SERVICE USER AND STAFF EXPERIENCES OF THE THERAPEUTIC RELATIONSHIP AFTER PHYSICAL RESTRAINT IN A SECURE HOSPITAL

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I want to thank my lovely cohort of Trainees, who through the last three years have grown to be such good friends. I have particularly valued our group messages, keeping each other laughing and being there to answer any questions about the research (no matter how dull the question seems!)

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The therapeutic relationship is the relationship between service users and staff, based on collaboratively working towards the service users’ goals. Within a secure hospital environment, staff sometimes have to physically restrain service users, as a last resort to manage risk. The aim of this research was to explore both service user and staff perspectives of the therapeutic relationship after physical restraint in a secure hospital environment. This was investigated in an independent sector medium-low secure hospital in Wales. Ten semi-structured interviews were conducted with five service users and five staff members; all of whom had been involved in at least one incident of physical restraint. These participants described their experiences of therapeutic relationships with those that they had been involved in a physical restraint with. Interpretative Phenomenological Analysis was used to separately analyse the service user and staff member data. Four master themes emerged from the service user experiences: changes to the therapeutic relationship; appraisal of the necessity of physical restraint; emotional impact; and dependency and power. A further three master themes emerged from the staff member experiences: personal impact; conflicting professional roles and responsibilities; and making sense of the physical restraint. These findings are discussed in relation to implications for secure hospital services and recommendations for future research are outlined.
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1.1 CHAPTER OVERVIEW

This introductory chapter provides an overview of the key concepts that are relevant to this research project. Inpatient mental health care and secure services are defined alongside two key components of this care; the therapeutic relationship and the use of restrictive interventions. Research that considers the experience of both service users and staff of physical restraint are synthesised and reviewed, including a Systematic Review of service user experiences within inpatient mental health and secure services. These studies suggest that the experience of physical restraint may have an impact upon the therapeutic relationship between service users and staff members. The rationale and aims of the current research project are outlined.

1.2 INPATIENT MENTAL HEALTH CARE SERVICES

1.2.1 Acute mental health wards and psychiatric intensive care units
Inpatient mental health care aims to support service users in a safe and therapeutic environment, when experiencing acute difficulties with their mental health (Joint Commissioning Panel for Mental Health, 2013). There are different types of inpatient mental health care depending upon the service user’s needs. Acute mental health inpatient wards provide assessment and treatment for a range of mental health difficulties, whereas Psychiatric Intensive Care Units (PICU) provide high intensity care for those who cannot be safely managed on the acute inpatient wards.
1.2.2 Secure hospital services

When a service user’s risk of harm to themselves or others and their risk of escape from hospital cannot be safely managed in other mental health services, they can be detained in a secure hospital. NHS England (2013) provide definitions and guidance regarding the provision of secure hospital care. Secure hospitals provide care and treatment for individuals who are both detained under the Mental Health Act (1983, amended in 2007) and pose a significant risk of harm to others. These service users have complex mental health needs and may have co-morbid difficulties of substance misuse and personality disorder. Many of these service users have had contact with the criminal justice system and have either been charged with or convicted of a violent offence. Additional restrictions can also be placed upon them by the Ministry of Justice. Secure hospitals can be either high, medium or low secure; each of these having differing levels of procedural, physical and relational security (high secure environments being the highest levels of security).

Secure services aim to provide therapeutic services to service users who present a significant risk of harm to others in the least restrictive environment possible. These services aim to both assess and treat mental health difficulties using a recovery focused approach, whilst simultaneously managing and attempting to reduce the risk of harm the service user poses to both themselves and others (NHS England, 2013).

1.3 THE THERAPEUTIC RELATIONSHIP

1.3.1 Defining the therapeutic relationship

The ‘therapeutic relationship’ has multiple definitions and has been difficult to operationalise and define (Brown et al., 2012; Farrelly et al., 2014; McCabe & Priebe, 2004); this has been due to different theoretical approaches and frameworks conceptualising the therapeutic relationship in alternative ways (Kazantzis et al., 2013). In the literature, the therapeutic relationship has also been referred to as the working alliance, therapeutic alliance and helping alliance (McCabe & Priebe, 2004).

Despite the multiple terms associated with a therapeutic relationship, each of these are underpinned by the same notion. ‘Relationship’ refers to an alliance and emotional connection between two people, whereby both appraise the other based on their interaction
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(Farrelly et al., 2014). Whereas ‘therapeutic relationship’ establishes that this connection and relationship is defined around the service user’s treatment (Farrelly et al., 2014), whereby the professional has the skills to maintain and improve the health of the service user (Chan et al., 2014). It is suggested that through the therapeutic relationship, via collaborative work, mutual trust and an affective bond, treatment goals can be established and achieved (Stiles-Shields et al., 2013; Theodoridou et al., 2012).

1.3.2 Importance of the therapeutic relationship

Within a mental health inpatient environment, service users interact and develop therapeutic relationships with multiple staff members, not just the lead clinician (Theodoridou et al., 2012). National guidelines produced by National Institute for Health and Clinical Excellence (NICE, 2009) and the Royal College of Psychiatrists (2009), cite the importance of the therapeutic relationship. This relationship is important in nursing roles, however it is argued that in mental health nursing it is particularly significant (McCabe & Priebe, 2004) as it forms the core of the nursing role (Muller & Poggenpoel, 1996). It is argued that the development of a relationship based on empathy and trust is a fundamental objective of Mental Health Nurses (Bland et al., 2001).

The therapeutic relationship is one of the most significant factors in the treatment of mental health problems (Roche et al., 2014). In a review of the therapeutic relationship and treatment of severe mental illness, it was found that a more positively evaluated therapeutic relationship consistently predicted both short and long term outcomes, demonstrated through multiple scales and measures (McCabe & Priebe, 2004). The therapeutic relationship has been recognised as one of the most consistent effective predictors of treatment outcome (Priebe & McCabe, 2008) including service engagement, medication adherence and service satisfaction (Roche et al., 2014). This has been demonstrated across various clinical populations and settings (McCabe & Priebe, 2004). A more positive therapeutic relationship can be established by empowering service users to become involved in their own care and to have influence on the services that support them (Catty, 2004), which again has been linked to improved outcomes (Gehrs & Goering, 1994; McCabe & Priebe, 2004).

Numerous studies have demonstrated the significance of the therapeutic relationship. These studies have concluded that the therapeutic relationship is equally or even more important than the specific therapeutic technique (e.g. Antoniou & Bloom, 2006; Johnson & Caldwell,
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2011; Lambert & Barley, 2011) or particular treatment method (Norcross & Wampold, 2011). In inpatient mental health contexts, the therapeutic relationship is also likely to be used to deliver other aspects of treatment such as medication (Weiss et al., 1997). Not only has the therapeutic relationship been associated with better treatment outcomes, a positive association has also been found between the therapeutic relationship and quality of life within a mental health context (McCabe et al., 1999).

A literature review of service users’ expectations of inpatient mental health care (Hopkins et al., 2009) identified that service users both want and value a good therapeutic relationship as part of their inpatient treatment (Johansson & Ekund, 2003; Olusina et al., 2002). A study which looked at service user experiences of their hospital admission identified that the therapeutic relationship was valued as one of the most important aspects of their care and they particularly valued this relationship being a trusting one (Gilburt et al., 2008).

There are risks associated with the absence of a good therapeutic relationship between service users and staff members. Without this, only biological aspects of the service user’s difficulties can be treated, consequently the social and interpersonal aspects of that service user’s difficulties will be neglected (Peplau, 1997). Mental Health Nurses help support people to live meaningful lives (Browne et al., 2012) which requires a partnership between them and the service user, as opposed to the service user becoming a passive recipient of treatment (Peplau, 1991).

1.3.3 Difficulties with the therapeutic relationship within inpatient mental health care settings

Despite the clear significance of the therapeutic relationship in terms of both clinical outcomes for the service user and their quality of life, establishing and maintaining this relationship can be challenging in some mental health settings (Dziopa & Ahern, 2008). Within mental health inpatient services and secure hospitals, service users can be detained under the Mental Health Act (1983). In these environments, mental health professionals face the challenge of often handling new and unpredictable experiences (Berg & Hallberg, 2000) and simultaneously need to develop a complex set of skills to develop a good therapeutic relationship (Dziopa & Ahern, 2008). In addition to such challenges, the staff must also attempt to build a therapeutic relationship with service users whom are detained against their will (Rask & Brunt, 2006) and whom may be receiving involuntary treatment (Scanlon,
Wider organisational factors also influence both service users and staff in these environments, which may add further pressure to the therapeutic relationship (Catty, 2004).

In a literature review of 31 studies regarding the therapeutic relationship, nine key constructs that underpin a good therapeutic relationship were identified (Dziopa & Ahern, 2008). The reviewed studies were from a variety of mental health settings, including secure, inpatient, mental health nursing and community settings. Two of these constructs were availability of the nursing staff and for the service users to feel that they are being treated equally; these may be difficult to attain in mental health environments where service users are detained involuntarily.

The ‘availability’ aspect on the therapeutic relationship involved nursing staff spending time with service users and adopting therapeutic as opposed to control techniques. These control techniques sometimes have to occur in this environment due to risk to the service user or others as the staff members serve a dual role in that they are expected to provide therapeutic input whilst maintaining security (Mason et al., 2008; Mason et al., 2009). A literature review of service users’ expectations of inpatient mental health care also identified that this availability can be hard to establish, due to professionals non clinical commitments such as attending meetings and administrative tasks. These are perceived as a barrier to the development of good therapeutic relationships (Hopkins et al., 2009). The second concept of equality within the therapeutic relationship again may be difficult to establish in an environment where service users are involuntarily detained, as the Nurses’ power is particularly evident when the service user is detained against their own will.

Another study, which was conducted in Britain, asked service users to share their experience of hospitalisation (Gilburt et al., 2008). These service users said that trust was important in the therapeutic relationship, however this can be jeopardized by coercion, for example being forced to take medication or being detained involuntarily. This finding has been supported in other studies which found that those involuntarily admitted to hospital had a poorer therapeutic relationship with their Psychiatrist (Roche et al., 2014) and that perceived coercion was negatively associated with a poorer therapeutic relationship. Overall, the involuntary and sometimes coercive nature of inpatient and secure mental health environments seems to pose challenges for a good therapeutic relationship to be developed between service users and staff members.
1.4 RESTRICTIVE INTERVENTIONS

1.4.1 Defining types of restrictive interventions

Another aspect of inpatient mental health care can involve the use of restrictive interventions by staff members with service users. These restrictive interventions should be used only as a last resort to manage risk to both the service user and others, when preventative de-escalation measures have been unsuccessful. The Department of Health (DOH) have provided guidelines for the use of restrictive interventions (2014); within these guidelines restrictive interventions are described as:

‘Deliberate acts on the part of other person(s) that restrict an individual’s movement, liberty and/or freedom to act independently in order to: take immediate control of a dangerous situation where there is a real possibility of harm to the person or others if no action is undertaken; and end or reduce significantly the danger to the person or others; and contain or limit the person’s freedom for no longer than is necessary’ (p.14).

There are numerous types of restrictive interventions, including physical restraint, mechanical restraint, chemical restraint and seclusion. For clarity, the DOH (2014) definitions of these interventions are detailed in Table 1 below.
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<tr>
<td>Mechanical restraint</td>
<td>‘The use of a device to prevent, restrict or subdue movement of a person’s body, or part of the body, for the primary purpose of behavioural control’ (p.27).</td>
</tr>
<tr>
<td>Chemical restraint</td>
<td>‘The use of medication which is prescribed, and administered for the purpose of controlling or subduing disturbed/violent behaviour, where it is not prescribed for the treatment of a formally identified physical or mental illness’ (p.28).</td>
</tr>
<tr>
<td>Seclusion</td>
<td>‘The supervised confinement and isolation of a person, away from other users of services, in an area from which the person is prevented from leaving,’ ‘Its sole aim is the containment of severely disturbed behaviour which is likely to cause harm to others’ (p.28).</td>
</tr>
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Table 1 DOH definitions of restrictive interventions.

1.4.2 Purpose of restrictive interventions in inpatient mental health and secure hospitals

Views of the purpose of restrictive interventions have changed over time. Research articles published in the 1970’s and 1980’s stated that stated that restrictive interventions intended to teach service users to develop internal control, calm them and to preserve the unit atmosphere (Cotton, 1989; Fitzgerald & Long, 1973; Gutheil, 1978).

However these attitudes have changed; restrictive interventions are not to be used in any circumstances to teach internal control or maintain a certain atmosphere. The United Kingdom (UK) Government produced guidance stating that these methods must only be used when necessary due to the risks posed to the service user or others in that environment (DOH, 2014). In many countries, restrictive interventions are used as a last resort within mental health settings to ensure safety (Adams et al., 2007); this includes the management of aggressive, disruptive and violent behaviour (Chien et al., 2005; Kuosmanen et al., 2007).
Restrictive interventions are an integral aspect of inpatient mental health care (Delaney, 2001). Both NICE (2015) and DOH (2014) specifically discuss the use of these interventions in relation to inpatient mental health and secure services. NICE guidelines (2015) state that restrictive interventions are most likely to be used in these environments, compared to other health settings. The DOH (2014) also acknowledge that secure services are an environment that service users’ needs and histories mean that they may present with behaviours that challenge. Consequently, the DOH place emphasis on services adhering to the following laws, policies and guidelines to adopt a recovery focused approach.

1.4.3 Regulations relevant to restrictive interventions in inpatient mental health and secure hospital services

Restrictive interventions should always be avoided wherever possible (Bower et al., 2000; Taylor et al., 2009). Despite this, a number of court cases have evidenced when restrictive interventions have been misused and abused (Rutledge & Pravikoff, 2003). Recent serious and abusive incidents, such as those that occurred at Winterbourne View Hospital, led to a national damming response (DOH, 2012). The mental health charity MIND have published a document in relation to the use of physical restraint use (MIND, 2012), which documents concerns about physical restraint use and injuries that can be sustained as a result. Incidents such as these have suggested a need for clear regulations that protect service users from the potential abusive use of these interventions. Therefore a number of policies, laws and guidelines must be adhered to when considering the use of restrictive interventions.

Within inpatient mental health and secure services, both the Mental Health Act (MHA, 1983) and the Mental Capacity Act (MCA, 2005) are relevant in relation to restrictive interventions. Service users within these services can be detained under the MHA (1983). Within the MHA (1983), guidance is provided on the range of interventions that are recommended for therapeutic management of inpatients, whose behaviour presents a risk either to themselves or others. The MHA (1983) states that organisations and services that use restrictive practices, are responsible for staff to be trained in relation to these restrictive measures and restrictive interventions must always be safe and ethical. If staff believe that a person lacks capacity to consent and believe that restrictive interventions are necessary to prevent harm to that person, then they may use reasonable and proportionate force (MCA, 2005).
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The DOH (2014) have also recently published guidance in relation to the use of restrictive interventions. They describe the different levels of intervention that should occur as a response to any behaviours that challenge through a three-step model. Staff should initially implement primary prevention strategies; these enhance the service users’ quality of life and ensure that their needs are met. The next step is the implementation of secondary preventative strategies; involving the recognition and response to early signs of the service users’ arousal or distress. Both primary and secondary interventions should be implemented prior to the consideration of any tertiary strategy; this is the use of planned restrictive interventions. These guidelines clearly state that restrictive interventions must only be used a last resort and for the shortest time possible, to ensure service user and staff dignity, safety and respect. The DOH reinforce that when restrictive practices do need to be used, they must be implemented ethically and in line with the aforementioned legal frameworks.

NICE (2015) have also recently updated their guidelines in relation to short term management of violence and aggression in mental health, health and community settings. This guidance includes inpatient mental health and secure hospital care and highlights the crucial role that both the organisations and staff members who provide care have in relation to restrictive interventions. The organisation is responsible for ensuring that staff are trained in de-escalation techniques to attempt to avoid incidents of restrictive interventions and to ensure that these methods are always used prior to any restrictive practice. Restrictive interventions may only be used if de-escalation attempts have not been effective at containing the risks. The guidelines state that it is important for staff to maintain their emotional regulation and self-management at these times, again to reduce the need for restrictive interventions.

Restrictive interventions should only be used in line with the service user’s human rights (Kingdon et al., 2004). The NICE (2015) guidelines state that any attempts to manage violence and aggression must be in compliance with the Human Rights Act (1988) and the European Convention of Human Rights. To ensure that these are complied with, restrictive interventions should always be used in proportion to the degree of threat posed (Liegeois & Eneman, 2008).
1.4.4 Prevalence of restrictive interventions

A number of studies have attempted to capture the demographics of service users who are most likely to be secluded and restrained; however reviews of this literature indicate mixed findings (Fisher, 1994). This review found that older service users were consistently less likely to have been secluded or restrained. Gender, race nor diagnosis were consistently associated to the likelihood of restrictive interventions being used. More recent and longitudinal studies have suggested that service users who are more acutely unwell are at a higher risk or being restrained or secluded (Happell & Koehn, 2010).

A wide range of restrictive intervention prevalence rates have been published, therefore it is hard to determine just how frequently this actually occurs in inpatient mental health and secure services. A review undertaken in regards to physical and chemical restraint use in mental health institutions (Rutledge & Pravikoff, 2003) reported that the frequency of seclusion and restraint varies greatly in reports, ranging from 4% to 44% of adult mental health patients having been restrained. Despite the large variation of the reported rates of seclusion and restraint, it is unclear why these prevalence rates vary so greatly (Bower et al., 2000).

MIND recently published ‘Mental Health Crisis Care: physical restraint in crisis’ (2012). Due to uncertainty regarding the prevalence and frequency of physical restraint, using the Freedom of Information Act, MIND requested the number of physical restraint incidents to be shared by 54 NHS mental health trusts in England. A significant disparity in the use physical restraint across England was evident; in one trust there had been 38 incidents of physical restraint in one year while in another there were over 3,000 reported incidents. No further information was provided as to why there was such a discrepancy between trusts. Independent mental health providers were not approached in relation to this report; therefore the findings are limited to that of NHS services.

1.4.5 The need to reduce restrictive interventions

Despite the frequency and prevalence of restrictive interventions not being entirely clear, the need to reduce the use of these restrictive intervention is recommended by both NICE (2015) and DOH (2014) guidelines.
NICE (2015) document that there is a need to prevent violence and aggression in services and consequently the need for restrictive interventions. These guidelines state that staff training is necessary for this to be possible and that all services that use restrictive interventions need to have a restrictive intervention reduction programme. Within these guidelines clear guidance is provided in relation to what reduction interventions should entail.

The DOH (2014) also acknowledge the need to reduce the use of restrictive interventions. They note that services are responsible to increase the use of other approaches rather than restrictive interventions, for example positive behavioural support, which has been shown to enhance quality of life and reduce behaviours that challenge (Allen et al., 2012). Models such as the Safewards Model (Bowers, 2014) have been developed which have been shown to be effective at reducing the frequency of conflict and containment, such as physical restraint. The DOH (2014) recommend that this model be implemented across services to reduce the incidence of physical restraint. The DOH state that the reduction of restrictive interventions is so important due to the physical and psychological impact they can have upon service users and staff and the consequential impact upon service users’ recovery.

1.5 SERVICE USER AND STAFF EXPERIENCES OF PHYSICAL RESTRAINT

1.5.1 Experience of physical restraint

Despite policies, laws and guidance in relation to restrictive interventions, the impact of these interventions upon service users and staff have been relatively unexplored in research (Hawkins et al., 2005). Most research related to restrictive interventions has focused upon trying to determine the frequency of restraint, as opposed to the experience upon those involved (Wynn, 2004). As a result, not enough is currently known about the effectiveness or harm of these measures (Sailas & Fenton, 2000).

The regulations in relation to restrictive interventions vary across the world. Different types of restrictive interventions are preferred and advised as preferable options. In Britain, restrictive interventions rarely involve mechanical restraint, instead physical restraint is used when necessary (Sequeira & Halstead, 2002; Sequiera & Halstead, 2004). Much of the literature that currently exists is therefore not necessarily applicable to British hospitals.
(Sequeira & Halstead, 2004) as it is difficult to compare these experiences of service users and staff in Britain, as mechanical restraint is not routinely experienced in Britain.

In relation to physical restraint, little is known about the impact this has upon those involved in this restrictive intervention (NICE, 2005). There is some research regarding the experience of seclusion and physical restraint (e.g. Kontio et al., 2012; Ray et al., 1996), however in these studies it is difficult to determine the impact of the physical restraint per se as these two interventions have been explored simultaneously. There are no controlled studies showing the value of physical restraint, however of the literature that does exist it appears that there are some negative impacts associated with its use (Sailas & Fenton, 2000).

The DOH (2014) and NICE (2015) guidelines both acknowledge the physical and psychological impact upon service users and staff due to the use of physical restraint. They recommend that this is attended to as part of the post incident reviews of the physical restraints, for the service users and the staff members involved in the physical restraint and others who witnessed this. However, so little is known about the potential consequences and impact upon those involved, that more research is needed and recommended by NICE (2015). Research into the experiences of physical restraint are important to be aware of, as understanding of the impact of restrictive interventions would contribute to the judgment of their use (Georgieva et al., 2012).

1.5.2 Staff experiences of physical restraint

There have been relatively few studies regarding Mental Health Nurses’ perceptions of physical restraint (Bigwood & Crowe, 2008) and the psychological effects upon these staff members (Sequeira & Halstead, 2004). Prior to the year 2000, there had been no research into Mental Health Nurses’ thoughts and feelings about physical restraint use (Marangos-Frost & Wells, 2000). A small number of research studies have asked mental health nurses that work either in mental health inpatient or secure hospital services about their experience of physically restraining service users. Some of the key themes have been summarised below, including: conflicts and dilemmas experienced by the staff, the emotional impact upon them and how they cope with this.
1.5.2.1 Conflicts and dilemmas

It seems that Mental Health Nurses experience a number of conflicts and dilemmas in regards to physical restraint. These Nurses may have to implement physical restraint as part of their role, despite the ethical dilemma experienced (Rutledge & Pravikoff, 2003), especially in relation to restraint on acute mental health wards (Middlewick, 2000). The nature of nursing is considered to be fundamentally about caring, yet Nurses are having to use restrictive interventions (McHugh et al., 1995) due to the level of risk that presents. The following studies detail some of the conflicts experienced and attempts made to manage this feeling.

In one study, conducted with Mental Health Nurses in New Zealand (Bigwood & Crowe, 2008), a key theme was the conflict experienced between the Nurses’ roles of maintaining a therapeutic relationship with the service users alongside the need to gain control in some situations by using restrictive interventions. When the Nurses knew that attempts had been made to de-escalate the situation prior to the physical restraint, this helped them deal with this conflict. Also, if they felt able to continue their therapeutic relationship with the service user, they again felt less conflicted. Whereas when the Nurses felt the intervention had been preemptive and they felt unable to justify their actions, they felt uneasy.

The importance of using physical restraint as a last resort to reduce difficulties associated with conflicting roles has been supported by other studies. Mental Health Nurses who worked within an unlocked mental health unit in Canada shared that they experienced a decision dilemma whereby they needed to consider the potential harm the physical restraint may cause and only act if there is no other alternative (Marangos-Frost & Wells, 2000). Similarly, in another study based on focus groups with inpatient Mental Health Nurses across different wards in Ireland, the authors identified a clear theme that restraint should only be used as a last resort, when all other methods have been attempted (Moran et al., 2009).

This concept of the conflicted roles that nursing staff experience was also detailed in a study conducted in a secure hospital (Sequeira & Halstead, 2004). Mental Health Nurses were interviewed about their experience of physical restraint and several shared that they experienced intense and distressing feelings in relation to the restraint; these staff members were the same Nurses that suggested that the restraint may be traumatizing for service users. It seems that these Nurses experienced a conflict between not wanting to traumatise and cause harm to service users they were caring for, yet having to physically intervene due to risk.
1.5.2.2 Emotional impact

Despite there being a paucity of research regarding the experience of physical restraint, a key theme of the research is the emotional impact this can have upon staff members. This has been demonstrated in both inpatient mental health settings and secure mental health settings.

Involvement in physical restraint can cause anxiety, fear and stress related responses in Mental Health Nurses in both inpatient mental health environments (Bigwood & Crowe, 2008; Bonner et al., 2002; Moran et al., 2009) and secure inpatient settings (Lee et al., 2003; Sequeira & Halstead, 2004). Fear in both of these settings was attributed as being due to fear of harm to themselves and being potentially assaulted during the physical restraint (Bigwood & Crowe, 2008; Moran et al., 2009; Sequeira & Halstead, 2004). It seems that physical harm being sustained during physical restraint is not uncommon; a postal questionnaire of British staff members who worked in secure mental health and Psychiatric Intensive Care Units (PICU) reported that 21.6% of the respondents had been physically hurt during the last physical restraint they had been involved in (Lee et al., 2003). These injuries ranged from black eyes and a broken nose to scratches and bruises. There is a potential for staff members to be traumatised by such incidents; in one study a staff member described a particularly traumatic response to a physical restraint incident which had involved the service user threatening them with a weapon (Bonner et al., 2002). This theme of staff members becoming emotionally distressed was also found in a study using random sampling of staff (Sequeira & Halstead, 2004), therefore it does not seem that this fearful and anxious emotional response has been found due to a response bias of people who have had particularly difficult emotional experiences following physical restraint self-selecting to participate in research.

Two studies have reported that staff can experience feelings of anger and frustration following involvement in a physical restraint, however the reasons for these feelings were different in these studies. One study conducted in an inpatient mental health service (Bonner et al., 2002), found that staff members were angry and frustrated at the failures of communication between staff and service users and what they perceived as their failure to meet that service user’s needs. The Nurses also shared frustration associated with having to deal with lots of risk issues after the physical restraint and that this consequently meant sending less time with the service users after the incident. One of the staff members reflected that this can consequently impact the therapeutic relationship.
Another study that was conducted with Mental Health Nurses in a secure setting (Sequeira & Halstead, 2004) found that the anger experienced was sometimes directly felt in relation to service users whom they had physically restrained. This anger was experienced when the staff members believed that the service user had a degree of control over their actions and yet were frequently violent to others. Potentially this may have an impact upon the therapeutic relationship if these beliefs are held. It was found that anger was not felt in relation to incidents where staff had prevented service users from harming themselves. Somewhat worryingly, two of the 17 staff shared thoughts of deliberately harming the service users they had physically restrained, although they did not act on these thoughts. Both of these staff members said that they had felt uncomfortable with these thoughts and attributed this to the power they had during physical restraint coupled with the anger they may have simultaneously experienced.

1.5.2.3 Coping with the emotional experience

Following the experience of emotional distress caused by the involvement in physical restraint, some staff suppress their emotions (Moran et al., 2009) and become involved in physical restraints on an auto-pilot nature (Sequeira & Halstead, 2004). One of the studies conducted in an inpatient mental health service (Moran et al., 2009) found that the Nurses oscillated between the expression and suppression of emotional distress and that suppression was a method of self-protection. The emotional suppression was linked to their beliefs that they needed to get on with the job as the risks were ongoing. It also helped them cope with the difficulties they experienced of managing the conflict of the roles; of providing care to service users whilst simultaneously potentially having to physically restrain them. Within a secure inpatient setting (Sequeira & Halstead, 2004), Nurses described becoming hardened to their emotional experience due to repeated experience of physical restraint and reported an automatic, as opposed to an emotional, response to the physical restraint. Some of the sample described having no emotional reaction to the physical restraint at all, which perhaps could be linked to the suppression of emotions. Ambivalence was shared about accessing support, as although some staff felt there was a need to talk, at times it was felt unacceptable to do so.

Another study based in an inpatient mental health service (Bonner et al., 2002) revealed more adaptive methods of coping with emotional distress. Staff shared that containment and support was particularly helpful for them. This consisted of good planning, team work and
practical support from other wards when the physical restraints occurred. The staff also shared their views about support after the physical restraints and overall staff suggested that debriefing and evaluation of the incident was helpful for them. However, some shared concerns about the impact poor debriefing can have. One staff member shared that if they felt they were just ‘going through the motions’ (Bonner et al., 2002, p.470) and it was poorly facilitated, then debriefing can be an unhelpful process.

1.5.3 Service user experiences of physical restraint

Prior to 1996, there were no publications of service user experiences of restraint (Ray et al., 1996). Research since this time has identified that service users can experience restrictive interventions as traumatic and harmful within inpatient mental health services (Frueh et al., 2005). These perceptions of restrictive interventions being a negative and difficult experience have been demonstrated as stable over time (Gardner et al., 1999). However this research is not specifically related to physical restraint in that it comprises experiences of mechanical, physical and chemical restraint; there is a clear lack of research into service user experiences of physical restraint within mental health inpatient and secure settings. Service users have stated that they do not believe that their perspectives are taken into account in relation to physical restraint (Soininen et al., 2013). It is therefore important to identify what service users’ experiences of physical restraint are, as it seems that despite physical restraint being used in inpatient mental health and secure services, there is limited exploration of these service users’ experiences.

A summary of the existing research that explored adult service user experiences of physical restraint follows, however please refer to section ‘1.8 Systematic Review’, where this research is systematically reviewed, synthesised and critiqued. Overall, the research indicated that physical restraint can be a very emotional and traumatic experience. Service users have described it as degrading and abusive (Knowles et al., 2015) and that it can evoke memories of past traumatic events (Bonner et al., 2002; Haw et al., 2011; Wynn, 2004). Not only do the service users have to cope with this difficult emotional response, some also felt that the physical restraint had not always been justified and alternative approaches had not been attempted before the use of physical restraint (Bonner et al., 2002). Negative attributions were made about staff (Knowles et al., 2015) and there were some feelings that staffs’ actions
had been unnecessary and were a way of setting limits and demonstrating power (Wynn, 2004).

1.6 THE THERAPEUTIC RELATIONSHIP AFTER PHYSICAL RESTRAINT

1.6.1 Importance of the therapeutic relationship and physical restraint
A systematic review suggests that both physical restraint and the therapeutic relationship are two of the eight key domains related to quality of institutional care for people with long term mental health problems (Taylor et al., 2009). Despite this, little is known about the relationship between these two aspects of care in inpatient mental health and secure services. On one hand a relationship based on trust, understanding and empathy is attempting to be built; while on the other staff may have to intervene physically against the service user’s will. It is questionable how compatible the therapeutic relationship and physical restraint can be (Knowles et al., 2015), particularly within an environment where the service user is already detained against their will. This may set up challenges to building a therapeutic relationship even before a physical restraint occurs. A connected therapeutic relationship is needed for good communication (McCabe, 2004) which is key for the prevention of restrictive interventions being used. Therefore it is important to understand the impact physical restraint may have upon the therapeutic relationship and communication within this relationship. Not only this, it is important to understand the potential impact as this could influence their ability to work together therapeutically and consequently impact the service user’s care, treatment and recovery.

1.6.2 Links between the service user experience of physical restraint and the therapeutic relationship
As the aforementioned literature review suggests, there is a paucity of research into service user and staff experiences of physical restraint in inpatient mental health and secure hospital settings. Of these studies, just one explored the experience of the therapeutic relationship after physical restraint (Knowles et al., 2015). Despite this, each of these studies indicate that
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the experience of physical restraint may have a detrimental impact upon the therapeutic relationship.

The literature that explores service user experiences of physical restraint suggests that service users have a lot to cope with after this has occurred. Not only have they experienced an event that can be traumatic in itself, it is those whom are supposed to care and protect them that have restrained them. Service users commented on the justification of the physical restraint and whether they accepted if this should have happened (Bonner et al., 2002; Knowles et al., 2015); the study which directly focused on the therapeutic relationship found that this had a detrimental impact upon the relationship if the physical restraint was perceived as unjustified. A power imbalance was perceived by service users who had been physically restrained; consequently they felt infantilized (Knowles et al., 2015) and humiliated (Wynn, 2004).

However, these studies focused on the intrapersonal rather than the interpersonal effects of physical restraint; they did not comment on the impact this had on the service users’ perceptions of their relationship with these staff members.

Despite the research indicating that service users experienced distressing and potentially traumatic responses to the physical restraint, none of the research commented upon whether this has an impact upon the therapeutic relationship afterwards. Nonetheless, one study found that emotional experience can lead to service users avoiding staff members who had been involved in the restraint (Bonner et al., 2002). Service users made negative attributes about the staff that had been involved in the physical restraint (Bonner et al., 2002; Haw et al., 2011; Knowles et al., 2015; Wynn, 2004), however again these studies did not explore the potential longer term impact on the therapeutic relationship. Just one of the studies reported that reduced trust in the staff members could damage the therapeutic alliance, however this was not explored any further. Similarly to staff members, some service users reported that they suppressed their difficult emotions and avoided the staff members who had been involved, which reduced the communication between the service users and staff (Knowles et al., 2015), potentially impacting upon the therapeutic relationship.

1.6.3 Links between staff experiences of physical restraint and the therapeutic relationship

Of the limited studies that investigate nursing staff experiences of physical restraint, the results indicate that there can be a detrimental impact upon the therapeutic relationship after
such incidents. In a postal questionnaire of secure services and Psychiatric Intensive Care Units (PICU) in England and Wales, staff reported that one of the negative outcomes after the physical restraint was the impact this had on the relationship between service users and staff (Lee et al., 2003). However, further exploration of the nature of the impact physical restraint had and why they believed it had such an impact was not detailed.

As previously detailed, staff experience an ethical dilemma when they have to physically restrain service users and many shared difficult emotional reactions, including fear and anger. Two of these studies found that staff can respond to this emotional reaction by suppressing this and not discussing the impact it has upon them (Moran et al., 2009; Sequeira & Halstead, 2004). There are potential negative and dangerous consequences of staff suppressing their emotional responses. It is argued that if staff members are unable to cope with these intense and potentially traumatising emotions, this will impact upon the therapeutic relationship (Steele, 1993). Staff members may emotionally and psychologically disengage from the service users and this detached and impersonal approach would hinder the relationship between the service users and staff members (Morse, 1991). It has been evidenced that ongoing emotional suppression can reduce the healing and caring aspects of the role (Rowe, 2003) and if staff do not have a way to express distressing emotions, this could be at the detriment of the service user’s care (Sequeira & Halstead, 2004). Inevitably, suppression of emotional distress can lead to an inability for staff to effectively relate and communicate with service users; this would reduce the possibility of de-escalation methods being adopted (Moran et al., 2009), which would maintain this cycle of emotional distress and emotional suppression.

1.6.4 The therapeutic relationship after physical restraint in a secure hospital

The literature that explores experiences of physical restraint in inpatient mental health care and secure hospital settings suggest that this experience could influence the therapeutic relationship after such incidents. There is limited information on experiences of physical restraint within secure services (Haw et al., 2011).

Service users that are detained in a secure hospital may be particularly vulnerable to experiencing difficulties establishing and maintaining positive therapeutic relationships. Many service users in a secure environment have had disruptions in early attachment relationships in childhood (Taylor, 2011), which subsequently impact their ability to develop
relationships as adults. The development and maintenance of relationships may be particularly challenging in an environment where service users are involuntarily detained due to a combination of mental health difficulties, their offending behaviour, or risk of harm to themselves or others and restrictive interventions may be used against their will. Service users may consequently experience a perceived loss of autonomy, which has been associated with poorer appraisal of the therapeutic relationship in an inpatient mental health setting (Theodoridou et al., 2012). In secure services the length of stay is longer than other inpatient mental health settings, therefore the opportunity to develop a therapeutic relationship and for this to impact outcomes and quality of life is increased (Knowles et al., 2015).

1.7 CONCLUSIONS

It would be theoretically and clinically relevant to explore how service users perceive their relationships with staff members after physical restraint, where perhaps it may be difficult to repair these relationships due to existing attachment and relationship difficulties. The one research paper that has investigated the experience of the therapeutic relationship after physical restraint was conducted in a secure hospital and focused on service user experiences. The therapeutic relationship is relational, involving the dynamic interaction between service users and staff members. It is therefore important to explore both service user and staff experiences of the therapeutic relationship after physical restraint, to gain an understanding of both perspectives.
1.8 SYSTEMATIC REVIEW

1.8.1 Aims
The present research study aims to explore both service user and staff perspectives of the therapeutic relationship following physical restraint in a secure hospital. An initial literature search yielded only one relevant research article that explored the therapeutic relationship after physical restraint, without placing any restrictions to the setting or environment.

Therefore, the focus of this Systematic Review was broadened beyond the experience of the therapeutic relationship. It was felt this was necessary to gain a broader understanding of the research topic. Research that explores staff and service user experiences of physical restraint in secure and inpatient mental health settings is sparse, but this is particularly evident of service user’s perspectives. This Systematic Review is focused on the exploration of service user’s experiences of physical restraint in secure hospital and inpatient mental health settings.

The review aimed to provide a structured and critical review of this literature. This review will include: the methodology and criteria used to search for relevant research articles; details of the quality framework applied; the main methodological limitations of this research; and a meta-synthesis of these papers.

1.8.2 Search methodology
Key words were identified based on: titles of relevant papers identified in the initial literature; liaison with Clinical and Academic Supervisors and the author’s own knowledge of terms related to the Systematic Review question.

Figure 1 below illustrates the search terms that were used. To maximise the number of relevant papers to be identified, the key words were matched to ‘subject headings’ in each of the databases searched. A complete list of all ‘subject headings’ searched for can be viewed in Appendix A.
Figure 1 Systematic Review search terms.

(restrain* OR physical intervention*)

AND

(sector service* OR secure hospital* OR secure ward* OR secure unit* OR secure facil* OR psychiatric service* OR psychiatric hospital* OR psychiatric ward* OR psychiatric unit* OR psychiatric facil* OR inpatient)

AND

(service user* OR client* OR patient*)

AND

(experience* OR view* OR perspective* OR attitude* OR opinion* OR account* OR understanding* OR interpret* OR outlook* OR perception* OR descri* or expla*)

The following databases were searched on February 15th 2016 and January 7th 2017 using the aforementioned keywords and subject headings: PsycINFO (1806 – February Week 2 2016); Ovid Medline R (1946 – February Week 2 2016); Web of Science Core Collection; and Cumulative Index to Nursing and Allied Health Literature (CINAHL). Each of the databases were searched for journals and articles published in the last 30 years, between 1986- February 15th 2016.

A total of 1925 papers were identified from this search. The titles of these papers were initially screened for relevance to the review, using the inclusion and exclusion criteria outlined in section ‘1.8.3 Search criteria’ of the Introduction Chapter and 642 remained. The abstracts of these papers were then screened against the search criteria, following this 33 papers remained. These papers were sought in full text and the inclusion and exclusion criteria were applied. Following this four papers met all of the criteria to be included in this Systematic Review. Reference lists of the 33 papers and also the review articles identified were searched to generate further relevant studies for the review, but no further studies were identified. Figure 2 illustrates a diagram of the overview of the Systematic Review process.
Total Papers Identified: 1925

After manually screening titles: 642

After manually screening abstracts against inclusion and exclusion criteria. The following papers were excluded:
- Staff views (66)
- Mechanical/chemical restraint (25)
- Frequency of restraint (34)
- Seclusion (54)
- Interventions to reduce restraint (62)
- Not adults (93)
- Review/commentary (48)
- Theoretical models (7)
- Demographics of those restrained (65)
- Randomised Control Trials (5)
- Older adult not mental health (7)
- Reasons for restraint (3)
- Caregiver’s perspective (1)

33 remain for full text review against inclusion and exclusion criteria. The following papers were excluded:
- Not available in English (1)
- Not looking at experience of restraint (1)
- Review/commentary (2)
- Not all participants adult (2)
- Mechanical restraint (1)
- No distinct results section about physical restraint (6)
- Duplicate (15)

4 remain that meet all search criteria. Reference lists of the 33 papers outlined above and review/commentary papers articles searched for further relevant papers.

No further relevant papers identified.

4 papers to be included in Systematic Review.

Figure 2 An overview of the Systematic Review process.
1.8.3 Search criteria

It is suggested that tight boundaries for inclusion criteria are set, as an overly large sample can be problematic during a meta-synthesis, as the depth of analysis required cannot be attained (Sandelowski et al., 1997). Therefore the following search criteria were applied, so that the papers identified for this Systematic Review were particularly relevant to the study being conducted for this research.

1.8.3.1 Inclusion criteria

- Research (qualitative or quantitative) that includes service user experiences of physical restraint in an inpatient mental health/secure environment;
- Studies of adult participants (at least 18 years of age);
- Studies of service users who were either in inpatient mental health or secure services at the time of the data collection or retrospective accounts of service users no longer within the service; and
- Studies that have been conducted in the last 30 years.

1.8.3.2 Exclusion criteria

- Studies which include other coercive methods (e.g. mechanical restraint, seclusion or chemical restraint) but do not investigate physical restraint specifically;
- Studies in which not all of the participants experienced physical restraint and the results do not differentiate between different types of coercive methods;
- Studies which investigate only the frequency of restraint;
- Articles which detail interventions to reduce restraint;
- Literature reviews, systematic reviews, letters, commentaries, replies to articles;
- Studies which include children/adolescents (under the age of 18);
- Studies which focus on staff or caregiver experiences of restraint;
- Studies relating to characteristics or demographics of patients/staff/hospitals associated with restraint;
- Theoretical models related to restraint;
- Randomised control trials;
- Studies carried out in a Learning Disability or residential setting for older adults with physical health problems;
- Studies that investigate reasons for restraint being used;
- Studies looking only at behavioural changes after restraint;
- Duplicate articles; and
- Non English language articles.

1.8.4 Results and quality framework

A total of four studies met the search criteria and were included in this Systematic Review. Summaries of each of these studies are detailed in Table 2. Although both quantitative and qualitative studies were included in the search criteria, only qualitative articles remained after applying inclusion and exclusion criteria.

The application of quality criteria in qualitative research is widely debated (Atkins et al., 2008). There is a lack of consensus of whether to apply criteria, how to do so and which criteria to use (Spencer et al., 2003). Authors of a meta-ethnographic approach are divided as to whether quality scores or assessment should be used (Atkins et al., 2008). Quality ratings can be misleading as these may reflect the quality of the write up of the results, rather than the research itself (Atkins et al., 2008). Studies included within a meta-synthesis should not be excluded based upon quality, as there are wide variations as to what is considered good and poor quality in qualitative studies (Sandelowski et al., 1997).

Despite this debate, it is recommended that the quality of such studies can be commented upon as part of this process (Sandelowski et al., 1997). Therefore the quality framework Support Unit for Research Evidence (SURE, 2013), developed by Cardiff University, was applied to critique these studies in a narrative form, as opposed to quality scores. Personal communication to the authors of SURE supported this decision. An overview of how each of the studies met the criteria outlined by this quality framework can be viewed in Table 3.
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<table>
<thead>
<tr>
<th>Author, date and country</th>
<th>Aims</th>
<th>Participant demographics</th>
<th>Method</th>
<th>Results/main themes</th>
<th>Clinical Implications</th>
</tr>
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</table>
| Knowles *et al.*, (2015). England. | To explore service user perceptions of the impact of physical restraint on their relationships with staff in a medium secure environment. | 16 ‘opted in’, seven did not meet inclusion criteria and one was unsuitable due to communication difficulties. Eight participants; one female and seven male. All ‘white British’. Aged 27-51 (mean = 39). Detained in the secure unit between three and 72 months (mean = 42). Detained in secure care (prisons and secure services) between seven and 336 months (mean = 151). Restrained between two and 50 times (mean = 17). Time since last restraint ranged from six weeks to three years (mean = One year 10 months). | Qualitative design. Semi structured interviews with service users recruited from a medium secure unit in North England. Service users ‘opted in’ by completing a slip and placing it in a sealed letterbox on the ward. Interviewed participants for up to 45 minutes. Thematic analysis used. | 1) Restraint reinforces inequality of power in the staff-service user relationship. 
(2) Restraint was an abusive, degrading and traumatic experience. 
(3) Perceived justification impacts upon whether the restraint is accepted and can impact upon relationships with staff. 
(4) Negative attributes and motives of some staff. 
(5) Learning to cope with powerlessness after the restraint. | Important for power imbalance to be addressed for therapeutic gains to be achieved. Staff to help service users express their emotions to help avoid restraint occurring. Staff to allow service users to openly express their feelings about the restraint. Organise staff training which includes service user views of restraint and the therapeutic relationship. Staff to consider the emotional impact of restraint in supervision. More open communication between staff and patients about impact of physical restraint experiences may be useful in explaining behaviours of those involved. Importance of open communication and expression of feelings about the restraint, rather than just suppressing them, debrief patients collaboratively with staff. |
| Haw *et al.*, (2011). England. | To report forensic rehabilitation inpatients’ experiences and preferences of restrictive interventions (including physical restraint). | 79 of 252 inpatients met the inclusion criteria. Of these, 57 (72%) agreed to take part in the study. 57 participants; 27 male and 30 female. Aged 19-52 (median = 29). Detained in the hospital between 0.1-6.3 years (median = 1.9). | Qualitative design. Semi structured interviews with service users from medium and low secure and open wards within an independent mental health hospital. Service users were identified by their | Main themes relevant to physical restraint: 
1) Physical restraint can prevent violence to self and others. 
2) Experience of unpleasant thoughts and emotions. 
3) Experience of physical pain and discomfort. | To increase communication between service users and staff. To increase attention to the respect and dignity of service users involved in physical restraint. Ensure restrictive interventions are as least distressing as possible. Incorporate service user views about restrictive interventions into care plans. |
<table>
<thead>
<tr>
<th>Wynn (2004). Norway.</th>
<th>To explore mental health inpatients’ experiences of restraint.</th>
<th>Consultant Psychiatrist as potential participants, if they met inclusion criteria. Interviewed participants for approximately 30 minutes. Thematic analysis used.</th>
<th>4) Loss of control and privileges. 5) Attitudes and beliefs about staff.</th>
<th>Encourage service users to make advances statements about the use of restrictive interventions.</th>
</tr>
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<tbody>
<tr>
<td>To investigate the subjective effects of physical restraint upon service users and</td>
<td>Three assessed and found unfit to participate due to ongoing severe psychotic symptoms. One refused to participate, no reason requested nor given. 12 participants, nine male and three female. Aged 21-60 years (mean=39). Nine had been restrained one or more times prior to the current restraint. Seven had been both physically and pharmacologically restrained in the same incident. Duration of the restraint ranged between two and 15 hours (mean= six hours 20 minutes).</td>
<td>Qualitative design. Interviews with service users after physical restraint recruited from Psychiatric Departments at the University Hospital of Northern Norway (107 bed facility). Sampling was purposive, based on recently being involved in restraint and in a condition to participate in an interview. Interviews lasted between 15 and 45 minutes. Interviewed on average 11 days after the restraint. Grounded Theory analysis.</td>
<td>1) Multiple perceptions of why the restraint has been used. Acceptance of why restraint was used varied. 2) Opinions about whether restraint could have been avoided: positive communication prior to restraint could help deescalate; varying levels of criticism of use of restraint. 3) Experiences of the restraint: varying levels of resistance; regret; emotional reactions; memories of previous trauma; feeling protected and calmed; feeling helpless and vulnerable; experience of physical discomfort; belief that they should have been released earlier. 4) Consequences of the restraint: feeling angry at staff; restraint is unnecessary and abusive; hospitalisation experienced negatively afterwards; demonstration of power; fear that it may happen again; distrust of staff and alliance damaged; integrity violated; treated unfairly.</td>
<td>Need for discussions with service users after the incident. Train staff to reduce need for restraint and consider alternatives to restraint. Increase staff knowledge of psychological consequences of restraint so alternative measures are chosen. Use least restrictive measure and prevent out of control situations happening. Use alternative and less restrictive measures particularly when service users have experienced abuse.</td>
</tr>
<tr>
<td>Bonner et al., (2002). UK.</td>
<td>To investigate the subjective effects of physical restraint upon service users and</td>
<td>Qualitative design.</td>
<td>1) Antecedents: ward atmosphere, failed communication. 2) During restraint: embarrassment and fear, use as a last resort (staff view).</td>
<td>Need to establish policies and mechanisms for routine debriefing for both staff and service users in this setting.</td>
</tr>
<tr>
<td>Staff and perceptions of what was helpful and unhelpful during and after the restraint. Consider the feasibility of using semi structured interviews for this research question.</td>
<td>This was the only information provided in relation to participant demographics.</td>
<td>Semi structured interviews at a mental health inpatient unit. After any incident of physical restraint, the service user and two staff members interviewed as soon as possible after the restraint. 30 minute interviews. Miles and Huberman (1984) analysis.</td>
<td>Planning containment and support (staff view). 3) Aftermath: distress, resolution and need for understanding and support for service users, resolution and debriefing (staff). 4) Other issues for service users: fear of restraint, restraint and re-traumatization, agency staff less invested in care. 5) Other issues for staff: ethical issues, re-traumatization.</td>
<td>Need to train agency staff so they are aware of what’s expected of temporary staff. Staff need to focus on early triggers and escalation, to move towards prevention strategies rather than reactive. It appears feasible to use interviews in this type of research question.</td>
</tr>
</tbody>
</table>

Table 2 Summary of studies included in the Systematic Review.
## Chapter One: INTRODUCTION

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Does the study address a clearly focus question/hypothesis?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Setting</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Perspective</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Intervention or phenomena</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td><strong>Comparator/control (if any)?</strong></td>
<td>Not applicable</td>
<td>Yes</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Evaluation/exploration</strong></td>
<td>Exploration, general questions outlined</td>
<td>Exploration, general questions outlined</td>
<td>Exploration, main topics explored outlined</td>
<td>Exploration, main questions outlined</td>
</tr>
<tr>
<td><strong>2</strong> Is the choice of qualitative method appropriate?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Is it an exploration of e.g. behaviour/reasoning/beliefs</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Do the authors discuss how they decided which method to use?</strong></td>
<td>No, not detailed why interviews were used</td>
<td>No, not detailed why interviews were chosen</td>
<td>No, not detailed why interviews were chosen</td>
<td>No, not detailed why interviews chosen</td>
</tr>
<tr>
<td><strong>3</strong> Is the sampling strategy clearly described and justified?</td>
<td>Yes, opt in</td>
<td>Yes, selected by involvement in at least two restrictive interventions in two years</td>
<td>Yes, purposive</td>
<td>Yes, after physical restraint incidents</td>
</tr>
<tr>
<td><strong>Is it clear how participants were selected?</strong></td>
<td>Yes, opt in method described, those who were excluded were clearly defined</td>
<td>Yes, due to involvement in restrictive interventions</td>
<td>Yes, based on recent physical restraint</td>
<td>Yes, based on recent physical restraint</td>
</tr>
<tr>
<td><strong>Do the authors explain why they selected these particular participants?</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Is detailed information provided about participant characteristics and about those who chose not to participate?</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td><strong>4</strong> Is the method of data collection well described?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
### Chapter One: INTRODUCTION

<table>
<thead>
<tr>
<th>Question</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the setting appropriate for data collection?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is it clear what methods were used to collect data?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there sufficient detail of the methods used?</td>
<td>Yes</td>
<td>Yes</td>
<td>Partly, general topics explored are discussed but guide mentioned was not included</td>
<td>Yes</td>
</tr>
<tr>
<td>Were the methods modified in the study, if yes is this explained?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Is there triangulation of the data (more than one source of data collection?)</td>
<td>No, just interviews</td>
<td>No, just interviews</td>
<td>No, just interviews</td>
<td>No, just interviews</td>
</tr>
<tr>
<td>Do the authors report achieving saturation?</td>
<td>No, they do comment that the sample size was thought to be enough due to the richness and breadth of data collected</td>
<td>No, not commented upon.</td>
<td>Yes</td>
<td>No, due to time constraints as it was a pilot study</td>
</tr>
<tr>
<td>Is the relationship between researcher(s) and participants explored?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Did the researcher report critically examining/reflecting on their role and any relationship with participants?</td>
<td>No</td>
<td>Yes, identified as a study limitation</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Were any potential power relationships involved?</td>
<td>No</td>
<td>Yes, the researchers worked at or previously worked at the research site</td>
<td>Yes, the researcher was a doctor at the research site</td>
<td>No</td>
</tr>
<tr>
<td>Are ethical issues explicitly discussed?</td>
<td>Partly, states ethical approval gained, no mention of other ethical considerations</td>
<td>Yes, ethical approval obtained, discussed informed consent, information sheets, Nurse in charge assessing appropriateness of involvement in study</td>
<td>Yes, assessing whether condition allowed them to be appropriate to participate, provided with oral and written info, informed consent</td>
<td>Yes, consent from Psychiatrist and team, information sheets, 24 hours to decide, consent forms</td>
</tr>
<tr>
<td>Question</td>
<td>None</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
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<td>---------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is there sufficient information on how the research was explained to participants?</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Was ethical approval sought?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Are there any potential confidentiality issues in relation to data collection?</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>7 Is the data analysis/interpretation process described and justified?</td>
<td>Yes, thematic analysis.</td>
<td>Yes, thematic analysis.</td>
<td>Yes, Grounded Theory described and process followed</td>
<td>No, states technique but does not explain what the technique involves</td>
</tr>
<tr>
<td>Is it clear how the themes and concepts were identified in the data?</td>
<td>Yes, process outlined</td>
<td>Yes, process outlined</td>
<td>No, diagram of theory is not presented. Only four themes identified and categories were not clearly specified and memos not presented</td>
<td>Yes, process outlined</td>
</tr>
<tr>
<td>Was the analysis was performed by more than one researcher?</td>
<td>Cannot tell</td>
<td>Yes, two researchers.</td>
<td>Cannot tell</td>
<td>Yes, independently by three researchers</td>
</tr>
<tr>
<td>Are negative/discrepant results taken into account?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>8 Are the findings credible?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Are there sufficient data to support the findings?</td>
<td>Yes, quotations</td>
<td>Yes, quotations</td>
<td>No, mostly figures of numbers of people who said things, lack of illustration through quotes and not labelled participants so unclear who expressed what</td>
<td>Yes, quotations</td>
</tr>
<tr>
<td>Are sequences from the original data presented (e.g. quotations) and were these fairly selected?</td>
<td>Yes</td>
<td>Yes</td>
<td>No, as above</td>
<td>Yes</td>
</tr>
<tr>
<td>Are the data rich (i.e. are the participants’ voices foregrounded)?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Are the explanations for the results plausible and coherent?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Are the results of the study compared with those from other studies?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Is any sponsorship/conflict of interest reported?</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>10</td>
<td>Did the authors identify any limitations?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Are the conclusions the same in the abstract and the full text?</td>
<td>Yes</td>
<td>Partly</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 3 SURE Quality Framework, qualitative studies.
1.8.5 Methodological issues

An important aspect of a meta-synthesis is to determine the methodological comparability of these studies (Sandelowski et al., 1997). A number of methodological issues were identified of each of the four research papers, drawn from the limitations that the authors identified in the research papers and through use of the quality framework previously presented in section ‘1.8.4 Results and quality framework’. These methodological issues are compared across each of the studies.

1.8.5.1 Sample

A number of factors associated with the sample impact upon the generalisability of the findings. Small sample sizes (range of 6-12 service users) each from one particular setting were used, therefore it is difficult to generalise these findings confidently to other settings. Participants were predominantly male in two of the studies (Knowles et al., 2015; Wynn, 2004) and therefore these findings may be more representative of a male perspective. It would be useful to conduct similar research with female service users to explore similarities and disparities between experiences of physical restraint. At present there is such little research in this area that one is unable to ascertain whether these views are gender specific. Only one study included details of the participants’ ethnicity (Knowles et al., 2015); these participants were white British. It is therefore questionable whether these findings may apply beyond white British service users and further research of service users from different cultural backgrounds would further the knowledge in this area. Due to the other studies not recording participant ethnicity, this reduces the quality of the reporting and ability to make comparisons to other research. One of the papers was conducted in Norway (Wynn, 2004), therefore it is difficult to determine whether the findings generalise to a United Kingdom population. This is due to differences in physical restraint policy and regulations and typical duration of physical restraints.

1.8.5.2 Methodology

Several methodological limitations have been identified. The rationale that interviews were chosen was not stated in any of the papers; interviews may have limited how openly participants were able to be about their experience. All of the participants were currently hospitalised and they may have been wary of whether what they disclosed may impact upon
their care and treatment. This may be particularly true of both the Haw et al., (2011) study and Wynn’s (2004) study, in which the researchers either currently worked at the research site or had previously. The other two studies however do not state the relationship between the interviewer and the participants, therefore it is difficult to conclude the impact the interviewer may have had upon how open participants were during the interview.

Two of the studies asked participants about their experiences of physical restraint relatively soon after the physical restraint (Bonner et al., 2002; Wynn, 2004) whereas the other two asked retrospectively up to two (Haw et al., 2011) or three years after the restraint (Knowles et al., 2015). It does not appear significant as to when the accounts were provided, as the focus of the research papers were upon experience rather than factual accuracy and memory of the incident. However, it is important to acknowledge that interactions between the service users and the staff members, whom were involved in the physical restraint, may have influenced their recall of the incident. Due to how few studies there are, it is difficult to draw strong conclusions about the experience of physical restraint from a service user perspective. Further research that looks at service user perspectives of physical restraint immediately after the incident and their perspective some time later would be helpful. This would allow the accounts of the service user experiences to be compared, to see if service user perceptions of physical restraints vary depending upon when they recall the incident.

1.8.5.3 Analysis

The reliability of the analysis process is questionable as two of the studies do not record whether more than one person was involved in the analysis of the results (Knowles et al., 2015; Wynn, 2004). Within Wynn’s (2004) study, the Grounded Theory analysis and categories and subthemes are not clearly presented. At times there is insufficient data presented to support the comments being made in the text.

It was difficult to draw conclusions about whether saturation had been achieved in the analysis of three of the studies included in the review. Two of the papers did not comment on whether they had achieved saturation (Haw et al., 2011; Knowles et al., 2015) and another of the papers stated that recruitment ended due to time constraints, rather than saturation (Bonner et al., 2002). Therefore it is difficult to conclude whether themes and conclusions that were made in these papers were based upon fully saturated data and therefore whether all of the important themes and perceptions were fully explored.
1.8.5.4 Insufficiency of information provided

All four studies failed to provide some details that were necessary for the reader to draw firm conclusions about the rigour and quality of the studies. This included ample information about ethical considerations and how many researchers completed the analysis process (Knowles et al., 2015), how the study was described to participants (Haw et al., 2011), what questions were included in the question guide (Wynn, 2004) and why participants selected chose not to participate (Bonner et al., 2002). Additionally, Wynn’s study (2004) investigated both pharmacological and physical restraint. Although the authors stated that those who had also been pharmacologically restrained gave the impression that the pharmacological restraint was overshadowed by the physical restraint, no quotations from the interviews were included to support this statement. Therefore, although it seems that these emotional reactions are attributable to the physical restraint, some of the distress may have been attributable to forced medication.

1.8.6 Meta-synthesis

1.8.6.1 Definition of a meta-synthesis

Meta-synthesis is ‘research of research’ (p.5, Paterson et al., 2001), integrating the findings of related qualitative studies (Walsh & Downe, 2005). A meta-synthesis goes beyond just the aggregation of findings, it requires an interpretation of the data from these studies (Bondas & Hall, 2007; Walsh & Downe, 2005), which goes beyond the statements of the original studies whilst maintaining the integrity of them (Erwin et al., 2011). This therefore generates a new integrated interpretation of the findings, which are presented to increase understanding of a particular phenomenon (Bondas & Hall, 2007).

In a meta-synthesis, all important similarities and differences between the selected studies should be accounted for (Sandelowski et al., 1997), including language, concepts and ideas shared in the participants’ experiences. The author creates third order constructs, involving the construction of new themes from the interpretation of the selected studies (Erwin et al., 2011). Findings can be synthesised from the same author or across different authors and findings (Sandelowski et al., 1997). Due to there being so few studies regarding service user experiences of physical restraint, the studies that will be meta-synthesised will be written by different authors.
1.8.6.2 Rationale for completing a meta-synthesis

The process of meta-synthesis helps to address concerns about the utility of qualitative research (Sandelowski et al., 1997). Questions have been raised about the ethics of synthesising qualitative research, as the particulars of peoples’ experiences may be lost (Sandelowski et al., 1997). Despite this, it has been warned that a lack of synthesis across studies will leave ‘little islands of knowledge’ (p. 71, Glaser & Straus, 1971), with a lack of understanding being drawn across studies of a similar nature.

The process of meta-synthesis allows for a higher level of analysis to be reached and there is potential to gain generalisability across the studies (Sandelowski et al., 1997). However it is important to acknowledge that these generalisations are generalisations of a particular experience (Sandelowski et al., 1997). This can open new insights and the development of new understandings (Walsh & Downe, 2005) and the construction of greater meaning through the use of an interpretative process, providing deeper insights that an individual study could provide (Erwin et al., 2011). This process can help develop evidence-based care as it allows for complex knowledge and data to be brought together (Bondas & Hall, 2007).

1.8.6.3 Meta-ethnography

Noblit and Hare (1988) are the most commonly cited authors in regards to meta-synthesis publications (Bondas & Hall, 2007). They write about a particular type of meta-synthesis: meta-ethnography. This process involves commenting on the similarities and disparities between the papers and reflection of how they go beyond each other (Bondas & Hall, 2007), extending what is known in a particular area (Campbell et al., 2003). The concepts that are derived may not have been derived from the original studies and therefore third order constructs, an interpretation of an interpretation, evolve (Cambell et al., 2003).

Meta-ethnography is the best developed methodology for synthesising qualitative data (Campbell et al., 2003). It is particularly effective approach with smaller number of studies, typically two to six (Atkins et al., 2008). It is based on an interpretative approach to research (Noblit & Hare, 1988), which fits with the author due to the interest and value they place upon understanding individual experiences and perceptions. A meta-ethnographic approach allows for a systematic comparison of studies which goes beyond the findings of the original
studies (Noblit & Hare, 1988). The steps followed to develop this meta-ethnography are presented in Figure 3.

1) Choose the area of interest to synthesise.
2) Decide the relevance of such studies.
3) Read and re-read these studies, noting themes in considerable detail.
4) Determine how these studies are related, creating a list of key themes and concepts.
5) Translate the studies into each other: consider similarities, disparities and exceptions. Compare the studies whilst maintaining the particular.
6) Synthesising translations: ensure the whole is greater than the sum of its parts. New concepts and themes are developed.
7) Expression of the synthesis: express in a way that is accessible to the audience.

Figure 3 Steps to complete a meta-ethnography.

Steps one and two are detailed in the aims and search criteria, described earlier in the Systematic Review. The author read these studies numerous times, noting key concepts from each of the studies and considered how these concepts across the studies related to each other (step three and four). As the identified studies were considered as directly comparable and similar in nature, reciprocal translation was undertaken. This process involved the translation of each study into the themes of the other studies, as part of step five and six of the procedure (Noblit & Hare, 1988). Each of the concepts, themes and organizers from each study were considered whilst considering how the studies related to each other (Noblit & Hare, 1988). The following table illustrates a comparison of each of the studies, in relation to third order constructs developed from the author’s interpretation of these studies.
### Chapter One: INTRODUCTION

<table>
<thead>
<tr>
<th>Study no *</th>
<th>Self-attribution</th>
<th>Relational attribution</th>
<th>Reason for the use of physical restraint</th>
<th>Acceptability &amp; justification of the physical restraint</th>
<th>Power inequality</th>
<th>Emotional distress</th>
<th>Attributions about staff</th>
<th>Minimising the use of physical restraint</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
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</tr>
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</tr>
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<td>✓</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>


Table 4 Meta-ethnography of reviewed articles.
1.8.7 Meta-synthesis narrative of studies

The final step of a meta-ethnographic approach is to present the synthesis in an accessible form. The studies included in this Systematic Review are synthesised as a narrative below.

1.8.7.1 Reasons for the use of physical restraint

Three of the four studies directly asked service users about their perception of why the physical restraint occurred. It seems that some service users attribute the reason for the restraint as being their personal responsibility, however in other cases attribute this to wider contextual and relational influences. Reasons as to why this is so remain unclear, however when considering the clinical implications of this, it seems that a discussion between those involved in the restraint may be helpful, to discuss different perspectives as to why the restraint happened and therefore how to try and prevent this from occurring again in future.

Self-attribution

Within three of the studies, some service users attributed their own behaviour as the reason physical restraint was used. One of the studies conducted in a forensic rehabilitation environment, found that a majority of the service users said that their own violent behaviour was the most common reason leading to physical restraint (Haw et al., 2011). Other explanations were provided as reasons that led to the use of restrictive interventions in general, however these were not specifically linked to physical restraint per se. These other reasons included the service user being destructive to property and harming themselves. Service users in forensic and secure hospital settings often have a history of challenging or violent behaviours, perhaps making it more likely in this system for service users to attribute the blame to their own violent behaviours.

Similarly, within an inpatient mental health setting, some service users made self-attributions as the reason for physical restraint. Service users identified that risk of self-harm or physical aggression against staff preceded physical restraint, however broader reasons were provided than the aforementioned study, including: refusal of treatment; refusal to follow staff directions; and verbal aggression (Wynn, 2004). Some of these service users were able to identify that it had been a combination of these antecedents which led to the physical
restraint. Three of the 12 service users could not identify a reason that the restraint had occurred, however the paper does not establish whether this was due to the antecedent being unclear to the service user or due to other factors. Different self-attributions were provided in another study of inpatient service users’ experiences of physical restraint. Whereas the other two studies focused on the service users’ actions, within this study the service users suggested that the restraint occurred due to their internal processes, for example they were unwell or unable to access support due to fear of physical restraint (Bonner et al., 2002).

Relational attribution

In two of the studies, service users made relational attributions as to what led to the physical restraint. It was suggested that the ward environment and failed communication between staff and the service user were the common antecedents for physical restraint (Bonner et al., 2002). Failed communication included feeling unheard and dismissed by staff in the lead up to the restraint and believing mixed messages were provided by staff (Bonner et al., 2002). Similarly, in another study, failed communication between the service user and staff was also a key factor identified, but more so in how the staff approached them at the time of the restraint (Wynn, 2004). These service users identified that they felt staff had approached them in an intimidating manner which led to them feeling threatened, therefore increasing the likelihood of physical restraint.

1.8.7.2 Acceptability and justification of the physical restraint

Three of the research papers comment on whether the physical restraint was perceived as justified and the level of acceptance that the restraint had happened varied both within and across the research papers. Numerous reasons are stated as to why some physical restraints were perceived to be acceptable or not.

In three of the studies, service users shared that the use of restraint had been unacceptable. It was perceived as ‘completely unnecessary’ (p.130, Wynn, 2004), wrong and unjustified (Knowles et al., 2015) and that it should not have been used (Haw et al., 2011). In one study, service users identified that restraint felt particularly unnecessary when they felt they were taken by surprise and had not expected it (Bonner et al., 2002). Another study went beyond the feelings of unacceptability and focused upon the impact this had upon the therapeutic relationship. When the incident was perceived as unjust, there was an experience of increased
hostility towards staff which created difficulty within the relationship with them, whereas when it was perceived as justified they feel able to have a positive relationship with the staff members who were involved in that restraint (Knowles et al., 2015).

A number of factors were noted as influencing service user perceptions of the acceptability of them being restrained. It was perceived as acceptable if they felt it had been used to prevent harm to either themselves or others (Haw et al., 2011; Wynn, 2004), to contain the situation (Bonner et al., 2002; Wynn, 2004) and if they understood and accepted the reasons it had occurred (Bonner et al., 2002; Haw et al., 2011). If the service users understood why it had happened, the service users were less critical of the use of the restraint (Bonner et al., 2002). Whether the restraint was perceived as happening too quickly or as an overreaction to events, with a lack of de-escalation techniques used to diffuse the situation before acting, influenced the perception of acceptability (Haw et al., 2011; Knowles et al., 2015). These studies varied as to when the interviews took place; it is interesting that these perceptions of injustice are evident not just in the immediate aftermath of the physical restraint, but remain for some time later.

In two studies, it appeared that some service users had become desensitised to the experience of physical restraint (Haw et al., 2011; Wynn, 2004). Service users shared that the experience of physical restraint ‘wasn’t such a big deal…I’ve been in restraint before’ (p. 132, Wynn, 2004) and expressed an indifference at being restrained again (Haw et al., 2011). Although it may seem that these service users accepted that restraint was used, it seems more so that they have become tolerant and more accepting that physical restraint is being used in this environment, rather than accepting of the reason it was used in their case.

1.8.7.3 Power inequality

Difficulties with the power inequality between service users and staff were reported by service users both within inpatient mental health settings and secure hospital environments. Consequently some service users reported feelings of powerlessness and shared how they coped with these feelings.
Feelings of powerlessness

Three of the studies referred to how powerless service users can feel during and after physical restraint. Service users shared that they felt helpless and vulnerable (Knowles et al., 2015; Wynn, 2004), powerless (Haw et al., 2011; Knowles et al., 2015) and infantilised and controlled (Knowles et al., 2015). Two of the studies related these feelings of powerlessness to how they perceived they had been treated by staff. They shared that they felt staff had used physical restraint to demonstrate their power (Haw et al., 2011; Wynn, 2004) and that restraint can be misused with undue force to set limits (Wynn, 2004) and as a punishment (Haw et al., 2011). One of the studies went on to illustrate how this demonstration of power inequality continues after the physical restraint, through the loss of privileges and plans for the future (Haw et al., 2011). Events associated with physical restraint, such as staff documenting the events, further demonstrated that staff are more powerful (Knowles et al., 2015).

In the study conducted in a medium secure hospital, power inequality was presented as one of the key themes (Knowles et al., 2015). This study identified that the service users believed physical restraint reinforced the power imbalance, which is already present before such incidents. In contrast, within the study looking at service user views from a secure rehabilitative setting (Haw et al., 2011), power inequality was not identified as a distinct theme. It is possible that this may not have been as dominant a theme, due to the rehabilitative setting and the range of ward security. Power differences may not be as evident on low secure and open wards compared to medium secure wards. This theme of power inequality may be more evident in secure mental health services, where a key aspect of staff’s role is to manage forensic risk which can involve implementing restrictions as to what the service user can do, in addition to attending to their mental health needs.

It seems that the power inequality between service users and staff can become evident at the time of restraint. However, two of the studies illustrated that at the time of restraint feelings of powerlessness can change to a perception of an abusive dynamic between service users and staff. One service user described physical restraint as an ‘abusive act’ (p.133, Wynn, 2004) and another study service users referred to restraint as an assault and that staff can be abusive and degrading, which can leave the service user feeling that the restraint had been ‘dehumanising’ (p. 575, Haw et al., 2011). It seems that physical restraint can at times be perceived by service users as an abusive act by staff, as a misuse of their power.
Coping with a lack of power

Three of the studies referred to how service users coped with their perception of a lack of power. Two of these studies referred to direct methods that the service users engaged in. During the physical restraint service users described fighting back and trying to regain power, both during and after the physical restraint (Knowles et al., 2015). Similarly, in Wynn’s study (2004), perhaps again linked to a lack of power, some service users describe feeling backed into a corner and coping by defending themselves. The study lead by Knowles et al., (2015) went beyond Wynn’s (2004) study, as it also revealed that service users coped with powerlessness via indirect methods. Service users described suppressing their negative emotions and feelings about the staff involved in the physical restraint, noting that they could not express these feelings to staff and that their feelings had to be hidden (Knowles et al., 2015). This led to the use of subversive and indirect methods to communicate their difficult emotions towards staff, such as avoidance, engaging superficially and making staff aware that they did not like them through their behaviour and non-verbal communication. Overall it seems that although these service users had described very difficult emotional reactions to the physical restraint, some even traumatic reactions, they do not feel able to communicate this with staff.

In another study (Bonner et al., 2002), coping strategies were not directly explored. However, this study did explore what the service users would like to have in place to help them cope after the physical restraint. Commonly service users stated that perceived kindness and attention from staff was helpful in the aftermath of the physical restraint, which supported them to build up an objective understanding of what had happened.

1.8.7.4 Emotional distress

In all four studies, service users shared that they experienced emotional distress, both during and after the physical restraint. Service users described feeling embarrassed (Bonner et al., 2002; Haw et al., 2011) and in some cases a sense of shame, humiliation and a loss of dignity due to the experience of physical restraint ((Bonner et al., 2002; Haw et al., 2011; Wynn, 2004). Other service users shared fearful and panicked experiences (Bonner et al., 2002; Wynn, 2004) and that in some cases service users were hypervigilant after the restraint, fearful of sleeping and of restraint occurring again (Wynn, 2004). Experiences of anger were also shared (Bonner et al., 2002; Wynn, 2004), in one of these studies the service user shared
that the anger was due to feeling that the restraint had been unnecessary (Wynn, 2004). Less commonly, experiences of hysteria (Wynn, 2004) and isolation (Bonner et al., 2002) were detailed as potential emotional distress after the restraint. A vast range of distressing emotions were experienced by these service users, although it seems that some of the particular emotional reactions were particular to certain individuals’ experiences.

One of the studies went beyond the conclusions drawn from the other papers, as it explored the impact of these emotional difficulties upon their behaviour and interactions with staff (Bonner et al., 2002). Service users described being fearful of physical restraint and therefore avoided staff. One service user identified that this actually increased her risk of becoming more unwell and therefore being restrained in future; paradoxically, restraint appeared to actually perpetuate this person’s difficulties.

Not only was the physical restraint detailed as a difficult emotional experience emotional, all four studies referred to the physical restraint experience as either traumatic in itself, or as a trigger for previous traumatic and abusive memories. Physical restraint was experienced as an ‘abusive, degrading, traumatic experience’ (p.466, Knowles et al., 2015) and labelled as barbaric, medieval and torturous. It was noted within this study that the power imbalance accentuated the abusive dynamic. Some of these service users described experiences associated with post-traumatic stress disorder, such as vivid dreams and thoughts of the physical restraint that preoccupied their mind (Knowles et al., 2015). The experience was described as degrading and that there was a dynamic of feeling abused and helpless.

Three of the studies found that physical restraint led to distressing memories of previous traumatic events. These memories included those of prior sexual abuse (Haw et al., 2011), being abused as a child and memories of being raped (Bonner et al., 2002). In one of the studies the author reported that three of the six service users stated that they have had memories and flashbacks of previous traumatic events, such as other experiences of physical restraint, sexual assault and childhood memories (Wynn, 2004). The sampling method used approached service users immediately after physical restraint; therefore these results would not be due to a sampling bias of service users choosing to take part due to particularly difficult experiences. It would be important to investigate in larger samples how frequently service users experience these traumatic reactions and relive previous traumatic memories after physical restraint.
Service users were interviewed at different time periods after the physical restraint. Some accounts were provided either immediately after (Bonner et al., 2002) or several days after (Wynn, 2004) the physical restraint; it is likely that these studies captured emotions experienced at the time of and in the immediate aftermath of the restraint. Whereas another of the studies explored experiences of physical restraint up to two years prior (Haw et al., 2011), illustrating the longer term emotional impact that physical restraint can have upon those who are restrained.

1.8.7.5 Attributions about staff

Each of the studies reported what the service users thought and felt about the staff members that physically restrained them. It seems that some service users felt that staff were just doing their job (Haw et al., 2011) and that they felt staff had a caring attitude towards them during the physical restraint (Haw et al., 2011; Knowles et al., 2015). Some service users were able to reflect that staff had helped to calm them and protect them from themselves and others during the physical restraint (Wynn, 2004). However, it seems that these more positive attributions were from the minority of service users; a majority characterised the physical restraint as a negative experience and made negative attributions about staff members (Haw et al., 2011).

In three of the studies, service users made attributions about the characteristics of the staff who had restrained them. Staff members who were characterised negatively were believed to enjoy inflicting pain and must be unemotional and cold to be able to restrain somebody (Knowles et al., 2015). However, only two direct quotes were used to illustrate this view and it is unclear how common this perception was among the service users. There was a large range between how frequently the service users had been physically restrained (between two and 50 times), it would be interesting to know whether those restrained more frequently were those that had this perception. Staff were also described as unapproachable (Bonner et al., 2002), harsh and uncaring (Haw et al., 2011) and that temporary agency staff were perceived as even less invested in their care than regular staff members (Bonner et al., 2002).

Within another of the studies, attributions about staff were more so about how they perceived staff behaviour, unlike the other studies which commented upon their personal characteristics. Service users believed that staff actions can be unnecessary and abusive, resulting in unfair treatment (Wynn, 2004). There were also views that staff had caused them
physical discomfort and that they should have been released earlier than they had been (Wynn, 2004).

When service users considered the attributions of staff members, trust seemed to be a key issue. In three of the studies, both from a secure hospital environment and an inpatient mental health setting, service users reported a loss of trust after the physical restraint (Haw et al., 2011; Knowles et al., 2015; Wynn, 2004). Less trust was generally felt towards staff who were involved in the restraint in one of these studies (Knowles et al., 2015); whereas in another, the perception that undue force had been used and that the physical restraint had been of an abusive nature was said to lead to a loss of trust felt towards the staff members (Haw et al., 2011). Some service users explained that the distrust that they felt towards staff meant that their alliance had been damaged (Wynn, 2004).

1.8.7.6 Minimising the use of physical restraint
Each of the four studies suggest that staff training is required to help minimise the use of physical restraint. They shared how significant it is for staff to realise the importance of using the least restrictive measure (Wynn, 2004); to focus on prevention rather than reactive strategies such as investment of time to know and understand the service user (Bonner et al., 2002) and helping service users express their emotions to avoid escalation to a physical restraint (Knowles et al., 2015); and having more open communication to help de-escalate situations before reaching crisis point (Haw et al., 2011; Wynn, 2004). Within this training, staff could be informed of service user views of restraint and how this impacts their relationship with staff (Knowles et al., 2015) and what the potential psychological impact can be. This may be particularly salient for individuals that have experienced prior abusive or traumatic experiences (Wynn, 2004). Supervision is suggested as a useful forum for staff to consider the emotional impact of the physical restraint (Knowles et al., 2015).

1.8.8 Conclusions
Despite there being limited research regarding service user experiences of physical restraints within an inpatient and secure hospital environment, the findings of these studies have significant implications for clinical practice. Service users considered the reasons for the physical restraint and this seems to influence their perception of whether the restraint was acceptable and justified. The power inequality between service users and staff becomes
amplified at the time of a physical restraint, which can leave service users feeling powerless with limited methods to cope with this. A vast range of distressing emotions were associated with the experience of physical restraint, with the potential to perceive restraint as traumatic and abusive. Memories of previous trauma can be activated, again perpetuating the emotional distress. Perhaps unsurprisingly, service users’ perceptions of staff members were largely negative and the experience can have an impact upon the service users’ ability to trust staff. In all four studies, the need to minimise the use of restrictive practice was emphasised.

1.9 STUDY AIMS

There is a lack of research regarding service user and staff experiences of physical restraint in mental health inpatient and secure hospital settings. The studies that have been included within the meta-synthesis suggest that physical restraint can be an extremely difficult experience for service users.

Within these settings, service users have to continue their therapeutic relationships with staff. Despite this, only one study has explored the experience of the therapeutic relationship after such events in a secure hospital (Knowles et al., 2015). Therapeutic relationships involve both staff and service users, yet the aforementioned research solely focuses on service user perspectives. The therapeutic relationship by definition is relational in nature between service users and professionals. Therefore this research will focus on both service user and staff perspectives of the therapeutic relationship after physical restraint in a secure hospital setting.
2.1 CHAPTER OVERVIEW

The following chapter provides an overview of the methodology of the research. Included within this is: a rationale for the approach taken; details of the quality framework followed; details of the participants; ethical considerations; data collection and data analysis.

2.2 DESIGN

This research utilised a qualitative design. The research aimed to explore both staff and service users’ perspectives of the therapeutic relationship following physical restraint in a secure hospital setting. Both staff and service users, either working at or receiving care within the research site in South Wales, were interviewed using a semi structured interview. The experience of the therapeutic relationship after physical restraint was the focus of the research, not an account of a specific physical restraint, therefore unpaired interviews were conducted. The analysis was completed using Interpretative Phenomenological Analysis (IPA).

2.3 QUALITATIVE RESEARCH

2.3.1 Philosophy

Qualitative research is concerned with how people make meaning and sense of events and experiences, as opposed to looking at cause and effect relationships (Elliott et al., 1999.) It aims to consider peoples’ subjective experiences and how they have made sense of these (Willig, 2008).
Broad questions are asked, as opposed to testing specific hypotheses, to achieve a depth of understanding which can be made more precise by asking more specific questions throughout the data collection (Fossey et al., 2002). Qualitative methodology requires interpretive rather than statistical analysis and is often used at the exploratory stages of research (Brown & Lloyd, 2001).

Qualitative approaches can be helpful in understanding perspectives, behaviours and contexts and can help develop understandings and knowledge in poorly understood areas of health (Fossey et al., 2002). Despite qualitative research often having small numbers of participants, the theories generated from this research can be generalizable, even though the results are not statistically generalizable (Brown & Lloyd, 2001).

2.3.2 Rationale

As this research focused on service user and staff experiences, a qualitative methodology appears to be the most appropriate. Qualitative methods are appropriate when exploring individuals’ perceptions of social phenomena (Tong et al., 2007), which in this research is the experience of the therapeutic relationship after physical restraint. It was hoped that through exploration of participants’ experiences of therapeutic relationships after being involved in a physical restraint, an interpretation could be developed to attempt to understand this within the context of a secure hospital setting. Interpretive Phenomenological Analysis is the approach that was followed in this research.

2.4 INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

2.4.1 Overview of Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) involves detailed exploration of individuals’ meaning of their experiences (Pietkiewicz & Smith, 2012). The analysis involves both the participant and the researcher, therefore both the lived experience and a reflective interpretation (Reid et al., 2005). The participant reflects upon an individual experience and shares this, which is an attempt of the participant to make sense of what they have experienced. The researcher then tries to understand the phenomena from the individual
participant’s viewpoint (Shinebourne, 2011), interpreting the participant’s account and reflections (Smith et al., 2009). Therefore the interpretation is always tentative and subjective (Smith et al., 2009).

2.4.1 Theoretical underpinnings

There are three theoretical perspectives that are central to IPA: phenomenology, hermeneutics and idiography. Each of these are detailed, to illustrate the underpinnings of an IPA approach.

Firstly, phenomenology is a philosophical approach to studying the lived experience (Smith, et al., 2009). Studies which adopt a phenomenological approach, look at how individuals perceive a particular phenomenon (Pietkiewicz & Smith, 2012). This approach allows for the analysis of peoples’ perceptions of particular experiences, as the individual reflects consciously on an experience that they have had (Smith et al., 2009). IPA focuses on understanding these experiences, not attempting to fit these experiences into predefined categories or concepts (Smith et al., 2009).

Secondly, an IPA approach relies heavily on hermeneutics. Hermeneutics derives from the Greek work which means ‘to interpret’ (Pietkiewicz & Smith, 2012). Within IPA, the researcher attempts to understand an experience from the participant’s perspective; this is known as a double hermeneutic process (Pietkiewicz & Smith, 2012). This consists of the individual participant attempting to make sense of their experience, followed by the researcher making sense of that participant’s meaning making (Smith & Osborn, 2008). The researcher attempts to understand that particular experience, from the perspective of the participant (Pietkiewicz & Smith, 2012).

Finally, IPA is concerned with idiography, as it emphasises the importance of the individual and the particular. IPA considers a particular experience, of particular people, in a particular context (Smith et al., 2009). This approach emphasises understanding the meaning of a particular experience for that individual (Smith et al., 2009). This thorough and systematic analysis of individual experiences relies on detail and depth of analysis, as opposed to attempting to make claims at a population level (Smith et al., 2009). Only after detailed examination of each case would the researcher cautiously comment upon similarities and differences of different participants experiences (Pietkiewicz & Smith, 2012). Although themes are generated that capture numerous participants’ experiences, individual narratives
are captured within these and contrasted and compared with each other (Pietkiewicz & Smith, 2012).

2.4.3 Rationale

An initial literature search suggested that there are relatively few published research papers relating to staff and service users’ experience of physical restraint in a secure hospital or adult mental health inpatient setting. Of those papers which have investigated this, there was only one research paper that explored their experiences of the therapeutic relationship after physical restraint.

The aim of this research was to understand the experiences of the therapeutic relationship after a physical restraint; IPA allows for personal meaning of these experiences to be explored. This is particularly important, so the voices of service users and staff members are heard. The aforementioned literature search clearly illustrates that these voices are not currently salient in research literature. IPA allows for the phenomenon of experiences of the therapeutic relationship after a physical restraint to be explored in the particular context of a medium secure environment. Individual narratives can be appreciated and illustrated, whilst also allowing for comparisons and contrasts between individual experiences to be made.

IPA also lends itself well to the researcher; it requires curiosity, empathy and willingness to enter the participant’s world (Smith et al., 2009). Hearing the participants’ experiences of therapeutic relationships after physical restraint is something that the researcher particularly values and considers important.

2.5 QUALITY FRAMEWORK

It is important that qualitative research is of good quality and guidelines have been developed to assess this. A framework for the review of the quality of qualitative research has been outlined here (Elliot et al., 1999), alongside a description of how the author attempted to fulfil this criteria in italic font.
2.5.1 Owning one’s perspective

To own one’s perspective, theoretical orientations and personal anticipations should be specified and understanding of the phenomena being studied should be stated. This involves trying to recognise own values, interests and assumptions and how these will influence understanding. Descriptions of any experiences or training relevant to the matter and initial beliefs about the research should be included.

The author has provided a reflective account under section ‘2.5.8 Reflexivity’ of the Method Chapter, to consider factors which may have influenced the research process and understanding of the data. A reflective journal was also kept, to reflect on personal and professional feelings and thoughts experienced throughout the research process.

2.5.2 Situating the sample

To situate the sample, describe the participants and their life circumstances to aid the reader in judging the range of people the findings may be relevant to.

Demographic information relating to each participant was collected at the interviews and is recorded within section ‘2.6.6 Participant demographics’ of the Method Chapter.

2.5.3 Grounding in examples

Provide data examples to illustrate analysis. This allows the reader to appraise the fit between the data and the analysis. Offering at least one or two examples of each theme is considered to be good practice.

Anonymised direct quotes illustrate each master theme and subtheme. This will allow the reader to understand how the themes were conceptualised.

2.5.4 Providing credibility checks

A variety of credibility checks can be used e.g. check the understanding of the analysis with the informants; triangulation of the analysis; compare varied perspectives; ask someone with experience in the research area to review the themes.
Themes were reflected upon in supervision, with both the Academic Supervisors and Clinical Supervisor. The Clinical Supervisor works within the secure hospital in which the research took place; therefore her experience helped to develop, inform and validate themes in the analysis in relation to her perspective gained from working within this setting. Throughout the process, themes were reflected upon with another Clinical Psychologist, who works within a different secure hospital setting. This Clinical Psychologist and the Academic Supervisor also viewed and coded one of the transcripts, to check the validity of the coding process.

2.5.5 Coherence

Form a data-based narrative or map, organising categories into figures or diagrams. Group ideas and provide a verbal narrative of the model.

In the Results Chapter, a table outlining each of the master themes and subthemes within these are presented for clarity. Subsequently, each of the themes are illustrated with a verbal narrative presented alongside quotations to further clarify the master themes and subthemes. A variety of fonts are used to convey the different master themes, subthemes and participant quotations that support these.

2.5.6 Accomplish general versus specific tasks

Specify the limitations of extending the findings to other contexts. Use diverse informants and emphasize who the results may apply to.

In the Discussion Chapter, limitations of the generalisability of the results are discussed in relation to the demographic and number of participants.

2.5.7 Resonating with the readers

The analysis should resonate with the readers and be judged to accurately represent the subject matter. The reader should feel that the analysis accurately reflects the responses provided by the participants.
It is hoped that through adhering to the above criteria, particularly remaining self-reflective throughout the research process, that the findings will resonate with the readers and capture the participants’ experiences. Direct quotes are presented in the Results Chapter, to attempt to accurately represent the subject matter.

2.5.8 Reflexivity

There is an interaction between the researcher and the participant; data emerges from this interaction (Glasser & Strauss, 1967). As it is impossible for the researcher to completely set aside their own perspective, it is important for them to be self-reflective (Elliott et al., 1999). Although bias is not eliminated from the research process, self-reflexivity helps the researcher become more aware of their personal influence upon the process.

Self-reflection allows the researcher to be aware of their own preconceptions and reflect on these throughout the research process (Rice & Ezzy, 1999). Through the process of reflecting upon their own assumptions, values and interests, this can improve the ability of the researcher of openly listening to participants’ experiences (Ahern, 1999; Mills et al., 2006) and help them understand the potential bias their assumptions may have upon the research process (Ahern, 1999), including the construction of meaning in research analysis (Willig, 2008).

However self reflexivity is not only important to become aware of potential biases. A researcher’s perspective may make particular insights and understandings of the data possible (Willig, 2008) therefore it is an important part of the research process. Continuous self reflexivity throughout the research process helps to improve the validity of the research, as it ‘discourages impositions of meaning by the researcher’ (Willig, 2008, p.10). By the researcher reflecting upon their own assumptions which may influence the research, this provides readers of the research with information regarding how the data may have been influenced by preconceptions (Mills et al., 2006).

Strauss and Corbin (1967) also advocate for qualitative researchers to keep a reflective journal about the research area throughout the research process, to help consider how personal reflections may influence the analysis. An example of the author’s reflective journal can be viewed in Appendix B.
2.5.9 Self-reflexivity

Following is a personal reflection from the author of this research, in an attempt to consider how the author may influence the research process. This is written in the first person as it is a personal reflection.

I am a 26 year old British female who was born and grew up in Swindon. I moved to Cardiff when I was 18 and am currently training on the South Wales Doctorate of Clinical Psychology. I am particularly influenced by theoretical perspectives that focus on the significance of early relationships and how this influences later relationships, such as Attachment Theory and Cognitive Analytical Therapy.

Prior to clinical training I worked clinically in a secure hospital setting. I was particularly struck by the fact that service users and staff have therapeutic relationships with each other in this environment, despite any personal feelings or thoughts that they have about each other. Many of the service users in this environment had experienced difficult early upbringings for a range of reasons, which would impact upon their ability to build secure and trusting relationships. This seemed to be particularly evident after incidents such as physical restraint, where due to the environment those involved would continue their relationships despite the fact that such a potentially violent and risky situation had occurred.

I personally have never been involved in a physical restraint. I have been involved in an incident where I was threatened on one of the secure hospital wards. Following this I was very distressed and found it difficult to return to the ward that this had happened on. There was no conversation between myself and this service user about this incident following it occurring. This led me to think that in this environment, incidents such as this unfortunately are not rare, yet the service users and staff continue to have a therapeutic relationship. I am curious about the impact that significant incidents that occur on the ward may have on both service users and staff and their ability to work together therapeutically.

I think it is important to acknowledge some of my preconceptions and values that may influence the analytical process. Due to my previous experience in this setting, I thought that having a therapeutic relationship after a physical restraint can be a difficult experience. I particularly value the importance of respecting and valuing different people’s perspectives and believe it is important to address power imbalance between professionals and service users. I believe it is important to consider what support could be put in place to help service users receive the best care possible and for staff to feel safe and valued in their jobs.
2.6 PARTICIPANTS

Following are details of the participants who took part in the research. This includes the recruitment context, the inclusion and exclusion criteria used to decide whether participants were appropriate to take part in the research and the procedure used to select them. Details are provided about the sample size and demographics of these participants.

2.6.1 Recruitment context

Both service user and staff participants were recruited from an independent sector medium-low secure hospital in South Wales. Service users receive healthcare from NHS Health Boards from across the United Kingdom. Most are detained under the Mental Health Act due to a combination of mental health difficulties, their offending behaviour or risk of harm to themselves or others. Staff member participants were employed by the hospital when they participated in the research.

2.6.2 Inclusion criteria

For clarity, service user and staff inclusion criteria have been described separately.

Inclusion criteria for service user participants:

- Currently receiving care at the research site;
- At least 18 years of age;
- Able to provide informed consent;
- Able to recall at least one incident of physical restraint and the therapeutic relationship after this incident. This physical restraint can have occurred at the research site or any other secure institution;
- At least one of the staff members who physically restrained them has worked on the same ward as the service user since the physical restraint (therefore the service user has had an opportunity for a therapeutic relationship with a staff member who has physically restrained them);
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- Assessed by the Nurse in Charge and the author as being able to participate in relation to their risk to self and others; and
- No significant communication difficulties (hearing or speech problems) that would impair their ability to describe their experiences, due to the importance of communication at the interview.

Inclusion criteria for staff member participants:

- Currently employed at the research site;
- At least 18 years of age;
- Able to provide informed consent;
- Able to recall at least one incident of physical restraint and the therapeutic relationship after this incident. This physical restraint can have occurred at the research site or any other secure institution;
- At least one of the service users who they physically restrained has been on the same ward as them since the physical restraint (therefore the staff member has had an opportunity for a therapeutic relationship with a service user whom they have physically restrained);
- Have attended the research site’s training for the safe and therapeutic management of violence and aggression; and
- No significant communication difficulties (hearing or speech problems) that would impair their ability to describe their experiences, due to the importance of communication at the interview.

2.6.3 Recruitment procedure

The Psychologists in the Multi-Disciplinary-Teams (MDT) shared participation information sheets, consent forms and background to the research with their MDT. The MDT were made aware that participant information sheets and consent forms could also be provided in Welsh language if requested. Service users and staff who met the inclusion criteria were identified by the MDT.

The identified service users were approached by a staff member who knew them well and they gave them Participant information sheet (service user) v2 (Appendix C) Service users
were asked to complete Consent to be contacted form (service user) v1 (Appendix D) if they agreed to meet with the author to discuss participation.

The MDT shared Participant information sheet (staff) v2 (Appendix E) with the identified staff members. Staff were asked to complete Consent to be contacted form (staff) v1 (Appendix F) and provide preferred contact details, if they agreed to be contacted by the author to discuss participation in the research.

These consent forms were then forwarded to the author.

2.6.4 Sample size

The total potential population available to participate in this research were 110 service users and 223 staff members. The research site confirmed, based on their record of the frequency of physical restraints, that there would be greater than the anticipated number of participants required that would meet the inclusion criteria.

Small samples allow for an intensive focus of the participants’ experiences (Shinebourne, 2011). This enables a time consuming case by case analysis of the particular phenomena (Pietkiewicz & Smith, 2012), in this case the experience of the therapeutic relationship after physical restraint. Small samples are preferable to allow a focus on the depth, rather than breadth, of rich qualitative data (Pietkiewicz & Smith, 2012; Smith et al., 2009) as large data sets can inhibit reflection and the dialogue within the interpretation (Smith et al., 2009).

A total of 10 participants were recruited and participated in the research; five service users and five staff members. One service user who consented to participate in the research subsequently changed his mind at the time of the interview. A reason for this was not asked for nor provided.

2.6.5 Participant Demographics

Pseudonyms are not presented in relation to individual participant demographics, to protect the anonymity of participants due to the presentation of quotations. A relatively homogenous sample was recruited, to focus on the particular experience within the particular context (Smith et al., 2009) of a therapeutic relationship after physical restraint in a secure hospital environment. Five service users took part in the research, two of whom were male and three
female. The range of time that these service users had been cared for at the research site were between 11 months to 5.5 years (mean = 3 years).

Of the five staff member participants, two were male and three were female. Three of the staff members were Mental Health Nurses and two were Health Care Workers. Nine participants agreed for their age and ethnicity to be included in this research report. The age range of these participants were 20-49 years (mean = 31) and all of these participants were either white Welsh or white British in ethnicity.

2.7 ETHICAL AND RISK CONSIDERATIONS

Prior to data collection and recruitment, careful consideration was made in regards to ethical research conduct and management of risk. These relevant considerations are outlined below.

2.7.1 Ethical approval
This research was reviewed and received favourable opinion by South West-Exeter Research Ethics Committee. See Appendix G for Research and Development approval documentation.

2.7.2 Informed consent
The service user participants were provided with Participant information sheet (service user) v2 (Appendix C) by a staff member who knew them well. The purpose of this was to provide information about the research to inform their choice about whether they wished to meet the author to discuss participation. The service user then completed Consent to be contacted form (service user) v1 (Appendix D) if they agreed to meet the author to discuss the research. When the author met the service user, the service user completed Consent form to participate (service user) v1 (Appendix H) if they agreed to participate in the research.

Staff member participants were provided with Participant information sheet (staff) v2 (Appendix E). Again, the purpose of this was to provide information about the research to inform their choice about whether they wished to meet the author to discuss participation. The staff member completed a Consent to be contacted form (staff) v1 (Appendix F) if they
agreed to meet the author to discuss the research. When the author met the staff member, the
staff member completed *Consent form to participate (staff) v1*, (Appendix I) if they agreed to
participate in the research.

2.7.3 Right to withdraw

Each participant was informed that participation in the research was entirely voluntary and
that they could withdraw at any time. The participants were made aware that they could pause
or terminate the interview at any time. This was also detailed in the information sheets, which
each participant was provided.

2.7.4 Capacity

The Nurse in Charge was responsible for assessing each service user’s capacity to consent to
meeting the author to discuss the research further. The author was responsible for assessing
each participant’s capacity to consent to participating in the research, at the time of the
interview.

2.7.5 Risk and confidentiality

The research site’s procedures and the British Psychological Society (BPS) Code of Conduct
were followed by the author at all times.

Participants were informed using the participation information sheets (Appendices C and E)
about confidentiality. They were made aware of the transcription process, how their
information would be stored, how long it would be stored and what would be included in the
anonymised research report.

Participants were made aware that any information associated with risk, either to the
participant or others, would be shared immediately after the interview with either the Nurse
in Charge (if the participant was a service user) or the participant’s line manager (if the
participant was a staff member). If any information pertaining to risk had to be disclosed, the
participant would be informed of this where possible. Any further concerns regarding
disclosures or risks were discussed with the author’s Clinical Supervisor to decide upon
whether further action was appropriate.
2.7.6 Safety during research interviews

Prior to meeting the author, the Nurse in Charge assessed service user participant risk and decided whether it was appropriate for them to meet the author. The risk assessment included assessment of recent events and the impact on the service user, their baseline mood and risk to themselves and others.

The author was responsible for monitoring each participant’s risk of harm to themselves or others throughout the interview. If at any time during the interview the author had thought that it was unsafe/inappropriate for the interview to continue, the interview would have been terminated early by the author.

The author wore a personal alarm during interviews with service user participants. This alarm was connected to the ward’s alarm system and could be sounded if necessary. The author was aware of the research site’s security protocol to ensure that relevant members of staff were aware of where the interviews with service user participants were taking place.

If participants became distressed during the interview, the author was responsible for attempting to reduce this arousal, using skills relevant to their clinical training. If the participant remained distressed, they would have been offered to have a break during the interview. Following this, the participant would have then been supported to decide whether they wanted to continue the interview or not. In relation to staff member participants, the author was responsible for deciding whether or not it was appropriate and safe for the interview to continue. In regards to service user participants, any risks associated with the service user participants would have been discussed between the author and Nurse in Charge who would have collaboratively decided whether or not it was appropriate and safe to continue the interview.

2.7.7 Conflict of interest

The author was not employed by the research site nor working clinically with any of the service user participants at the time of data collection.
2.8 DATA COLLECTION

Following are details regarding how research materials were developed and the procedure followed to conduct interviews with the participants.

2.8.1 Development of research materials

The author and Clinical Supervisor attended a Service User’s Council Meeting within the research site, which representative service users attend from across the hospital. The Hospital Director, Lead Nurse and an Independent Advocate were also present. At this meeting, those present were asked for their perspectives about the research proposal, participant information sheets and consent forms. Initial ideas about themes that could be explored in the interviews were also discussed. These suggestions helped design the research materials.

A semi structured interview structure was developed to elicit the participants’ experiences of the therapeutic relationship after physical restraint. This consisted of an interview guide of a small number of open ended questions, which began with more general questions to more specific and personal questions. This is recommended as it allows rapport to be built throughout the interview (Willig, 2008). As the questions were open ended, this allowed the author to explore the responses in more detail (Brown & Lloyd, 2001). The initial interview schedule can be viewed in Appendix J.

2.8.2 Procedure

The interviews were conducted for up to one hour. Areas associated with ethical considerations (e.g. consent, capacity, risk) are described in detail in section ‘2.7 Ethical and risk considerations’ of the Method Chapter.

The author contacted the Nurse in Charge to arrange a convenient time for the interview with service users who had provided consent to be contacted. Risk assessments were completed immediately prior to the interview. At the interview, Participant information sheet (service user) v2 (Appendix C) was discussed by the author with the service user. Consent form to participate (service user) v1 (Appendix H) was completed to participate in the interview if
the service user agreed to participate in the research. The interview was then conducted and audio-taped. After the interview, the service user was provided with *Debriefing information sheet v1* (Appendix K) and offered an opportunity to ask any questions about the research.

Staff members who provided consent to be contacted were contacted by the author to ask if they still wish to participate in the research. If they did wish to participate, a mutually convenient time was arranged to conduct an interview. *Participant information sheet (staff) v2* (Appendix E) was discussed by the author with the staff member. *Consent form to participate (staff) v1* (Appendix I) was completed to participate in the interview if the participant agreed to participate in the research. The interview was then conducted and audio-taped. After the interview, the staff member was provided with *Debriefing information sheet v1* (Appendix K) and offered an opportunity to ask any questions about the research.

### 2.9 DATA ANALYSIS

Guidelines were followed to conduct the analysis to capture the main principles that guide IPA (Smith *et al.*, 2009). Details of each of the steps followed are outlined below. The service user data and staff member data were analysed separately.

#### 2.9.1 Transcription

Each interview was transcribed verbatim within two days of the interview taking place. Each interview took approximately three to four hours to transcribe, depending upon the interview length. This allowed the author to become immersed in the data and to reflect on emerging themes, therefore transcription was the beginning of the analysis process. The use of pseudonyms were used to ensure anonymity. The author kept a reflective journal throughout the transcription process, to reflect on themes emerging from the data.

#### 2.9.2 Data management

Interviews were recorded using an audio recorder and then transcribed by the author. Details of which participant each of the audio recordings and transcripts were associated with were stored separately and securely, so that these remained anonymous to ensure confidentiality.
Additional demographic data that was collected in regards to each participant was stored securely and separately to the audio recordings and transcripts to ensure individual participants were not identified. All quotes and transcripts were anonymised prior to being viewed by the author’s supervisors and a Clinical Psychologist who worked within a different secure service. An example of a transcription noting can be viewed in Appendix L.

2.9.3 Analysis
The process of data analysis began during the transcription of each of the interviews. An analysis of the data began to emerge using multiple methods: reading and re-reading; noting; the development of themes (as outlined below). Each of these steps took place before moving to the next participant’s transcript of their experience and repeating the aforementioned process. Patterns were then looked at across each of the participant’s experiences, to consider similarities and discrepancies. This process was aided by working collaboratively with supervisors and colleagues to enhance the validity of the analysis.

2.9.4 Reading and re-reading
Each of the audio recordings were listened to twice and the transcripts were read multiple times throughout the analysis, to immerse the author in the data. After each of the interviews, the author documented some of the most striking things that were noticed from the interview, in an attempt to bracket off these impressions before a more formal process of noting commenced. This helped the author to become aware of aspects of the transcripts that were particularly salient and rich and assisted in the development of awareness of contradictions within the same transcript.

2.9.5 Noting
A line by line analysis was conducted, to remain close to the data and to consider each of the participant’s experience in detail (Larkin et al., 2006). This process helped prevent only preconceived ideas and themes being explored with participants. During this, things of interest were noted, to develop a comprehensive and detailed set of notes regarding each participant’s experience. Notes were made in regards to the meaning the participant had made
from their experience, for example: relationships; principles; values, events (Smith et al., 2009).

Three types of exploratory notes were used at this stage of the analysis: descriptive, linguistic and conceptual. Descriptive comments focused on the content and subject of what was being described by the participant. The specific language that the participant used was captured using linguistic comments, particularly noting the potential significance of particular words, phrases or metaphors that the participant used to share their experience. More interpretive comments were made in conceptual notes; moving further away from what was said to an analytic understanding of what this meant for that particular individual.

Section ‘2.5.4 Providing credibility checks’ of the Method Chapter, describes methods undertaken to increase the credibility and quality of the coding process.

2.9.6 Development of emergent themes

Following the process of noting, the data set had broadened to both the transcript and the detailed comprehensive set of notes. It is important to maintain the complexity of this breadth of data, whilst reducing the volume of this (Smith et al., 2009). At this stage primarily the notes were used, however the author constantly compared the notes and emergent themes with the original data to ensure that the emergent themes captured the experiences of the participants.

Following this, the author considered how the emergent themes fitted together. Not all of the emergent themes were incorporated into this stage of analysis, the author focused upon the research question and attempted to maintain emergent themes that related to this. The emergent themes that did not cluster together at this stage were revisited as analysis continued, to ensure that important themes were not discarded. Files of transcript extracts were constructed, to document which extracts supported each of the emergent themes. This process of noting and development of emergent themes was repeated for each of the individual participants. Although the author can be influenced by analysis of previous transcripts, the aforementioned steps were followed closely and systematically for each transcript whilst maintaining a reflective journal, so that new themes could emerge that reflected the individual’s meaning of their experience.
2.9.7 Emerging patterns across cases

After each individual interview had been analysed, the author made connections across the different experiences. During this process, themes from the different interviews were clustered together and themes went through a process of being relabelled. There was an increased theoretical focus, as some themes that had already been identified were clustered together under a higher conceptual label of master themes with subthemes within them.

A file was made for each master theme and subthemes that emerged with the quotations from each participant. Numerous quotations from participants reflected each master and subtheme. Therefore the most salient quotations were chosen to be included in the Results Chapter.

2.9.8 Narrative interpretation

The interpretation of the participants experiences are presented as a narrative in the Results Chapter, illustrated with direct quotations from participants. Within this narrative, similarities and disparities are emphasised, both within individual experiences and across participants experiences (Eatough & Smith, 2008). The narrative is presented in a structure of master themes and subthemes within these.
CHAPTER THREE: RESULTS

3.1 CHAPTER OVERVIEW

Throughout this chapter, the presentation of interview quotations illustrate the development of the master themes and subthemes. The service user and staff member data have been analysed separately using an Interpretative Phenomenological Analysis methodology. Firstly, the service user analysis is presented, followed by the staff member analysis.

Interview quotations will be presented with gender neutral pseudonym names, to protect the anonymity of the participants. The service user pseudonyms are: Charlie, Alex, Joey, Leigh and Billie. The staff member pseudonyms are: Frankie, Taylor, Ashley, Jamie and Jesse. Participant quotations are presented in italics for clarity.
3.2 SERVICE USER ANALYSIS

Overall within the analysis of the service user data four master themes emerged, each with a number of subthemes, as illustrated in the table below.

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Subthemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes to the therapeutic</td>
<td>Re-evaluation of the therapeutic relationship</td>
</tr>
<tr>
<td>relationship</td>
<td>Disengagement from the therapeutic relationship</td>
</tr>
<tr>
<td></td>
<td>Engagement and repair of the therapeutic</td>
</tr>
<tr>
<td></td>
<td>relationship</td>
</tr>
<tr>
<td>Appraisal of the necessity of</td>
<td>Acceptance levels of physical restraint</td>
</tr>
<tr>
<td>physical restraint</td>
<td>Factors influencing acceptability</td>
</tr>
<tr>
<td>Emotional impact</td>
<td>Forceful and fearful experiences</td>
</tr>
<tr>
<td></td>
<td>Staff detachment and denial of emotional impact</td>
</tr>
<tr>
<td>Dependency and power</td>
<td>Forced dependent relationship</td>
</tr>
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<td></td>
<td>Disempowerment</td>
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</tbody>
</table>

Table 5 Service user analysis of master themes and subthemes.
3.2.1 Master theme one: Changes to the therapeutic relationship

Throughout their narratives, service users reflected upon how their therapeutic relationship with staff had changed or shifted following a physical restraint. Within this master theme, three subthemes emerged: *re-evaluation of the therapeutic relationship, disengagement from the therapeutic relationship* and *engagement and repair of the therapeutic relationship.*

3.2.1.1 Re-evaluation of the therapeutic relationship

A key experience for each of the service users was a process of re-evaluating their relationship with the staff members that restrained them. The re-evaluation of the relationship varied between the service users.

For example, a deterioration of the relationship was exemplified when Charlie reflected that “It [the relationship] broke down. [I] Didn’t want to be around them [staff] at all.” The use of the word “broke” emphasises how significant this change was, so much so that Charlie did not want to be in the presence of staff members. Similarly, the language Alex used to communicate his evaluation of the relationship with staff who had restrained them portrays a vast deterioration in the therapeutic relationship. The rupture of the therapeutic relationship has an even more substantial impact upon Alex’s relationship with staff, as the damage to the therapeutic relationship is irreparable.

Alex: “There’s not enough time in the world to heal what she’s done.”

The concept that the therapeutic relationship can deteriorate after physical restraint was also amplified by Joey. Joey repeatedly used the words “broke” and “break” when referring to the relationship with the staff whom restrained them.

Joey: “It got to the point that it was so bad that I didn’t trust the staff and it caused such a break down in the relationship.”

Joey: “It made it so difficult, the relationship completely broke down. Literally from that one restraint.”

For Joey, the change in the therapeutic relationship was substantial. Trust within the therapeutic relationship was important to Joey and this had been jeopardised. This is further
accentuated in the following extract, where Joey reflected upon the changes to the relationship with staff involved in the physical restraint.

Joey: “All of a sudden it totally changed. I used to have a laugh and a joke with the staff and I found there was different officers that were involved in the restraint, that I’d become very very close to and knew my personal history and stuff like that and I talked to them on a regular basis. I couldn’t do that with them anymore.”

The enormity of the change in the relationship was emphasised through the use of “totally” and “completely” changed. The fact that this was “all of a sudden” exemplifies just how abruptly Joey perceived the relationship to have declined after the physical restraint. Joey had invested in the relationships with staff, which may have made the changes to the therapeutic relationship more stark.

In contrast, Leigh believed the therapeutic relationship remained relatively unchanged.

Leigh: “I’ll let them get on with what they need to do and they let me on with what I’ve got to do... Just be normal with them.”

In Leigh’s narrative, the physical restraint had a different meaning than what is shared by the other service users. Prior to the restraint, Leigh only engaged with staff to get immediate needs met, for example “…just asking him a question if I needed to know something and asking for a drink if I needed to get a drink or something like that.” As Leigh had not been particularly invested in the relationship prior to the restraint, unlike Joey, the physical restraint seemingly had minimal impact upon Leigh’s evaluation of the relationship with the staff team. Leigh also had more control in regards to the physical restraint, due to the intentional choice to behave in a way to initiate this reaction from staff. “I kind of wanted to be kept in ICS [Intensive Care Suite] so I went for a couple of staff members. I went to attack them but I didn’t mean to really hurt them.” Being restrained did not lead to a re-evaluation of the therapeutic relationship for Leigh, which seems to be a combination of how detached from the relationship Leigh was beforehand and an understanding that staff restrained her due to her deliberate act of instrumental violence.

3.2.1.2 Disengagement from the therapeutic relationship

Following the physical restraint, four of the service users shared incidents when they either wanted to or had disengaged from staff members who had physically restrained them. When
this occurred, this did not allow for the repair of the therapeutic relationship. Disengagement from the staff took different forms: tending to either actively avoid, or passively ignore members of staff who had been involved in the physical restraint, thus detaching themselves from the relationship.

Charlie repeatedly communicated in the interview no longer wanting contact with those involved in the physical restraint.

Charlie: “I was, leave me fucking alone, I don’t want to know you. I didn’t want to work with my keyworker...I wouldn’t speak to them for ages and ages, months and months. I don’t speak to them now.”

The experience of physical restraint had a profound impact and serious consequences upon Charlie’s therapeutic relationships with staff. As a therapeutic relationship requires the staff member to provide care and treatment for the service user, it is unlikely that this would have been possible as Charlie completely detached from them. Charlie repeated throughout the interview “I didn’t want to know them”, accentuating the disengagement and detachment felt towards these staff members and perhaps Charlie’s principles that therapeutic staff should not restrain and expect the therapeutic relationship to continue.

Charlie: “I didn’t want to know them. I didn’t want to be in the same room as them...If you don’t like them or you don’t get on with them, you don’t want a relationship with them, because you feel like what’s the point? If I don’t get on with them I’ll stay out of their way.”

Charlie would actively reject staff who were even in close proximity. The vulnerability of Charlie is striking; reliant on staff for care and treatment yet unable to seek support due to feeling the relationship lacks purpose as staff have gone beyond the role of caring and have had to take control.

Similarly to Charlie, who would “stay out of their way”, Alex’s narrative involved disengaging and actively avoiding staff that had been involved in the physical restraint. Alex repeatedly shared “I don’t want a relationship with her” and “I’m going to stay away from them, because I don’t like them”.

Alex: “She could come and ask me to do a session and I’d ignore her. She’d try talking to me and I’d ignore her. If I was in the side room and she’d walk in the side room I’d walk out. I’d avoid her at every cost... I did kind of cut off and didn’t want anything to do with the staff that restrained me.”
Chapter Three: RESULTS

Alex persistently avoided and disengaged from a member of staff involved in the restraint. This both included passively ignoring the staff member and actively moving away to avoid and disengage from her company. The description of “cut off” from staff perhaps illustrates that the avoidance of staff can apply both physically and emotionally, Alex detached from them as a method of self-protection.

Joey also did not want a relationship with the staff involved in the restraint. However, whereas Charlie and Alex described avoiding the relationship, Joey made extreme threats, in an attempt to keep staff away from immediate proximity.

Joey: “I will throw the tv [television]... I will slash you with a piece of glass.”

On this occasion, Joey’s arm was broken during the restraint and Joey was “absolutely petrified” of staff following this. Whereas Charlie and Alex both disengaged from their relationships with staff members as they did not want to know them, Joey’s response seems to be driven by fear. Joey “didn’t want to seek help because I was scared...I wouldn’t go up the corridor to go and get my meds because he was on meds duty.” Due to the fear and vulnerability that Joey experienced after the physical restraint, this consequently had an impact upon the care and treatment that Joey felt able to seek from the staff member involved in the restraint. Those that were in a role to protect and care for Joey, were now the people Joey felt in need of protection from. Due to a lack of power and means to self-protect, Joey had to resort to being physically aggressive to maintain personal safety.

Unlike Charlie and Alex, whose disengagement from staff was being limited to those that had physically restrained them, Joey’s disengagement spanned more broadly across the staff team to include staff members who had not been involved directly in the restraint.

Joey: “The rest of the staff sided with him so I didn’t want to talk to them.”

Joey perceived that the staff were not allied with service users; instead they had united together against Joey. Those who were uninvolved in the restraint would have to choose a “side”; staff had a choice of whether to side with either the service user or the staff that had been involved in the restraint. At the time of this physical restraint, the differences between service users and staff became more apparent to Joey creating a divide in the relationship.

In contrast to service users disengaging and avoiding staff members, Billie believed that a staff member avoided them after the physical restraint. Billie shared that the staff member
would no longer spend time with them, whereas prior to the physical restraint that staff member had invested in the relationship.

Billie: “We’d have a laugh and she’d help me do my hair for example. And like help me download music onto my laptop and stuff and now it’s like she hasn’t got time for me...Before she spent loads of time on my laptop, helping me do things and that.”

Billie reflected upon the change within the therapeutic relationship, perceiving that the staff member chose to disengage after the restraint. Prior to the restraint, Billie felt that the relationship with this staff member went beyond treatment needs; possibly conceptualising the relationship as a friendship. This contrasts greatly with Billie’s description of the staff member after the physical restraint, as no longer having time for her.

Billie: “And then after I would be like could you do this with me and she’ll just say oh I’m busy at the moment I’ve got other things on. She’s hasn’t got much time for me anymore...She might not want to have one to one’s with me when I’m struggling, she might say we’ll just wait for another member of staff, or she’s busy.”

Billie’s perception was that the staff member could no longer meet her care and support needs, even when Billie was “struggling” and in need of this support. Being asked to wait for another staff and that the staff member is busy, contrasts greatly with the staff member’s prior behaviour, of having time to spend with Billie beyond the immediate treatment needs. Billie may feel rejected and uncared for due to the perception of staff disengaging at this potentially vulnerable time.

3.2.1.3 Engagement and repair of the therapeutic relationship

Three service users discussed instances where it had been possible to approach and engage with staff members who had restrained them. This experience allowed for some reparation of the relationship between them.

Alex described a staff member’s actions after the physical restraint. Alex perceived that the staff attempted to repair the relationship back to how it had been prior to the restraint.

Alex: “It was as if they were, it was as if she was purposefully trying to make things go back to the way things were. Which I think went a long way to helping me change my attitude more quickly.”
Staff approaching and engaging with Alex helped them to rebuild their relationship, as this changed Alex’s perception of them. As documented in the prior subtheme, Alex had wanted to stay away from this staff member. Seemingly, staff members approach and attempts to repair the relationship, can help service users re-appraise and re-engage with the therapeutic relationship. The staff member’s actions offers alternative evidence that does not fit with Alex’s negative perception of them, therefore leading Alex to consider a new perspective of the staff member’s intentions within the relationship.

Similarly, Joey described how a staff member approaching after the physical restraint. The staff member approached Joey to discuss the restraint and what had led up to this.

Joey: “She came back the next day and she actually came into my room...She said what the hell happened because I’ve never seen you like that? And I was just like I don’t know, it was literally just to do with the money. I said this is my beliefs and I explained to her the psychiatric side of why I believe things about money. And she said I didn’t know any of that. And I was like I know you wouldn’t have done that to annoy me, but at the time I thought you were doing it to piss me off and try and get one over on me. I said I thought your attitude stank about it. She was like I didn’t mean to, she explained she was busy and why she reacted in the way that she did. And we were both able to see each other’s point of view.”

Joey and the staff member were able to approach and engage in a conversation, which allowed them both to mentalize about each other’s perspectives, motives and intentions. This enabled Joey and the staff member to reflect upon and understand what had led to the physical restraint and appreciate the other’s view. For Joey, sharing the misunderstanding of each other’s intentions allowed for the reparation of their therapeutic relationship.

Leigh also reflected on the benefits of service users and staff approaching each other after the physical restraint, in order to repair the relationship between them.

Leigh: “Just to say you know it’s something that happened in the restraint and just wanted to make sure that I knew that and just clear the air.”

Clearing the air may refer to there being some difficulties between service users and staff after a physical restraint, or an atmosphere between them. The staff member whom Leigh described approached to explain their intentions and that what had happened within the restraint did not go beyond that. Discussing this allowed for Leigh to understand that staff member’s intentions and perspective, similarly to Joey’s experience.
3.2.2 Master theme two: Appraisal of the necessity of physical restraint

Throughout their narratives, service users reflected upon a process of appraising the necessity of physical restraint by staff members. Within this theme, two subthemes emerged: acceptance levels of physical restraint and factors influencing acceptability.

3.2.2.1 Acceptance levels of physical restraint

Each of the service users reflected upon whether they felt that physically restraint by is an acceptable or necessary practice. Three service users were conflicted in their views as to whether physical restraint is acceptable.

Charlie: “People in your team shouldn’t be restraining you. Not unless they have to...Try and understand why they have to do it as part of their job.”

Throughout most of the interview, Charlie shared difficult experiences of physical restraint. However in this extract, Charlie fluctuated between sharing the view that the therapeutic team should not restrain, yet in the next sentence, stated an exception to this rule, that they may “have to”. This reflects a dissonance that Charlie experienced. Despite a belief that staff should not restrain service users, Charlie identified that there may be circumstances that this may have to happen. Charlie shared an awareness that having to restraint is not necessarily a willing choice that the staff make, but a requirement of their professional role.

This conflict between levels of acceptance of the necessity of physical restraint was also shared by Alex.

Alex: “She should never have done it...As far as I’m concerned, it shouldn’t have happened.”

Alex: “She was just in the wrong place at the wrong time. She was just doing her job. It could have been anybody...It could have been any member of staff.”

In these two extracts, Alex discusses the same physical restraint. The fluctuation between Alex’s levels of acceptance of the physical restraint is apparent here and he expresses ambivalence about the role staff have in restraining service users. On the one hand, Alex felt that it should “never” have happened; whereas on the other, seems to accept that this was not personal and the staff member was just situated at the incident and had to react to this. Similarly to Charlie, Alex referred to physical restraint as being part of the “job” for staff in
the service. It seems that some of the ambivalence between whether the physical restraint is acceptable comes from feeling it “shouldn’t” happen, yet knowing it is a requirement of the staff to do this in some situations.

Billie also experienced ambivalence between whether physical restraint is an acceptable and necessary measure.

Billie: “Yeah like sometimes I think oh I could bloody kill them and then other times I think they’re just doing their job.”

There is a stark contrast between Billie’s feelings; on one side, Billie would like to “bloody kill them”, yet on the other, they are “just” doing their job. This accentuates the contrast between the emotional response to being physically restrained and the cognitive understanding, similarly to Alex and Charlie, that it is part of the “job” for staff. This is emphasised by Billie questioning why staff physically restrain service users, when they would not like it to be done to themselves.

Billie: “Like it pisses me off that they wouldn’t like to be pinned down, so how do they do it to other people? That’s one thing that always gets to me. They wouldn’t like it so why do they do it to us? And I know they say it’s to keep us safe and to keep other people safe, but it’s still not very nice.”

Billie experiences difficulty in understanding the staff members’ role to physically restrain service users, repeating that “they wouldn’t like it”. The use of the word “pinned” emphasises the powerless nature of being restrained, which again conflicts with the aim of the restraint, which Billie was able to see is to maintain service user safety. The act of physical restraint is aversive and therefore it seems to be difficult to understand how it can be accepted, despite understanding that the overall aim is to maintain safety.

Whereas Charlie, Alex and Billie fluctuated between their levels of acceptance, the remaining two service users remain firmer in their view of whether the physical restraint was acceptable. An emerging theme evident throughout the interview with Leigh was an acceptance that physical restraint was necessary.

Leigh: “I just took it as it came really. I just had to be restrained at the time and that was that...I needed to be held down, I went to attack them.”
Leigh understood why the physical restraint occurred; because Leigh had attacked a staff member. Leigh was able to see that their own personal actions had led to the restraint and therefore she is able to accept the necessity of the restraint. This acceptance is final and concrete, in the phrase of “that was that”, as Leigh detaches from the emotional response and shares the logical reasoning behind the restraint.

Whereas Leigh remains certain that the restraint had been necessary, Joey repeatedly stated that the physical restraints they had had been involved in were unnecessary and should not have happened.

Joey: “Because technically it’s not meant to happen, when they’re authority looking after you that’s not meant to happen. It was totally wrong."

Joey: “You don’t need to restrain me.”

Joey repeated that restraint is “not meant to happen”. Joey did not accept that physical restraint is acceptable, nor that it should it happen. Joey discussed the dual role that staff have, to both look after and care for service users and to restrain. These roles conflict; Joey believes that it is wrong for people who are in a role of care to restrain, emphasised by the word “totally”, reflecting the absolute nature of this belief. The dual role of caring and control through the use of physical restraint are incompatible for Joey.

3.2.2.2 Factors influencing acceptability

Within the service users’ narratives, a number of factors were shared that influence the perception as to whether the physical restraint was an acceptable and necessary measure. Three service users referred to how quickly they perceived staff to have chosen to use physical restraint. When de-escalation measures were perceived to have been used prior to physical restraint, this increased a sense of the restraint being acceptable. Conversely, when it was felt restraint was used as a first response, this was perceived as unjust and inappropriate.

Alex: “You automatically jumped to restraining me, you didn’t even try and talk to me or nothing like that. I’ll jump straight in there... there’s ways and means of dealing with things and not automatically getting radio happy.”

Alex repeated the word “automatically”, perceiving that restraint was the staff’s first reaction. This imagery illustrates Alex’s view that staff are willing and ready to “jump” to
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restraint, without due consideration of alternative means of managing the situation. Alex perceived that staff have a lack of thought or consideration before they restrain service users; for Alex their sense of self-worth may be challenged due to the perception that staff have been disrespectful in their lack of consideration of other less restrictive and invasive options before resorting to physical restraint.

Alex: “I believe assistance should only ever be called if every other means has been exhausted: if you’ve tried to talk a person down; if you’ve tried to walk a patient into ICS without putting hands on them. And you’ve tried every other means in the book.”

Alex suggests multiple methods that staff should use prior to using physical restraint. “Every other means” should be “exhausted”, which is a stark contrast to the rushed approach that Alex felt had led to the physical restraint. In Alex’s experience, it is important that staff have considered these alternative options before resorting to physical restraint, for Alex to feel valued and respected, rather than react without consideration of the service user as an individual.

Similarly to Alex perceiving physical restraint as a way staff automatically respond, Joey repeated the phrase “heat of the moment” when portraying the perception of how staff responded in their decision to physically restrain. Joey stated that they “rushed in”; suggesting Joey did not perceive that this physical restraint was well considered or that other means of managing the situation had been exhausted before resorting to physical restraint. Again, this suggests a perception of a lack of regard and respect for the service users.

However, this was not Joey’s perception of every incident of physical restraint. Joey shared another incident in which they felt that staff adjusted their approach and used the least restrictive measure possible.

Joey: “He was like, ‘don’t worry about restraining her, put hold on her, but don’t fully restrain her to the ground’. And I was like ‘Thank you’. It made me think, they’re listening to me here...They were very very good, they were kind.”

Joey felt that one of the staff members instructed other staff to be least restrictive and in turn felt listened to and that the staff had been kind to them. In contrast to the aforementioned experiences, Joey felt valued by the staff by being listened to, reaffirming Joey’s view that they are indeed a caregiver as they are demonstrating care, rather than total control. Billie
also shared the importance of staff using de-escalation measures, prior to the consideration of physical restraint.

Billie: “They should try and verbally de-escalate you and give you quite a lot of time. Like I had a care plan that said I needed to be restrained every time I cut my face, so I was on quite a strict care plan. And some staff would talk to me and other staff would be like ‘assistance, assistance!’ And I was like oh my god that’s ridiculous.”

Billie reflected upon discrepancies between different staffs’ approaches towards her, in situations that may lead to a physical restraint. Alex and Joey described instances where staff reacted quickly, whereas Billie shared the need to staff to take their time in these situations and talk to the service user. This contrasts greatly with how Billie experienced some staff members calling for assistance from other staff; Billie’s dismay with this approach is highlighted by the term “ridiculous” being used to accentuate this reaction. When reflecting on staff approaches to physical restraint, Billie stated it was “nice to know they’ve tried” to deescalate and use other methods, prior to restraining service users. It is important to Billie to feel as though staff have not rushed to physically restrain and have valued the service user in considering alternative means to manage risk.
3.2.3 Master theme three: Emotional impact

A key experience that service users shared was the emotional impact that they can experience, following a physical restraint. This master theme consists of two subthemes: **forceful and fearful experiences** and **staff detachment and denial of emotional impact**.

3.2.3.1 Forceful and fearful experiences

Four of the service users, perceived that forceful methods were used during the physical restraint.

Charlie: “Two others, they tried to take me to the floor but they couldn’t get me to the floor. Then they dragged me across the carpet all the way to ICS.”

Alex: “I didn’t see them grab hold of me, because I had my back to the staff... I’ve always had a thing about people grabbing me from behind...I couldn’t breathe.”

Joey: “He was getting rougher and rougher every time he came in and in the end he got me on the bed and restrained me. And instead of putting my arm behind my back he pulled my arm outward in an L shaped motion and my humorous broke. He turned my arm and broke it across my elbow and up my humorous.”

Billie: “Jab me.”

This vivid language was used to share the narratives of how they perceived they were treated by staff members. Although least restrictive practice should be used, it is apparent that these measures can be perceived as invasive, forceful and in some cases violent. Again these service users may question their value and integrity, as those that are meant to care for them have responded in what they perceive as violent and forceful manner.

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1 As outlined in section ‘2.7 Ethical and risk considerations’ of the Method Chapter, this transcript was discussed in Clinical Supervision. Risks were explored with both the service user and the Clinical Supervisor and this was not deemed to be a new disclosure of an incident of harm and there was no evidence of any known ongoing risk to either this service user or any other service users. The service user reported that this had happened during a previous custodial sentence (specific details were not disclosed) and that they had reported this incident at the time. This was independently investigated and the investigation concluded that no misuse of restraint procedures had occurred.
Not surprisingly, in the context of understanding how forceful physical restraints can be perceived, two of the service users shared their experiences of fearful reactions both during and after the physical restraint.

Alex: “Well I wouldn’t go as far as say panicked, but for want of a better word, panicked, and fought back.”

Alex: “I’d be more cautious around them. I was more on edge whenever they were around me.”

For Alex, the fearful response went beyond the time of the physical restraint. Alex would feel fearful in the presence of those involved in the restraint and felt hypervigilant and wary around these staff members.

Many of the words and phrases Joey used to emphasise the impact of the restraint suggest a traumatic reaction to this experience of being physically restrained.

Joey: “I was scared, absolutely petrified...Because he had scared me so much, the whole team had kind of thing...I mean I was literally having panic attacks because they were restraining me... and I felt dread, I felt sick, I felt every single emotion that I possibly could. Total fear. I didn’t feel safe there at all.”

Not only did Joey experience a strikingly fearful response, this experience leads Joey to question their personal safety at this service. Joey repeatedly referred to experiences of “dread” feeling “sick” and “total fear”; the multitude of ways that Joey attempted to explain this experience of fear highlights just how much of an ordeal this had been.

Joey repeatedly referred to one experience of physical restraint as being abusive. Joey repeated the belief that the staff member who led the restraint was an “abuser” and that “they physically abused me”. This perception of abuse is further accentuated as Joey “cowered” away from staff, depicting an image of vulnerability and powerlessness.

3.2.3.2 Staff detachment and denial of emotional impact

Despite service users experiencing an emotional impact during and after the physical restraint, a narrative emerged amongst four of the service users that staff were emotionally detached from the physical restraint.
Joey: “He came across as blank. Like he’d detached himself from it. Like he had no emotions.”

The notion of a lack of an emotional response from staff was also highlighted by Charlie. Despite the perception that staff “dragged” Charlie across the floor, Charlie believed that “it didn’t bother them [staff].” Charlie was asked how he thought staff felt after the physical restraint; despite sharing multiple ways that the restraint influenced Charlie, Charlie did not believe that the incident had any effect on the staff member. Staff have a role of care and treatment for service users; seemingly if a service user believes that staff are not “bothered” about using restrictive practice, this may influence the therapeutic relationship and the potential for the repair of this.

Alex offered an explanation as to why staff did not show an emotional response to physically restraining service users.

Alex: “As staff you’re not allowed to have personal feelings about the job... you’re told when you walk into the job you’re not allowed to have personal feelings about it. You’re told leave your personal feelings at the door.”

Alex makes a presumption about staff and reflects that the lack of feelings that they have is due to their professional role. Alex’s perception of staff having to “leave your feelings at the door” portrays an image of staff who are detached from any emotional reaction to their professional role; despite the fact that much of their role is about caring and providing treatment for service users through a therapeutic relationship.

Billie has a different perception to the other three service users. Billie too believes that staff do not express their feelings, however shares that they do experience an emotional reaction. However, due to wanting to remain “professional”, they minimise this.

Billie: “I just feel like obviously staff are being professional so they’re not going to say I don’t like you. So they’re like oh don’t worry about it. And you can just tell they’re bloody angry like... They’re like oh I accept your apology but I know they’re just being professional.”

Billie believed that despite on the surface staff state that things are ok within the relationship, under the surface they remain angry, yet they deny this. The need to appear “professional”, in Billie’s view, means that staff do not express how they feel. Within Billie’s narrative, a belief of being unlikeable and unacceptable emerged and the experience of the therapeutic...
relationship after physical restraint seems to confirm this. Perhaps these staff members did not like Billie as she perceived, or perhaps Billie’s beliefs may have made it difficult to see or accept evidence to counter these conclusions. Billie goes on to explain how this can cause issues within the therapeutic relationship.

Billie: “I still feel like they’ve got a problem with me. But they say oh no it’s alright. There’s underlying issues like... I’ve asked if they’ve got a problem with me and they say no you’re just being paranoid. I’m not being paranoid, I’m not stupid, I know when someone’s got a problem with me.”

Still several months after the physical restraint had occurred, Billie believed that the staff member involved in the restraint had a “problem”, yet states that things are “alright”. Despite attempts to discuss what Billie believes is denial with the staff member, Billie stated that the staff member suggested Billie is “paranoid”, attributing the difficulties within the relationship to Billie. Perhaps the staff member could not acknowledge their own responsibility and role within the therapeutic relationship or potentially Billie struggled to attend to and acknowledge information that is contrary to Billie’s self beliefs. Billie shared that there were persistent difficulties within their therapeutic relationship, as a consequence of the physical restraint.
3.2.4 Master theme four: Dependency and power

The master theme of dependency and power emerged as service users shared that they are dependent upon staff members for their care and treatment, however this creates a discrepancy of power within the therapeutic relationship. This master theme consists of two subthemes: **forced dependent relationship** and **disempowerment**.

### 3.2.4.1 Forced dependent therapeutic relationship

Within the service users’ narratives, their experiences of a dependent relationship with staff members became evident; they are reliant and dependent upon staff members for their care and treatment.

Alex: “So I have to have some sort of relationship with him whether I want it or not. That’s beside the point.”

Alex shared the lack of choice service users have in regards to their relationships with staff. Regardless of whether Alex may “want it or not”, Alex has to have this relationship in order to communicate personal difficulties to them and receive care. There is an inevitability, that whether or not service users wish to continue the relationship, they have to. Alex goes on to reflect on the nature of the therapeutic relationships.

Alex: “If you can get over the fact that, for want of a better word, staff are here to keep you safe from yourself, you can learn to have a relationship with them... I wouldn’t go as far as saying a relationship, but you do kind of get along with them.”

There are limitations of the dependent therapeutic relationship. Service users must “learn” to have these relationships, implying that this relationship does not come naturally to Alex and is somewhat superficial. Clearly there can be barriers to the therapeutic and dependent relationship between service users and staff.

The forced nature of the dependent relationship between service users and staff is reinforced by Billie.

Billie: “I guess it’s just difficult because you have to work with the staff on a day to day basis and when you hurt them it makes it difficult. You feel like they’re holding a grudge against you.”
Similarly to Alex, Billie uses the phrase “have to” when illustrating the necessity of having a relationship with staff. Again this reflects the lack of choice service users have in regards to whether to have these therapeutic relationships, they are dependent upon staff but are powerless as to whether they want to be or not. Billie discusses the difficulties it can create in the therapeutic relationship, after a physical restraint if the service user harms a staff member. Despite having to work with staff, Billie was aware that the staff member may have feelings towards them that could impact upon their relationship.

The concept of the dependent relationship between service users and staff and the difficult nature of this is captured also by Joey.

   Joey: “But then the trouble was I was in a catch 22, because I was self-harming and they were coming in, which is obviously bringing them in, but I was self-harming because I was stressed with them. So it was a vicious loop.”

   Joey: “You can’t get away, you can’t suddenly up and leave. The same in hospital, you can’t just up and leave.”

Joey felt dependent upon the staff, which was a particularly difficult dynamic after physical restraint. At this time, staff provided support in the form of restrictive practice, to prevent further harm to Joey. However this type of support and dependency was distressing for Joey and Joey felt it perpetuated the distress and self-harm. Despite wanting to be removed from the relationship and situation, the restrictions placed upon service users meant that this was not an option. Joey remained powerless and futile with a lack of choice and autonomy within this environment, which was reinforced at the time of physical restraint.

The significance of trust within this dependent therapeutic relationship was shared by four of the service users. They reflected on the necessity of trust between service users and staff in this environment; however the trust within the relationship can be reduced after incidents such as physical restraint and this can have an impact upon them.

   Charlie: “Then I struggled with them staff, I can’t trust them, can’t work with them...Try and get back into the trust. If you don’t trust them you can’t have a relationship with them Sit down and talk to them. Depends on the person if you have trust issues don’t it.”

Despite being dependent upon staff, after the physical restraint Charlie was unable to which consequently leads to him feeling unable to work with them. As Charlie was reliant and dependent upon them for care, this could potentially have an impact upon treatment.
Charlie’s solution was that staff members need to attempt to gain trust again; however reflected that service users may have difficulties trusting people. Service users within this environment can often have had difficult early life experiences which may lead to difficulties trusting others. Incidents such as a physical restraint may reinforce the belief that service users should not trust staff; those that they are dependent upon can physically restrain them against their will.

The notion of service users having to trust staff within the therapeutic dependent relationship is shared by two of the service users.

Alex: “Seeing as he’s got a very important role with me, I wouldn’t say trust him. But to some degree I have to trust him.”

Again the phrase “have to” emphasises the forced nature of the relationship between service users and staff. Alex does not feel able to trust that staff member now, yet is torn by the reality that within this environment trust is needed within the therapeutic relationship and is therefore left in a disempowered and dependent position. Billie also shared the view about the need for trust in the therapeutic relationship.

Billie: “I find it hard. It’s really difficult because you’ve got to learn to trust them…they expect you to trust them but they don’t trust you. Trust works two ways.”

Billie: “So they’ve lost my trust now. I don’t trust any of them now… still find it really hard to trust them.”

In the first extract, similarly to Alex who comments on the need to “learn” to have a relationship with staff, Billie also feels that you also have to learn to trust staff. The dependency upon staff was emphasised by Billie, stating that although they have to trust staff, this is not reciprocated. This emphasises the perceived one-directional nature of the relationship; that service users rely and depend upon staff but that there is a conditional nature to this relationship; that staff are there to provide care. Physical restraint seems to have highlighted that the therapeutic relationship is not a ‘normal’ type of reciprocal relationship, which can impact upon how the relationship is perceived. The long lasting nature that the loss of trust can have upon the therapeutic relationship is shared by Billie. The trust between service users and staff can already be fragile before a physical restraint and as it is described as “lost”; this trust may not be able to be restored after physical restraint.
Joey also reflected upon how a loss of trust in the therapeutic relationship after physical restraint impacts the therapeutic relationship.

Joey: “I didn’t trust the staff and it caused such a breakdown in the relationship... made me question whether or not I could trust them.”

Joey used the word “breakdown” to share how the lack of trust in staff who had been involved in the restraint influenced the therapeutic relationship between them. This imagery provides a powerful message of the potential consequences that physical restraint can have upon the relationship and that potentially this can be extremely detrimental.

3.2.4.2 Disempowerment

Within a secure hospital environment, service users are detained against their will and are dependent on the staff for their care and treatment. However, the relationship dynamics appear to change when staff move to a restrictive role, such as a physical restraint. At the time of a restraint, the power imbalance between service users and staff can become more apparent and is reinforced. Some of the experience of disempowerment seems to derive from events that can take place during the restraint, for example having items removed due to risk. However some of the experience of disempowerment arises from a subjective experience of inferiority, that staff are in a position of power and service users subsequently can feel disempowered and vulnerable.

Charlie: “Got put in blues. Being abusive, threatened to kill the doctor. Then they came in, acuphased me. Gave me medication. Stayed in there for two days. Every time they came in I had to have finger food because I couldn’t have sharps.”

Charlie repeats how things are done to service users during different stages of the physical restraint: Charlie was put into non-rip clothing; acuphased; given medication; remained in seclusion for two days; and became restricted in his access to items of risk. Within Charlie’s narrative, how little control or power Charlie had following the physical restraint is evident, leaving Charlie in a reliant and vulnerable position. The concept of being powerless is also shared by Alex.

Alex: “You just think all you want to do is prove you’re bigger than me because you’ve got the set of keys. You take the set of keys out of the equation and you’re nothing and I’ll prove to you you’re nothing. And you just want to fight back.”
After the physical restraint, Alex’s belief that staff think that they are superior to service users was reinforced. Alex’s perception that staff intend to show they are “bigger” and perhaps more powerful, ignites an urge in Alex to show to them that service users are not in a powerless position. Alex will “fight” in an attempt to move away from a powerless to more powerful position; it is not comfortable for Alex to feel disempowered in relation to the staff. Alex repeated “fight” multiple times, perhaps suggesting a strong desire to move away from a disempowered position, which was also shared by Joey.

Joey: “It felt like I was battling a big wall, on my own, against literally the government. And it was just like, do you know when you try and fight the system and you don’t win, that’s what I felt that I was doing....I’ve got one hell of a fight on my hands.”

Powerful images are depicted: a big wall, the Government and a whole system. This emphasises Joey’s view of how powerful and strong staff were following the physical restraint, exemplifying just how much of a struggle the “fight” against this would be. Joey used the words “fight” and “battle”, extreme measures that Joey is willing to resort to, to accentuate the struggle against the staff whom Joey perceived as powerful. This powerless position is illustrated by the fact that Joey felt “on my own”; despite being in an environment that is meant to support and care for service users, Joey felt isolated and powerless after the physical restraint.

Whereas Alex and Joey wanted to “fight” against this disempowerment, Billie on the other hand shares a more resigned view that service users are powerless and have a lack of agency over the situation.

Billie: “We can’t do anything about it.”

Billie: “I’m praying for her not to be in ward round.”

In Billie’s experience, there were no solutions to experiencing this disempowerment and that Billie has no influence over this. Billie was left “praying” that those involved in the physical restraint were not involved in their care; illustrating a powerless and futile position in which Billie can only pray to get things to change.

Whereas other service users shared a position of disempowerment, Joey’s experience goes beyond this. Disempowerment made Joey feel that the staff were in a position of an abuser. For Joey, those that have a role to provide care and treatment have caused harm; this makes
the use of restraint feel even more abusive. During this particular physical restraint, Joey believed that disproportionate force had been used.

Joey: “It was strange, because here I was facing, like I said my abuser, and it was hard... And that was what I saw them as, as an abuser. Because technically they’d physically abused me.”

Joey repeated the view of this staff member being an “abuser”. Joey is the only service user who uses this term; highlighting the extent of the perceived violation of the caring relationship Joey had with staff members. Joey also used terms such as “teach me a lesson” and “disciplined” to illustrate how staff in this particular incident had treated them; putting Joey into a position of not only feeling powerless and childlike but “abused”.
3.3 STAFF MEMBER ANALYSIS

Within the analysis of the staff member data three master themes emerged, each with two subthemes within them, as illustrated in the table below.

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Table 6 Staff member analysis of master themes and subthemes.
3.3.1 Master theme one: Personal impact

When staff reflected about the impact of physical restraint upon the therapeutic relationship, they considered the personal impact that the physical restraint had upon themselves. This master theme consists of two subthemes: acknowledgment of the emotional impact and dismissal and denial of the emotional impact. Some staff were able to acknowledge the emotional impact that the physical restraint had upon them, whereas others tended to dismiss or deny the impact of the physical restraint. Two participants fluctuated between acknowledgement and denial of the emotional impact, suggesting that reflections of the personal impact of physical restraint is not static and can change with the appraisal of the event.

3.3.1.1 Acknowledgment of the emotional impact

When considering the therapeutic relationship after physical restraint, three of the staff members acknowledged that the emotional impact following the physical restraint could influence their therapeutic relationships with service users. Two staff members recognised that they had experienced an emotional impact following the physical restraint. Another staff member was able to acknowledge staff may experience an emotional reaction, however they only shared emotional reactions of fellow colleagues, not of herself.

Taylor shared feeling extremely fearful after the physical restraint, during which Taylor had been held hostage.

Taylor: “I just felt like I was going to pass out. My knees were, my legs were just weak. I couldn’t even talk to the police because my jaw was just bouncing... I was terrified. I was like oh my god. I just didn’t know what to do.”

The extreme physical impact that the experience had upon Taylor is illustrated; Taylor’s jaw “bouncing” exemplifies the extreme physical and emotional impact this incident had. Taylor’s was left in a position of uncertainty, unsure what to do next, incapable of even communicating. Taylor met with the service user following the physical restraint and shared the emotional impact that the incident had had.

Taylor: “I said I was terrified, you came towards me with a screwdriver. I was like I didn’t know what you was going to do.”
Not only did Taylor share fear of the weapon with the service user, Taylor acknowledged fear of the uncertainty of the incident. The incident was unpredictable and this left Taylor feeling vulnerable. For Taylor it was important to have the opportunity to acknowledge the emotional impact of the incident with the service user who was involved.

Concerns of how the therapeutic relationship may change following this incident also evoked difficult emotions for Taylor.

Taylor: “I was scared, not scared obviously I knew he couldn’t do anything he was behind a big metal door. But I just felt scared of what he might say or scared about how he might react.”

Taylor’s concern was primarily how their therapeutic relationship may have changed following this incident, rather than her physical safety. Taylor does not experience fear in regards to the service user physically harming her, despite the fact Taylor was held hostage with a weapon. Instead Taylor felt scared and wary of how the service user may react due to their therapeutic relationship changing. Taylor’s emotional investment in the therapeutic relationship lead to subsequent concerns as to whether the incident may have a detrimental impact upon their relationship.

Jesse also acknowledged the emotional impact that physical restraint had. Similarly to Taylor, much of this emotional response was in relation to how Jesse believed that the therapeutic relationship would have changed and apprehension about this.

Jesse: “I was very anxious that I could possible start him escalating again. I was embarrassed for him. I had seen this man naked. You’re aware that you’ve taken away possibly his dignity at this point, so you’re very worried on how he would react to you. My main one was that I was anxious that I would start him off again. And also embarrassment on his behalf, because he knows that I’ve seen him like that.”

Jesse shared a number of emotional responses to the physical restraint. Jesse was anxious and worried about how the service user may react to staff and that Jesse may in fact cause him to escalate rather than be able to help him. Not only this, but Jesse felt embarrassed for him, reflecting on the perspective of the service user and how undignified he must have felt. Much of Jesse’s emotional response is in relation to the ability to perspective take and therefore feel compassion and concern towards the service user, due to how they must have felt during and following the physical restraint.
Jesse not only acknowledged compassion towards the service user, an experience of anger was also acknowledged.

Jesse: “At the time when you’re going in there, you do sort of feel a bit of anger. Why did you have to do that to make us do it?...It’s difficult because you get quite angry that it’s really didn’t need to get that far.”

Jesse questioned why the service user would “make us” do the physical restraint, suggesting that Jesse feels uncomfortable and angry with having to restrain service users as part of the professional role. Although Jesse understood that the service user needed to be restrained at that time, this did not prevent feelings of guilt and discomfort that this is one of her professional responsibilities. This can then be experienced as difficult emotions towards the service user, as it is difficult to cope with ambivalent feelings of not wanting to restrain yet having to as an obligation of the profession.

Due to the emotional impact that physical restraint can have, Jesse found that a number of coping strategies can be helpful.

Jesse: “Me personally, I just need five minutes out. Possibly sit in the office, sit in the toilet. Sit in the clinic, wherever. Just away from the ward and away from possibly other patients...you just need to get away.”

Jesse needed to process the emotional impact of the restraint; it did not matter where, the important part was that there was time and space to process the impact that the incident can have upon those involved. Benefits of seeking support were also highlighted.

Jesse: “Talk to your peers, you know I get on quite well with my colleagues and I am able to talk openly with them which comes in handy...we are able to talk about them professionally and not hold grudges. So it is a nice feeling really when you go and talk to someone and discuss it.”

Discussing the personal impact with colleagues seems to have helped Jesse with the therapeutic relationship. This assisted with the ability to not “hold grudges”; instead the incident could be personally processed leaving Jesse feeling better afterwards.

Whereas Taylor and Jesse reflect upon the emotional impact upon themselves, Frankie only commented upon the potential emotional impact restraints have upon colleagues and their therapeutic relationships with service users.
Frankie: “There was a lot of fear around her, a lot of fear...People were afraid to go close to her and because they were scared of her... some of them were angry and upset with her.”

Despite not acknowledging a personal emotional response to the physical restraint, Frankie shared that staff were fearful of the service user whom they had restrained. This fear appears to impact upon the therapeutic relationship, as they do not feel able to even be close to her let alone develop a therapeutic relationship. Again a range of emotions were shared: fear, anger and upset, illustrating the range of emotional responses that staff may have following a physical restraint about the relationship they have with that service user.

Although Frankie did not acknowledge a personal emotional response regarding the service user, Frankie did acknowledge feelings about team members involved in the restraint.

Frankie: “Angry that the on call doctor did not do what he had to do when he was initially contacted. Like I said because a lot of damage could have been averted... I did that when I had a chat with the doctor on call. I let him know exactly how I felt. Frustrations and anger.”

Frankie shared the anger and blame felt towards a member of the team, whom Frankie felt was responsible for staff being harmed during the physical restraint. Frankie felt able to share these feelings with this particular staff member; perhaps it was easier for Frankie to acknowledge the emotional response experienced towards a team member rather than towards a service user, whom Frankie had a professional obligation to continue care for.

3.3.1.2 Dismissal and denial of the emotional impact

Four of the five staff members either dismissed or denied that they had experienced an emotional impact following the physical restraint. This varied between staff members in regards to the extent to which they did this, the ways in which they dismissed their emotions and in which contexts.

When Frankie was asked about an emotional response to the physical restraint, Frankie denied having any emotional response whatsoever.

Frankie: “I didn’t feel the fear.”

Frankie: “If she’s unwell, why do I have to be angry? What’s the point in me being angry, with someone who’s unwell and not realising what she was doing?”
Although Frankie mentioned both fear and anger, Frankie denied experiencing either of these emotions. Frankie dismissed a personal emotional response as there is no purpose to it, which may be fuelling the denial of emotions. Frankie was able to perspective take and understand that the service user’s actions that led to the restraint were because she was unwell. Although this understanding may be helpful for Frankie to formulate what led to the restraint, it also appears to reinforce to Frankie that staff therefore must not experience emotions following a restraint, as they are somehow unjustified because they should be able to understand the service user’s difficulties and not be effected by this. The need to understand professionally takes priority over the personal impact of such an incident.

Jamie also denied any personal emotional impact of the physical restraint.

Jamie: “Honestly it doesn’t affect me in the slightest...You’ve just got to let it go, straight through and not take anything to heart.”

Jamie did not acknowledge any emotional impact throughout the whole interview. The complete denial of personal emotions in reaction to having to restrain a service user may be reinforced by a cultural belief of how staff should react to restraints. Jamie perceived that staff have “just got to let it go”; that once an incident such as physical restraint has occurred it is in the past and should have no further impact upon staff. Jamie’s perception was that staff should not allow physical restraint to impact them emotionally nor personally. Ashley also appears to hold a similar belief of how staff should handle their emotions following a physical restraint.

Ashley: “Somehow you have to sort of distance yourself from them feelings.”

Similarly to Jamie, who stated that you have “got to” let emotional reactions go, Ashley believed that staff “have to” dismiss and distance themselves from their emotions. These phrases imply a perceived obligation to not react emotionally; a belief that somehow removing oneself from emotional reactions is beneficial to staff. This could be a cultural belief that professionals within a caring profession should not experience emotional reactions to the work that they are involved in. This belief however has an impact upon staff’s ability to accept or ask for support.

Ashley: “Sometimes that they don’t have the de-brief because people say no I’m ok, I don’t need it.”
When staff deny the emotional impact of physical restraint, this can then lead to refusal of support that is offered following the incident. Despite support being offered, beliefs around the need to dismiss or deny any emotional impact following such incidents, could lead to staff continuing to dismiss and deny their feelings, rather than acknowledge them with support.

Whereas the aforementioned staff members completely denied an emotional impact following restraint, in Taylor’s experience this was context dependent.

Taylor: “I couldn’t believe it. It didn’t seem real like it had actually happened, but yeah in work I didn’t think about it to be honest….I didn’t think about it.”

Once Taylor was no longer in the work context, Taylor was able to acknowledge the emotional ordeal and surreal nature of the experience. Despite Taylor’s physical safety being at serious risk, within a work context the emotional impact had been dismissed. Taylor avoided thinking about or acknowledging what had happened whilst in a work context; this was temporarily advantageous as it allowed for the completion of risk management duties. However this dismissal of emotions within this context did not extend to when Taylor was not in the professional role at home. For some staff it may be beneficial to dismiss or deny emotional impact whilst attempting to complete work associated tasks, however this may not always continue outside of this environment.

Both Ashley and Jamie dismissed their emotional responses by depersonalising. Both repeatedly stated that how the service users reacted towards them was not personal towards them nor aimed towards them specifically. This depersonalisation helped both Ashley and Jamie to distance themselves from their emotional responses to the restraints.

Ashley: “He was just angry at the time and it wasn’t aimed at me… It’s easier I think to deal with things when you know it’s not against you and it’s their problems and it’s part of their makeup… how I deal with it is the fact that I don’t take it personally.”

Attempting to depersonalise why the service user behaved towards them in a certain way helped Ashley to process and cope with the situation. Through the perception that the service user would react in a similar way to any other staff member, Ashley was able to cope with the situation and simultaneously dismissed an emotional response. As there was nothing personal in how the service user has reacted towards them, no emotional response was warranted. Ashley acknowledged that if staff were to recognise that they personally had had an influence upon the service user, then it may have an impact upon the therapeutic relationship.
Ashley: “I think I might feel differently if it’s personal to me. It doesn’t matter what we say or do then, they feel that I’ve personally done something to them I probably wouldn’t be concerned with dealing with that person or going in.”

It seems that distancing self from the emotional response, via depersonalisation of the incident, is a coping mechanism to enable staff to continue their therapeutic relationships. Ashley perceived that if staff were to not detach themselves from the emotional response, it may become more difficult to continue the therapeutic relationship and provide care and treatment as necessary.

Similarly to Ashley, Jamie depersonalised how the service user reacted. Despite the service user being verbally abusive, Jamie was able to dismiss a personal emotional response to this as Jamie perceived that the verbal attack was due to the professional role, not towards Jamie as an individual. Jamie formulated the service user’s behaviour as non-intentional, abdicating responsibility from the service user as they were not well. The diminished responsibility of service users consequently meant that Jamie viewed the behaviour as less personally targeted.

Jamie: “He’s not well and what he says is because he’s not well. Why should I hold a grudge against him? I don’t think it’s personal towards me. It’s just because I’m a member of staff and I work here. That’s who he’s aimed it at ...You can’t sort of take it personally.”

By attributing the service user’s reaction towards Jamie as being due to his professional role and the service user’s mental state, Jamie was able to deny any personal emotional reaction. Similarly to Ashley, this means that an emotional response is unwarranted and therefore any potential emotional reaction to the physical restraint becomes dismissed and denied.
3.3.2 Master theme two: Conflicting professional roles and responsibilities

Staff shared that they have conflicting professional roles and responsibilities. This master theme consists of these two roles and therefore two subthemes: **risk management and safety** and the **supportive role**.

### 3.3.2.1 Risk management and safety

Throughout the staffs’ narratives, the vast range of responsibilities that they have within their professional role were evident. They have a professional duty to manage risk and maintain safety for all those in the environment whilst also providing support and care for service users and ensuring they also receive adequate support themselves. When staff shared their experiences of the therapeutic relationships that they have with service users after physical restraints, several of them believed that risk management had to be prioritised and managed before the therapeutic relationship could be attended to.

A number of responsibilities were associated with risk management: manage risk in the environment, manage risk to people and the need to document these risks. Risk management had to take priority, regardless of the potential impact upon both service users and staff and the therapeutic relationship between them. These needs could only be addressed, once safety had been established. If there were ongoing risks, the impact on service users may not be addressed as adequately, consequently impacting the therapeutic relationship.

Staff members focused on different aspects of risk management. In Frankie’s experience, staff have a huge range of responsibilities in relation to management of risk to people within the environment, both during and after the physical restraint. This included the service user, other members of staff, and external agencies such as emergency services.

Frankie: “So it was massive for me, in the sense I was here, there and everywhere. Trying to make sure everyone was fine. But thankfully I managed to get everything under control… I had to make sure the patient was safe, I had to make sure my staff was safe. I had to ensure the police and ambulance crew on site were safe as well.”

Frankie’s role of maintaining safety was prioritised. The expression “here, there and everywhere” suggests that Frankie’s role of risk management was vast. Even within this one professional role, Frankie felt pulled in different directions as attempts were made to maintain safety and manage multiple risks. A chaotic situation was shared, which through Frankie’s
efforts staff were able to establish control. Frankie repeatedly referred to safety; at the time of
the physical restraint safety was prioritised and risk was managed, the therapeutic
relationship was not a priority at this time.

Not only do staff have the responsibility to maintain safety, staff also shared their
responsibility for documenting the physical restraint and the associated risks. Staff stated that
this was a priority and needed to be done immediately, to ensure that the incident was
recalled and recorded accurately.

Frankie: “Straight away I got everyone who was involved in the restraint to write a
statement, because it was still fresh and got all signed... And I wrote a statement to cover
everything as well. So every single member had the times what positions they were in what
she was doing at that time. So everyone had that in order and it all fitted in you know. So
there was a clear picture of what had happened.”

Taylor: “There was so much paperwork that you had to do. By the time the police came it
was about half past two three o clock in the morning, I went on my break, came back and did
all my paperwork...there’s no point in me going home because then I have to come back at
some point to do the paperwork. So I just said I’ll stay and do that whilst it’s in my mind.”

Frankie shared the necessity of the documentation of the restraint being both immediate and
in great detail. Frankie appears to be under great pressure to ensure each aspect of the
documentation is accurate, comprehensive and logical. Similarly for Taylor, much time was
spent documenting the restraint and recalling this to relevant parties. However for Taylor,
these things were prioritised over Taylor’s emotional needs; despite being held hostage
during the restraint, relentlessly Taylor prioritised risk management and did not attend to
personal emotional needs. Not only can risk management take priority over attending to the
therapeutic relationship, but it can even prevent staff from attending to their own emotional
needs.

Risk management was described as being prioritised over the quality of the therapeutic
relationship with the individual service user.

Taylor: “I don’t care because I know that I’m protecting myself, protecting the patients and
protecting the ward. And there’s not going to be any issues. So I don’t care if it ends up that
we’ve got restraints and we’ve got to put them into ICS, because I’ve said no to them,
because I know I’ve done the right thing. I don’t mind if they don’t like me anymore.”
Taylor shared that by restraining patients and managing risk, this can have a detrimental influence upon the therapeutic relationship and how the service user may perceive staff. There appears to be a conflict of dual roles: for staff to on one hand to provide security and on the other to provide a good therapeutic relationship through which treatment goals can be achieved. Taylor manages this dissonance by using rationalisation; that it is the “right” thing to do to prioritise the safety of staff and service users. Taylor viewed staff’s role as that of a protector, to ensure safety and this must be upheld even at the expense of the therapeutic relationship if necessary.

At the time of the physical restraint, the management of imminent risk was also prioritised over understanding the reasons that may have led to the incident.

Taylor: “You don’t care about why he’s doing it, you care about managing the risk.”

Taylor repeated the words “don’t care” when referring to other aspects of the professional role, that Taylor does not perceive as significant at the time of the physical restraint. Taylor did not care if the service user no longer likes them, nor did Taylor care why they were behaving in this way. Taylor’s narrative did not portray a lack of care, but that in that moment of imminent risk, all focus had to be on maintaining safety before other aspects of the professional role could be focused upon.

The concept of safety and risk management being prioritised at the time of the physical restraint, was reinforced by Jesse. Jesse focused on how the responsibility of managing the risk of harm to others took priority over the potential detrimental influence upon the therapeutic relationship.

Jesse: “We had to break everything that we had built initially just to make sure that he was safe... That’s when it gets difficult when you’ve got to do a restraint because you flashback all the things you’ve put into the relationship, all the things that we’ve spoken about, possibly things that have happened to him in the past.”

Jesse shared an experience of having to restrain a service user to prevent him from harming himself. Jesse had found it difficult to develop a therapeutic relationship with this person, as the service user found it difficult to trust staff and tended to disengage from interaction. Despite this, Jesse’s interaction with this service user had improved over time; however this relationship was fragile and Jesse perceived it has easily broken when staff had to physically restrain to ensure safety. Jesse was aware of the service user’s history and the potential
impact a physical restraint could have upon them, yet had to deal with conflicted feelings as risk management and safety had to be prioritised over this.

Similarly to Taylor, Jesse rationalised in order to cope with the dissonance felt about having to physically restrain people they are providing care for.

Jesse: “We’re here to support you. We are here to do what it needs to take to get you to be well again. We’re not here to stick you on the floor purposefully. We’re here to make sure you’re safe to make sure you’re supported.”

Jesse shares a personal value, to support service users in their recovery. The priority is to support them, however Jesse rationalised that there are times when physical restraint is the means to which staff support service users, as a last resort in order to support them.

Despite staff sharing that they expect physical restraint in this secure hospital setting, two staff members shared that they felt uncomfortable with the role of potentially restraining service users that they were caring for.

Jesse: “Well we don’t want to do a restraint. We never want to do a restraint. Sometimes it appears that it just happens because we want to do it and that’s not the case at all. This becomes a moral issue for a member of staff...You question yourself a lot when you go through things like that whether you’re doing the right thing. Although you know you are, you still question it.”

Jesse shared feeling uncomfortable with physical restraint being part of their professional role. Despite stating that physical restraint is necessary to maintain safety, Jesse continued to experience an internal conflict which is experienced as a moral dilemma. Despite knowing that staff were providing safety, physical restraint was not a comfortable experience for them. Taylor also experienced conflict as to whether physical restraint is helpful in the long-term for service users.

Taylor: “We are just containing them, like sometimes I feel like we don’t even help them in fact in sometimes we make it worse.”

Taylor questioned whether using the means of physical restraint is actually beneficial, acknowledging that physical restraint can have a detrimental impact upon the individual. Despite accepting that this is an aspect of the professional role, the compatibility of physical
restraint with a therapeutic relationship is highly doubted by Taylor and is not readily accepted.

3.3.2.2 Supportive role

The professional role of staff members is multi-faceted. As well as the management of risks within the environment, staff are also required to provide support. Staff offer support to service users in their care through the development of a therapeutic relationship, to their fellow colleagues and are responsible of ensuring that they themselves receive adequate support to continue their professional role. Staff shared that once imminent risks had been managed and documented adequately, that they then could engage in their role of offering and receiving support.

Three staff members portrayed the significance of their role in supporting the service users after the physical restraint. Frankie shared a metaphor, illustrating her role as a supportive professional to aid service users’ recoveries.

Frankie: “From when something has happened and you deal with it, it should not distract from your main aim as to be the support for their recovery journey. So, another analogy, the ship going from A to B, halfway through or along the journey there is a leak or there is a storm off shore. Washes onto the shore with people in it and cuts and bruises what not. Support the people, help their cuts and bruising. Plaster, first aid what not. Support them to build the bridge so they can get to point B. So this is part of it. Through the recovery journey, they’ve lied on the shore, you’re patching them up, supporting them. Giving them things to be able to take the water out of the boat so they can get to B.”

Frankie likens a physical restraint to a ship in a storm, harm has been caused and the professional’s role is to help repair this damage. Despite having a set-back in their recovery, the service user needs staff to support them through a therapeutic relationship. This support involves acknowledging the pain and difficulties the service user may be experiencing and providing support so they are able to focus on their treatment and recovery. Frankie speaks of helping them to “build a bridge”, which could be the development of skills to continue in their recovery following the physical restraint. The physical restraint may be a set-back, but once risk has been managed staff can help them to progress and recover from this. Providing support and care to service users is integral to Frankie’s view of the role of staff.
Ashley also shared the need for staff to continue to offer support to service users after a physical restraint.

Ashley: “Normally from their experience people do walk away and give up on them and stuff like that. And I think it’s important that we don’t give up on them and that is when they start to trust certain members of staff and that’s a really important part.”

Ashley perceived that staff’s role in offering support is crucial, in relation to the service users’ early histories. Provision of a consistent, trusting relationship, despite what the service users’ actions may have been, is a fundamental part of their treatment. Only through providing this consistent support can the service users begin to establish trusting therapeutic relationships with staff, to enable them to progress. It is important to continue to support the service users despite how they react to staff members.

Ashley: “They might have threatened like to do in my car, to do things, but I still actually take the time to speak with them after even though they’ve been threatening. So that in itself is like a bit of a trust thing that sometimes they’re trying to push people away but I don’t sort of react to what they initially want.”

The need for trust is emphasised by Ashley. Despite the service users potentially threatening staff and conveying that they do not want support, it is crucial that staff members maintain their supportive approach to enable trust to be re-established. By investing in the relationship and conveying that they are available to support them, regardless of their actions, this enables a therapeutic relationship to develop and be maintained.

Taylor shared an experience of physical restraint, in which Taylor had been extremely emotionally distressed afterwards. Despite this, Taylor felt that in returning to work, it was necessary to see the service user whom Taylor had restrained.

Taylor: “When I came back I felt like I needed to go see him for him.”

Taylor “needed” to see the service user for his needs. Taylor seems to feel pressured to put the needs of a service user before staff’s own needs. Taylor perceived that offering support to this service user would help that individual, however did not acknowledge whether this is consistent with what support Taylor personally required at the time. Sometimes the “need” to provide consistent care and support to service users can lead to staff needs being neglected. Although staff have a responsibility to ensure they receive adequate support, the needs of service users can be prioritised at times. However, it may be that Taylor’s own value set
means that putting the service user’s needs first felt beneficial to her too. A sense of putting the service user’s needs first may help Taylor to feel a sense of closure and resolution following the difficulty of the restraint.

Not only do staff have a role to provide support to service users, but they need to ensure that they and their colleagues receive adequate support to enable them to fulfil their professional role. Without adequate support, Jesse shared that their role can become extremely stressful.

Jesse: “We didn’t do a lot of discussing. Didn’t do a lot of talking. And it got to the point where a lot of the staff were stressed.”

Staff have conflicting responsibilities and it appears that their own personal needs can be last to be addressed. Understandably, without the time and space to discuss and reflect upon their work, this can create a culture of stress and burn-out. However Jesse reflected upon the reasons that can lead to this culture.

Jesse: “I think staff should be given immediate time off ward. It’s not something that can be facilitated straight away, because due to the amount of work and the amount of staff that we’re given, it’s an impossible request really. But I do think that staff would benefit after a restraint from a good half hour off the ward to have that time... You get quite stressed and anxious. Also, coming back onto a ward where there are 16 other patients that know that you’ve been involved in a restraint, so their behaviours also start escalating. You just want to remove yourself away from that I think.”

Despite staff needing time to process and attend to their own emotional needs after a physical restraint, other responsibilities were prioritised. Workload and the needs of the service users on the ward needs to be addressed, in the context at times of staff shortages. Despite the potential benefit to those staff members to have time away from the ward, this cannot be facilitated due to the context and conflicting responsibilities.

Jesse: “Supervision is a massive part and sometimes we don’t get as much as we need. From someone that’s not part of the ward because it’s so easy to have a perspective of the ward and have an opinion of the patients.”

Formal support was acknowledged by Jesse as an important part of her professional role, to enable good therapeutic relationships with service users. Accessing this support enables different perspectives to be generated, to help the staff members to understand the service users’ needs and actions and not to become rigid in one perspective. As with having time...
away from the ward to look after personal needs, accessing support is perceived as important, but not always facilitated.

Staff access to support can be multi-functional. On one hand it can provide personal support to staff to attend to their own emotional needs and it can also foster a shared understanding of the service users to enable staff to work therapeutically with these individuals.

Frankie: “Through my debriefing I did explain this recovery journey thing, that we have got to try and work with her and try and get to the bottom of that behaviour and try and get her to reflect about how she affects others and herself. Because she could potentially be losing out with staff members not interacting with her.”

Through access to staff support, in Frankie’s experience this helped staff to be able to understand the service user’s needs. By having time and space to understand this, Frankie believes that this will aid staff in their interactions with this service user and to help them understand the role they have in their recovery after the physical restraint. This supportive role enables staff to continue their therapeutic relationships with the service user; Frankie perceives that without this, this could impact upon the relationships between staff and service users.

Similarly to Jesse, Frankie also refers to formal provision of support to staff that can help them in their professional role. When asked what can help therapeutic relationships after a physical restraint, staff support was named as a crucial factor.

Frankie: “I think it is good for people who have experience to pass some of their knowledge to the staff and share that. Probably have things like reflective practice to talk things through. The opportunity to vent how we’re feeling as well.”

Supportive forums, such as reflective practice, are viewed as multi-functional by Frankie. One on hand, it provides the opportunity for information and knowledge to be shared between staff members, to aid professional development. On the other hand, it is an opportunity for staff to acknowledge their emotional reactions to their work, to support them within their professional role and therapeutic relationships with service users.
3.3.3 Master theme three: Making sense of the physical restraint

Staff shared a process of making sense of the physical restraint after it had occurred. The first part of this sense making was in relation to understanding the service user; what had lead the service user to the point of physical restraint. The second part of this process was making sense of the therapeutic relationship that they have with the service users, reflecting upon the rupture and repair of the relationship following physical restraint. Therefore this master theme consists of two subthemes: understanding the service user and rupture and repair of the therapeutic relationship.

3.3.3.1 Understanding the service user

Each of the staff members shared that following the physical restraint, they went through a process of attempting to understand what had led to the incident. Part of this was attempting to understand the service user and what may have been happening for them which may have made the restraint more likely.

Three of the staff members make sense of what led to the restraint by making attributions about how “well” the service user was at the time.

Frankie: “The first time I had any contact with her she was sniggering. And my reaction was, why are you sniggering? You’ve hurt someone. And I did ask her what she thought was funny. Her response was I felt like doing it and I did it. And upset the police as well because that is wasting police time isn’t it. But that went to show to me that she really was unwell.”

By attributing the service user’s actions as being due to being unwell, Frankie made sense of the service user’s reaction. Frankie understood that the service user laughed in response to the harm she had caused, as being due to not being well at the time. It is important to Frankie to explore with the service user what her perspective is and in doing so Frankie feels that the service user is less responsible for her actions, as her mental health influenced her interactions and responses. This seems important for Frankie to understand, as her therapeutic role is reliant on her being able to understand the service user’s perspective and work alongside service users even when they are presenting in a challenging manner. Jamie also has the understanding that being unwell contributed to the service user’s actions in relation to the physical restraint.
Jamie: “They’re not well. They’re not well at that time. You can’t sort of hold a grudge against a patient... When he’s not well he’s extremely vulgar.”

Jamie repeats the phrase “not well” throughout the interview, as Jamie’s believes that this can lead to physical restraints occurring and consequent difficulties within the therapeutic relationship. It is important to Jamie to not blame the service user for being “vulgar” towards staff and instead come from an understanding approach that service users’ mental health may influence their behaviour and interactions. This helps Jamie in the interactions with this service user, that despite repeated insults and personal comments made towards Jamie, Jamie is able to continue to invest in the therapeutic relationship.

Jesse reflected upon how making sense of and understanding the service user as being unwell aided interactions and relationship with the service user.

Jesse: “Ensure that you’re not brittle towards them because this man in particular was mentally unwell at that point.”

Due to difficulties within the interpersonal relationship between the service users and staff after the physical restraint, Jesse could see that being brittle may be a reaction staff could have towards the service user. However it seems that within Jesse’s professional role, it is important to reflect upon the service user’s mental health and how this is influencing them. This enables staff to understand the service user’s perspective and therefore aid their interactions with them as the staff understand why they are behaving in a certain way.

Jamie: “Looking back at the nature nurture years, that they’ve had these situations arise and the end result is that even though they’ve been difficult, it’s some form of attention they’re wanting...even staff that are on the ward working with the patients regular, they forget the difficulties they’ve had through their upbringing. And sometimes it’s just reminding them that you know this person hasn’t had the same upbringing you have.”

Following the physical restraint, Jamie’s understanding of the service user’s actions goes beyond them not being well. Jamie formulated what may have led to the restraint in relation to the service user’s history and early experiences and also considers the motivations for their behaviours, for example social attention. Jamie has developed an understanding of the service user which helps Jamie to continue the professional role and relationship with the service user. Not only this, but Jamie believed in the benefit of sharing this formulation of the service
user’s difficulties with other staff members, to also help them to understand the service user’s perspective and motivations for challenging behaviour.

3.3.3.2 Rupture and repair of the therapeutic relationship

Staff reflected upon their own and the team’s therapeutic relationship with service users after a physical restraint. The therapeutic relationship changes; three staff members shared a pattern of challenges within the relationship immediately after the physical restraint. However, these difficulties within the relationship were not irreparable. Despite challenges, staffs’ therapeutic relationships changed over time following the physical restraint.

Frankie: “Everything went back to that before. To me it was a glitch.”

Frankie reflected upon the changes to the therapeutic relationship after the physical restraint, but that these changes were short-lived. In Frankie’s experience, ruptures or a “glitch” should be expected within therapeutic relationships within this environment. Frankie had learned the significance of attempting to improve the therapeutic relationship within the therapeutic role, so that it resembles something of what it had been previous to the “glitch”, to show that relationships can have difficulties yet still progress and repair.

Jesse shared both the immediate and longer term impact that the physical restraint had upon the therapeutic relationship with the service user.

Jesse: “I think our relationship was, although it was knocked, you could see there was a significant knock there and some of the hard work had been unpicked, it wasn’t completely ruined. There was something there to build on again.”

Similarly to the “glitch” mentioned by Frankie, a “knock” to the relationship was described. Immediately following the restraint a deterioration of the relationship was perceived. For Jesse, despite the work and time that Jesse and the service user had invested into building a good therapeutic relationship, a significant incident such as physical restraint had the potential to challenge their relationship. The “hard work” seems to reflect the effort that building a strong therapeutic relationship can take within this environment. The therapeutic relationship has been ruptured back to a time when it was not as strong, however there is the potential to rebuild and repair the relationship despite this. Jesse was also asked about the therapeutic relationship with this service user in the longer term and whether it returned to what it had been before the physical restraint.
Jesse: “I think so yeah, if not better to be honest. His behaviour has significantly improved over recent weeks. We’ve managed to change his observations, we’ve managed to get him out of ICS. We’ve managed to get him upstairs into his bedroom. So, the progressive steps and the successes have been noted. Staff feel like they have achieved something. And his appearance, he’s taking more care of himself. He’s relating to staff more, he’s engaging more. Although it is still very minimal, the engagement and interaction is definitely more than it used to be.”

Through continued engagement and investment in the therapeutic relationship, the staff team were able to support this service user to make significant personal improvements after the physical restraint. The numerous improvements to this service user’s quality of life are seen as an achievement for staff; due to their continued persistence in the relationship despite the prior deterioration, they were able to support this individual to progress both as an individual and with his interpersonal relationships. The changes do not have to be drastic for a sense of achievement to be felt by Jesse; for Jesse even minimal small improvements to the therapeutic relationship are something that should be acknowledged and celebrated. For Jesse, perhaps working within a medium secure environment has helped Jesse to appreciate that small improvements, particularly within relationships, are indeed significant.

Whereas Frankie and Jesse shared that their therapeutic relationships either returned to the prior quality or even improved, Taylor’s experience was different.

Taylor: “We didn’t have the same relationship, like I knew that was gone, and that’s what really upset me as well. When I actually realised that all our hard work and building our relationship was gone, because there’s no trust.”

The therapeutic relationship significantly deteriorated following the physical restraint, a rupture that Taylor felt ended the existing relationship with that service user. The relationship had not only changed, it was “gone”. The definitive and absolute nature of this word which Taylor repeated exemplifies the disappointment and upset expressed due to the loss of the relationship. Similarly to Jesse, Taylor appreciated that therapeutic relationships take time to build within this secure environment. This is something that is not easy to develop and incidents such as physical restraint can have a vast impact upon trust, which underpins a therapeutic relationship as the service user is reliant on the staff for their care.
Despite acknowledging that the therapeutic relationship with that service user had now gone, this did not prevent Taylor from developing a good quality therapeutic relationship with this service user after the physical restraint.

Taylor: “It did get better, towards the end. I don’t know it did get better, it wasn’t where it was before, it was never going to be there, but it was it was a good therapeutic relationship in the end.”

The therapeutic relationship had changed; for Taylor this was a different relationship to what they had before but still had the potential to be a good working relationship. Taylor’s narrative illustrates a dynamic of being torn between acknowledging that the therapeutic relationship had improved, yet trying to communicate that it could not go back to what the relationship had been before. Physical restraint can change the therapeutic relationship between service users and staff, yet a good therapeutic relationship can be re-established in the right conditions.

Despite acknowledging that a therapeutic relationship can be re-established following a physical restraint, Taylor emphasised the tension between having a therapeutic relationship yet being expected to physically restrain service users when necessary.

Taylor: “You do need to build that basic relationship with someone, but how can you do that when you’ve got to constantly restrain them. They’re not going to accept you.”

Therapeutic relationships can be established between service users and staff and the aforementioned staff all share that it is possible to repair relationships following ruptures. However, Taylor shared the necessity of the therapeutic relationship yet questions how this really is possible when staff have the additional role of maintaining safety, sometimes through the use of restrictive practice. Fundamentally, for Taylor acceptance and trust are needed within the therapeutic relationship, and the act of physical restraint can put pressure upon this.
4.1 CHAPTER OVERVIEW

The following chapter summarises the results of this study in the context of existing theory and research. Clinical and service implications arising from these findings are discussed. Both the strengths and limitations of this study are outlined, following which recommendations for further research are suggested.

4.2 RESEARCH FINDINGS AND THE RELEVANT LITERATURE

The aim of this research was to explore service user and staff experiences of the therapeutic relationship after a physical restraint in a secure hospital setting, using an Interpretive Phenomenological Analysis. Firstly the results from the service user experiences will be outlined, followed by the staff member experiences. Four master themes were identified from the service user experiences: changes to the therapeutic relationship; appraisal of the necessity of physical restraint; emotional impact; and dependency and power. A further three master themes were identified from the staff member experiences: personal impact; conflicting professional roles and responsibilities; and making sense of the physical restraint. The research findings of this study are presented in the context of existing theory and literature.

4.2.1 Service user experiences

4.2.1.1 Changes to the therapeutic relationship

The service users described a number of changes to the therapeutic relationship, following the physical restraint. A process of re-evaluation took place, which contributed to whether they
felt able to engage and repair the therapeutic relationship or whether they disengaged from this. Some service users shared that they were able to repair the therapeutic relationship, acknowledging that there had been changes but that they had been able to engage and continue with the therapeutic relationship. Unfortunately in some cases, there was a re-evaluation and deterioration of the therapeutic relationship. Some service users shared that there were times where they did not feel it was possible to move forward with the therapeutic relationship.

Perhaps unsurprisingly, some service users found it difficult to continue the therapeutic relationship with the staff that had restrained them, therefore resulting in a disengagement from the therapeutic relationship. Most service users described incidents where they subsequently did not want to engage in the therapeutic relationship. Such avoidant behaviours are in line with findings from a prior research study of service user experiences of the therapeutic relationship after physical restraint (Knowles et al., 2015). Similarly to the present study, some service users felt unable to engage with the staff that had restrained them and due to the environment would passively disengage if they could not avoid them completely.

It is argued that the relationships between service users and staff in mental health settings can resemble those of attachment relationships (Adshead, 1998). Staff members can provide a secure base and help service users to contain their anxiety and arousal to help the service user work towards their recovery (Adshead, 1998). However, the results from the present study suggest that due to the changes in the therapeutic relationship after physical restraint, some service users found it difficult to relate to the staff members in this way. Therefore staff would be unable to help them to manage the potential distress following the physical restraint. The importance of understanding what has happened during the restraint with staff members was found when interviewing service users in an inpatient mental health service (Bonner et al., 2002), however it seems that this would not be possible if service users have disengaged from the therapeutic relationship.

Multiple factors might make it difficult for service users to approach staff and maintain the therapeutic relationship after physical restraint. If service users have experienced difficulties in their early childhood attachment relationships, they may dismiss the staff members, find it difficult to engage with them, be preoccupied or perhaps ambivalent to the support offered (Adshead, 1998). Their emotional arousal may not be soothed, therefore the service users
may not want to continue their therapeutic relationship with these staff members. Avoidance of the relationship would make it difficult for the service user and staff member to engage and therefore repair the therapeutic relationship and continue with this.

Conversely, some service users were able to engage with the staff members that had restrained them which enabled them to repair the therapeutic relationships. When anxious, an individual tends to seek proximity and contact with an attachment figure (Weiss, 1991), which is argued to be the staff member in the case of mental health services (Adshead, 1998). Service users may already have difficulties within their attachment relationships which are triggered at the time of physical restraint. Unlike the Knowles et al. (2015) study, participants in the present study shared that they valued staff approaching and engaging with them and this had a positive impact upon the therapeutic relationship. Service users in this study stated that this allowed them to clear the air, repair the relationship and move forwards with their relationship.

4.2.1.2 Appraisal of the necessity of physical restraint

The narrative from the service users’ accounts revealed that service users engage in an appraisal process after a restraint. This contributed to the aforementioned re-evaluation of the therapeutic relationship. Levels of acceptance as to whether the physical restraint should have happened varied between service users. Even within individual accounts, the level of acceptance fluctuated throughout the interview, suggesting the complexity of processing which occurs for service users after such an incident. At times it was unclear what influenced the degree to which restraint was seen as acceptable. One factor however which seemed relevant was whether or not de-escalation methods were used before resorting to physical restraint. The use of least restrictive practice was valued and appreciated, as alternative measures to physical restraint had been considered.

The service users in this study recognised the importance of attempting all other methods prior to physically restraining, partly due to the impact physical restraint can have upon the therapeutic relationship. The importance of de-escalation techniques being used has been shared by both service users (Haw et al., 2011) and staff members (Marangos-Frost & Wells, 2000; Moran et al., 2009) in previous research.

The appraisal of whether the restraint was necessary seemed to influence whether service users felt able to have positive therapeutic relationship afterwards. This is similar to a
previous study of service user perceptions of the therapeutic relationship after physical restraint (Knowles et al., 2015). Service users in the Knowles et al. (2015) study shared that when physical restraint was used when it was not deemed to be justified, this can have a detrimental impact upon their therapeutic relationship and perceptions of injustice led to increased hostility and difficulties within the therapeutic relationship. Prior research has shown that when service users believe that staff had a caring attitude towards them during restraint they are likely to hold positive attributions of these staff members (Haw et al., 2011; Knowles et al., 2015). In contrast, if the physical restraint was believed to be unnecessary and abusive and that they should have been released earlier, negative attributions of the staff were evident (Wynn, 2004).

4.2.1.3 Emotional impact
Service users shared the distressing emotional impact that the physical restraint had upon them. Often emotive and strong language was used to describe how they were treated and that they felt vulnerable and fearful. In one case a service user recounted a reaction that seemed to reveal a traumatic response after the physical restraint. This influenced how the service users interacted with the staff members, as fearful responses were associated with those that had physically restrained them.

Fearful and traumatic reactions to physical restraint have been reported studies of service users (Bonner et al., 2002; Haw et al., 2011; Knowles et al., 2015; Wynn, 2004) whom had been physically restrained in both inpatient mental health and secure hospital settings. It seems that this distressing emotional response is not uncommon after physical restraint. In an environment where physical restraint may at times be deemed necessary to prevent harm, it seems important that staff are aware of the potentially fearful and traumatic reactions to the physical restraint and how this may influence the service users’ perceptions of the staff. The staff whom are meant to provide care and treatment for the service users simultaneously have a role to physically restrain them if necessary.

Some service users in this study also reported that they believed staff were detached from their emotions and tended to deny an emotional experience. Research regarding staff experiences of physical restraint vary in their reports as to the emotions staff experience. Whereas some staff have acknowledged the emotional impact this has had upon them shared (Bigwood & Crowe, 2008; Bonner et al., 2002; Lee et al., 2003; Moran et al., 2009; Sequeira
& Halstead, 2004) others reported suppression of emotions (Moran et al., 2009) or even a complete lack of emotional response (Sequeira & Halstead, 2004). It is difficult to ascertain what emotional reaction the staff members that restrained these individuals experienced. What is important is that some of these service users were emotionally distressed following the physical restraint and they believe that staff were completely unaffected, which is not congruent with their emotional experience.

4.2.1.4 Dependency and power

Within the secure hospital environment, service users are dependent upon staff members for their care and treatment. Service users shared the difficulties they experienced due to the lack of choice they have in being dependent upon staff this and that at the time of the physical restraint the relationship dynamics change between service users and staff. The dependent dynamic can change to one of disempowerment, as the power imbalance between service users and staff is reinforced. In one service user’s experience, this led them to feeling abused by staff.

The service users shared that trust is a significant aspect of the dependent relationship with staff. Trust is important within the secure hospital environment, so that a genuine shared understanding of the service user’s difficulties and strengths can be understood, to enable them to work towards their recovery. Trust has been attributed as one of the key elements leading to service users feeling emotionally safe, having a sense of security that they will come to no harm (Mollon, 2014). A review within inpatient mental health services identified that what service users’ value most about their relationships with staff is to feel able to trust them (McAndrew et al., 2014).

Despite the need for trust, creating trusting therapeutic relationships can be difficult in an environment where service users are involuntarily detained and there are unbalanced power structures (Hem et al., 2008). A trusting and secure attachment relationship is needed within the therapeutic relationship; yet at the time when service users have potentially experienced a difficult emotional experience associated with a physical restraint, they experience distrust in staff. Service users in this study described feeling unable to trust staff and unable to engage with them; this has a detrimental impact on the therapeutic relationship. This loss of trust has also been found in previous research of service user experiences of physical restraint (Haw et al., 2011; Wynn, 2004), particularly when service users felt undue force had been used and
the restraint had been perceived as abusive (Haw et al., 2011). Similarly to this study, service users have shared that distrust felt towards staff members damaged the therapeutic relationship (Wynn, 2004). In the context of reduced trust influencing the therapeutic relationship, the extent to which staff members could soothe service users may be questionable. There is the potential for limited opportunities for the therapeutic relationship to be repaired to enable staff to support the service user in their care and treatment.

Power appears to be an important systemic factor that influences the therapeutic relationship. There are issues of containment and power in secure hospital settings (Clayton, 2006); service users are detained against their will, some with additional restrictions placed upon them due to Ministry of Justice restrictions. Higher incidents of conflict between service users and staff in mental health inpatient settings have been attributed to these power differences, particularly when staff refuse service users’ requests and attempt to ensure service users comply with ward rules (Bowers & Crowder, 2012). Due to the restrictive nature of the secure hospital environment, service users and staff have to continue within the dependent relationship, regardless of the quality of the therapeutic relationship. This again reinforces the lack of power service users have within this setting. Power structures within mental health services are an important element of the therapeutic relationship between service users and mental health services (Bracken, 2012) and these power structures can influence service users’ abilities to develop relationships with staff (Chorlton et al., 2015).

It seems that this power imbalance is something that is then exacerbated at the time of the physical restraint, leaving the service users feeling disempowered. This notion is supported by prior research regarding service user perspectives of the therapeutic relationship after physical restraint (Knowles et al., 2015). This research indicated that service users feel particularly controlled after being physically restrained; the need for staff to document information related to risk management after such incidents reinforces this power difference. Such risk assessment and management may lead to further restrictions being placed upon the service user, for example they may temporarily no longer be permitted to leave the ward following a physical restraint, again reinforcing the power imbalance between service users and staff. These difficulties with power imbalance may help explain why some service users perceive physical restraints as unnecessary and abusive, as shared by one of the participants in this current study and also shared as a theme in the Knowles et al. (2015) study of service user experiences of physical restraint in a secure hospital environment.
The service users in the present study shared that they are in a vulnerable position of disempowerment after physical restraint. This feeling of disempowerment is supported by previous research which has shown that service users can feel helpless and vulnerable due to their experience of physical restraint (Knowles et al., 2015, Wynn, 2004). Similarly to previous research (Knowles et al., 2015), in response to feeling powerless service users in this study described attempting to regain this power which could create difficulties within the therapeutic relationship between service users and staff.

4.2.2 Staff member experiences

4.2.2.1 Personal impact

Staff members varied in how able they were to acknowledge the personal impact that the physical restraint had upon them. Whereas some were able to acknowledge the emotional impact this had upon them, others dismissed and denied this. Both in this present study and the paucity of research that has addressed experiences of physical restraint in secure and inpatient mental health services, staff experiences of fearful and traumatic reactions to physical restraint have been shared (Bigwood & Crowe, 2008; Bonner et al., 2002; Lee et al., 2003; Moran et al., 2009; Sequeira & Halstead, 2004). It seems that the experience of a distressing emotional response is not uncommon after physical restraint. Some staff members described experiencing a fearful reaction to the physical restraint, this being true of staff if they had been physically assaulted or hurt during the incident, which is not uncommon in secure hospital services during physical restraint (Lee et al., 2003). However this present study goes beyond the previous literature, revealing the complexity of emotional experiences staff can have after such an incident. A range of emotions were shared: fear; anxiety; embarrassment on behalf of the service user and anger. It seems that staff can experience a diverse range of emotions following a physical restraint and there is a variation as to how able the staff were to identify and share this.

Whereas some staff could acknowledge the emotional impact, others minimised or denied any emotional impact or oscillated between acknowledgment and denial. Beliefs that seemed to drive this were complex and varied amongst staff members. Some shared an obligation to be there to support the service user and this seemed to be prioritised over their own emotional wellbeing. Staff appeared to perceive that there is no purpose of an emotional response and so
they must distance themselves emotionally. Others used methods such as distancing themselves from their feelings or depersonalising how the service user may have reacted towards them and attempting to understand why the incident had happened; seemingly this helped the staff to cope with the experience of the restraint. Although this seemingly serves some function for the staff, this could potentially have detrimental consequences for the staff members, service users and the therapeutic relationship.

The minimisation and dismissal of emotions is supported by the existing literature of staff experiences of physical restraint. When staff take on a controlling role, they can appear emotionally cool and controlling (Hamilton, 2010). Nurses in another study reported that they suppress their emotions, due to the conflict of their dual role to contain risk and have a therapeutic relationship and due to the fact that risks are ongoing after a physical restraint (Moran et al., 2009). This reflects the duty that staff in this study reported to manage risk and the multiple roles and responsibilities that this entails, as detailed in the next master theme. Staff within another study in a secure hospital setting described becoming hardened to their emotional response and that their response became automatic, while others reported no emotions at all (Sequeira & Halstead, 2004). Again, this supports the findings of the present study, that the emotional response that staff experience becomes secondary to their other roles and responsibilities. If staff become emotionally detached and are neglectful of their own emotional needs, it is questionable how able they will be to support service users and other staff members after a physical restraint. This would then impact upon the ability for therapeutic relationships to be repaired after such incidents.

4.2.2.2 Conflicting professional roles and responsibilities

Staff have conflicting professional roles and responsibilities. On one hand they are responsible for risk management and maintaining safety, in which the environment requires them to take on a custodian role and potentially have to physically restrain service users. The risk management responsibilities are vast, including the management of risk in the environment, management of risk to people and the documentation of such risks. On the other hand, staff simultaneously have a supportive role, to ensure that service users and staff members, including themselves, access the support they need. This allows for the development and maintenance of good therapeutic relationships between service users and staff, enables understanding to be developed as to what led to the physical restraint and for staff to attend to their emotional needs following the restraint. This risk management role was
described as being in conflict with the other parts of their profession. Staff shared feeling uncomfortable with these conflicting roles and responsibilities and that risk management always needed to be prioritised.

Within secure services, there are “competing agendas” (p.181, Hamilton, 2010) for staff to both provide care and treatment yet maintain control and security to manage risks. The conflict of professional roles and responsibilities that staff have shared within this current study are supported by the Boundary Seesaw Model developed based in forensic inpatient services (Hamilton, 2010). This model illustrates the difficult balance of these two competing agendas that staff are faced with on a daily basis. Physical restraint is referred to as an example of the controlling role that staff sometimes have to enact within this environment, which can be detrimental for the care and treatment focus of the therapeutic relationship.

Although staff must work towards a balance of providing care and maintaining control and managing risks, they must do so to be responsive to the service user’s needs. This model demonstrates the conflict that staff members shared within this study, of having a clear role to manage risk, yet feeling conflicted due to the impact this may have upon the service user and their ability to support them in the therapeutic relationship.

The concept that staff experience conflict within their professional roles and responsibilities is supported by research that has explored staff experiences of physical restraint within secure and inpatient mental health settings. Staff shared that physical restraint is an ethical dilemma (Rutledge & Pravikoff, 2003) which they feel conflicted with (Middlewick, 2000). They shared that although a part of their role, it was a decision dilemma that they faced and must always be used as a last resort (Marangos-Frost & Wells, 2000; Moran et al., 2009). Similarly to this study, staff felt conflicted by being in a position to manage risk in this way (Bigwood & Crowe, 2008) and that they were concerned with the potential impact this could have upon the service users after the restraint (Sequeira & Halstead, 2004). However none of this prior research refers to the impact that this dual role has upon the therapeutic relationship. Previous research suggests that staff within the present study experience a conflict with their role to manage risk in this way, however staff shared that these conflicting roles can have an impact upon the therapeutic relationship.

Once imminent risks have been managed, staff shared that they have a role to provide support to the service users following the physical restraint. Service users find it difficult to communicate with staff after such incidents (Knowles et al., 2015). Therefore it is important
that such communication and emotional expression is facilitated and supported by staff as this can help to avoid escalation of situations that may lead to a physical restraint (Haw et al., 2011; Wynn, 2004). The support staff offer service users fits with the attachment literature; if staff are able to provide sensitive and appropriate support relative to the service user’s needs and level of arousal (Adshead, 1998), this can help support the service user and may make it possible for service users to engage therapeutically with staff. This seems significant following what may have been a traumatic event for the service user, therefore the staff member can offer care and comfort (Bowlby, 1979) which can provide emotional containment for the individual. Being a trusted and consistent figure is an important part of being an attachment figure (Adshead, 1998). When anxious, an individual tends to seek proximity and contact with an attachment figure (Weiss, 1991), which is argued to be the staff member in the case of mental health services (Adshead, 1998). Perceived kindness and attention from staff has previously been shown to be helpful from a service user’s perspective in coping with the experience of a physical restraint (Bonner et al., 2002), therefore it is important that staff have the capacity to provide this.

As well as the responsibility to provide support to service users, staff also acknowledged the importance of staff accessing support for themselves. Staff shared that stress can increase when staff do not access or receive appropriate support and that there is a lack of time and space needed to recognise staff’s emotional needs following a physical restraint. Staff recognised the need for formal support to be in place, for example supervision and reflective practice, for staff to consider their own needs and to understand patients to help foster the therapeutic relationship.

The staff members in this study shared the importance of accessing support as part of their professional role. Examples of support were shared both in regards to immediately after a physical restraint, such as debriefing and time away from the immediate environment, and support that should be accessed regularly such as supervision, reflective practice and peer support. There is a requirement for all clinical staff to access support via supervision, particularly those who work in secure mental health services (Quality Network for Forensic Mental Health Services, 2011). A study conducted in a secure hospital environment found that a substantial proportion of professionals had elevated occupationally related stress and psychological distress, due to the stressful and challenging environment, which at times led to burnout (Elliot & Daley, 2013). Access to supervision is key in the development of reflective practice for both Nurses and Health Care Workers who work within secure mental health
services (Long et al., 2014), helping to support staff in such stressful working environments (Dickinson & Wright, 2008). Staff in this present study felt that access to these support forums help them personally and professionally and contribute to a good therapeutic relationship with service users.

Staff have multiple responsibilities and roles within this environment, supporting both service users and their colleagues. It is important that they feel supported to be able to manage these competing demands. Various benefits of staff accessing support in inpatient mental health settings have been documented; staff have reported that good planning, team work and practical support can be containing and supportive for them (Bonner et al., 2002). Prior research has also shown that staff suppress their emotions after involvement in physical restraint (Moran et al., 2009; Sequeira & Halstead, 2004), therefore the opportunity to discuss these incidents safely can be beneficial for these professionals to promote expression of difficulties rather than staff suppressing and struggling with these. Studies have shown the dangers of staff experiencing emotional difficulties in relation to physical restraint, such as becoming hardened to the experience of physical restraint or having thoughts to harm service users (Sequeira & Halstead, 2004). Accordingly, access to appropriate professional support is clearly a fundamental aspect of a professional’s role within this environment.

Despite staff acknowledging the need for support, they also acknowledged the constraints of support. Due to external pressures of managing the immediate risks within the environment and limited staff numbers, staff reported that they were not always able to access support. This is consistent with research which elicited Nurse and Health Care Worker perspectives of the main obstacles to obtaining clinical supervision within a secure inpatient setting. A number of organisational pressures were identified such as a lack of time, staff shortages and work pressures (Long et al., 2014). The staffs’ ability to access support needs to be facilitated and promoted by the service to enable them to work effectively with service users towards their recovery in the most therapeutic and safe way possible.

4.2.2.3 Making sense of the physical restraint
Staff shared the importance of attempting to understand the service user and the difficulties they may experience, for them to continue the therapeutic relationship with service users who may have assaulted them or behaved in ways that are difficult to understand. This involved a process of formulating how well the service user was at the time and considering different
factors that may have influenced their actions prior to and during the physical restraint. Not only was it important that staff were able to do this for themselves, they also shared that it is important that staff support their colleagues to do this.

This process helped these staff members to understand the service user’s perspective, to enable them to understand what may have led to the incident of physical restraint and to understand that what has happened was not a personal attack against them. This process seemed to enable staff to continue to invest in the therapeutic relationship and their professional role. To the author’s knowledge, there has not been any prior research of staff perspectives of the therapeutic relationship after physical restraint, therefore little is known about what processes are important for staff to enable them to continue the therapeutic relationship.

As already identified in the master theme of ‘Conflicting professional roles and responsibilities’, staff shared how fundamental staff support is for allowing them to reflect on incidents such as physical restraint. Access to forums such as supervision is fundamental in allowing for the development of reflective practice of professionals working within a secure services (Long et al., 2014) to reflect and make sense of their professional work, to further understand the individuals they are working with and to consider their therapeutic relationships.

As part of this process of making sense of the physical restraint, staff reflected upon the therapeutic relationships between service users and staff. They considered the potential for rupture and repair; restraint appears to cause a potential rupture within the therapeutic relationship which consequently leads to changes within the relationships between the service user and staff members. Staff reflected that although there are changes to the therapeutic relationship, a process of repair can happen to help the service user towards their therapeutic goals. The conflict between risk management roles and the development of a therapeutic relationship was shared again, emphasising the tension between physical restraint and the therapeutic role that staff have (Hamilton, 2010).

This fits with the literature regarding the role of staff members to provide ongoing care and support for service users and the role they have as an attachment figure for them (Adshead, 1998). Research suggests that service users may actively or passively avoid and disengage from the therapeutic relationship (Knowles et al., 2015). It is therefore important that staff are able to understand these behaviours to enable them to repair the therapeutic relationship,
particularly as these individuals may have experienced difficulties in their early attachment relationships (Adshead, 1998).

4.3 IMPLICATIONS FOR CLINICAL PRACTICE AND SERVICE DELIVERY

The implications of this research for both clinical practice and service delivery are outlined below. These implications and recommendations will be shared with the service in which the research was undertaken and potentially other secure services, in hope that this will influence the support that is offered to service users and staff members to enable them to develop and maintain therapeutic relationships that promote the recovery of service users.

4.3.1 Address systemic difficulties

This study suggests that the secure hospital environment can create difficulties in the therapeutic relationship between service users and staff. Within this system, relationships between service users and staff can have an imbalance of power and there can be difficulties in establishing trust.

The secure hospital environment is restrictive, due to the need to manage risk. The findings from this study suggest that the power imbalance between service users and staff becomes increasingly evident at the time of physical restraint. Arguably, this power imbalance needs to be addressed (Knowles et al., 2015). Increasing service user choice and sense of autonomy in all possible ways within the limits of this environment could help to address power imbalance. The therapeutic relationship by definition is concerned with the service user receiving care and treatment, however increasing their role and responsibility in their own treatment could help to address these difficulties with power. Providing service users with opportunities to discuss their views and any difficulties that may cause conflicts within the therapeutic relationship could be beneficial. It would be important for service users to be provided this opportunity with someone with whom they feel comfortable, to work towards a collaborative therapeutic relationship. Trust was identified as important yet difficult to establish in the therapeutic relationship within this environment. Therefore, transparency and
honesty from the staff is crucial, especially as some service users may experience difficulties developing trusting relationships due to their own personal histories.

4.3.2 Service user support systems

This study and previous research clearly portrays that physical restraint can be a very distressing and an emotionally arousing experience, potentially causing traumatic reactions and leaving service users feeling disempowered. It is crucial that service users, who may already have a history of prior traumatic events, have the opportunity to discuss the impact of the physical restraint upon them. These discussions should provide the service user with the opportunity to openly express their feelings in a safe and contained environment. The service user may not wish to discuss this immediately during debriefing of the incident; they should be offered opportunities to discuss the impact when they feel ready and able to do so.

Some service users shared that they believe that staff members are not emotionally effected by physical restraints at all. Opportunities for open communication between service users and staff involved in the physical restraint and the impact this had could be helpful when appropriate. This could facilitate their ability to continue with their therapeutic relationship and gain an understanding of each other’s perspectives, rather than disengage and avoid the therapeutic relationship.

4.3.3 Staff support systems

Staff members in this study shared that maintaining good therapeutic relationships with service users in the context of using restrictive practices can be challenging. This study has shown several important roles that staff members have after a physical restraint. They have a role to manage risk simultaneously as they offer support to service users and colleagues, whilst ensuring that they personally also receive the support they need to continue within their professional role.

Supporting service users involves the provision of emotional support, helping them to feel safe, contained and validated after they have been restrained. Both this study and previous research have shown that service users can become particularly distressed and traumatised after incidents of physical restraint. Therefore, staff members need to feel skilled and able to support service users at this particularly emotional and vulnerable time. Not only do staff
members support service users, some are also responsible for supporting their colleagues. This requires the ability to consider both the emotional impact of the physical restraint on the staff member and helping them to understand the service user’s behaviours in the wider context of their histories and potential difficulties.

Due to the roles that staff have to support both their colleagues and service users after a physical restraint, it is important that staff access support themselves to enable them to do this. It is important that staff access this support regularly, not only in response to an incident of physical restraint, although the need may feel more immediate at these times. Creating a culture where it is acceptable to discuss the emotional impact of the working environment is crucial, as many staff shared that their emotional response can become secondary to their duty to manage risk. Staff within this study suggested forums such as reflective practice, peer support, supervision and debriefing as ways in which they could be supported.

These supportive systems would enable to staff to discuss the emotional impact of the physical restraint upon them and reflect upon the incident together as a team. Staff members also suggested that being offered time away from the immediate ward environment after being involved in a physical restraint would be helpful for them. However, due to pressures and the necessity to manage the immediate risk, this cannot always be facilitated at a time when staff may be at most need of this. Enabling the ability to access these support forums need to be facilitated from a service level; where possible to increase staffing levels so that staff members can access this support while maintaining the safety of environment. Auditing of staff attendance at supportive forums such as supervision and reflective practice would allow for services to have increased awareness of what support the staff do access. This would enable the service to become more aware of factors that enable staff to attend these forums, but also importantly when and why staff were not able to attend these; this would allow for these impeding factors to attendance to be addressed. Increased access to supportive systems could enable the staff members to support the service users more effectively, build a good therapeutic relationship, develop professionally and address their own emotional needs.

4.3.4 Staff training and awareness

Staff within this study shared that within a secure hospital environment, they expect that physical restraint may have to occur to manage risk. However, staff may perhaps be less aware of the potential impact physical restraint could have upon service users and staff.
Helping staff to understand that physical restraint can be very distressing and traumatising for both service users and staff and can leave service users feeling disempowered and unable to trust staff may influence staff behaviour and interactions with service users after such events.

Training staff so that they are aware of their role to provide support could influence their interactions with the service users and the potential therapeutic relationship they can develop. This training could involve increasing staff understanding of attachment theory and how early childhood relationships influence later relationships in life, including those between service users and staff members. By staff becoming more aware of the research that has found that involvement in physical restraint can be emotionally distressing for staff members, this may also encourage staff to feel able to ask for and access support. This is particularly important in an environment where staff members have shared that there is a need to continue to manage risk, potentially at the expense of their own emotional response.

4.4 STRENGTHS AND LIMITATIONS OF THE PRESENT STUDY

4.4.1 Strengths of the research study
To the author’s knowledge, this is the first research study which has explored both service user and staff experiences of the therapeutic relationship after physical restraint. The only known prior research that has investigated the therapeutic relationship after physical restraint (Knowles et al., 2015), only attained the views of service users. In this present study, the perspectives of both service users and staff members were explored. This allowed for the interpersonal nature of the therapeutic relationship in secure hospital settings to be considered, which would not have been possible had only one perspective been captured. This research consequently illustrated the dynamic nature of the therapeutic relationship after physical restraints in a secure hospital environment; identifying multiple intrapersonal, interpersonal and organisational factors that can influence this.

Guidelines regarding the use of Interpretative Phenomenological Analysis (Smith et al., 2009) and the quality of qualitative research (Elliot et al., 1999) were closely adhered to and considered throughout the research process. This allowed for the exploration of the service user and staff experiences; which reflected the participants’ experiences yet acknowledged
Chapter Four: DISCUSSION

the researcher’s experiences, values and interests that may have influenced the research process. Although this is just one interpretation of the results, not an absolute truth, adherence to these guidelines should increase the validity of the model. By selecting Interpretative Phenomenological Analysis, this allowed for the exploration of this research area where relatively little is currently known and to appreciate the meaning that these individuals attributed to their experiences.

An additional strength of the study is that service user recoveries in the context of the use of physical restraint and the therapeutic relationship remained central to this research. Service user perspectives were sought in the design of the research to ensure all research materials were appropriate. Both service user and staff perspectives were sought in the development of the initial interview schedule, so that the questions asked during the research encompassed multiple perspectives. The results of this research will be shared with the service in which the research was conducted and all of those who participated, in consideration of how this could inform service user care. The Systematic Review focused on service user perspectives to reflect critically about the existing literature that has explored service user views in relation to physical restraint, due to the lack of power they have historically had regarding whether restrictive interventions are used.

As identified in the Systematic Review detailed in the Introduction Chapter, prior research of service user experiences of physical restraint in secure and inpatient mental health services have been predominantly from a male perspective. Therefore these findings add to the literature base in relation to a female perspective and further develops the limited understanding of service user experiences of physical restraint and their therapeutic relationships with staff after this.

4.4.2 Limitations of the research study

Although this research presents valuable findings that have clinical and service implications, the study has several limitations. Due to time constraints, the analysis has not yet been checked with the informants as to whether this interpretation fits with their experiences. However, credibility of the emerging themes were discussed with the participants throughout the analytical process. Supervisors and a Clinical Psychologist who worked within a different secure hospital were also liaised with throughout the analysis to improve the validity of the study.
Participants in this study were selected based upon prior involvement in a physical restraint; it was not a requirement that service users and staff had been involved in the same incident. Therefore, none of the participants discussed the same incident of physical restraint nor the same therapeutic relationship. Paired interviews of participants who were involved in the same physical restraint could further the exploration of the therapeutic relationship through interpretation of the interactions between them. Random sampling could have helped eliminate bias of sampling methods, however this would have generated ethical considerations.

Due to the small number of participants within qualitative research, often the representativeness of the sample can be questioned. Only a small number of participants were recruited and these participants were either detained at or worked at the same independent sector secure hospital in Wales, with limited ethnic diversity. Information regarding when the physical restraint had occurred was not recorded; therefore it is difficult to comment upon whether the experience of the therapeutic relationship differs depending upon when the individuals reflect upon this and whether this perception changes over time.

4.5 RECOMMENDATIONS FOR FURTHER RESEARCH

This research offers a preliminary conceptualisation of service user and staff experiences of the therapeutic relationship after physical restraint in a secure hospital setting.

Recommendations for future research that could further develop this understanding are outlined below.

To the authors knowledge this is the first research study to explore both the experiences of service users and staff of the therapeutic relationship and physical restraint. These initial understandings of the therapeutic relationship after physical restraints could be developed through further qualitative research in secure hospital settings. Conducting further research within secure settings with different levels of security and restrictions, could explore whether the perceptions of the therapeutic relationship after the use of restrictive interventions varies in differing levels of restrictive environments. This research was within an independent sector secure hospital setting; facilitating research within other secure hospital settings, including NHS secure services, would help readers to further understand the experience of the therapeutic relationship after physical restraint. Within this research there was limited ethnic
diversity among the participants; exploration of this research question, both within Britain and other countries, with a wider range of cultural and ethnic diversity could contribute to the literature regarding the therapeutic relationship after such incidents in secure settings. Longitudinal qualitative research would help determine whether the perception of the therapeutic relationship after a physical restraint changes over time.

During this research service users and staff shared factors that are helpful in the development and maintenance of positive therapeutic relationships after a physical restraint, which has significant clinical and service implications. However this was not a direct focus of this study; research that specifically explores this could be influential in regards to making direct service recommendations. Service users and staff in this study shared that they do not think it is beneficial for staff who have a therapeutic relationship with service users to physically restrain them; alternatives to this and how this could practically be implemented could be investigated.

As previously noted, this study did not entail paired interviews where service users and staff members discuss the same incident of physical restraint and the subsequent therapeutic relationship. Research of this nature could investigate their perceptions of each other and the relational interactions between these perceptions.

Further research that investigates the disparities of these experiences of the therapeutic relationships after physical restraint could aid the understanding of individual perceptions of the therapeutic relationships. For example, it may be helpful to investigate whether attachment style or trauma history is associated with different perceptions of the therapeutic relationship after physical restraint. It may be that some service users within this setting may be particularly vulnerable to experiencing difficulties with the therapeutic relationship due to these factors.

4.6 CONCLUSIONS

This research has explored service user and staff experiences of the therapeutic relationship after physical restraint in a secure hospital setting. To the author’s knowledge, there has only been one previous study regarding the therapeutic relationship after physical restraint. This
current study therefore contributes to the understanding of these experiences and helps to address the paucity of research in this area.

Through the use of Interpretative Phenomenological Analysis, the experiences of both service users and staff members were explored. Four master themes were identified from the service user experiences: changes to the therapeutic relationship; appraisal of the necessity of physical restraint; emotional impact; and dependency and power. Service users shared a process of re-evaluating their working relationship with staff following the physical restraint, with the potential for either disengagement from or engagement and repair of this relationship. When appraising the necessity of the physical restraint, the level of acceptance of this varied and several factors influenced this such as the perception of whether de-escalation methods were attempted beforehand. A difficult emotional experience was shared by some, consisting of fear and in some cases experiences consistent with a traumatic reaction. In contrast to this, some service users perceived that staff were detached from and tended to deny their emotional experience after physical restraint. Finally, a theme of dependency and power emerged. Service users reflected upon the dependent relationship that they have to have with staff for their care and treatment and that this can leave them feeling disempowered, particularly after incidents such as physical restraint.

A further three master themes were identified from the staff member experiences: personal impact; conflicting professional roles and responsibilities; and making sense of the physical restraint. Staff members varied as to whether they were able to acknowledge the personal impact that physically restraining service users had upon them; some were able to acknowledge that they experienced an emotional impact and that this could influence the therapeutic relationships whereas others dismissed and denied that the incident had any personal impact upon them. Through the staffs’ narratives it became apparent that they have conflicting roles and responsibilities; on one hand to manage risk and safety and on the other to provide support to service users and colleagues and to ensure that they personally access the necessary support. Staff also shared a process of making sense of the physical restraint. This involved attempts to understand the service user and what led to the use of physical restraint and reflections upon the rupture and repair of the therapeutic relationship following a physical restraint.

This is just one understanding of the therapeutic relationship after physical restraint in a secure hospital environment, drawn from the experiences of both service users and staff
members. Through this study and the Systematic Review conducted as part of this research, this research project will help to address the paucity of literature in this area. It is hoped that this research can contribute to the development and maintenance of therapeutic relationships which promote service users’ recoveries within a secure hospital setting, through the consideration and implementation of the recommendations for clinical practice and service delivery.


REFERENCES


REFERENCES


REFERENCES


141
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APPENDIX A, SYSTEMATIC REVIEW SUBJECT HEADINGS

The following ‘subject headings’ were selected during the Systematic Review process.

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APPENDIX B, REFLECTIVE JOURNAL EXTRACTS

2-11-15 (After interview one)

The service user seemed to answer the questions very quickly, I wonder if this is something that is difficult to reflect upon if the physical restraint occurred a long time ago? This service user seemed to focus on his emotions and thoughts rather than that of the staff members, I wonder why this was so. This individual seemed to focus heavily on the mistrust that he felt towards the staff members after the physical restraint.

1-12-15 (After interview six)

The service user that I interviewed today seemed to be caught between feelings of having to rely on staff, despite not wanting to, due to how they treated her during the physical restraint. It seems that through isolating herself and pushing staff away, this was the only way she felt able to keep herself safe in this environment. Despite this, I was surprised that she felt able to accept other staff members whom she perceived as accommodating and available. These staff member seemed to help the service user to perspective take and remained as an available and consistent figure, which this service user experienced as supportive despite the fear and uncertainty that she was experiencing at this vulnerable time.

29-12-15 (After interview 10)

One of the key things that stood out in today’s interview was the difficult balance in the relationship that service users and staff have to work towards. Their relationship is built upon the staff member providing care, yet due to how much time they spend together in their day to day interactions, some service users can misconstrue this as a friendship. This seems to then cause difficulties when staff implement boundaries or have to take on a restrictive role of using physical restraint. The relationships between service users and staff seem to change frequently, due to the nature of the environment where risk management has to be maintained and prioritised.
Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting

Participant Information Sheet (Service User)

Introduction

You have been invited to participate in research about what it is like to continue to have a relationship with staff members after you have been involved in a physical restraint with them. Please take your time to read this information sheet before deciding whether you would like to give consent to take part in this study. The following information provides details about why the study is being carried out and what it would involve to take part.

Purpose of the research

The aim of the research is to explore both service user and staff experiences of continuing to have a relationship with people that they have been involved in a physical restraint with. In particular, I am interested in what it is like to work together after these incidents and whether the physical restraint has any impact on the relationship afterwards.

Researchers involved

My name is Megan Duffy, I am currently a Trainee Clinical Psychologist training on the South Wales Doctoral Programme. As part of my training I am carrying out research which is supervised by Dr Rosemary Jenkins (Academic Supervisor, South Wales Programme in Clinical Psychology) and Dr Suzanne Nicholas (Clinical Psychologist, Llanarth Court Hospital). None of the researchers are paid to be involved in this research.

Why have I been approached?

I hope to interview up to 12 people during my research; this will be a mixture of both service users and staff members. The interview will involve discussing your experience of relationships with people that you have been involved in physical restraint with.

The Multi-Disciplinary Team have agreed that you can be approached to ask you if you would like to take part in this research. This is because you may be able to
describe your experiences of your relationships with staff after they have physically restrained you.

To take part in the research you need to be able to remember at least one physical restraint that you have been involved in.

You need to be able to describe what it was like to have a relationship with staff members after they have physically restrained you.

Do I have to take part?

You do not have to take part in this research, your involvement is completely voluntary. It will have no impact upon your treatment and care. If you do decide to take part, you can change your mind at any point and your data will not be included.

Consent

If you decide that you would like to take part in this research, please complete the ‘consent to be contacted form’ that you were given with this information sheet and give this to the Psychologist on your ward. These will be forwarded to Dr Suzanne Nicholas. If you agree to be contacted, I will arrange a meeting with you to discuss the research further.

At this meeting, you can ask me any questions that you may have, before deciding whether to take part or not. If you decide that you would like to take part I will ask you to complete a consent form. I will then ask you about your relationships with people who you have been involved in a physical restraint with. This conversation will be recorded and will take about one hour. I will provide you with a copy of this Participant Information Sheet and the Consent Form for your own records.

What happens with my information?

After our meeting, I will type out exactly what was said during our meeting. Everyone’s names will be changed and information that could identify you will not be used. This information will all be stored securely and will be destroyed one year after I have completed the research.

My supervisors will look at parts of the typed interviews to help me think about what different people involved in the research have said. They will not know who these transcripts belong to. As part of my training I have to write my findings up as a report. Some quotes from the interviews and examples of the typed interviews will be recorded as part of this report.

At the end of the interview I will ask if you would like a summary of the research findings. After completing the research, my completed report will be available to access in Cardiff University Library System and I also hope to publish the findings in an academic journal.

Confidentiality

All information gathered will be kept confidential. The only exception to this is if during the interview I become concerned about your welfare or safety, or the welfare or safety of others, I will let the Nurse in Charge on your ward know. Wherever possible I will let you know if I have to disclose any information.
In the interview I will ask about relationships with other people. However I will ask you not to name these other people if possible. If you do name other people, I will change or leave out their names when I type the interviews.

**Potential disadvantages of participating in this research**

Due to the nature of the research question, potentially it may be distressing to discuss previous incidents of physical restraint. However I will be mainly focusing on what it was like to have a relationship with other people involved in the restraint, rather than the physical restraint itself.

Every effort will be made to reduce any distress you may experience, such as taking a break or stopping the interview if you wish.

Participation in this research does not result in payment.

After the interview there will be an opportunity to discuss any questions or concerns that you have with me. If you have any further questions or concerns in relation to the research, please contact Dr Suzanne Nicholas.

**Potential advantages of participating in this research**

By taking part in this research, this provides you with an opportunity to discuss your experience of physical restraint and your relationships with the staff involved afterwards. While I cannot guarantee that taking part will help you personally, your contributions to this research will hopefully improve the understanding of relationships between service users and staff after physical restraint; something which relatively little is currently known.

**If I don’t want to continue with the study?**

If you decide that you do not want your interview to be included in the study, please let Dr Suzanne Nicholas know and your data can be destroyed. Any decision to withdraw from the study will not affect your treatment and care.

**What if there is a problem?**

If you have any concerns about any part of this research, you can discuss this with me and I will do my best to answer your questions. Alternatively, you can contact Dr Suzanne Nicholas. If you wish to make a complaint, about a member of staff or about the effects of participating in the study, please report this to the Nurse in Charge and they will follow the Llanarth Court Hospital Complaints Policy and Procedure.

**Who has reviewed the study?**

This study has been reviewed and received favourable opinion by South West-Exeter Research Ethics Committee. This means that they have looked at this study in detail and have said it is a safe and appropriate study.

**More information**

Please contact Dr Suzanne Nicholas, in the Psychology Department, for any further information regarding the study. Alternatively, please ask one of the staff members to contact Dr Nicholas and she can arrange to discuss the research with you.
If you consent to meet with me, I will be happy to answer any questions you may have before deciding whether you would like to take part in the research. Thank you for reading this information sheet and considering taking part in this research.

Contact details

Dr Suzanne Nicholas (Clinical Psychologist, Clinical Supervisor, Llanarth Court Hospital)
Telephone number: 01873 840555

Megan Duffy (Trainee Clinical Psychologist)
Telephone number: 029 2087 0582

Dr Rosemary Jenkins (Clinical Psychologist, Academic Supervisor)
Telephone number: 029 2087 0582
CONSENT TO BE CONTACTED FORM (SERVICE USER)

Please initial the box

I consent to meet Megan Duffy to discuss participation in the research titled ‘Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting.’

____________________
Hospital Ward

____________________  ______________________  ______________________
Name of Participant     Date                    Signature

g_________  ____________  ____________
Name of Person taking consent.  Date  Signature
Introduction
You have been invited to participate in research about what it is like to continue to have a relationship with service users after you have been involved in a physical restraint with them. Please take your time to read this information sheet before deciding whether you would like to give consent to take part in this study. The following information provides details about why the study is being carried out and what it would involve to take part.

Purpose of the research
The aim of the research is to explore both service user and staff experiences of continuing to have a relationship with people that they have been involved in a physical restraint with. In particular, I am interested in what it is like to work together after these incidents and whether the physical restraint has any impact on the relationship afterwards.

Researchers involved
My name is Megan Duffy, I am currently a Trainee Clinical Psychologist training on the South Wales Doctoral Programme. As part of my training I am carrying out research which is supervised by Dr Rosemary Jenkins (Academic Supervisor, South Wales Programme in Clinical Psychology) and Dr Suzanne Nicholas (Clinical Psychologist, Llanarth Court Hospital). None of the researchers are paid to be involved in this research.

Why have I been approached?
I hope to interview up to 12 people during my research; this will be a mixture of both service users and staff members. The interview will involve discussing your experience of relationships with people that you have been involved in a physical restraint with.

The Multi-Disciplinary Team have agreed for you to be approached to ask if you would like to take part in this research. This is because you may be able to describe
your experiences of your relationships with service users after you have physically restrained them.

To take part in the research you need to be able to remember at least one physical restraint that you have been involved in.

You need to be able to describe what it was like to have a relationship with service users that you have previously physically restrained.

**Do I have to take part?**

You do not have to take part in this research, your involvement is completely voluntary. It will have no impact upon your employment. If you do decide to take part, you can change your mind at any point and your data will not be included.

**Consent**

If you decide that you would like to take part in this research, please complete the ‘consent to be contacted form’ that you were given with this information sheet and give this to the Psychologist on your ward. These will be forwarded to Dr Suzanne Nicholas. If you agree to be contacted, I will arrange a meeting with you to discuss the research further.

At this meeting, you can ask me any questions that you may have, before deciding whether to take part or not. If you decide that you would like to take part I will ask you to complete a consent form. I will then ask you about your relationships with people who you have been involved in a physical restraint with. This conversation will be recorded and will take about one hour. I will provide you with a copy of this Participation Information Sheet and the Consent Form for your own records.

**What happens with my information?**

After our meeting, I will type out exactly what was said during our meeting. Everyone’s names will be changed and information that could identify you will not be used. This information will all be stored securely and will be destroyed one year after I have completed the research.

My supervisors will look at parts of the typed interviews to help me think about what different people involved in the research have said. They will not know who these transcripts belong to. As part of my training I have to write my findings up as a report. Some quotes from the interviews and examples of the typed interviews will be recorded as part of this report.

At the end of the interview I will ask if you would like a summary of the research findings. After completing the research, my completed report will be available to access in Cardiff University Library System and I also hope to publish the findings in an academic journal.
Confidentiality

All information gathered will be kept confidential. The only exception to this is if during the interview I become concerned about your welfare or safety, or the welfare or safety of others, I will let your Line Manager know. Wherever possible I will let you know if I have to disclose any information.

In the interview I will ask about relationships with other people. However I will ask you not to name these other people if possible. If you do name other people, I will change or leave out their names when I type the interviews.

Potential disadvantages of participating in this research

Due to the nature of the research question, potentially it may be distressing to discuss previous incidents of physical restraint. However I will be mainly focusing on what it was like to have a relationship with other people involved in the restraint, rather than the physical restraint itself.

Every effort will be made to reduce any distress you may experience, such as taking a break or stopping the interview if you wish.

Participation in this research does not result in payment. However, the interview will take place in your working hours.

After the interview there will be an opportunity to discuss any questions or concerns that you have with me. If you have any further questions or concerns in relation to the research, please contact Dr Suzanne Nicholas.

Potential advantages of participating in this research

By taking part in this research, this provides you with an opportunity to discuss your experience of physical restraint and your relationships with service users involved afterwards. While I cannot guarantee that taking part will help you personally, your contributions to this research will hopefully improve the understanding of relationships between service users and staff after physical restraint; something which relatively little is currently known.

If I don’t want to continue with the study?

If you decide that you do not want your interview to be included in the study, please let Dr Suzanne Nicholas know and your data can be destroyed. Any decision to withdraw from the study will not affect your employment.

What if there is a problem?

If you have any concerns about any part of this research, you can discuss this with me and I will do my best to answer your questions. Alternatively, you can contact Dr Suzanne Nicholas. If you wish to make a complaint, about a member of staff or about the effects of participating in the study, please report this to your Line Manager and follow the Llanarth Court Hospital Complaints Policy and Procedure.
Who has reviewed the study?

This study has been reviewed and received favourable opinion by South West-Exeter Research Ethics Committee. This means that they have looked at this study in detail and have said it is a safe and appropriate study.

More information

Please contact Dr Suzanne Nicholas, in the Psychology Department, for any further information regarding the study. If you consent to meet with me, I will be happy to answer any questions you may have before deciding whether you would like to take part in the research.

Thank you for reading this information sheet and considering taking part in this research.

Contact details

Dr Suzanne Nicholas (Clinical Psychologist, Clinical Supervisor, Llanarth Court Hospital)
Telephone number: 01873 840555

Megan Duffy (Trainee Clinical Psychologist)
Telephone number: 029 2087 0582

Dr Rosemary Jenkins (Clinical Psychologist, Academic Supervisor)
Telephone number: 029 2087 0582
CONSENT TO BE CONTACTED FORM (STAFF)

Please initial the box

I consent to be contacted by Megan Duffy to discuss participation in the research titled ‘Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting.’

Preferred contact details (only fill in details that you wish to be contacted on)

Telephone number………………………………………………………………………………………………………………

Preferred day/time to receive telephone calls.

…………………………………………………………………………………

Email address…………………………………………………………………………………………………………………………

_______________

Hospital Ward

_______________  _____________  ___________
Name of Participant  Date  Signature
01 September 2015

Miss Megan Duffy
South Wales Programme in Clinical Psychology
Floor 11, Tower Building, 70 Park Place
Cardiff
CF10 3AT

Dear Miss Duffy

Study title: Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting.

REC reference: 15/SW/0209
IRAS project ID: 181446

Thank you for your letter of 21st August 2015, responding to the Committee’s request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Mr Mark Dawson, nrescommittee.southwest-exeter@nhs.net. Under very limited circumstances (e.g. for
student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

**Confirmation of ethical opinion**

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

**Conditions of the favourable opinion**

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

*Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.*

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at [http://www.rdforum.nhs.uk](http://www.rdforum.nhs.uk).

*Where a NHS organisation’s role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.*

*For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.*

*Sponsors are not required to notify the Committee of approvals from host organisations*

**Registration of Clinical Trials**

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.
There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

**It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).**

**Ethical review of research sites**

**NHS sites**

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

**Approved documents**

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

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Indemnity Insurance]</td>
<td>Version 1</td>
<td>21 August 2015</td>
</tr>
<tr>
<td>Interview schedules or topic guides for participants [Interview schedule]</td>
<td>Version 1</td>
<td>25 June 2015</td>
</tr>
<tr>
<td>IRAS Checklist XML [Checklist_21082015]</td>
<td></td>
<td>21 August 2015</td>
</tr>
<tr>
<td>Letter from sponsor [Letter from sponsor]</td>
<td>Version 1</td>
<td>21 August 2015</td>
</tr>
<tr>
<td>Other [Clinical Supervisor CV]</td>
<td>Version 1</td>
<td>08 June 2015</td>
</tr>
<tr>
<td>Other [Debriefing information sheet]</td>
<td>Version 1</td>
<td>09 June 2015</td>
</tr>
<tr>
<td>Participant consent form [Consent to be contacted form (service user)]</td>
<td>Version 1</td>
<td>22 May 2015</td>
</tr>
</tbody>
</table>
Statement of compliance

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

After ethical review

Reporting requirements

The attached document “After ethical review – guidance for researchers” gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

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 use the feedback form available on the HRA website:
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/SW/0209 Please quote this number on all correspondence

With the Committee’s best wishes for the success of this project.

Yours sincerely

PP
Dr Denise Sheehan Chair

Email:nrescommittee.southwest-exeter@nhs.net

Enclosures: “After ethical review – guidance for researchers” [SL-AR2]

Copy to: Miss Helen Falconer
CONSENT FORM TO PARTICIPATE (SERVICE USER)

Title of research project: ‘Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting.’

Please initial all boxes

1. I confirm that I have read and understand the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that participation will involve my interview being audio-taped, with use of anonymised verbatim quotation. ☐

4. I understand that my information will be stored securely in a filing cabinet, and the information I provide will be anonymised for use in the study. ☐

5. I understand that if I disclose anything related to either risk to myself or other people, this information will have to be shared with the Nurse in Charge on my ward. ☐

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

_________________________  ______________________  ______________________
Name of participant  Date  Signature

_________________________  ______________________  ______________________
Name of person taking consent.  Date  Signature
CONSENT FORM TO PARTICIPATE (STAFF)

Title of research project: ‘Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting.’

Please initial all boxes

1. I confirm that I have read and understand the Participant Information Sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment being effected.

3. I understand that participation will involve my interview being audio-taped, with use of anonymised verbatim quotation.

4. I understand that my information will be stored securely in a filing cabinet, and the information I provide will be anonymised for use in the study.

5. I understand that if I disclose anything related to either risk to myself or other people, this information will have to be shared with my Line Manager.

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

____________________________  ______________________________  ______________________________
Name of participant              Date                                Signature

____________________________  ______________________________  ______________________________
Name of person taking consent    Date                                Signature
APPENDIX J, INITIAL INTERVIEW SCHEDULE

INTRODUCTION (SEMI STRUCTURED PROMPTS)

1. Introduction
   **Prompts**
   - Go through participation information sheet to check understanding
   - Complete consent form
   - Ask for permission to take notes in addition to taping
   - Confirm interview length and opportunity to have breaks

2. Elicit worries / questions
   **Prompts**
   - Any worries or questions before we start?

3. Background information
   **Prompts:**
   - It would be useful if I can to get a bit of background information about you.
     - Age range
     - Gender
     - Job title/service user
     - Length of time at current hospital
     - Wards that you have stayed/worked on
     - Where you were prior to this hospital

INTERVIEW (SEMI STRUCTURED PROMPTS)

1. General relationships between staff and service users
   **Prompts:**
   - What are relationships between staff and service user’s like at this hospital?
   - What has been your experience of working with staff / service users?
   - Describe what a positive relationship between service users and staff is like.
   - Describe what a difficult relationship between service users and staff is like.

2. Physical restraint

   I will be asking you about your relationships with service users/staff members after physical restraint. It might be helpful for you to think about a specific example of a physical restraint, where you can remember what it was like to work with the service user/staff members involved afterwards.

   **Prompts:**
   - Please tell me your experience of what this physical restraint was like?
   - What happened prior to the restraint?
   - What happened during the restraint?
   - What happened after the restraint?
   - When did this restraint happen?

3. Reactions immediately after the physical restraint
   **Prompts**
Tell me about the first time you worked with this service user/staff members after the physical restraint.
When did you have to work with them again?
What did you think when you saw them again?
How did you feel when you saw them again?
What did you do when you saw them again?
What do you think they thought when they saw you again?
What do you think they felt when they saw you again?
What did they do when they saw you again?

4. Relationship after the physical restraint
Prompts:
- What was your relationship with this service user/staff members like after the physical restraint?
- What did you think about your relationship after the restraint?
- What do you think they thought about your relationship afterwards?
- What was your relationship like straight after the restraint?
- Was your relationship the same as it had been prior to the restraint?
- How was your relationship different after the restraint?
- Any long term changes to the relationship?
- Has your relationship change over time? How so?

5. Ideas for the future in relation to physical restraint and the therapeutic relationship
Prompts:
- What ideas do you have that would help service users and staff have a more positive experience in their relationship after a physical restraint?
- What could you do?
- What could the other person do?
- What could be put in place to help?

6. Other comments
Prompts:
- Is there anything else that you wanted to say about your experience of working therapeutically with someone that you have been involved in a physical restraint with?
- Have you got any other comments?

7. Closing
Prompts:
- That’s all I wanted to ask, thank you for your time in helping me
- How has it felt to talk about this today?
- Has it raised any issues/feelings/thoughts that you were not aware of before?
- Do you have any concerns or questions about what we’ve been talking about?
- Discuss debrief form
Service user and staff experiences of the therapeutic relationship following physical restraint in a forensic inpatient setting

Debriefing Information Sheet

Thank you very much for your participation in this research. The study aimed to explore service user and staff experiences of the therapeutic relationship following physical restraint. I was interested in gaining an increased awareness of what factors relate to difficulties and positive experiences of the therapeutic relationship following a physical restraint and to understand this in relation to a forensic inpatient environment.

Both the therapeutic relationship and physical restraint have been identified as important for treatment outcomes and quality of institutional care for people with long term mental health problems. Despite this, there has been relatively little research which explores service user and staff experiences of physical restraint and the therapeutic relationship and even less research that considers these two factors in relation to each other. In a forensic setting, service users and staff continue to have a therapeutic relationship following a physical restraint, yet it seems relatively little is known about service user and staff experiences of this.

It is hoped that further information into this area will improve forensic services’ understanding and awareness of physical restraint and its relation to the therapeutic relationship. I hope that it will contribute to the delivery of a service user and staff led service, by considering their perspectives about what factors contribute to the establishment and maintenance of a therapeutic relationship following physical restraint.

Further information

If you would like a summary of the research findings, I will send you this after I have submitted by research in September 2016.

Please contact Dr Suzanne Nicholas, in the Psychology Department, for any further information regarding the study (01873 840555). If you are a service user, please ask one of the staff members to contact Suzanne and she will arrange to meet with you. She will be happy to discuss any further questions or concerns that you may have.
**APPENDIX L, EXAMPLE OF TRANSCRIPTION NOTING**

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Noting</th>
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</table>
| P: The relationship was difficult because I ended up sustaining a physical injury which was a broken arm, so it made me very very wary of the staff. It made me very very wary of the staff. I didn’t have a particularly good...I started off having a very good relationship with them, I developed relationships with them very well. There was an officer who came in and restrained me and it ended up in physical injury and after that I was so scared of him I wouldn’t go up the corridor to go and gets my meds because he was on meds duty. So I was very very scared, I was not taking my painkillers which then made it awkward with the rest of the staff. The rest of the staff sided with him so I didn’t want to talk to them. I didn’t feel safe there at all, I was wondering every time someone came in my room was I going to get injured again? Was something bad going to happen? Because technically it’s not meant to happen, when they’re authority looking after you that’s not meant to happen. And I’d been restrained many times over the years, but unfortunately this one went wrong. They actually restrained me the wrong way which is why it made it even harder because they got angry with me and that’s why the restraint went wrong, because they did it the wrong way because they were in a bad temper. So it made it hard because every time I did self harm then, which was the reason I was being restrained anyway, it kind of caused trouble because I was self harming more and I was getting worried sick that I was going to get restrained and injured again, so it put pressure on me, it put pressure on the staff. I got very aggressive with the staff because of being in pain and not trusting anybody. I didn’t know who to turn to literally. We had all the investigation and everything and I felt I wasn’t listened to with the investigation. Because I got my solicitor involved and kind of said well I’ve been injured kind of thing and he said alright we’re going to take this further. It caused a lot of animosity with the staff members, because they were under pressure to comply with the investigation and my solicitor, but unfortunately nothing got done with it kind of thing. So once I did get out of hospital I was like right I’m never going back there. But unfortunately I did end up going back there. But I requested a transfer. It got to the point that it was so bad that I didn’t trust the staff and it caused such a break down in the relationship kind of thing. | Sustaining a physical injury  
Feeling scared/wary of staff  
Use of ‘very very’ to exemplify how scared?  
Changing of relationship  
Avoiding relationship  
Avoidance impacting upon care received.  
‘very very’ again with scared to accentuate fear?  
Service users are in a position of powerlessness  
Impacting upon wider relationships with staff  
Us and them?  
Not wanting further contact with staff  
Feeling alone  
Feeling unsafe and scared  
Fearing future harm  
Changing of perspective of staff  
‘It’s not meant to happen’ repeated  
Believing staff anger impacted upon restraint delivery  
Feeling stuck/no options/unsupported  
‘kind of caused trouble’ – self blame?  
Use of the word ‘pressure’ repeated  
‘aggressive’ to describe self – self preservation?  
Reducing trust  
Feeling stuck, unable to get care necessary  
Feeling unheard  
Furthering difficulties in relationship due to SU raising allegations – powerless?  
‘nothing got done with it’ – complaint about improper conduct sufficed to nothing  
Reducing trust afterwards  
‘Break down’ of relationship |