviews but they will be in a position to contain, comfort and signpost the participant to find further support, e.g. The Samaritans or through a GP referral. Participants will also be given, in a written format, details of the staff well being and counselling services available to them as employees. Should a participant become upset, they will be asked if they wish to terminate the interview or take a break. Should they wish to terminate the interview they will be asked if they want to withdraw consent to use the data collected so far. If a participant should become too distressed, the researcher will take the decision to terminate the interview. Respect for the individual’s autonomy and dignity will be upheld at all times. Following the interview, there will be a debrief where the purpose of the study will be explained, again, to participants and they will have the chance to raise any questions or concerns.

Consideration has been given to what would happen should a participant disclose anything that may be a cause for safeguarding concerns, such as abuse on the wards. The researcher would have a duty of care to report this. Therefore, the limits of confidentiality will be made clear both at the start of the interview and on the participant information sheet. Should such an incident occur, the Ward Manager (or whomever is Acting Ward Manager in their absence) will be informed immediately and they will be responsible for taking...
appropriate action. Should there be a need for escalation, then the Clinical Lead for inpatient acute wards or psychiatric intensive care units will be contacted. The field supervisor will also be available to provide support in making appropriate safeguarding and incident reports according to the Trust's policies and procedures. The participant would be made aware of what is happening and kept informed. They will be given the opportunity to discuss their concerns with the researcher. The participant will be asked if they still agree to their data being used in the study or whether they wish to withdraw.

It is believed that the risk of harm incurred by taking part in this study would be no greater than the risk faced day-to-day. As interviews will take place outside shift hours participants will be given an Amazon gift voucher as a small token of appreciation, and compensation, for their time. It is felt that this research would be of benefit to both service users accessing, and clinical teams working in, inpatient acute mental health wards to better understand challenging events that occur on these wards.

Interviews will be transcribed by a professional transcription service who will be required to complete and sign a confidentiality agreement.

Ethical Approval From Other Bodies

<table>
<thead>
<tr>
<th>10 Does this research require the approval of an external body?</th>
<th>Yes</th>
<th>No</th>
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<tr>
<td>If “Yes”, please state which body:-</td>
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<tr>
<td>This research requires research and development approval through the Integrated Research Application System (IRAS). No further ethical approval will be required as participants will be staff members with capacity to consent.</td>
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<tr>
<td>This research will also require the approval of South London and Maudsley NHS Foundation Trust (SLaM) Research and Development department (R&amp;D).</td>
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11 Has ethical approval already been obtained from that body?

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<th>Yes—Please append documentary evidence to this form.</th>
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| No

If “No”, please state why not: Approval will be sought by IRAS following approval from the University of Lincoln’s Ethics Board.

Similarly, SLaM R&D will require the approval from IRAS and the University of Lincoln’s Ethics Board before considering their approval for the project.

Please note that any such approvals must be obtained and documented before the project begins.

APPLICANT SIGNATURE

I hereby request ethical approval for the research as described above.

I certify that I have read the University’s ETHICAL PRINCIPLES FOR CONDUCTING RESEARCH WITH HUMANS AND OTHER ANIMALS.

____________________________________

Applicant Signature

__________________

Date

____AMY MELLOW____

PRINT NAME

FOR STUDENT APPLICATIONS ONLY –

Academic Support for Ethics

Academic support should be sought prior to submitting this form to the designated Ethics Committee within the Faculty

☐ Undergraduate / Postgraduate Taught application

☐ Postgraduate Research Application

Academic Member of staff nominated by the School/Department (consult your project tutor)

Director of Studies
I support the application for ethical approval

_____________________________________
Academic / Director of Studies Signature

_____________________________________
Date

PRINT NAME

FOR COMPLETION BY THE DESIGNATED ETHICS COMMITTEE WITHIN THE FACULTY

Please select ONE of A, B, C or D below:

A. Ethical approval is given to this research.

B. Conditional ethical approval is given to this research.

10 Please state the condition (inc. date by which condition must be satisfied if applicable)

C. Ethical approval cannot be given to this research but the application is referred on to the University Research Ethics Committee for higher level consideration.

11 Please state the reason

D. Ethical approval cannot be given to this research and it is recommended that the research should not proceed.

12 Please state the reason, bearing in mind the University’s ethical framework, including the primary concern for Academic Freedom.
Signature of the Chair of the designated Ethics Committee within the Faculty

_____________________________________
Signature

Date

Chair of __________________________________________
Email Correspondence Between University of Lincoln REC and Chief Investigator

From: Patrick Bourke  
Sent: 30 June 2016 13:44  
To: Amy Mellow  
Cc: Zoe Mead; Matthew Newman  
Subject: RE: Submitting an amendment for Ethics

Dear Amy,

I am happy to agree this by Chair’s Action.

Patrick Bourke (Chair SOPREC)

---

Dr. Patrick Bourke  | Senior Lecturer

College of Social Science  
University of Lincoln. Brayford Pool, Lincoln, Lincolnshire. LN6 7TS  
tel:  

staff profile  |  lincoln.ac.uk  |  

---

From: Amy Mellow  
Sent: Thursday, June 30, 2016 12:25 PM  
To: Patrick Bourke

Subject: Submitting an amendment for Ethics

Dear Dr Bourke,

I would like to submit a minor amendment to my research proposal to be considered by the ethics committee. This is that a professional transcription service will now be used for the transcription of interview data. This service will be asked to complete and sign a confidentiality agreement. Please see the attached document, changes are on page 7 and in appendix 6 (confidentiality agreement to be completed and signed by the professional transcription service), pages 43-44, of the attached document.
I look forward to hearing your response,

Many thanks

Amy Mellow

From: Zoe Mead
Sent: 29 June 2016 09:39
To: Simon Clarke <SClarke@lincoln.ac.uk>; Amy Mellow <14498821@students.lincoln.ac.uk>; Soprec <Soprec@lincoln.ac.uk>
Cc: Anna Tickle <anna.tickle@nottingham.ac.uk>
Subject: Re: Application for ethical approval - PSY1516137

Dear Amy

Thanks for your email. As outlined below, your submission does not need to be resubmitted as it was conditionally approved. Your grade on blackboard does not require an update as the approval had been given.

Regards

Zoe

Get Outlook for iOS

From: Simon Clarke
Sent: 10 June 2016 14:53:05
To: Soprec
Cc: Amy Mellow Zoe Mead; Anna Tickle
Subject: Re: Application for ethical approval - PSY1516137

Dear Soprec,

Many thanks for your email. As Amy Mellow's supervisor I can confirm that she has now added the debrief to her ethics application (attached). I therefore approve this amendment.

Please let me know if there is anything else you need.

Best wishes,

Simon

Dr. Simon Clarke
Academic Tutor/Senior Lecturer
Dear Amy

This is to confirm that your application for ethical approval was conditionally approved, pending the following amendments:

- The debrief needs to be added to the application

Your supervisor can approve make the relevant changes, there is no need to resubmit.

Kind regards

Soprec
Appendix 2. Health Research Authority Letter of Approval

Health Research Authority

Miss Amy Mellow  
Trainee Clinical Psychologist  
Lincolnshire Partnership NHS Foundation Trust  
Bridge House,  
University of Lincoln, Brayford Pool  
Lincoln   LN6 7TS

29 July 2016 (reissued 30 August 2016 to correct PIS and ICF version numbers)

Dear Miss Mellow,

Letter of HRA Approval

Study title: What Are Nurses’ Discourses of Difficult to Manage Behaviour on Acute Inpatient Mental Health Wards?

IRAS project ID: 139456

Protocol number: Not available

Sponsor: University of Lincoln

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. Please read Appendix B carefully, in particular the following sections:

- Participating NHS organisations in England – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- Confirmation of capacity and capability - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria) - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.
It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices
The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval
The attached document “After HRA Approval – guidance for sponsors and Investigators” gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope
HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hso-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback
The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training
We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is 199456. Please quote this on all correspondence.
Yours sincerely

Michael Pate
Assessor

Email: hra.approval@nhs.net

Copy to:

Prof Sara Owen – Sponsor’s representative – University of Lincoln
Gill Dale – Lead NHS R&D Contact - South London and Maudsley NHS Foundation Trust
Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of 04/10/2016 (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and ______________________ with principal offices at ________________________________, (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by Amy Mellow which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University’s request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University’s prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University’s request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.
The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of

_______________________________________________________________
Signed: ........................................... Name:
................................................................
Title: ............................................................ Date:
......................................................................

Signed for and on behalf of the University of Lincoln
Signed: ............................................... Name:
................................................................
Title: .................................................... Date:
..................................................................
Appendix 4. Participant Information Sheet

South London and Maudsley NHS Foundation Trust
Participant Information Sheet

(Final version 2.0: July 2016)

IRAS ref: 199456

Title of Study What Are Nurses’ Discourses of Difficult to Manage Behaviour on Acute Inpatient Mental Health Wards?

Name of Researcher(s): Amy Mellow

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the purpose of the study?

Research has shown that nurses working in acute mental health settings are a group particularly vulnerable to occupational stress and burn out. This has been found to be largely due to the difficult service user presentations and behaviours that they manage on the wards (Jenkins & Elliott, 2004).

The purpose of this study is to gain a better understanding of how inpatient mental health nurses make sense of and manage some of the difficult experiences they face on the wards. In particular we are interested in the service user presentations and behaviours that you find difficult to manage and how you make sense of these.

Why have I been invited?

You are being invited to take part because you are a Registered Mental Health Nurse, working on an Acute Mental Health Ward or Psychiatric Intensive Care Unit (PICU). We are inviting between eight and twelve participants like you to take part.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw up until your interview has been transcribed (two weeks after the date of the interview), and without giving a reason. This would not affect your legal rights.

**What will happen to me if I take part?**

If you chose to take part, then you will take part in a one off individual interview with the researcher. This interview will be recorded using a Dictaphone. Recording will not start until you have had an opportunity to ask any questions and all paper work, including the consent form, has been completed. Before the interview can start the researcher will ask you to sign a consent form and complete a separate form with you personal contact details. You will be assigned an individual participant number; this will keep your interview data anonymous. When you are ready, the researcher will commence the interview and turn on the Dictaphone. You are asked not to give any personal identifiable information whilst the Dictaphone is turned on.

The interview will be semi-structured and so should feel more like a conversation. The interview is expected to last around an hour. This will be outside of your working hours and so you will be compensated for your time with a £10 Amazon voucher.

Once the interview has been completed, the researcher will turn off the Dictaphone and give you an opportunity to ask further questions. You will then be free to go. Once all of the interviews have been completed they will be transcribed verbatim and the recording will be deleted. The researcher will then analyse the transcripts and write the findings into a report. If you wish for the researcher to send you a summary of the findings, then this will be sent to you by email once the report has been completed.

**Expenses and payments**

You will be compensated for their time with a £10 Amazon voucher.

**What are the possible disadvantages and risks of taking part?**

It is unlikely that any risks or discomfort will be incurred by taking part in the study. We understand that this is a sensitive topic for some people. If you wish to take a break and come back at any point during the interview then please let the researcher know. Similarly, if you feel you would like to stop, please tell the researcher and the interview will be terminated.
If you become upset or the researcher feels you are getting upset, the researcher will ask if you wish to continue, would like to take a break or wish to stop the interview. If you become very upset then the researcher will terminate the interview and offer you details of where you can access support.

**What are the possible benefits of taking part?**

We cannot promise the study will help you but the information we get from this study may help to better inform future practice.

**What happens when the research study stops?**

The study will stop once the final interview has been completed. The researcher will then begin to transcribe and analyse all of the interviews. A report of the findings will then be written. You can still contact the researcher using the contact details given at the end of this information sheet during this time if you have any further questions. Once the report has been written, the researcher will send you a summary of the findings.

**What if there is a problem?**

If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. The researchers contact details are given at the end of this information sheet.

**Will my taking part in the study be kept confidential?**

We will follow ethical and legal practice and all information about you will be handled in confidence.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database. All interviews will be anonymised and a unique participant number given. We ask that you do not disclose any personal identifiable information, for yourself or anyone else, whilst the Dictaphone is turned on and recording. If you do mention any names, then these will be changed to a pseudonym in the transcription process. Any other personal identifiable details will be blanked out in the transcription.

Your personal data (address, telephone number) will be kept until the end of the analysis. This is so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All research data will be kept securely for 7 years. After this time your data will be disposed of securely. During
this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

Although what you say in the interview is confidential, should you disclose anything to us which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate persons. This is so that the appropriate safeguards can be put in place. Should this happen, the researcher will terminate the interview and discuss this with you in more detail.

**What will happen if I don’t want to carry on with the study?**

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. If you withdraw after the analysis has been completed (two weeks after the date of the interview) then the information collected so far cannot be erased and this information may still be used in the project analysis.

**What will happen to the results of the research study?**

The results of the study will be written up into a report and submitted to the University of Nottingham and the University of Lincoln as part of the researcher’s qualification towards a Doctorate in Clinical Psychology. The report will also be submitted for publication.

You will not be identified in any report or publication, but anonymous and non-identifiable quotations from the interviews will be used in writing up the results section.

**Who is organising and funding the research?**

This research is being organised and funded by the University of Nottingham and the University of Lincoln.

**Who has reviewed the study?**

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by The University of Lincoln Research Ethics Committee.

**Further information and contact details**

Do you have any questions?

**Contact Details:**
Amy Mellow

The Trent Doctorate in Clinical Psychology, Bridge House, University of Lincoln, Brayford Pool, Lincoln LN6 7TS
Appendix 5. Participant Consent Form

Title of Study: What Are Nurses’ Discourses of Difficult to Manage Behaviour on Acute Inpatient Mental Health Wards?

IRAS ref: 199456

Name of Researcher: Amy Mellow

Name of Participant: __________________________

1. I confirm that I have read and understand the information sheet version number 2.0 dated July 2016 for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason. I understand that should I wish to withdraw after my interview has been transcribed, then the information collected so far cannot be erased and that this information may still be used in the project analysis.

3. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports.

4. I understand that my details will be kept confidential.

5. I understand that should I disclose any information that raises serious concern for my safety, or the safety of others, confidentiality will be breached to ensure appropriate safeguards can be put in place. I

Please initial in box
understand that should this occur then the interview will be stopped and
the researcher will discuss this with me.

6. I agree to take part in the above study.

_________________________  ____________  ______________________
Name of Participant        Date           Signature

_________________________  ____________  ______________________
Name of Person taking consent  Date           Signature

2 copies: 1 for participant and 1 for the project notes

If you would like to receive a summary of the findings or a copy of
the final research report then please complete the form below
(please write in block capitals):

I would like to receive a summary of the findings.  [Y]  [N]

I would like to receive a copy of the final research report.  [Y]  [N]

_________________________
Name of Participant

_________________________
Email Address

_________________________
Telephone Number
Appendix 6. Participant Debrief Sheet

Title of Study What Are Nurses’ Discourses of Difficult to Manage Behaviour on Acute Inpatient Mental Health Wards?

Thank you for your participation in the research project. Your views and experiences are very important to us, and will help us to understand behaviours that are difficult to manage in inpatient services. Your interview will be kept completely anonymous and confidential and you will have two weeks from the date of your interview if you change your mind and wish to withdraw. You can withdraw by contacting the principal researcher on the email address provided below. If you find you have any questions or concerns about this research, please do not hesitate to contact the principal researcher on the same email address.

If the interview has raised any difficult feelings or distress, then the Department of Occupational Health and Wellbeing can provide support and counselling to South London and Maudsley staff. Their details can be found below.

Best Wishes

Amy Mellow (Principal Researcher)

Contact Details: Amy Mellow - 14498821@students.lincoln.ac.uk

Department of Occupational Health and Wellbeing

3rd Floor
Jenny Lee House,
34, Love Walk
London SE5 8AD
Appendix 7. SEMI-STRUCTURED INTERVIEW SCHEDULE

SEMI-STRUCTURED INTERVIEW SCHEDULE

(Final version 2.0: 07/02/16)

Title of Study: What Are Nurses’ Discourses of Difficult to Manage Behaviour on Acute Inpatient Mental Health Wards?

Before the interview

1. Give participant information sheet and read through it. Ask if they have any questions.
2. Complete participant information sheet, consent form and assign participant number. Give voucher.
3. Remind participant to not give any personal identifiable information, e.g. names once the dictaphone has been turned on.
4. Turn on dictaphone and commence interview.

The interview: Please note that this is a semi-structured interview, following a topic list organised as questions. The aim is for the interview to feel conversational and give the participant space to express what they feel are the important issues and discuss their opinions and experiences.

Icebreakers and Demographic Questions:

1. How long have been a registered mental health nurse? What attracted you to mental health nursing?
2. Where did you train?
3. Had you done anything else before?
4. Have you been on any additional training courses?
5. What sort of service do you work in? How long have you worked there for? When did you qualify? Where did you work before? What’s the team like where you are?
6. What disciplines/professions work on the ward – who makes up your team?
7. What sort of service users do you usually work with, e.g. gender, diagnosis?

Topic List:

1. What are the challenging or difficult to manage behaviours that you experience when working on the ward(s)? Can you give me an example?
   a. How does it make you feel when it happens?
   b. Why do you think those service users behave in that way?
   c. Do you think there is anything that could prevent/reduce the risk of this behaviour happening?
2. What do you do to manage this behaviour individually and as a team?
   a. Can you talk me through an example? (Consider asking about verbal de-escalation, restrictive interventions, medical interventions, MDT working).
b. Is this standard practice? What would standard practice be?

c. Have there been any times where you feel challenging behaviour was managed badly? Can you give me an example? Why do you think that happened like it did? How do you feel about that?

d. Can you give me an example where challenging behaviour was managed well/without PI? Why do you think that happened like it did?

e. What training have you had about the different kinds of challenging or difficult to manage behaviours you mentioned and how to manage these?

f. What support is available for you as an individual and as a team?

Final Question

Is there anything else that you would like to talk about regarding challenging behaviour and/or how these are managed on the ward?

That is the end of the interview. Thank you for your participation.

*Turn off dictaphone and give space for questions. Give Amazon voucher.*
Appendix 8. Recruitment Flyer

Challenging Behaviour on Inpatient Mental Health Wards

We Would Like To Invite You To Take Part in Our Research Study

Research has shown that nurses working in acute mental health settings are a group particularly vulnerable to occupational stress and burn out. This has been found to be largely due to the difficult service user presentations and behaviours that they manage on the wards (Jenkins & Elliott, 2004).

The purpose of this study is to gain a better understanding of how inpatient mental health nurses make sense of and manage some of the difficult experiences they face on the wards. In particular we are interested in the service user presentations and behaviours that you find difficult to manage and how you make sense of these.

Who Can Take Part?

You can take part if you are a Registered Mental Health Nurse working on an Acute Inpatient Mental Health Ward

What Will Happen If I Take Part?

If you decide you want to take part, you will be invited to attend a one off individual interview, lasting approximately an hour. This will be kept anonymous and confidential. The interview will take place outside of your working hours and so you will be given a £10 Amazon voucher as compensation for your time. Your participation is voluntary, so if you change your mind, you will have the right to stop the interview and withdraw from the study.

What are The Potential Benefits Of Taking Part?

We cannot promise the study will help you but the information we get from this study may help to better inform future practice.

It is unlikely that any risks or discomfort will be incurred by taking part in the study. We understand that this is a sensitive topic for some people. If you wish to take a break and come back at any point during the interview then please let the researcher know. Similarly, if you feel you would like to stop, please tell the researcher and the interview will be terminated. If you become very upset then the researcher will terminate the interview and offer you details of where you can access support.
Where Can I Get More Information?

If you have any questions, would like more information or would like to participate in the study, please do not hesitate to contact the researcher.

This research has been organised and funded by the University of Lincoln and University of Nottingham as part of a Doctorate in Clinical Psychology. This project has been reviewed and approved by a Research Ethics Committee.

Q&A

Do I have to take part? No! Your participation is voluntary.

How will it be used? After all interviews have been completed, they will be transcribed and analysed. A report will be written and submitted to the Trent Doctorate in Clinical Psychology, and for publication.

Is it confidential? Yes! All data will be anonymised and kept confidential. However, anonymised quotations may be used in the write up to illustrate themes.

I want to take part. What should I do now? Get in touch to arrange an interview!

Contact Details:
Amy Mellow
Doctorate in Clinical Psychology
Bridge House
University of Lincoln
Brayford Pool
Lincoln, LN6 7TS
Appendix 9. Recruitment Email (sent by Field Supervisor)

i) Recruitment Email: (Subject: Opportunity to take part in research)

Hello,

I would like to invite you to take part in an exciting research opportunity!

My name is Amy Mellow and I am conducting a research project as part of a Doctorate in Clinical Psychology. I am interested in your experiences of the ‘challenging’ or ‘difficult to manage behaviours’ that you face on the ward as a Registered Mental Health Nurse, and how these are managed. I would like to invite you to participate in an interview lasting approximately one hour. I appreciate the busy nature of your work, and that this is likely to take part outside of your shifts, and so you will be compensated for your time with a £10 Amazon voucher. Please see the study information leaflet attached.
If you are interested in taking part, have any questions, or would like more information, then please do not hesitate to get in touch:

Amy Mellow: 14498821@students.lincoln.ac.uk

Doctorate in Clinical Psychology,
Bridge House, University of Lincoln,
Brayford Pool, Lincoln LN6 7TS
Appendix 10. Transcription Conventions

Transcription Symbols
(taken from Wetherell, Taylor & Yates, 2001; p. 62)

(.5) The number in brackets indicates a time gap of tenths of a second

(.) A dot enclosed in a bracket indicates a pause in talk of less than two tenths of a second

.hh A dot before an ‘h’ indicates speaker in-breath; the more ‘h’s the longer the in-breath

Hh An ‘h’ indicates an out-breath; the more ‘h’s the longer the out-breath

(( )) A description enclosed in a double bracket indicates a non-verbal activity, e.g. ((banging sound))

- A dash indicates the sharp cut-off of the prior word or sound

: Colons indicate that the speaker has stretched the preceding sound or letter. The more colons the greater the extent of the stretching

( ) Empty parentheses indicate the presence of an unclear fragment on the tape

(guess) The words within a single bracket indicate the transcriber’s best guess at an unclear fragment

. A full stop indicates a stopping fall in tone. It does not necessarily indicate the end of a sentence

, A comma indicates a continuing intonation

? A question mark indicates a rising inflection. It does not necessarily indicate a question

Under Underlined fragments indicate speaker emphasis

↑↓ Pointed arrows indicate a marked falling or rising intonational shift. They are placed immediately before the onset of the shift.

CAPITALS With the exception of proper nouns, capital letters indicate a section of speech noticeably louder than that surrounding it
Degree signs are used to indicate that the talk they encompass is spoken noticeably quieter than the surrounding talk.

‘More than’ and ‘less than’ signs indicate that the talk they encompass was produced noticeably quicker than the surrounding talk.

The ‘equals’ sign indicates contiguous utterances.

Square brackets between adjacent lines of concurrent speech indicate the onset and end of a spate of overlapping talk.

A double left-hand bracket indicates that speakers start a turn simultaneously.
Appendix 11. Steps for Analysis

Analysis Steps


Discursive Psychology

1. **READING:**
   - First take time to READ the transcripts carefully, at least once, without any attempt at analysis.
   - Aim to experience as a reader some of the discursive effects of the text.
   - For example, a text may feel like an apology even though the words ‘I’m sorry’ are not spoken. Or the text may make it sound like there is a war going on, when the topic of the transcribed speech is that of a forthcoming election.
   - Reading the text before analysis allows you to become aware of what the text is doing. The purpose of analysis is to identify HOW the text manages to accomplish this.

2. **CODING:**
   - Reading and rereading of transcripts is followed by the selection of material for analysis or coding.
   - This is done in the light of the research question(s).
   - All relevant sections of text are highlighted, copied and filed for analysis.
   - Make sure that all material that is potentially relevant is included – therefore even those that are indirectly or vaguely related to the research question
   - The use of certain key words in NOT required for selection of textual material.
   - All implicit constructions (MacNaughten, 1993) must be included.
   - NB: We can never produce a full discourse analysis of a text: Our research question identifies a particular aspect of the discourse which we decide to explore in detail and coding helps to select relevant sections of the texts which constitute our data. There are many aspects that will not be analysed, this means that the same text can be analysed again, generating further insights.
3. ANALYSIS:

- Discourse analysis proceeds on the basis of the researcher's interaction with the text.
- Potter and Wetherell (1987; 168) recommend that throughout the process of analysis the researcher asks 'Why am I reading this passage in this way?' 'What features [of the text] produce this reading?'
- Pay close attention to the constructive and functional dimensions of discourse. In order to facilitate a systematic and sustained exploration of these dimensions of discursive accounts need to be attended to:
  - CONTEXT
  - VARIABILITY
  - CONSTRUCTION
- How does the text construct its objects and subjects?
- How do such constructions vary across discursive contexts?
- What are the consequences of their deployment?
- Pay attention to terminology, stylistic and grammatical features, preferred metaphors and other figures of speech which may be used in construction (Potter & Wetherell, 1987 p.149 term this ‘interpretive repertoires’).
  - NB. Different repertoires are used to construct different versions of events.
- Different repertoires can be used by the same speaker in different discursive contexts to pursue different social objectives.
- IDENTIFY the action orientation of accounts – both interviewer and interviewees contributions are required
  - Pay careful attention to the discursive contexts within which accounts are produced and trace their consequences for the participants in the conversation - REQUIRES US TO EXAMINE LANGUAGE IN CONTEXT
- Pay attention to alternative and contradictory versions of events. The presence of tensions and contradictions among the interpretative repertoires used by speakers demonstrates that the discursive resources people draw on are inherently dilemmatic (See Billig et al., 1988; Billig, 1991). This may relate to the action orientation of talk.
  - See pages 151-153 for example
**Foucauldian Discourse Analysis**

Six stages for discourse analysis that allow the researcher to map some of the discursive resources used in a text and the subject positions that they contain and to explore their implications for subjectivity and practice. However, bear in mind that this does not constitute a full analysis in the Foucauldian sense.

REFER to Interrogating Discourse and DA chapter final (3) for viva prep.

1. Discursive Constructions
   - This stage of analysis is concerned with the ways in which discursive objects are constructed. The discursive objects of interest depend on the research question.
   - It is important not to only look for key words as both IMPLICIT and EXPLICIT references need to be included.
   - The search for constructions of the discursive object is guided by shared meaning rather than lexical comparability. The fact that the text does not contain a direct reference can tell us a lot about the way in which the object is constructed. E.g. a in a relative’s discourse about illness without naming it, references to ‘it’, ‘this awful thing’, or ‘the condition’ construct the discursive object as something unspeakable, perhaps unknowable.

For an example see p. 156-7.

2. Discourses
   - Having identified all sections of the text that contribute to the construction of the discursive object, we focus on the differences between constructions.
   - What appears to be one and the same discursive object can be constructed in very different ways.
   - This stage of analysis aims to locate the various discursive constructions of the object within wider discourses. For example, in an interview with a woman talking about her experiences of her husband’s prostate cancer, she might draw on biomedical discourses when she talks about the processes of medical procedures, diagnosis, treatment etc., she might draw on a psychological discourse when talking about the emotional impact or beliefs on why she thought her husband developed prostate cancer, and a romantic discourse when she describes how she and her husband find the strength to fight the
illness together. Therefore the same object, prostate cancer, can be described as many different things within the same text.

See . 157-8 for example

3. Action Orientation
   ▪ This stage involves a closer examination of the discursive contexts within which the different constructions of the object are being deployed.
   ▪ What is gained by constructing the object in this particular way, at this particular point in time/ the text?
   ▪ What is its function and how is it related to other constructions produced in the surrounding text? For example, using the same example of a wife as in stage 2. The biomedical discourse might allow for her to attribute responsibility for diagnosis and treatment to medical professionals, her use of a romantic discourse may have been produced in response to her own role in her husband’s recovery, and served to emphasize her role and that she is contributing to his recovery and the psychological discourse may serve to disclaim responsibility for a carcinogenic lifestyle.
   ▪ A focus on Action Orientation can allow us to gain a clearer understanding of what the various constructions of the discursive object are capable of achieving within the text.

   See p. 158-9 for example

4. Positionings
   ▪ Having identified various constructions of the discursive object within the text and located them within wider discourses, we now take a closer look at subject positions which they offer
   ▪ A subject position within a discourse identifies ‘a location for persons within the structure of rights and duties for those who use that repertoire’ (Davies and Harre, 1999 p.35).
   ▪ I.e. discourse construct subjects as well as objects and therefore make positions of meaning available.
   ▪ Subject positions differ from roles in that they offer discursive locations from which to speak and act, rather than prescribing a particular part to be acted out. Roles can be played out without subjective identification, whereas taking up a subject position has direct implications for subjectivity (see stage 6).

   See p. 159 for example
5. Practice

- This stage is concerned with the relationship between discourse and practice.
- Requires systematic exploration of the ways in which discursive constructions and subject positions contained within them open up or close down opportunities for action.
- By constructing particular versions of the world, and positioning the subjects within them in particular ways, discourses limit what can be said or done.
- Further, non-verbal practices can, and do, form part of discourse. For example, the practice of unprotected sex can be bound up with a marital discourse which constructs marriage and its equivalent – ‘the long term relationship; as incompatible with the use of condoms (Willig, 1995).
- Thus certain practices become legitimate forms of behaviour from within particular discourses. Such practices in turn, reproduce the discourses which legitimate them in the first place.
- In other words, speaking and doing support one another in the construction of objects and subjects.
- This stage of analysis maps the possibilities for action contained within the discursive constructions identified in the text.

See p.160 for example.

6. Subjectivity

- Final stage of this analysis explores the relationship between discourse and subjectivity. Discourses make available certain ways of seeing the world and certain ways of being in the world. They construct social as well as psychological realities – discursive position plays an important role in this process:
  - Once having taken up a particular position as one’s own, a person inevitably sees the world from the vantage point of that position and in terms of the particular images, metaphors, storylines and concepts which are made relevant within the particular discursive practice in which they are positioned (Davies and Harre, 1999; p.35).
- This stage traces the consequences of taking up various subject positions from the participant’s subjective experience. Having asked questions about what can be said and done from within different discourses (Stage 5).
- We are now concerned with what can be felt, thought and experienced from within various subject positions.
This stage is the most speculative because we are attempting to make links between the discursive constructions used by participants and their implications for subjective experience.

Since there is no necessary direct relationship between language and various mental states, we can do no more than delineate what can be felt, thought, and experienced from within various subject positions; whether or not, or to what extent, individual speakers actually do feel, think, or experience in these ways on particular occasions is a different question (and one that cannot be based on discourse alone).

p. 161

WRITING UP is an important part of the analysis. Potter and Wetherell (1987) and Billig (1997) draw attention to the fact that writing a report itself is a way of clarifying analysis.

The attempt to produce a clear and coherent account of one's research in writing allows the researcher to identify inconsistencies and tensions which, in turn, may lead to new insights. It may also be necessary for the researcher to return to the data in order to address difficulties and problems raised in the process of writing.
Appendix 12. Analysis Process – drawing it all together 1 (post-its)
Appendix 13. Analysis Process – drawing it all together 2 (mind maps)
Nurses working in acute mental health services are particularly vulnerable to occupational stress & burnout. The two main stressors identified have been understaffing & “physically threatening, difficult or demanding patients”1. 60,000 assaults were recorded against NHS stuff in England during 2011; 69% of which occurred within mental health & learning disabilities settings2. Over the course of their career registered mental health nurses (RMNs) are likely to be assaulted an average of 6.7 times3. The impact of CB is far reaching. It affects the health & safety of staff, service-users & carers4, can increase the risk of abuse, isolation & neglect for service-users, & increase stress & strain amongst caregivers5. Guidelines stipulate restrictive interventions should only be used as a last resort6. However, service-users have reported that this is the case in practice7. Some services that claim restrictive-interventions are only used as a last resort do not explore the root cause of the behaviour8. Ongoing political drivers aim to reduce the use of restrictive interventions9. Aims: to identify the discourses drawn on by inpatient RMNs to understand challenging behaviour and talk about its management.

Method
Participants: 7 RMNs, 1 male & 6 female, from acute wards and psychiatric intensive care units (PICU) across two hospital sites within the same NHS trust.
Procedure: Semi-structured interviews asking about challenging behaviour and its management.

Analytic Approach: Discourse Analysis (DA) was used. For this research discursive psychology and Foucauldian Discourse Analysis (FDA) approaches to DA were combined, with a greater focus on FDA.

Analysis
The dominant discourse was biomedical: “some people will behave that way because they are genuinely unwell, they have a mental illness and they might be hearing voices telling them, you know, not to take medication because it’s poison or whatever hh erm, or to assault, huh-hurt other people… it falls back to, you know them being unwell” (Samira). This acts to promote an “overuse” of medication and coercive interventions. This is further legitimised by high-risk discourses.

Systemic discourses constructed an organisation where staff and service-users are disempowered. Militaristic language, for example “commandeered” (James) & “frontline” (Jessica) to positioned nurses as following orders. Systemic discourses positioned CB as made unmanageable by “really, poor resources” (Denise). This further legitimised the use of medication, & coercive or restrictive interventions: “I don’t think staff feel they have enough time to kind of sit and (.) erm (.) deescalate properly… there’s a feeling that there’s no time for that… we need to contain, let’s medicate.” (Jessica).

Alternative discourses (emotional & psychosocial) were present but marginalised. These promoted empathy and understanding. However, some participants positioned themselves as naïve to their potential role and were dismissive of emotional constructions, instead describing the service-user as vengeful: “she was not happy about a record that was given (.) about her blah, blah, blah, so she attacked… see she’s planning it… this patient’s got that type of history” (Christina).

Discussion
Dominant biomedical and systemic discourses were found to act in ways that marginalise alternative emotional & psychosocial discourses. This acted to absolve individual accountability for nurses & to maintain the status quo. Participants positioned nurses as a group disempowered by the dominant constructions that lead to a reliance on control. Likewise, they positioned service-users as disempowered, voiceless & without autonomy. Arguably this frames CB as a coercive strategy used by some service-users to re-gain control in a place of disempowerment & restrictive interventions as a tool for nurses to regain control when faced with CB.

References

*Nurses’ Discourses of Challenging Behaviour in Inpatient Mental Health Services
*all names have been changed to protect anonymity