A Hermeneutic Inquiry into Adult Acute Mental Health Nurses’ Experience of Physical Restraint Procedures and Their Intervention Using Forced Touch with Patients

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The thesis is submitted in partial fulfilment of the requirements for the award of the degree of Professional Doctorate (Nursing) of the University of Portsmouth

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Abstract
Background: In the UK, adult acute mental health nurses use forced touch during physical restraint interventions. Forced touch refers to the quality of the physical force nurses use to restrict patients’ movement. There are few recent UK studies into nurses’ experiences of physical restraint. In particular, the meanings nurses give to forced touch appears to be missing from the literature.
Aim: The aim was to explore nurses’ experience of physical restraint procedures and specifically, to inquire into nurses’ experience of forced touch during physical restraint interventions. The research also aimed to provide a critical reflection of the notion of ‘physical restraint’ and ‘forced touch.’
Methods: A Heideggerian hermeneutic phenomenological approach was used to collect and analyse data from 14 nurses who engaged in semi-structured interviews with the researcher.
Findings: The overarching interpretation of nurses’ experience of physical restraint procedures was lived inconsistency represented in three major themes: lived moral inconsistency, lived knowledge inconsistency and lived care inconsistency. The nurses’ experience of the procedure included their moral struggles with their role in restraint and a perceived lack of care in the aftermath. Their experience of forced touch illuminated their preference for grasping different parts of the patient’s body and their experience of intimacy. They recalled a complex sequence of touches including forced, gentle, protective and compassionate touches.
Discussion and implications: Implications for practice include the importance of re-orientating restraint training towards a conceptualisation of touch to connect nurses with the meaning of bodily contact during restraint, and the potential influence upon care. The provision of ward-based trainers will also support nurses more effectively in their restraint practice, and develop the nursing discourse of forced touch.
Research implications: Mental health nursing touch demands greater attention because patients are often vulnerable and lack social contact. It is
important to understand how nurses learn to touch patients, their reactions to handling the body during physical restraint, and to understand the phenomenon in different cultures. Patients' perceptions of being touched during physical restraint are essential if the nursing profession is to develop practice in this area.
Declaration

Whilst registered as a candidate for the above degree, I have not been registered for any other research award. The results and conclusions embodied in this thesis are the work of the named candidate and have not been submitted for any other academic award.

Word count excluding tables, illustrations and figures 48 416
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ABBREVIATIONS

AHSN  Academic Health Science Network
C&R   Control and Restraint
CNO   Chief Nursing Officer
CQC   Care Quality Commission
DH    Department of Health
HSCIC Health and Social Care Information Centre
JCPMH Joint Commissioning Panel for Mental Health
MHAC  Mental Health Act Commission
MIND  Mental Health Charity
NHS   National Health Service
NICE  National Institute for Health and Care Excellence
NPSA  National Patient Safety Agency
NRES  National Research Ethics Committee
NRLS  National Reporting and Learning System
MSc   Masters of Science Higher Degree
PICU  Psychiatric Intensive Care Unit
PMVA  Prevention and Management of Violence and Prevention
QC    Queen’s Counsel
RCN   Royal College of Nursing
RCP   Royal College of Psychiatrists
RSU   Regional Secure Unit
SCIP  Strategies for Crisis Intervention and Prevention
SCMH  Sainsbury Centre for Mental Health
UK    United Kingdom
USA   United States of America
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CHAPTER 1: INTRODUCTION

1.1 Prelude: My orientation to the inquiry

My interest in nurses’ experience of intervening forcefully with their body to restrict patients’ movement during physical restraint interventions emerged whilst working as a Consultant Nurse in adult mental health wards. My role incorporated facilitating de-briefing meetings with staff following physical restraint incidents. At these meetings, I listened to nurses share accounts about their involvement in physical restraint procedures. Their recollections included the team’s decision-making process and planning for the procedure, as well as the physical restraint intervention itself including the approach to the patient, the holds and positions used, the forceful administration of medication, the patient’s response to the intervention, and safe withdrawal. They also reflected together in the aftermath about how well they thought the procedure went, their learning from the incident, and their perceived outcome for the patient and others on the ward.

Yet, I became increasingly interested in what they did not seem to say, that was, what it felt like for them to forcefully touch patients. The nurses’ narratives inferred their use of touch through their descriptions of the holds and techniques they used, rather than explicitly expressing their sensory experiences of using their body forcefully against people in their care.

More recently, I met with ex-patient and mental health worker, Paul, (permission given) who worked as part of the team at the local Prevention and Management of Violence and Aggression (PMVA) nurse training programme where he shares his experiences of being physically restrained. I talked with him about my interest in undertaking a study to explore mental health nurses’ experience of physical restraint procedures and their experience of forcefully touching patients
during their intervention. Paul showed interest in the study and agreed to share his own poignant account. He revealed how, during nurses’ physical restraint interventions, the quality of nurses’ touch was significant for him. He also revealed how, when nurses used touch sensitively, he knew how much they cared. Paul believed that the quality of nurses’ touch could herald the beginning of a therapeutic relationship with the nurse. He reflected:

‘Some people [nurses] just know how. Nurses need to know that if you cause pain, the immediate response is for people to pull away. They think this means that you are not complying so they cause you more pain to try and get you to do what they want you to do. One lady [nurse] knew how to apply just the right amount of pressure. I squeezed her hand just to say thank you for restraining me with sensitivity and not causing me pain. One of the things I’m good at is picking out who cares. It takes me just a few minutes to know whether nurses care about me by how they are with me. Laying on hands can [for me] be the beginning of a therapeutic relationship if it’s done properly. I believe that it can enhance, or illustrate, the potential of the relationship, like if it’s caring.’

Paul clearly described how he experienced nurses’ touch on a spectrum of force ranging from touch that felt uncaring and caused him pain, to touches that felt sensitive and, he believed, conveyed the nurse’s care. His experience ignited my desire to understand nurses’ experiences of physical restraint procedures and specifically, their thoughts, feelings and perceptions about using forced touch during their intervention. This curiosity influenced my choice of topic for this study. Understanding these roots of my choice was important because it reflected the values and beliefs that would influence my approach to the research project (Koch, 1995, p.830).
1.2 Introduction

In the United Kingdom (UK), the Royal College of Nursing (RCN) (2005, p.26) describes physical restraint as a ‘hands-on’ technique used by specially trained mental health nurses to immobilise patients safely and methodically with the intention of restoring a safe clinical environment. The Department of Health (DH) (2014a, p.25) defines physical restraint as:

‘any direct physical contact where the intervener’s intention is to prevent, restrict, or subdue movement of the body, or part of the body of another person.’

Similar to the nurses’ reflections during de-briefing sessions, these definitions only infer the degree of force used, thereby minimising the reality that nurses’ use their whole body to grasp patients and forcefully restrict their movement during physical restraint interventions. Thus, these interventions embody both the extremes of touching patients and forcefully containing them (Steckley, 2012, p.541).

The RCN and DH definitions also ignore the fact that nurses often remain in close bodily contact with the patient until they become calm, and not simply until movement has been ‘subdued’. Therefore, the quality of nurses’ touch changes in response to the patient’s behaviour over time, from their initial grasp of the patient to relinquishing their touch. Throughout their physical contact with the patient’s body, nurses continuously interact and talk with the patient (Alty & Mason, 1994, p.4). These physical restraint interventions therefore require complex physical, social and emotional nursing skills.

Adult mental health nurses’ experience of physical restraint interventions has had little research attention (Bonner, 2007, p.15) and there are few recent
studies available. Where studies do exist (Moran, Scott, Matthews, Staniuliene & Valimaki, 2009, p.599; Bigwood & Crowe, 2008, p.215; Bonner, 2007; Sequeira & Halstead, 2004; Lee, Gray, Gournay, Wright, & Parr et al, 2003, p.425; Bonner, Lowe, Rawcliffe & Wellman, 2002, p.465), they have not specifically explored nurses’ experience of forcibly touching patients’ bodies, the fundamental intervention of physical restraint itself. It seems that nurses themselves, the nursing profession, government agencies and nurse researchers all infer nurses’ use of touch when describing physical restraint procedures, rather than explicitly illuminating nurses’ experience of this forceful and close bodily contact with patients during intervention.

1.3 Aims of the research study

The aims of the research study are to:

1. Provide an up-to-date exploration of nurses’ lived experience of physical restraint procedures including their thoughts, feelings and perceptions of forced touch during physical restraint interventions.
2. Provide a critical reflection of the notion of ‘physical restraint’ and ‘forced touch.’

1.4 Objectives of the research study

To fulfil the overall aim of the research, this study has five objectives that address nurses’ use of forced touch in the context in which they work:

1. To explore adult acute ward mental health nurses’ lived experience of physical restraint procedures.
2. To inquire into what it is like for nurses to use forced touch during physical restraint interventions.
3. To provide a novel theoretical and intellectual contribution to the topic through explication of apparent assumptions made in the contemporary literature about nurses’ experiences of physical restraint, and inquiry into nurses’ experiences of forced touch.

4. To provide empirical knowledge by employing interpretative phenomenology, an approach to the topic area not evident in the available research literature.

5. To demonstrate the structural contribution of the findings to the nursing profession, and the practical application of the study findings to nursing practice.

1.5 Structure of Thesis

The thesis has six chapters representing the sequential phases of the research study. Chapter 1 introduces the topic of research, including my early orientation to the topic area and the structure of the thesis.

Chapter 2 sets out the definitions used within the thesis and contextualises the study within current nursing practice and policy. A review of the literature is undertaken and the justification for the study provided.

Chapter 3 sets out my approach to the study through explication of my ontological and epistemological considerations, my choice of methodology and method, and decisions taken.

Chapter 4 illustrates the findings, represented as one overarching theme and three major themes that describe nurses’ experience of physical restraint procedures and their experience of forced touch during physical restraint interventions.
Chapter 5 discusses the findings in the context of the contemporary literature and the implications for nursing practice. This chapter also sets out the strengths and limitations of the study and recommendations for future research.

Chapter 6 concludes with my reflections upon my experience of being a Professional Doctorate student and its influence upon my nursing life.

Chapter Two now sets out the definitions used within the thesis and contextualises the study within current practice and policy. A review of the literature is presented with justification for the study.
CHAPTER 2: BACKGROUND TO STUDY AND REVIEW OF THE LITERATURE

2.1 Background to the study

It is important to recognise that the terms used to refer to people in mental health care and the interventions employed by nurses to restrain them vary, both within clinical practice and across the literature. Therefore, for the purpose of clarity, it is important to define the terms used in this thesis as set out below.

2.2 Clarifying the terminology used in the thesis

2.2.1 The language used to describe restraint type

Many adult nurses in the UK train to intervene with physical restraint using a variety of Control and Restraint (C&R) holds and techniques to grasp and contain the patient’s body. In the local Trust, C&R techniques form part of the PMVA programme that also encompasses prevention skills. Although the term manual restraint describes C&R interventions most accurately and occurs frequently in the literature (Stewart, Bowers, Simpson, Ryan & Tziggili, 2009, p.750), the term physical restraint is commonly employed by nurses in the UK (RCN, 2005, p.26). Recent policy guidance on restrictive practices also uses the term physical restraint (DH, 2014a, p.25). Therefore, to ensure clarity about the type of nursing restraint under research within this thesis, the term ‘physical restraint’ is used.

In published studies, the type of restraint under study can be confusing because authors use the terms physical, mechanical, and manual restraint without always defining the type of force used, or simply use the term ‘restraint’. The use of mechanical restraint in the UK is extremely rare. It is only used in limited circumstances, such as extreme and frequent self-injurious behaviour, and for
security reasons such as transferring prisoners to hospital (DH, 2014a, p.25). There is some recent evidence of using leather wrist-waist restraints in women’s secure services in the UK to prevent life threatening self-harming behaviour (Carr, 2012, p.657). However, the use of mechanical devices is more common in the United States of America (USA), and across other European countries, although there have been substantial drives to reduce their use in the USA (Stewart, Van Der Merwe, Bowers, Simson & Jones, 2010, p.413). Mechanical restraints in the USA include confining the limbs on specially designed beds, restraining patients in chairs, straightjackets and camisoles (Mohr, Petti & Mohr, 2003, p.330). Hence, some of the research conducted outside of the UK relates to mechanical restraint and is not relevant to the UK context.

The focus of this thesis is nurses’ experience of physical restraint and not mechanical devices. Careful critique of the literature was necessary to determine the type of restraint used in each study and therefore, the relevance to UK care settings and the study focus.

2.2.2 The language used to describe touch during physical restraint

In the nursing literature, the language to articulate the quality of nursing touch during physical restraint interventions is not well developed. In nursing practice, the language of C&R training is in common parlance and reflects the techniques used, such as ‘thumb wrist holds’, and ‘holds’ used to ‘support, protect and secure’ patients. Similarly, the language used during C&R training to describe the role of the nurse in physical restraint interventions reflects the part of the patient’s body to be restricted by the nurse i.e., the ‘limb person’ relates to the nurse who has specific responsibility for restricting movement of one of the patient’s arms. An example of the language used is contained within the local training workbook (Local Trust, 2013) in Appendix 1. It appears that the terms
used to name these specific techniques may have contributed towards nurses' inference of touch in practice.

For the purposes of this thesis, and in the absence of any language to describe the quality of touches used by mental health nurses during physical restraint interventions, I agreed with my Clinical Supervisor that the term ‘forced touch’ described the quality of touch used by nurses during physical restraint interventions, the focus for this inquiry.

2.2.3 The language used to describe people in receipt of ward-based care

The naming of the people who receive mental health services is contentious and causes fundamental debates about the level of respect reflected in the language used (Barker, 1997, p.xvii). In most mental health settings, the term ‘service user’ is used, but it is less common in ward environments. In the literature, terms range from patient, client, resident, consumer, survivor, as well as service user. These changing labels reflect repetitive attempts to describe people in mental health services without stigmatising them (Rolfe & Gardner, 2003, p.552). Many ward nurses have reverted to the term ‘patient’ because, to them, it feels more honest than service user (Rolfe & Gardner, 2003, p.553). This may be particularly pertinent for inpatient units, where current levels of lawful detention for treatment have increased by 30% since 2014 (Health and Social Care Information Centre (HSCIC), 2014, p.6). Therefore, for the purposes of this thesis, the term patient is used because the research refers specifically to inpatient wards in which the term patient is in common parlance, a position also taken by Bonner (2007, p.15) in her research into physical restraint, and to reflect contemporary language in the UK.

The context of nurses’ use of physical restraint is now set out, followed by a thorough review of the contemporary literature in the area.
2.3 The reasons mental health nurses use physical restraint interventions

Inpatient mental health nurses care for patients who are in crisis and highly vulnerable, and when the risk to themselves, or other(s), indicates that care outside of hospital is no longer an option (Joint Commissioning Panel for Mental Health (JCPMH), (2015, p.8). These patients may be at risk of self-harm, suicide, violence to themselves or others, and severe self-neglect. Nurses therefore provide care for acutely sick and disturbed people that society no longer tolerates (Bowers, 2005, p.235). Therefore, some patient behaviours on wards can be highly challenging to the staff who are trying to provide care and treatment in a safe and supportive environment (Bowers, Nijman, Simpson & Jones, 2011, p.142). Thus, as part of their role, nurses have to maintain a safe, caring and secure environment whilst also preventing patients harming themselves or others (Bowers, 2005, p.233).

Nurses train in de-escalation skills to try to avoid using physical restraint interventions (Delaney & Johnson, 2006, p.198). The Code of Practice to the Mental Health Act, 1983 (DH, 2008, p.114) states that physical restraint interventions must only be used as a last resort, when de-escalation alone is insufficient to prevent aggressive behaviour. When patients become hostile, nurses are more likely to use verbal skills to talk with the patient, or lead them calmly away from the situation, rather than enforce physical restraint interventions (Foster, Bowers & Nijman, 2007, p.146).

However, at times, nurses intervene with physical restraint. Although assaults on staff are an obvious reason for nurses intervening (Stewart et al, 2009, p.751), nurses also intervene to separate fighting patients (Lee et al, 2003, p.427) and to prevent patient to patient aggression (Foster et al, 2007, p.145). In severe situations, nurses physically restrain patients to move them to a seclusion room (Hopton, 1995, p.111).
The current level of patient violence on mental health wards is of concern and the physical and emotional consequence for nurses is significant (Moylan & Cullinan, 2011, p.527; Stewart et al, 2009, p.749). Of the total number of patient incidents reported by National Health Service (NHS) mental health providers to the NHS National Commissioning Board Special Authority 16.1% related to disruptive and aggressive behaviour (NHS England, 2015). In my local Trust, the figure was 8.3 % over the same period (NHS England, 2015). Whilst the local figures are lower than the national picture, this may reflect the outcome of a concerted drive towards comprehensive training in PMVA for all staff. Nonetheless, the numbers remain of significant concern given the potential for violent and aggressive behaviour to culminate in nurses intervening with physical restraint.

Besides dangerousness, behaviours such as verbal threats, attempted absconding, disruptive behaviour, self-harm, damage to property, and refusal to comply with instructions (for example, to stop behaving in a manner that is perceived as threatening) may also result in nurses intervening with physical restraint (Stewart et al, 2009, p.751). Nurses may also give emergency intramuscular medication using physical restraint. This occurs when the patient cannot, or will not, consent to accepting medication (Bowers, Van der Merwe, Paterson & Stewart, 2012, p.30; Stewart et al, 2009, p.751; Department of Health (DH), 2008, p.120; Richardson, 2002, p.710), or when non-concordance has produced a severe relapse in the patient’s mental state that presents risks to themselves or others (Jarrett, Bowers, & Simpson, 2008, p.538). Finally, nurses may intervene with physical restraint to undertake personal care when patients are severely self-neglected. Nurses therefore intervene with physical restraint for a variety of reasons and in different circumstances.
2.4 Range of physical restraint interventions used by mental health nurses

Physical restraint interventions occur along a spectrum of reasonable force (Winship, 2006, p.55). When a patient's movement needs to be severely restricted, full physical restraint intervention using C&R techniques is used. However, mental health nurses also use a range of lower level touches and holds during their daily care of patients on adult acute wards.

2.4.1 Lower level touches and holds

Many mental health nurses use holds that comprise ‘gentle restraint’ (Winship, 2006, p.55). Examples of these touches include preventing harm to confused patients by blocking their path, or steering patients in a caring way to where the nurse wants them to go (Winship, 2006, p.56). They may also include physical contact with a verbal warning, such as body blocking and bear hugs (Ryan & Bowers, 2005, p.698). These coercive moves and touches do not involve the degree of physical force, or the duration of bodily contact associated with physical restraint interventions.

2.4.2 Holds and positions used during physical restraint interventions

At the time of this study, physical restraint interventions incorporated positions including prone, supine, sitting in a chair, standing, or kneeling. The prone position involves nurses taking the patient face down towards the floor (Stewart et al, 2009, p.749). This should be a controlled intervention, but may become uncontrolled when patients are very strong or highly resistive (Southcott & Howard, 2007, p.37). The DH (2014a, p.26) now recommends that there should be no deliberate intention to use the prone position and new training approaches are to be implemented using different techniques.
At the time of this study, full physical restraint interventions involved a three-person team to hold the patient’s body and restrict movement (Local Trust Policy, 2013; NICE, 2005a, p.53). One team member lead the intervention and applied holds to the patient’s head, and two members of staff each applied holds to the patient’s arms. To ensure safety, the nurse holding the head also had responsibility for maintaining the airway, protecting the neck and monitoring vital signs (Local Trust Policy, 2013). The approach and some of the holds used by nurses during physical restraint interventions are in Figures 2.1-2.5:

Figure 2.1: A three-person team prepared to intervene

Figure 2.2: Positioning hands on head

Figure 2.3: Seated physical restraint and de-escalation

Figure 2.4: Thumb wrist hold
2.4.3 Physical restraint techniques

In mental health care in the UK, C&R techniques have been the most common type of physical restraint interventions taught (Southcott & Howard, 2007, p.35). They were developed for prison staff in the 1980s (RCN, 2006, p.26; Stewart et al, 2009, p.750; Southcott & Howard, 2007, p.37). Their subsequent introduction to the high security psychiatric Special Hospitals followed the Ritchie Report (Ritchie, 1985) that documented concerns that staff who restrained Michael Martin, a patient at Broadmoor Hospital, had contributed to his death in 1979 through a lack of training in appropriate physical restraint techniques and the use of heavy sedation (Paterson et al, 2003, p.5). The original techniques have since seen many modifications that are more appropriate to the healthcare setting (RCN, 2005, p.26).

In 1996, there was an attempt to re-brand C&R interventions as ‘Care and Responsibility’ after modified techniques were implemented in response to concerns about the aversive nature of C&R (McDougal, 1996, cited in Bonner, Lowe, Rawcliffe & Wellman, 2002, p.466). However, there is little evidence of this re-branding in the literature or in current practice. More recently, PMVA training that includes C&R techniques has placed greater emphasis on preventative skills, understanding the causes of violence, and protecting the
dignity and rights of patients (Hollins & Paterson, 2009, p.377). However, there has never been a nationally approved set of holds and techniques used by nurses (Hollins & Stubbs, 2011, p.178; Butterworth & Harbison, 2011, p.31). Recent Department of Health (DH) guidance (2014a, p.35) continues to avoid determining specific techniques, placing greater guidance upon training programme content including prevention.

2.5 Frequency of physical restraint in adult mental health wards

In August 2014, the DH raised concerns that, in England, there was no comprehensive collection of data about physical restraint through incident reporting systems and, therefore, the quality of data reported at a national level was highly variable (Cross & Watkinson, 11th December 2014). Reliance upon incident reporting systems can cause particular difficulties because they depend upon voluntary reporting and use classification systems that may not capture the incident accurately (Vincent, 2010, p.81), and categorisation between agencies can vary.

Reports suggest that use of physical restraint interventions in England and Wales have been rising. The Healthcare Commission’s annual Count Me In census in England and Wales showed that in 2006, 8% of inpatients were subject to at least one episode of ‘hands on restraint.’ This rose to 11% in 2007 and again to 12% in 2008. By 2010, the sixth and final census, the numbers appeared to have stabilised at 12% (Care Quality Commission (CQC), 2011a, p.25). This data reflects all inpatient categories, and not just adult acute patients, and extrapolation of individual categories is difficult. Several other problems can also exist with this type of survey that mean the results may need to be viewed with some caution. First, terms such as ‘hands on restraint’ do not differentiate between full physical restraint intervention and other forms of lower level touches (as described in section 2.4.1), thereby masking the extent of
different types of intervention. Second, employing percentages of patients who have experienced physical restraint interventions mask the rate of usage, with some patients experiencing many episodes. Third, single day audits may not accurately reflect the picture across the year.

The frequency of physical restraint interventions is further complicated by variation across patient groups and ward type. Wards differ in terms of size, staffing, and layout. A review of 45 empirical studies of physical restraint on acute, secure and general adult wards (Stewart et al, 2009, p.749) (40 UK studies, 3 Australian studies, 1 Canada study, 1 New Zealand study), found that restraint is used on average on 5.0 occasions per month on a 20 bedded psychiatric ward and 50% of these restraints involve the prone position. The studies employed a range of approaches including questionnaires, incident reporting and qualitative methods, and most were small scale. Generalisations about restraint use are therefore difficult.

Data drawn from the local incident reporting system from seven acute adult 20-bedded wards between April 2014 and September 2014 (Local Trust data, 2014) revealed that nurses also used physical restraint interventions on average on 5 occasions per month per ward, although prone restraint was less evident, it accounted for between 26-33% of the positions used during the same period.

More recently, a DH benchmarking exercise was undertaken during August 2014 across all mental health Trusts in England. The aim is to standardise the reporting of information concerning physical restraint. The first benchmarking data showed revealed that physical restraint interventions are used on average 2 times for every 10 beds per month, and 0.4 of these restraints included the prone position (Cross & Watkinson, 2014). However, this provides data from a single month and therefore the audit will be repeated. The project aims to
enhance the consistency of reporting across agencies to achieve a clearer position from which to study the impact of restraint reduction activities.

In summary, there is no current comprehensive and consistent data collection of the degree of force, nor the position used, across acute mental health wards. The national benchmarking exercise will drive help to drive more consistent reporting of prone restraint, but it is not directed towards collecting data on lower level interventions. Therefore, the frequency and type of these nursing interventions are likely to remain poorly understood.

2.6 Effectiveness of physical restraint interventions

Physical restraint interventions are contentious because there are no controlled studies to demonstrate their effectiveness in changing behaviour (NICE, 2005a, p.67; Sailas & Fenton, 2000, p.1) and they carry significant risk of injury to staff and patients (Hollins & Stubbs, 2011, p.178; Moylan & Cullinan, 2011, p.1; Stewart et al, 2009, p.752). Physical restraint interventions may result in death arising from restrictive positions, the patient’s physical state, and the use of sedative medication (Paterson, 2003, p.5). Twelve deaths have occurred in health and social care settings since 1979 (Paterson et al, 2003, p.6). However, there is no clear evidence that other non-pharmacological interventions such as special observations, de-escalation or behavioural contracts are more or less effective in managing acute psychiatric crisis (Muralidharan & Fenton, 2006), and physical restraint interventions remain part of nursing practice. The lack of evidence for alternative interventions for challenging behaviour suggests that physical restraint interventions are likely to remain part of a range of interventions used by nurses in acute wards.
2.7 The legal position and clinical guidance

UK legislation does not explicitly describe the use of physical restraint interventions. Instead, Part IV of the Mental Health Act, 1983 (As amended) Section 62 (1d) concerning Urgent Treatment in mental health care environments infers its use in the term ‘treatment’ stating:

‘treatment which is immediately necessary and represents the minimum interference necessary to prevent the patient from behaving violently or being a danger to himself or others.’

Physical restraint interventions are extreme and the last resort to contain behaviour (DH, 2008, p.118). The degree of force used should be controlled (Hollins & Stubbs, 2011, p.178), and staff must minimise any risk to the patient, maintain their privacy and dignity, and protect the patient and others on the ward. The Mental Health Act Code of Practice (DH, 2008, p.114) emphasises that physical restraint interventions should only be used where de-escalation approaches have not resolved the situation and they should never be employed as a form of punishment. After physical restraint intervention, staff should try to re-establish the confidence of the patient to help them to identify and learn from triggers for their behaviour (DH, 2008, p.114).

Some patients experience physical restraint interventions to be excessive and over-zealous (MHAC, 2009, p.75) and in these circumstances, they may be unlawful (CQC, 2011b, p.5). In the case of Winterbourne View, a private Learning Disabilities hospital in Bristol, an investigation found systematic abuses of physical restraint interventions by staff who abused patients with furniture, as well as with bodily force, in acts of cruelty (DH, 2013a, p.13). During criminal proceedings, Judge Neil Ford, QC, stated:
‘The so-called restraint techniques were used to inflict pain, humiliate patients and bully them into compliance with the demands of their carers.’

(British Broadcasting Corporation, Oct 26, 2012).

Subsequent criminal prosecutions and imprisonment ensued for staff.

Physical restraint training programmes teach nurses how to use safe interventions proportionate to the assessed risk. Guidance now determines that staff must not use physical restraint interventions or breakaway techniques that rely on the use of pain, including holds where movement by the patient induces pain, other than for the purpose of immediate risk to life (DH, 2014a, p.26). Previous NICE guidance (NICE, 2005b, p.37) was open to greater interpretation, stating that on very rare occasions, staff may deliberately inflict pain where there is an immediate and high threat to safety. Therefore, current emphasis is upon nurses using greater skills to prevent behaviour escalating, and when physical intervention is used, avoiding imposing painful techniques with patients.

2.8 Physical restraint and mental health policy

In 2005, the Sainsbury Centre for Mental Health (SCMH) reported significant concerns about acute psychiatric wards following a survey of 303 wards. Nursing staff perceived safety to be much higher than patients did (SCMH, 2005, p.83) and there was an increasing use of locked doors to contain patients (SCMH, 2005, p.84). Some wards (18%) lacked access to a bed on a Psychiatric Intensive Care Unit (PICU) for highly disturbed patients leaving nurses to try to provide care in inadequate and unsafe environments (SCMH, 2005, p.87).

In 2006, the Chief Nursing Officer’s (CNO) Review of Mental Health Nursing (DH, 2006) heralded an opportunity to openly address nurses’ use of physical
restraint interventions, particularly at a time when concern about levels of disturbance in wards was high. Yet, despite contemporary studies that reported both nurses’ and patients’ distress and trauma (Sequeira and Halstead, 2004, p.37; Bonner et al, 2002, p.465 & Sequeira & Halstead, 2002, p.9), and the Healthcare Commission’s census revealing that 8% of inpatients were subject to at least one episode of ‘hands on restraint,’ nurses’ use of physical restraint interventions was not considered in the review, thereby missing an important opportunity to consider the scale and impact of its use.

The CNO Review (2006, p.22) did, however, recognise the important contribution that nurses made during critical times in patients’ lives. It emphasised the stressful nature of working on acute wards due to short staffing, frequent absconding and threats of violence, and the lack of time nurses had available to spend with patients. Yet, no opportunity was taken to discuss reducing physical restraint interventions or developing nursing practice in this area. This is surprising given that it is a not an insignificant part of nurses’ day-to-day practice in acute mental health care.

The current mental health strategy, No Health Without Mental Health (DH, 2011) focuses upon improving mental health outcomes by targeting prevention and developing resilience across the general population with the expressed intention to embed mainstream mental health services and reduce discrimination. The scope of the policy meant that physical restraint interventions were not addressed.

However, the issue of physical restraint intervention has now returned to the spotlight. The DH (2014b) recent launch of Closing the Gap sets 25 key priorities to support and speed the implementation of two key objectives contained in No Health Without Mental Health (2011) including the promotion of positive experiences of care and reducing avoidable harm to patients. A specific
objective is to end the use of high-risk prone restraint. To achieve this, the DH sought guidance from the RCN on national approaches to achieving this key priority through aforementioned new guidance (DH, 2014a) for introduction over the coming two years.

This guidance is timely in light of events at Winterbourne View Hospital and growing concerns from The Schizophrenia Commission (2012, p.25) that recently recommended the reduction of prolonged prone restraint. Similarly, the mental health charity MIND (2013, p.3) also ran a high profile campaign and recommended that prone restraint is categorised as a ‘Never Event.’ Never Events are defined by NHS England (2013, p.1) as;

‘serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.’

Never Events may result in serious harm or death, or hold high potential for harm regardless of the actual degree of harm caused (NHS England, 2013, p.2). Although prone restraint is not categorised as a Never Event, the new guidance states that there must not be any intentional use of this position on any surface (DH, 2014a, p.26). Renewed campaigns by the third sector and scandals relating to physical restraint intervention appear to have stimulated a desire to review how behavioural disturbance is managed within mental health wards.

2. 9 Nursing care during physical restraint intervention

It is suggested that when aggressive or violent situations erupt, the emotions of everybody in the vicinity can escalate, and patients and staff can feel both fearful and angry (Moylan, 2009, p.42), and that staff feel frustrated when their
attempts to try alternative options have failed (Winship, 2006, p.59). When de-escalation attempts fail and physical restraint interventions are used, nurses need sound knowledge and skills to care for the patient’s physical and psychological state.

Physical care includes ensuring that the airway is clear, monitoring the effects of the restraint position and observing for the use of tranquilising drugs on cardio-pulmonary status (RCN, 2005, p.90). Nurses also need to be aware of the potential impact of non-prescription drugs on the patient’s physical and mental state before, during and following intervention (RCN, 2005, p.90). Should the patient physically deteriorate, nurses must be competent to respond with intermediate life support skills (RCN, 2005, p.90).

Physical restraint interventions are also recognised as an intimate and deeply interpersonal encounter that demands compassion and sensitivity (Winship, 2009, p.45). Moylan’s (2009, p.45) humanistic perspective on physical restraint intervention determines that nurses must be fully present with the patient throughout all phases of physical restraint intervention. Presencing means being physically present as well as using touch to connect with the patient’s experience (Benner & Wrubel, 1989, p.13). Nursing patients during physical restraint interventions therefore challenges them to use forced touch skilfully to keep patients safe, whilst ensuring excellent physical care, dignity and respect throughout. Nurses’ experience of using forced touch during physical restraint interventions is the particular focus of this thesis.

2.10 Determining the need for the research

To understand what the literature contained about adult acute inpatient mental health nurses’ physical and emotional experiences of using forced touch during physical restraint interventions, a thorough review was undertaken. Reviewing
the literature helps to determine whether the study is necessary to advance the field of inquiry and this is advocated in qualitative approaches (Savin-Baden & Major 2013, p.115; Holloway & Wheeler, 2002, p.31). A review also considers the ethical stance because where previous research is evident, engaging people in unnecessary further research may also breach the principle of beneficence (Speziale & Carpenter, 2007, p.58).

2.11 Focusing the review of the literature

The review focused upon adult acute mental health nurses’ experiences of intervening physically to restrain patients in their care, and specifically nurses’ experiences of forced touch whilst physically restraining patients. The goals of the review followed Savin-Baden & Major (2013, p.113) and sought to answer what is already known about the topic, whether a previous study or similar study had been conducted, and if so, what still needed to be known. The review also considered whether any assumptions about the topic existed in the contemporary literature to see whether engrained ideas had gone unchallenged (Savin-Baden & Major, 2013, p.113). This was important given that contemporary policy, local training approaches, and nurses’ own narratives had not described physical restraint interventions as forced touch.

The review sought studies to understand mental health nurses’ subjective experiences, including their perceptions, thoughts and feelings (Savin-Baden & Major, 2013, p.112). Studies employing questionnaire designs that included open-ended questions to elicit narrative were sought because these types of studies also offer the opportunity for participants to express their thoughts, attitudes and feelings freely (Oppenheim, 1992, p.113).

Only studies exploring nurses’ experience of physical restraint interventions in adult mental health inpatient wards were sought. Research focusing exclusively
upon seclusion are not presented because this form of environmental restraint isolates the patient from social contact (Alty & Mason, 1994, p.4) including physical contact with nurses. Studies in general hospital settings, older adult services, young people's services and learning disability services are not presented because these were not the focus of the study. The searches were undertaken over a seven-month period from June 2009 - December 2009 using subject-specific databases.

The search focused upon adult nurses' lived experience of physical restraint using terms generated to locate articles about the nursing experience in mental health inpatient settings using qualitative methodologies or mixed methods approaches. These were nurs*, restrain*, mental health OR psychiatr* to define the participant and the setting. To explore the experience, the terms were combined with perception* OR attitude* OR belief* OR experience*. The terms used to describe the approach were qualitative OR phenomenolog* OR focus group* OR ethnograph* OR grounded theory. One of the problems of searching for qualitative research studies is the terminology used in the title or abstract may not reflect the design of the study (Shaw et al, 2004, p.4). Therefore, hand searching of tables of contents of key journals was undertaken, e-mail alerts of new journal content were set up, and the reference lists of retrieved articles examined to locate articles not evident in the search results (Savin-Baden & Major, 2013, p.117).

Studies undertaken over the past twenty years were of interest because this reflected the period over which C&R has been used in psychiatric services (Bonner et al, 2002, p.466). Only studies in English were sought because funding for translation services was unavailable. The British Library Ethos service was searched using the broad term restrain*. Unpublished or grey literature can be helpful as it contains rich descriptions often excluded by word
limitations set by publishers (Savin-Baden & Major, 2010, p.49). One thesis was retrieved (Bonner, 2007) for which the pilot study (Bonner, 2002, p.465) had already been obtained through database searching. Throughout the research study, the literature was searched at regular intervals to seek any new studies in the topic area. The databases searched and the rationale is set out in Table 2.1:
<table>
<thead>
<tr>
<th>Database</th>
<th>Description</th>
<th>Rationale for searching</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cumulative Index to Nursing and Allied Health Literature (CINAHL) Ovid version</strong></td>
<td>American database containing indexing of nursing and allied health journals and publications from the National League for Nursing and the American Nurses Association. Contains a wide range of topics including nursing, medicine, biomedicine, patient health and seventeen allied health disciplines. Database includes access to books, dissertations, conference proceedings. Wide access to full text journals.</td>
<td>Offers access to literature published by wide range of health disciplines including nursing. Inpatient mental health teams are comprised of a range of professional backgrounds and literature from different professions brings diverse perspectives to the topic area. Search of literature from as many countries as possible is desirable to understand how widely the topic has been studied.</td>
</tr>
<tr>
<td><strong>British Nursing Index (BNI)</strong></td>
<td>Contains British based nursing and midwifery journal articles</td>
<td>Focus of study to be nursing in the UK. Database may contain nursing studies of physical restraint interventions in the UK context.</td>
</tr>
<tr>
<td><strong>RCN Journals Database</strong></td>
<td>Contains journals whose editors are particularly committed to encouraging more nurses to publish their work</td>
<td>Focus of study to be nursing in the UK. Database may contain nursing studies of physical restraint in the UK context. Accessible through professional membership.</td>
</tr>
<tr>
<td><strong>Medline Silver Platter Version</strong></td>
<td>Contains biomedical literature from around the world. Many full text articles available from biomedical sciences and life science journals and books. Includes many links to publishers’ websites and full text articles.</td>
<td>Offers access to literature published by wide range of health disciplines including nursing. Inpatient mental health teams are comprised of a range of professional backgrounds and literature from different professions brings diverse perspectives to the topic area. Search of literature from as many countries as possible is desirable to understand how widely the topic has been studied.</td>
</tr>
<tr>
<td><strong>PsychInfo</strong></td>
<td>An abstract database of the psychological literature</td>
<td>Psychological literature may contain psychologists’ studies of psychological aspects of physical restraint interventions as they work as part of the multidisciplinary mental health ward team.</td>
</tr>
<tr>
<td><strong>British Library Ethos Service</strong></td>
<td>On line index to higher degree theses awarded by British universities</td>
<td>Provides a search of full theses including unpublished work or grey literature that may offer useful work not accessible via databases of published studies. UK context is area for inquiry.</td>
</tr>
</tbody>
</table>
2.12 Findings from the review of the contemporary literature on adult mental health nurses’ experience of physical restraint


The study settings included three adult acute psychiatric wards (Moran et al, 2009, p.600; Bonner, 2007; Bonner et al, 2002, p.466), one general adult psychiatric ward and PICU (Bigwood & Crowe, 2008, p.216), one private secure ward (Sequeira & Halstead, 2004, p.3), and one incorporating Regional Secure Units (RSU) and PICUs (Lee et al, 2003, p.425). Each study was critiqued using Speziale & Carpenter’s (2007, p.104) qualitative criteria that guides systematic assessment of the essential methodological aspects of qualitative studies. A summary of the studies is set out in Appendix 2 and includes the study settings, participants, methodology, main findings and the strengths and limitations.
2.13 Critique of the methods and reporting of reviewed studies on nurses’ experiences of physical restraint

Of the reviewed studies, only two explored UK nurses’ lived experience of physical restraint in acute wards (Bonner, 2007; Bonner et al, 2002, p.465). Bonner et al’s (2002, p.465) qualitative pilot study preceded the 2007 doctoral study and it is now over ten years old, resulting in only one study being undertaken exploring the topic area in the UK in the last decade. Bonner et al’s (2002, p.465) pilot study was designed to test whether semi-structured interviews were a feasible method of collecting information from patients and staff (N=18, 12 nurses, 6 patients) in the immediate aftermath of physical restraint interventions. The study focused upon what nurses and patients found helpful and unhelpful during, and following, six physical restraint incidents, and explored their lived experience.

The authors concluded that semi-structured interviews effectively explored the participants’ experience. However, the findings do not represent the individual voices contributing towards each theme, nor describe the number of participants contributing towards them. This influences the confirmability because the study lacks a clear audit trail of the decisions taken (Streubert & Carpenter, 2007, p.49).

Bonner’s subsequent (2007) doctoral thesis drew upon the pilot study employing mixed methods to explore the psychological impact of physical restraint upon nurses and patients (N=60, 30 staff and 30 patients). Grounded theory guided the qualitative aspects of the study. The researcher used a focus group and two-part semi-structured interviews to collect qualitative data. In the semi-structured interviews, Part A built upon the pilot study to ask what participants found helpful and unhelpful about the physical restraint incident, and Part B gathered descriptive statistical information using a trauma questionnaire.
Bonner’s (2007) study concludes that physical restraint interventions can re-awaken trauma such as rape and assault for both staff and patients. Using a questionnaire as part of an interview was considered to be helpful in identifying traumatic experiences. However, the researcher’s attempts to handle any preconceptions about physical restraint interventions and trauma are unclear. In grounded theory approaches, as in other inductive designs, the researcher’s openness to their assumptions about the topic is important to understand its influence on the findings (Engward, 2013, p.8; Speziale & Carpenter, 2007, p.154). Bonner’s (2002, p.465) previous pilot study preceded the development of this thesis, yet how the earlier study and the researcher’s previous experience influenced the study is unclear, introducing some doubt about the credibility of the findings (Speziale & Carpenter, 2007, p.48).

Four studies explored nurses’ experiences in other adult settings. Two are from UK secure services (Sequeira & Halstead, 2004, p.3 & Lee et al, 2003, p.425), both of which are more than 10 years old. Sequeira and Halstead’s (2004, p.3) grounded theory study employed semi-structured interviews to understand the psychological effects of restraint and seclusion on nursing staff in a private secure hospital. Sampling bias was avoided by randomly selecting staff from restraint events to take part in the interview. Rich data is presented under theme headings and the nurses’ psychological experiences are clearly described. The methodology guided the analytic approach but there is no evidence of a grounded theory as an expected outcome to the methodology (Speziale & Carpenter, 2007, p.145). Similar to Bonner et al (2002, p.468), individual voices are not clearly represented in the themes, nor the number of participants contributing towards them and the study confirmability therefore is unclear (Speziale & Carpenter, 2007, p.49).

Lee et al (2003, p.425) gathered the views of 269 RSU and PICU nursing staff on the use of physical restraint using the anonymity of a postal questionnaire to
collect both quantitative and qualitative information. The researchers present only a few short phrases and words to illustrate the nurses' narratives and this constrains the credibility of the study (Speziale & Carpenter, 2007, p.105). However, the anonymity of a postal survey appears to have gathered stark responses that may not have been expressed using interview approaches (Bowling, 2005, p.421).

Finally, two more recent studies have been reported, both conducted from outside the UK (Bigwood & Crowe, 2008, p.215; Moran, 2009, p.599). Bigwood and Crowe’s (2008, p.215) New Zealand descriptive phenomenological interview study of nurses (n=7) clearly documents the setting and a culture of bed shortages and staffing problems. It also sets out the legal mandate to physically restrain and seclude patients in emergency circumstances in which patients present a danger to themselves or others (New Zealand Ministry of Health, 1992, p.57), placing nurses in a similar legal position to their colleagues in the UK. The researchers also describe how the responsibility for physical restraint has fallen primarily to nurses, as it has in the UK. The provision of such detailed information about the study setting and nursing context assists the transferability to the UK through resonance with the findings and the setting.

Moran et al's (2009, p.599) qualitative focus group study from the Republic of Ireland explored the emotions of nurses (n=23) who physically restrained and secluded patients. However, the setting description is limited to four psychiatric wards. The philosophic underpinnings of the study are unclear although the study presents rich data under three theme headings. The authors acknowledge the limitations of focus groups including the tendency to conform or censor information, thereby influencing the findings.

Similar to the studies conducted in the UK, the studies from outside of the UK make no mention of nurses’ experience of touch.
2.13.1 Assumptions within the reviewed literature


Apart from Bonner’s (2002, p.465) reference to laying hands on a patient, which itself does not fully describe the forceful quality of the nurse’s touch explored in the study, the studies provide scant connections between nurses’ experience of touching patients’ bodies and physical restraint interventions. Similar to my experience with nurses in practice, each of the studies inferred nurses’ use of forced touch without exploring their experience as part of the study into physical restraint. Bigwood and Crowe’s (2008, p.218) study includes a small amount of narrative in which a nurse connects her role in physical restraint with her role in providing daily care but there is no further exploration of the topic. The available literature therefore assumes either that the reader understands nurses’ experience of forced touch during physical restraint interventions, or has failed to focus upon it.

2.14 Main themes emerging from the reviewed literature on adult mental health nurses’ experience of physical restraint

Dividing the reviewed literature by themes is the most accepted format for understanding the findings from previous studies prior to qualitative research (Savin-Baden & Major, 2013, p.128). Figure 2.6 presents the extracted main themes and concepts from each study presented as a concept map. This
illustrates the grouping of the main themes and concepts arising across the studies and how they appear connected as a web of experiences (Savin-Baden & Major, 2013, p.126). The studies are identified against their reference number to illustrate the contribution to each theme.
Figure 2.6: Concept map of main themes from the literature of nurses' experiences of physical restraint

<table>
<thead>
<tr>
<th>Study author(s)</th>
<th>Reference Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bonner et al (2002)</td>
<td>1</td>
</tr>
<tr>
<td>Lee et al (2003)</td>
<td>2</td>
</tr>
<tr>
<td>Sequeira &amp; Halstead (2004)</td>
<td>3</td>
</tr>
<tr>
<td>Bonner (2007)</td>
<td>4</td>
</tr>
<tr>
<td>Bigwood &amp; Crowe (2008)</td>
<td>5</td>
</tr>
<tr>
<td>Moran et al (2009)</td>
<td>6</td>
</tr>
</tbody>
</table>

- **Working in disturbed atmospheres**
- **Part of nurses' job**
  - 1, 3, 4, 5, 6
- **It is the last resort**
  - 1, 2, 4, 5
- **Feeling ethically conflicted**
  - 1, 2, 4, 5, 6
- **Justified on therapeutic grounds**
  - 1, 4, 5, 6
- **Perceived impact on patients**
  - 1
- **Positive experiences**
  - 3, 4, 5, 6
- **Consequences for nurse**
  - 1, 2, 3, 4, 5, 6
- **Consequences for patients**
  - 1, 3, 4
- **Emotional consequences**
  - 1, 2, 3, 4, 5, 6
- **Coping**
  - 2, 5, 6
- **Preparation and debriefing**
  - 1, 2, 3, 4, 5
- **Releasing emotions**
  - 2, 4, 5
- **Adult Mental Health nurses' experience of physical restraint**
- **Physical consequences**
  - 1, 3, 4
The grouped main themes and concepts evident across the studies were found to be nurses’ belief that physical restraint was part of the job, nurses’ ethical dilemmas, the consequences of physical restraint for nurses, and coping with physical restraint. These are now discussed in turn.

2.14.1 Physical restraint is part of the ward nurse’s job

Nurses understood physical restraint to be an integral and unavoidable aspect of their work (Bigwood & Crowe, 2008, p.215; Bonner, 2007, p.172), but the ethical conflict they felt about having to restrain patients spoiled their enjoyment of the job (Bigwood & Crowe, 2008, p.215). They described their work in disturbed wards with disturbed patients (Bigwood & Crowe, 2008, p.218; Bonner, 2007, p.145 & Bonner et al, 2002, p.468). Nurses tolerated physical restraint because they sometimes had no other option (Bonner et al, 2002, p.465). They saw restraint techniques as one of the nursing tools available to them (Bigwood & Crowe, 2008, 219) and an effective way of bringing incidents under control (Lee et al, 2003, p.428).


As previously described, Bigwood and Crowe’s (2008, p.218) study is the only study in which nurses connect the idea of touching patients with physically restraining them. In this study, nurses believed that physical restraint was a nursing job because, of all professions, they touched patients most during their daily care. This belief seemed to support their ethical stance about good restraint practice, believing that if they owned the role of physical restraint, they could ensure high standards of intervention.
2.14.2 Mental health nurses’ ethical conflict

Nurses’ commonly described their ethical conflicts about using physical restraint as part of their job. They talked about how physical restraint goes against their conscience (Sequeira & Halstead, 2004, p.8) and how it conflicts with their nursing principles and caring attitude (Moran et al, 2009, p.601). Nurses believed their role has a primarily therapeutic function that sharply conflicted with the culture of control in which they worked (Bigwood & Crowe, 2008, p.220; Bonner et al, 2002, p.470). They described feeling trapped into using physical restraint because there was no other viable option (Bigwood & Crowe, 2008, p.221).

Forensic nurses (Sequeira & Halstead, 2004, p.7) expressed how their feelings of anger and conflict intensify when they perceived patients to provoke them into physical restraint. Nurses who had worked for more than five years in the same hospital also spoke of their boredom, frustration and low morale having endured frequent restraint incidents. They described disillusionment with using physical restraint repetitively with patients who they believed had control over their behaviour, and the nurses felt there must be a better solution (Sequeira & Halstead, 2002, p.8).

Nurses justified physical restraint on therapeutic grounds because they felt they have to take control of patients who were unable to control themselves (Bigwood & Crowe, 2008, p.218). Justification felt easier when they had been able to explore other options first (Moran, 2009, p.601; Bigwood & Crowe, 2008, p.220). When nurses intervened on the instructions of a colleague, rather than on their own clinical judgement, they spoke of how, afterwards, they wondered whether they could have done anything different (Bigwood & Crowe, 2008, p.220; Bonner, 2007, p.142; Bonner et al 2002, p.468). Some nurses believed
that they contributed to the necessity for physical restraint because they waited until situations escalated, rather than intervening early (Bonner, 2007, p.172).

2.14.3 Consequences for nurses of using physical restraint interventions
2.14.3.1 Physical consequences

Lee et al (2003, p.426) differentiated between the cause of nurses’ self-reported injuries during physical restraint. 13% of nurses’ injuries were reported to be caused by the patient and the incident itself accounted for 21.6% injuries. The injuries included ‘bruised ribs, ‘a broken nose,’ ‘a dislocated arm’ and ‘scratches and grazes.’ Environmental issues also placed nurses and patients at risk because of restraining in confined spaces and with unsafe furniture (Lee et al, 2003, p.427). Bonner et al (2002, p.469) describe a physical attack on staff with a weapon but do not describe the physical consequences. In her later study, Bonner (2007, p.140) describes a range of self-reported injuries (n=30), but does not differentiate between the causes. Injuries ranged from no injury (50%), to 10% nurses requiring treatment by a doctor, including one nurse’s attendance at the Accident and Emergency Department for a ‘back injury.’

2.14.3.2 Emotional consequences

All the studies described how frightened of injury and emotionally overwhelmed nurses felt at the point of having to restrain, whether they worked in acute or forensic settings (Moran et al, 2009, p.601; Bigwood & Crowe, 2008, p.215; Bonner, 2007, p.148; Sequeira & Halstead, 2004, p.5; Bonner et al, 2002, p.468). Their fear of injury could be so extreme that one nurse described quaking with fear (Moran et al, 2009, p.601). Another nurse described being incontinent (Bonner et al, 2002, p.465), and in another study, one nurse said she felt afraid of becoming incontinent (Sequeira & Halstead, 2004, p.6). Nurses also described how humiliated and foolish they felt when patients assaulted
them during restraint (Bonner, 2007, p.149), and how demeaning it felt to restrain patients (Lee et al, 2003, p.427).

Some nurses described suppressing feelings and intervening on autopilot. Bonner (2007, p.148) reported that 13% of nurses described becoming less aware of their emotional response during the restraint. Similarly, 50% nurses in Sequeira and Halstead’s (2004, p.9) study said they had no feelings during periods of restraint and nearly 25% described automatic responding in which they were not aware of any emotional response throughout the entire intervention. Some senior nurses recalled deliberately inhibiting their emotional distress to project a state of being in control to other staff and patients (Sequeira & Halstead, 2004, p.8). The authors conclude that nurses’ strong feelings of anxiety and anger about physical restraint interventions may reflect the forensic setting and the people they nursed.

Following physical restraint, nurses’ feelings manifested an ‘aftermath’ of anger and distress, and they spoke of feeling embarrassed and forlorn at having reached the point of physical restraint (Bonner, 2007, p.152; Bonner et al, 2002, p.468). Nurses also believed their use of force left a bad, uneasy atmosphere for everybody on the ward (Moran et al, 2009, p.601).

Bonner et al (2002, p.465) suggest that the most disturbing findings from their pilot study relate to three patients’ and several nurses’ descriptions of feeling re-traumatised by physical restraint in the context of a history of abuse or violence. The authors call for urgent research into the psychological effects of physical restraint. However, the recommendations do not incorporate patients’ physical experiences of nurses’ touch with patients with traumatic histories. Similarly, in Bonner’s subsequent (2007) study, the author suggests that the re-awakening of nurses and patients’ trauma from earlier experiences of bodily violations
arises because of the techniques used. Again, there is no discussion of nurses’
experience of forced touch during physical restraint.

2.14.3.3 Mental health nurses’ attitudes of concern

Some nurses reported concerns about colleagues’ behaviour during physical
restraint. They described witnessing the deliberate use of hyper-flexion and
wristlocks to induce pain, or to gain compliance with instructions (Lee et al
2003, p.427). Some nurses felt that their colleagues might not be able to
contain their emotions and may lose control with patients who assaulted
colleagues (Sequeira & Halstead, 2004, p.7). Whilst the nurses did not disclose
any intention to harm patients, some of them revealed having had thoughts of
doing so, and they described associated feelings of guilt (Sequeira & Halstead,
2004, p.7). One nurse in Sequeira & Halstead’s (2004, p.6) study, a discrepant
case importantly included to illustrate outlying data (Silverman, 2001, p.238),
revealed a male nurse’s belief in his natural tendency to protect others and how
he went with bravado into risky situations on his own, without regard for others’
safety.

Both Lee at al (2003, p.425) and Sequeira & Halstead (2004, p.8) describe
forensic nurses’ ambivalence about restraining. Nurses in Lee at al’s (2003,
p.429) study complained of working amidst ‘deck them first’ attitudes, using
restraint as a ‘legal way of hurting patients’, and a ‘bouncer’ mentality, as well
as a culture of intervening too quickly, rather than seeing physical restraint as
the last recourse of action. As previously suggested, Lee et al’s findings in
RSUs and PICUs may reflect the anonymity afforded by a postal survey that
increases likelihood of more honest responses about an area of professional
embarrassment or threat (Bowling, 2005, p.421).

Nurses in Bonner’s (2007, p.172) study described different concerns about
colleagues’ attitudes. Some reported colleagues taking sick leave to avoid C&R
training, or to avoid being on duty with aggressive patients. The nurses said that management should re-deploy staff who did not wish to restrain as part of inpatient work. The nurses also described colleagues who achieved their C&R competencies in the classroom, but failed to demonstrate competence in practice, leaving the team and patient at risk, as well as ruining the reputation of the nursing team.

2.14.3.4 Nurses’ positive experiences of physical restraint

Some nurses felt a sense of satisfaction when they were able to avoid physical restraint by using advanced de-escalation skills (Bigwood & Crowe, 2008, p.219). They also experienced restraint as a positive intervention when they believed that they had protected other patients and staff (Moran et al, 2009, p.601; Bigwood & Crowe, 2008, p.219; Lee at al, 2003, p.425). Participating with colleagues in physical restraint could also engender feelings of team cohesion and teamwork (Bigwood & Crowe, 2008, p.219; Bonner, 2007, p.155; Bonner et al, 2002, p.69), as well as creating a sense of safety and being in control (Bonner, 2007, p.173). Occasionally nurses felt that they built a bond with patients through the sharing of a highly significant event (Bigwood & Crowe, 2008, p.219).

2.14.3.5 Perceived impact upon relationships with patients

62% nurses in Lee at al’s (2003, p.427) study described difficulty in maintaining therapeutic relationships with patients following restraint and patients behaviours could escalate further in the context of a lack of resolution to the underlying pathology. Some nurses also spoke of emotionally detaching from patients and becoming hardened to the experience of physical restraint, causing problems with their emotional availability to patients (Moran et al, 2009, p.602 & Sequeira & Halstead, 2004, p.9). Nurses in Moran et al’s (2009, p.603) study
illuminated how their emotional suffering could cause the longer-term objectification of patients relating to them as ‘other’, creating the potential for breakdown in therapeutic relationships.

2.14.4 Mental health nurses coping with physical restraint

Conscious emotional and physical preparation helped nurses to cope with an impending restraint (Bigwood & Crowe, 2008, p.220; Bonner et al, 2002, p.469). They suppressed unpleasant feelings in order to get through it (Moran, 2009, p.601). Yet, even with preparation, the magnitude of what they had to face sometimes left them feeling inadequately prepared (Bigwood & Crowe, 2008, p.220).

The studies suggest that even though nurses suffered injuries and psychological distress, they adapted to their role in physical restraint. Nurses new to the ward took their cues from senior staff and became accustomed to participating, even though ward cultures gave little time for them to process their experience (Bigwood & Crowe, 2008, p.218). Their anxiety settled as the experience of physical restraint became more familiar (Sequeira & Halstead, 2004, p.6) and it became a disliked but accepted part of their job.

Although nurses described familiarity with their role, Moran et al (2009, p.602) suggests that having to deal with severe aggression consumed their psychological space that was necessary for empathy with the patient during restraint interventions. For some nurses, a state of hardening, whether conscious or unconscious, persisted and they remained psychologically defended against their feelings (Sequeira & Halstead, 2004, p.9). Nurses working in areas with frequent restraints described detached emotional states that also inhibited them from checking the patient’s comfort, taking their
observations, and assessing their emotional wellbeing during physical restraint (Moran et al, 2009, p.602).

Following physical restraint, the nurses believed formal and informal de-briefing to be positive mechanisms to talk through the event and their feelings (Bigwood & Crowe, 2008, p.221; Bonner, 2007, p.175; Lee et al, 2003, p.428; Bonner et al, 2002, p.470). However, nurses described the availability of support to be variable (Bonner, 2007, p.174; Bonner et al, 2002, p.469). Some night staff recognised their particular vulnerabilities in relation to lower staffing numbers and they actively sought de-briefing (Bonner, 2007, p.175). In contrast, nurses on forensic wards described macho climates of unacceptability, stigma and ambivalence about expressing their feelings or seeking support (Sequeira & Halstead, 2004, p.10). Female forensic nurses expressed their need for support more openly, but in the context of also experiencing the highest levels of distress about physical restraint (Sequeira & Halstead, 2004, p.10).

Following intervention, nurses said they coped by laughing and joking (Bigwood & Crowe, 2008, p.22; Sequeira & Halstead, 2004, p.12). Some saw this as a defence against revealing to colleagues less acceptable responses such as anxiety (Sequeira & Halstead, 2004, p.9). Those who suppressed their emotions during their intervention said they sometimes thought about them at home (Sequeira & Halstead, 2004, p.9). Colleagues of nurses who suffered severe physical injuries believed that their team members never really made a full psychological recovery and it had a long-term impact upon their personal lives and work with patients (Bonner, 2007, p.176).

2.14 5 Summary of mental health nurses’ experience of physical restraint

The review of the literature revealed only a small number of studies designed to understand nurses’ subjective experience of physically restraining patients in
adult acute mental health wards. The studies give a rich impression of nurses' experiences, but they do not illuminate nurses' experience of forced touch with patients during physical restraint intervention. Rather than explicit exploration, it appears that the studies assumed readers' understanding and therefore inferred forced touch, did not intend to focus upon forced touch, or they had not themselves considered physical restraint as forced touch.

This apparent lack of contemporary knowledge directed me towards a search of a second body of literature to see if this could shed any light upon the topic. A search of qualitative and mixed method studies into mental health nurses’ experience of touch in adult mental health wards was undertaken to understand if studies of nursing touch had explored nurses’ experience of forced touch. Broad search terms were used including mental health OR psychiatr* AND touch to capture any available published studies on the topic area. Secondary references were followed up to identify studies not retrieved through the search terms.

2.15 Findings from the literature review on adult mental health nurses’ use of touch

Only four available studies spanning over five decades specifically inquired into nurses’ experience of touch in their care of patients in adult mental health wards, and there were none from the UK. Two were from the Republic of Ireland (Gleeson & Higgins, 2009, p.382; Keogh & Gleeson, 2006, p.1172), and two in the USA (Tomassini, 1990, p.213; DeAugustinis, Isani & Kumler, 1963, p.271). A fifth study, undertaken in Sweden (Carlsson, Dahlberg & Drew, 2000, p.533), did not specifically focus upon nursing touch, but importantly illuminated nurses’ use of touch as a major theme arising from inquiry into nurses’ positive experiences with patients during violent and aggressive encounters, and was therefore included in the review.
The four studies explored different aspects of touch. These included nurses’ perceptions of using touch with patients who experience mental health problems (Gleeson & Higgins, 2009, p.382), male nurses’ experiences of caring for female patients (Keogh & Gleeson, 2006, p.1172), nurses’ experiences of deliberate non-procedural touch (Tomassini, 1990, p.213), and the meaning of touch amongst female staff and female patients in long-term mental health care (DeAugustinis et al, 1963, p.271).

A summary of the studies is in Appendix 3. Speziale and Carpenter’s (2007, p.104) framework for qualitative study criteria was again employed to examine the methodological features of the studies and their strengths and limitations, thereby demonstrating their contribution to the science of nursing.
2.16 Critique of the reviewed studies into adult mental health nurses’ experience of touch

The span of studies reveals a sporadic and limited interest in mental health nurses’ experience of touching patients. None of the studies explored physical restraint interventions and consequently there was no evidence of forced touch in this body of literature. In the studies, there were different approaches to studying touch and the samples were imbalanced in terms of the participant’s gender. DeAugustinis et al’s (1963, p.271) study contained an all-female sample. Tomassini (1990, p.213) and Carlsson et al (2000, p.533) also engaged predominantly female samples. It is unclear whether these study samples reflected the nursing populations at the time.

Keogh & Gleeson (2006, p.1172) focused specifically on male nurses (n=11, 5 general nurses and 6 psychiatric nurses) experiences of touch when caring for female patients. Later, Gleeson & Higgins’s (2009, p.382) sample was more balanced in an attempt to address the limitations of previous studies and contained 6 males and 4 females. However, the voices presented in the study are predominantly male with almost three times as many quotations from male nurses than female nurses. It is unclear if this is an attempt to ensure that male nurses’ perspectives in the Republic of Ireland are illustrated, but the female nurses’ experiences appear under-represented. The study appears to build upon Keogh & Gleeson’s (2006, p.1172) earlier research in the Republic of Ireland that specifically focused on male nurses. In both studies, male nurses’ expressed similar concerns about the potential for allegations of sexual impropriety. Gleeson & Higgins (2008, p.388) suggest that male nurses' fears may reflect the recent rise in public discourse in Ireland surrounding sexual abuse. Thus, the most recent studies of mental health nursing touch do not represent female nurses’ views, and therefore, any similarities and differences are unknown.
Carlsson et al’s (2000, p.539) descriptive phenomenological study explored positive encounters with aggressive and violent patients. Rich data portrays how the nurses (n=5) used skilled touch with even the most intimidating patients (Carlsson et al, 2000, p.539). They spoke of touching patients to tend to patients’ psychological wounds that they had expressed through violence and aggression. The nurses said they hoped that their touch gave something positive to patients at a peak of distress when they had become highly confrontational. Although not a study of nurses’ experience of forced touch, this study illuminates how mental health nurses’ may use touch carefully and sensitively even in hostile and aggressive encounters.

Unlike the three later studies in the review (Gleeson & Higgins, 2008, p.382; Keogh & Gleeson, 2006, p.1172 & Carlsson et al (2000, p.539), the two older studies (Tomassini, 1990, p.215 & DeAugustinis et al, 1963, p.271) do acknowledge the connection between physical restraint interventions and touch, but make only minor mention without exploration. Tomassini (1990, p.215) recognised physical restraint intervention as a form of touch, but only to exclude from the study design to stay focused specifically upon exploring nurses’ intentions to use non-procedural touch. DeAugustinis et al’s observational and interview study of the meaning of touch during interpersonal communication describes only incidental findings that included nurses’ touching assaultative patients to move them into a seclusion room (DeAugustinis et al, 1963, p.293). One participant mentioned the reciprocal nature of touch during restraint (DeAugustinis et al, 1963, p.294). Albeit that only brief connections in these two studies are made, researcher’s connections between touch and physical restraint interventions appear to have diminished over time with no substantial exploration of the topic.
2.16.1 Researchers’ suggested reasons for the paucity of studies into touch in mental health nursing

In each of the reviewed studies, the researchers suggest reasons for the paucity of studies into touch in mental health nursing. Tomassini (1990, p.213) suggests that professional caution about using touch with psychiatric patients has resulted in a lack of physical touch. Gleeson & Higgins (2009, p.382) make a similar argument citing a historical belief that psychiatric patients were too unpredictable to touch. Chatterton (2000, cited in Keogh & Gleeson, 2006, p.1172) suggests that the strict separation of the sexes in Victorian institutions may have given rise to a strong male tradition that has influenced the development and study of psychiatric nursing. The verbal tradition of the psychiatric profession is also proffered, the specialty being viewed as founded upon verbal processes in which the patient was not normally touched (DeAugustinis et al, 1963, p.271). Finally, Gleeson & Higgins (2009, p.382) suggest the type of patients on adult acute wards as a contributory factor because most are physically self-caring and do not require nurses to touch them to care for them.

Whatever the reason, clearly, touch has been a controversial subject in the psychiatric professions. Twenty-five years ago, Tomassini (1990, p.213) suggested that there was a growing interest in the value of touch in mental health nursing, yet the research literature has not yet revealed any great interest in the topic.

Given the limited information available in the literature, Figure 2.7 sets out the main ideas, rather than the themes, about mental health nurses’ use of touch.
Figure 2.7. Ideas in the literature about mental health nurses' use of touch
2.17 Summary of the research literature on mental health nurses’ experience of physical restraint and their use of forced touch

The concept map of the main themes from the research literature of nurses’ experiences of physical restraint (Figure 2.6, p.33) and the depiction of ideas in the literature about mental health nurses’ use of touch (Figure 2.7, p.47) draw together, and summarise, the available empirical evidence on the topic area.

Figure 1 represents the four recurring themes of nurses’ experiences of physical restraint in the research literature. These included nurses’ beliefs that physical restraint was part of their job, their perceived ethical dilemmas, their thoughts about the consequences of physical restraint, and how they coped with physical restraint. Yet, the nurses’ experience of forcefully touching patients appears absent from the researchers’ approach to understanding nurses’ experiences of being in restraint with patients. With only two of the studies, both by the same researcher, conducted in the UK (Bonner, 2007; Bonner et al, 2002, p.465) and now somewhat dated, there appears to be a dearth of relevant, current literature on the topic in this country.

Figure 2 draws together ideas, rather than themes, because of the small number of studies about mental health nurses’ use of touch available in the literature. No studies were conducted in the UK. The oldest available studies (Tomassini, 1990, & DeAugustinis, Isani & Kumla, 1963) do recognise physical restraint as a form of nursing touch, but do not focus on the topic. The later studies (Gleeson & Higgins, 2008; Keogh & Gleeson, 2006, & Carlsson, Dahlberg & Drew, 2000) do not consider physical restraint in their focus upon mental health nurses’ use of touch. Yet, the main ideas emergent throughout the findings describe touch as an essential aspect of mental health nursing (Gleeson & Higgins, 2008 & Carlsson, Dahlberg & Drew, 2000). These include how nurses’ use touch with sensitivity (Gleeson & Higgins, 2008) and how
positive encounters with aggressive patients embody touch (Carlsson, Dahlberg & Drew, 2000). It is unclear why researchers have not extended their interest to mental health nurses’ experience of touching patients during physical restraint. However, the inextricable link between nurses’ experience of forced touch interventions and physical restraint procedures is not acknowledged in the current literature.

The gap in the contemporary literature was, to my mind, surprising for a number of reasons. First, physical restraint interventions with adult patients in the UK rely entirely on the nurse using his or her body forcefully to touch and make direct contact with the patient’s body to restrict movement. The contemporary literature infers nurses’ experience of forced touch rather than exploring the topic.

Second, the responsibility for physical restraint interventions has generally fallen to nursing staff (Marangos-Frost & Wells, 2000, p.363) and they form part of ward-based nursing work in the UK. However, it was apparent that there has been little exploration by the nursing profession into this area of nursing practice, even though it may be highly significant for the nurse and the patient.

Third, nurses undertake regular, specific training that involves learning to touch patients using a variety of holds and techniques to restrict patient movement, yet there appears to have been little exploration in the literature of nurses’ experience of using touch in this way.

Finally, touch is not simply a forceful skin-to-skin (or body to body) contact between nurse and patient (Estabrooks & Morse, 1992, p.449). In the case of forced touch during physical restraint, the intervention encapsulates the complexity of the legal, cultural and environmental context of nurses’ work, local and organisational leadership, the intellectual understanding of the event, and
the personal dimensions of touch. Therefore, it can be argued that the current gap in the literature shows a lack of understanding given to nurses’ meanings of these layers of complexity embedded in their forced touch interventions.

2.18 Justification for the study

This study of nurses’ experiences of forced touch is important for two reasons. First, physical restraint procedures are part of acute adult mental health ward nurses’ practice but there is little recent literature on the topic. This study therefore aimed to provide up-to-date knowledge about nurses’ lived experience of physical restraint procedures.

Second, this research differentiates itself from previous enquiries into nurses’ experiences of physical restraint procedures by its unique enquiry into nurses’ experiences of forced touch during physical restraint interventions. Physical restraint interventions are impossible without nurses’ touching patients and patients touching nurses. Yet, how nurses’ experience this forceful and direct bodily contact remains unknown. Nursing touch is described as a multidimensional concept involving voice, posture, affect, intent and meaning (Estabrooks & Morse, 1992, p.450). It is said to be a hallmark of nursing practice because it connects nurses with the patient’s world in a direct and immediate way (Green, 2013, p.250). Yet, how mental health nurses experience forced bodily connection with patients during physical restraint interventions in the complexity of their work environment is unclear.

Developing this understanding may inform approaches to physical restraint practice and training because the meanings that nurses give to their touches may influence how they both physically touch and emotionally connect with patients before, during and following this crisis intervention. It is also important,
therefore, to enquire specifically into nurses’ experience forced touch with patients during physical restraint interventions.

Chapter 3 now presents the development of the methodology and method for the study.
CHAPTER 3: METHODOLOGY AND APPROACH TO STUDY

3.1 Introduction

This study addressed an opportunity to study nurses’ current experience of physical restraint procedures and to enquire into a previously unexplored experience, forced touch during physical restraint interventions, thereby commencing a discourse about nursing practice and training that is not currently present in the literature. It was possible that nurses’ experience of forced touch existed amongst nurses themselves in their personal spheres of practice (Van Dongen & Elema, 2001, p.150), but was not yet presented in the public domain.

3.2 Exploration of personal ontology and epistemology

As illustrated in the prelude to this thesis, the research question arose from my professional interests. Similarly, one’s personal philosophy about the nature of being in the world can also strongly influence the paradigm, methodology and method chosen for the study (Savin-Baden & Major, 2013, p.59; Denzin & Lincoln, 2005, p.2; Carolan, 2003, p.10; Parahoo, 1997, p.52; Koch 1995, p.827; Phillips, 1990, p.34). Therefore, an exploration of the basic beliefs through which I understand my world helped to determine the interrelationships between the ontological, epistemological and methodological levels of my inquiry (Denzin & Lincoln, 2005, p.19; Proctor, 1998, p.74). First, I explored my personal ontology, the vital initial phase of the research process (Denzin & Lincoln 2005, p.19; Koch 1995, p.827).

3.2.1 My ontological beliefs

Ontology is concerned with the nature of reality and our existence in our world (Denzin & Lincoln, 2005, p.22). In my professional and personal life, I believe
that reality has many different perspectives for people because we understand our world by subjectively living in it, experiencing it, and interpreting our experience to give meaning to it. Access to the world is through our body, shaping our understanding through our bodily existence (Oiler Boyd, 2001, p.77). I believe that nurses understand forced touch during physical restraint interventions because they participate in and experience it through their bodily existence. Each nurse who uses forced touch has their own physical, emotional and perceptual experiences of using it against someone in their care. Thus, nurses have multiple realities relating to their use of forced touch arising from their many subjective experiences in the world.

3.2.2 My epistemological beliefs

Epistemological beliefs concern our understanding about the nature of knowledge, how we believe it is constituted, and how to acquire it (Holloway, 1997, p.54). Understanding one’s epistemological beliefs is important because they justify the methodology and consequently the aim, function and assumptions of the method (Schwandt, 2001, p.71).

As a mental health nurse, I believe that people give meaning to experiences from their personal perspectives of living in their world. Mental health nurses have a long tradition of observing and listening to patients’ subjective experiences and interpretations of the world, and, some would argue that it has become elevated to an art (Munhall, 2001a, p.158). I believe we also understand our colleagues’ experiences by talking about our clinical work, observing each other in practice, and sharing our thoughts and feelings. Our interactions with patients and colleagues therefore shape our understanding of our clinical world and the people who inhabit that world. Following this, I also believe that the meaning of forced touch can be known by interacting with, and
listening to, the multiple perspectives of nurses who live forced touch in acute mental health wards.

These ontological and epistemological beliefs influenced my research question that asked,

‘What is it like for mental health nurses’ to use forced touch during physical restraint in acute mental health inpatient settings?’

Having illustrated these interrelationships, I selected a qualitative approach to my research project consistent with my ontological and epistemological stance, and my research question.

3.3 Qualitative research

Qualitative approaches take an emic perspective. The emic perspective values the subjective account of the interpretations and understandings of people from within the context and culture in which they live (Hall, 2006, p.32; Holloway & Wheeler, 2002, p.3; Porter, 2000, p.141). To understand this ‘truth,’ qualitative researchers must study phenomena though the eyes of a number of people in their lived situations to discover the consistencies, patterns and meanings that they give to their experience (Welford, Murphy & Casey, 2011, p.40). Studies are undertaken in the participants’ natural setting because the context of the research is critical to the study (Savin-Baden & Major, 2013, p.13).

Qualitative research is inductive in design, directed towards bringing knowledge about the phenomenon into view (Welford, Murphy & Casey, 2012, p.30). Inductive reasoning starts with a number of individual experiences and seeks commonalities that link them together (Holloway, 1997, p.91), bringing nurses’
shared understanding into view (Morse & Field, 1996, p.7).

In qualitative studies, researchers are the research instrument, engaging with and gathering data from people (Savin-Baden & Major, 2013). They accept that some researcher bias will be present, but that this also has the potential to enrich the study (Speziale & Carpenter, 2007, p.23; Grbich, 2007, p.8; Carolan, 2003, p.10). The culmination is the presentation of a thick description to illustrate the researcher’s comprehensive analysis and interpretation of the participants’ meaning of their experience (Holloway & Wheeler, 2002, p.13). Qualitative research was appealing to me because, as Cutliffe & Goward (2000, p.590) suggest, essential qualitative research skills including the purposeful use of self, the importance of the interpersonal relationship, and the ability to tolerate ambiguity all resonate easily with me in my work as a mental health nurse.

3.4 Choosing a research approach to answer the research question

There are a number of approaches to collecting and analysing qualitative data reflecting both the philosophical traditions of qualitative research and the pragmatic considerations of the researcher. Prior to selecting my approach, it was essential to think critically and identify the phenomenon of study because the phenomenon of interest significantly influenced my question and would therefore influence my approach (Biddix, 2013, cited in Savin-Baden & Major, 2013, p.93). The research question was directed towards understanding nurses’ lived experiences of forced touch interventions during physical restraint procedures. Thus, the central phenomenon, and therefore the focus of this study, was individual nurses who experience forced touch in their daily lives (Biddix, 2013, cited in Savin-Baden & Major, 2013, p.93). I considered a number of philosophical approaches to qualitative research including ethnography,
grounded theory and phenomenology that may help to answer the research question, as well as pragmatic considerations for a full time clinician.

Examining ethnography first, ethnography evolved from anthropology and it is the study of people, cultures and values (Savin-Baden & Major, 2013, p.196). An ethnography describes and interprets the meanings of a cultural or social group, or system, during their everyday life (Savin-Baden & Major, 2013, p.197; Creswell, 1998, 58). In an ethnographic approach, the group itself is the phenomenon and, therefore, collecting and analysing data from the group itself is the research focus (Savin-Major & Baden, 2013, p.90). In this study, the research question did not focus upon a group of nurses’ social and cultural meanings of forced touch as the central phenomenon. Therefore, an ethnographic approach would not answer the question. From a pragmatic stance, ethnographic approaches often involve extended engagement and observation in the field with the people there (Savin-Baden & Major, 2013, p.197); my full time clinical role would not afford the opportunity for extended immersion in the field.

Second, grounded theory is an approach to data collection and analysis that has its roots in symbolic interactionism (Holloway & Wheeler, 2002, p.153). The researcher explores social processes that present during human interactions (Streubert & Carpenter, 2007, p.133). The aim is to generate a new theory or refine existing theory that explains significant social processes and is grounded in the data (Streubert & Carpenter, 2007, p.137). In a grounded theory approach, the phenomenon of interest in a research study is therefore the social process (Savin-Baden & Major, 2013, p.89). In this study, the research question did not focus upon understanding nurses’ social interactions surrounding physical restraint interventions, and did not seek to generate or refine a theory.
therefore felt that this approach would not be appropriate to the research question.

Finally, phenomenological approaches draw upon the philosophy of phenomenology to understand the nature of human experience through exploration of what a number of people appear to have in common (Creswell, 1998, p.235). The central phenomenon is the individual’s experience of life circumstances or concepts (Savin-Major & Baden, 2013, p.90). The aim is to understand the phenomenon and describe the way in which it presents itself to the consciousness of the individuals who encounter it (Savin-Baden & Major, 2013, p.215). This approach presents what individuals have in common, rather than any attempt to portray the experience of a ‘group’ of people.

Of these three approaches, I selected a phenomenological approach because this seemed the most appropriate approach to answer the research question since this focused on experience, specifically acute adult mental health nurses’ individual experience of forced touch during physical restraint interventions, and the commonality of experiences across a number of nurses.

3.5 The importance of the patient’s voice

This research focused upon nurses’ experience of forced touch during physical restraint interventions. The research question developed following my aforementioned encounter with Paul and the identification and explication of a significant gap in the literature. Having listened to Paul’s poignant perceptions of nurses’ attitudes conveyed through their touch during physical restraint, I wished to understand from the nurses’ perspective how they perceived touching patients during physical restraint. I believed that gaining this understanding would provide information that would ultimately inform the nursing care of patients during physical restraint interventions.
Yet, the importance of the acute adult patient voice is indisputable. Studies of patients’ experiences of being physically restrained are extremely limited. Most concern the use of mechanical restraints, raising concerns about the transferability of the findings to the UK. No specific studies of patients’ experiences in adult acute mental health environments were located in Strout’s (2010, p.416) integrative review of the qualitative literature.

It is possible that researchers have avoided exploring patients’ perceptions because of the challenging ethical considerations, the patients’ mental state and wellbeing, the issues surrounding informed, ongoing consent, and the sensitivity of the topic area. Patients’ experiences of physical restraint may also be a source of embarrassment to nurses, the nursing profession, and organisations alike, and there may be a significant professional reluctance to research this area of practice. It may also be that researchers recognise patients’ experiences of physical restraint as suffering. Frank (2001, p.353) suggests that suffering is a difficult concept to articulate, and unfortunately, research refuses to acknowledge that some aspects of suffering have remained unsayable (p.358). It is therefore plausible that the experience of patients restrained by nurses has remained unsayable because the experience seems too difficult to articulate (Makaroff, 2012, p.481).

Therefore, as I progressed with this study, I also developed a growing sense of the urgency and importance of understanding the patient voice and the possible reasons for the absence of research in the area. Recommendations for future research in this area are in Chapter 5.

3.6 Selecting a phenomenological approach to answer the research question

Phenomenology was selected because it is a philosophical approach to the study of human experience, or what the experience of being human is like (Smith, Flowers & Larkin, 2009, p.11). My interest was to understand nurses’
experience of forcibly touching patients to restrict their movement. The concept of ‘phenomenon’ has its roots in the Greek language meaning to show itself in the light (Moran, 2002a, p.279). Phenomenology may be concerned with examining visible, surface meanings or latent meanings (Smith, Flowers & Larkin, p.24). The expression of phenomena is through our language, providing the researcher with insights into the meaning of the world for people, or what is real or true for them (Speziale & Carpenter, 2007, p.81; Mackey, 2005, p.180).

Phenomenology is not a single set of philosophical beliefs. It is a range of philosophies that vary significantly and often have contrasting perspectives (Munhall, 2001a, p.123). In itself, it does not provide a methodology, nor a method, but a philosophical framework to underpin methodology and therefore, nursing research methods (McConnell-Henry et al, 2009a, p.8). Hence, the philosophy is interpreted in a variety of ways to inform the methodology and methods used. There is no common agreement about how to pursue a phenomenological study. The only commonality amongst any type of phenomenological approach is to reveal the lived experience as it speaks for itself (McConnell-Henry et al, 2009a, p.8) by researchers taking a fresh view of the essential features of peoples’ experiences in their world (Moran, 2002b, p.1).

In phenomenological research, a common misunderstanding is that two dominant phenomenologists, Edmund Husserl and Martin Heidegger, share interchangeable philosophies, when in fact, they are very different (Dowling & Cooney, 2012, p.21; McConnell-Henry et al, 2009a, p.8). Unfortunately, phenomenological studies suffer from varying degrees of conceptual clarity in which researchers do not differentiate between phenomenological approaches (Jones, 2001, p.65). This is important because Husserl and Heidegger’s
philosophies inform two distinct strands of phenomenological research in nursing: descriptive (eidetic) and interpretive (hermeneutic) phenomenology. Distinguishing between these and selecting which phenomenological approach to employ is essential to ensure alignment with the researcher’s personal beliefs and the research question. Establishing this clarity from the outset helps to guide the inquiry and ensure that the foundations of the study are sound, with good science through from philosophy to method (Gelling, 2010, p.17; Speziale & Carpenter, 2007, p.25; Whitehead, 2004, p.512). To illustrate the decisions that informed the chosen phenomenology, the distinctions between these two dominant philosophers are now set out.

### 3.6.1 Husserlian phenomenology

Husserl introduced the study of human experience within the ‘life-world’ (McConnell-Henry, Chapman & Francis, 2009b, p.9). Life-world represents the grounding of human experience in our interactions with the world (Moran, 2002b, p.3). Husserl’s philosophy represents the mind-body split known as Cartesian duality in which our interactions with the world as object are cognitively developed and held as essences in our mind, forming our subjective reality of life-world (Holloway & Wheeler, 2002, p.172; Koch, 1995, p.828; Leonard, 1994, p.44). Essences are units of meaning that give common understanding amongst people about a phenomenon (Speziale & Carpenter, 2007, p.78). Husserl believed that essences are universal to all who have lived the experience and they have only one correct interpretation, or truth (Flood, 2010, p.9). His intention was to come face to face with these cognitive structures of consciousness to reveal the thoughts, feelings and perceptions of human experience through accurate description in language, to give true meaning and common understanding of the phenomenon (McConnell-Henry et al, 2009b, p.9; Speziale & Carpenter, 2007, p.79). Thus, the aim of a Husserlian phenomenological study is to describe the phenomenon through the essences
of the experience as they appear in people’s consciousness. This philosophical stance is essentially epistemological because it determines that we express our experience through our consciousness and this represents knowledge (Leonard, 1994, p.44).

Husserl believed that it was essential to reveal only the subject’s knowledge through a process of phenomenological reduction to give a clear view of the phenomenon of interest (Paley, 1997, p.188). This philosophical stance demands that the researcher engages in a process of bracketing, or epoché, putting one’s own thoughts and experience in parenthesis to exclude them from the participants’ description of the phenomenon (Bradbury-Jones, Irvine & Sambrook, 2010, p.25; Cerbone, 2006, p.22). Bracketing therefore attempts to achieve objectivity by identifying and suspending one’s personal beliefs and knowledge about the phenomenon to achieve an uncontaminated view (Savin-Baden & Major, 2013, p.214; Speziale & Carpenter, 2007, p.84).

When considering the application of phenomenological philosophy to research, some consider it almost impossible for researchers to achieve and maintain this bracketed stance whilst immersed in the participants’ world throughout the study (McConnell-Henry et al, 2009a, p.1). Indeed, questions about whether it is even possible to suspend one’s preconceptions remain unanswered (Gelling, 2010, p.5), or whether any interpretation is ever made devoid of personal judgement (McConnell-Henry et al, 2009b, p.9).

In choosing the phenomenology for the study, the influence of Husserl’s beliefs about the importance of objectivity led me to reject this approach and follow Heideggerian thinking. My personal beliefs incorporate the idea that who I have become through my life experience influences how I understand each situation.
that I encounter as a person and a nurse, and in turn, this influences how I understand physical restraint interventions with patients. Similar to Savin-Baden & Major (2013, p.215), I do not believe that I could simply bracket this knowledge. Heideggerian thinking takes a different stance on this key philosophical tenet.

**3.6.2 Heideggerian hermeneutic phenomenology**

Heideggerian hermeneutic phenomenology is a research approach rooted in phenomenological philosophy (Cohen, 2000, p.5). Heidegger differentiated his phenomenology from Husserl’s epistemological position by taking an ontological position of interpretation (Koch 1995, p.832; McConnell-Henry et al, 2009, p.8). Heidegger sought to understand what it means to be a person in the world (Flood, 2010, p.9; Mackey, 2005, p.180; Laverty, 2003, p.3; Cohen, 2000, p.5). For Heidegger, human beings are self-interpreting because they are influenced by the world in which they live (Flood, 2010, p.9), and they derive meaning from every situation they encounter (McConnell-Henry et al, 2009a, p.11). ‘Dasein’ describes Heidegger’s understanding of human existence that considered the self and the world to exist as one rather than separate entities (Walton, 1999, p.101). The philosophical assumption of indissoluble unity supports that people are constructed by their world, and construct their world through their background experience (Koch, 1995, p.831).

Heidegger defined hermeneutics as a process undertaken to interpret and comprehend our existence (Cohen, 2000, p.5). This philosophical desire has helped to embed Heideggerian perspectives in nursing practice and research (Pratt, 2012, p.12). Nursing centres upon the lived moments of being with others in healthcare (Gantalao, 2002, p.38). Heidegger believed that people exist in the world amongst other people and therefore develop shared
understanding of others’ contexts (Pratt, 2012, p.13). Heideggerian hermeneutic phenomenology can therefore help nurses to understand patients’ experience of being in health and ill health, as well as what it is to be a nurse, thereby helping nurses to know what it is to be a nurse.

As a nurse-researcher with experience of physical restraint, I believed that what I understood about the empirical, aesthetic, personal, ethical (Carper, 1978, p.13) and socio-political (White, 1995, p.76) aspects of physically restraining patients manifested from my lifetime of encounters with different clinical situations, patients and staff. Heidegger described this as co-constitutionality (Koch, 1995, p.831) in which my experience is inextricably linked with who I am as a person and my understanding of the world. I believed that my understanding of physical restraint would influence the research process and I could not simply forget, overlook, nor bracket out this part of my ‘self’ because my background pervades and influences my understanding (McConnell-Henry et al, 2009b, p.4; Johnson, 2000, p.142; Koch, 1995, p.831). Therefore, I chose to engage with a Heideggerian hermeneutic phenomenological approach to the research study.

3.6.2.1 Essential ideas of Heideggerian philosophy

Heidegger’s work is complex and can be difficult to grasp (Walton, 1999, p.101). However, it is important to understand the essential philosophical tenets relevant to the study including temporality, historicality, the hermeneutic circle, and being-with-others.

Heidegger believed that time (temporality) is integral to our existence. Time for Heidegger was not linear, but a movement between our range of experiences to make sense of our world (McConnell-Henry et al, 2009a, p.11). Temporality
describes how we do this with fluidity, our past life experiences being alive in our present and influencing future understandings (McConnell-Henry et al, 2009a, p.11; Watts, 2001, p.17).

Our history, or historicality, is the past that we bring to our current context and project towards our future. Heidegger believed that we encounter the world, question and interpret it based upon our historicality, or forestructure, and the social situation in which we find ourselves (Koch, 1996, p.176). He also believed that once we grasp an understanding of our world, or our ‘truth’, we disclose these revelations through speech by talking amongst ourselves (Moran, 2000c, p.230).

Historicality further relates to the notion of the hermeneutic circle. The hermeneutic circle describes the cyclical movements that we make to understand our existence by moving back and forth between our forestructures and what we already know about our world, and our new situation, in an iterative process of learning about our existence (Leonard 1994, p.57; Plager, 1994, p.72). Our historicality informs our interpretation because when we approach a new situation, we question it with knowledge derived from our past understanding, a kind of light that casts a pattern over the phenomenon, and we make a new interpretation (Moran, 2000c, p.237). Thus, our understanding is constantly changing as we continually re-interpret our world in a cyclical manner, moving between the parts of what we have already understood, to incorporate them with the new whole of our understanding (Leonard, 1994, p.57). Heidegger believed that people live their lives hermeneutically because they are always within in a circle of understanding (Moran 2000c, p.237; Plager, 1994, p.72).
Heidegger believed that being-in-the-world means being-with-others (Walton, 1999, p.120). Although human beings have unique perspectives on the world, we form a community of understandings that we share amongst ourselves and develop perspectives on our existence rooted in a shared cultural and social ethos (Conroy, 2003, p.2; Walton, 1999, p.120; Plager, 1994, p.70; Walters, 1994, p.24). Therefore, the context of our situation is vital in how we come to interpret our world. Time, place, situation, people and, importantly, our mood or disposition at the time, all contribute towards how we understand and speak of our existence in that moment (McConnell-Henry et al, 2009a, p.12).

These philosophical tenets influenced the decisions I made throughout the research project and I describe their influence upon the choices made regarding the approach to the study.

3.7 Approach to study

As stated, phenomenology is a philosophic attitude that guides a research approach, rather than a prescribed method (Flood, 2010, p.7). My first considerations related to the rigour of a hermeneutic study to ensure that, from the outset, a clear plan documented my decisions in a transparent manner.

3.7.1 Rigour

The aim of conducting a hermeneutic phenomenological study is to bring forth the final interpretation through a rigorous and systematic research process (Speziale & Carpenter, 2007, p.81). Selecting the approach to rigour is therefore an important decision to ensure the merit of the study. The literature presents an array of different criteria for judging the rigour of qualitative studies. deWitt & Ploeg (2006, p.215) criticise the rigidly held criteria of some authors.
because these generalise criteria across different methodologies, thereby ignoring the specific philosophical assumptions that underpin hermeneutic phenomenology. For example, deWitt & Ploeg (2006, p.222) criticise Sandelowski’s (1986) criteria of confirmability that demands researcher neutrality, a position inconsistent with Heidegger’s stance that the interpretations we make are never free of our previous understandings. As previously discussed, I believe that my historicality influences my present and future experiences and therefore, my decisions throughout the project.

deWitt and Ploeg (2006, p.223) propose a framework comprising five criteria that aim to preserve the integrity and legitimacy of hermeneutic phenomenological research through expressions of rigour, as opposed to rigidly held criteria. These criteria supported my decisions to ensure the rigour of this hermeneutic inquiry of physical restraint that takes a different methodological stance to previous studies on the topic. Table 3.1 illustrates the framework and my plan to demonstrate rigour:
## Table 3.1 Framework and plan to ensure study rigour

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Expressions of Rigour in the Study</th>
<th>Plan to demonstrate study rigour</th>
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<tr>
<td>Balanced Integration</td>
<td>Three characteristics determine evidence of balanced integration:</td>
<td>I will illuminate my reasons for choosing the philosophy to guide the study through demonstration of my own world-view. I plan to show how this influenced my chosen methodology and approach to answer my question. Throughout the study, the philosophical tenets will be woven into the decisions taken.</td>
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<td></td>
<td>The underpinning philosophy suits the researcher and the research topic.</td>
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<td>The report demonstrates a balance between the voice of the study participants and the philosophical explanation developed during the analytic phase.</td>
<td>The participants' voices will be presented as verbatim narratives. The theme and quote method will provide the balance of my own voice and the participants' voices. The participants' voices will be written in italics to distinguish them from my interpretation.</td>
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<tr>
<td></td>
<td>The researcher includes the philosopher's main tenets in the final interpretation.</td>
<td>Evidence of my situatedness will be demonstrated through the revelation of my forestructures to provide the background from which light is cast over the participants' stories to create the interpreted meaning. The findings will demonstrate evidence of a clear understanding of the hermeneutic circle and how the world is understood through a dialectical process, as well as emergent philosophical tenets in the nurses' stories.</td>
</tr>
<tr>
<td>Openness</td>
<td>Orientation and attunement toward the phenomena of inquiry throughout the study is demonstrated by opening the study to scrutiny.</td>
<td>Prolonged contact with the participants will be incorporated into the study design to allow them the freedom to tell their story and orientate me to their lived experience. The study context will be clearly described to ensure that the reader understands the setting and participants. The narratives presented will connect readers to the everyday life-world of the nurses and the very real situation that comprises the phenomenon.</td>
</tr>
<tr>
<td></td>
<td>The reader is situated firmly within the context of the phenomenon and can relate the experiences documented in the findings to their own lifeworld</td>
<td>The narratives will present the felt meaning of the narrated phenomenon as it was lived by the participants. The findings will illustrate my grasp of the experience presented for the reader in anticipation of resonance.</td>
</tr>
<tr>
<td>Concreteness</td>
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<tr>
<td>Resonance</td>
<td>There are felt effects upon the reader and a resonance with the experience occurs as the meaning from the text is juxtaposed with self-understanding</td>
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</table>
3.7.2 Reflexivity and the Heideggerian approach

Reflexivity concerns how the researcher understands their subjective impact upon each stage of the research process (Carolan, 2003, p.8). The decisions made, at each step, of this study influenced the findings because, as a researcher with experience of the phenomenon under investigation, I naturally brought ‘a lived world which is included in the study’ (Walters, 1992, p.25 cited by Geanellos, 1998a, p.156). From the Heideggerian perspective, my ‘self’ intersecting with the participants’ data (St Louise & Barton, 2002, p.1) comprised the final interpretation.

Therefore, I was obliged to lay out my experience of physical restraint and forced touch, and acknowledge it for the reader (Geanellos, 1998a p.156). In doing so, I illustrated my position before entering the hermeneutic circle of the study (Geanellos, 1998b, p.241). This early reflexive process enabled me to become more open to the possibilities of a new understanding with the participants by documenting my subjective experiences, attending to them carefully, and moving dialectically between each self-interpretation to consider their meaning (Finlay, 2003a, p.108). Laying open my pre-conceptions in this way helped to ensure that the final interpretation was made transparent, and my voice and the nurses’ authentic narrative were clearly distinguished for the reader (Vivilaki & Johnson, 2008, p.87; Geanellos, 1998a, p.156; Chambers, 1997, p.431).
I engaged in two reflexive processes prior to entering the hermeneutic circle of the study itself. These were:

1. Working out the origins of my forestructures and how these influenced the development of the research question.
2. Developing an awareness of my subjective position, or personal lens, in respect of the phenomenon itself.

3.7.2.1 Working out the origins of my forestructures

Following Heidegger, I explored my forestructures about physical restraint procedures and forced touch that had orientated me towards the phenomenon that I wished to investigate (Geanellos, 1998a, p.156). Forestructure, according to Heidegger, has three constituent parts (Leonard, 1994, p.57). First, forehaving is my taken-for-granted sense of the totality of the phenomenon. Second, foresight is the perspective from which I orientated towards the phenomenon, and finally, foreconception is my preliminary sense of what counts as a question and an answer for the study (Leonard, 1994, p.57). Table 3.2 details each constituent part of forestructure and illustrates how these orientated me towards my research question.
Table 3.2: Constituent components of my forestructures

<table>
<thead>
<tr>
<th>Component of Forestructure</th>
<th>Description</th>
<th>Personal Understanding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forehaving</td>
<td>My taken-for-granted sense of the totality of the phenomena.</td>
<td>Physical restraint is a fairly common intervention in which mental health nurses use forced touch to restrict patient’s movement with their body.</td>
</tr>
<tr>
<td>Foresight</td>
<td>My point of view orientated me towards the research question, the first moment of entering the hermeneutic circle</td>
<td>My orientation towards the phenomenon is from a Consultant Nurse’s perspective whose role incorporates facilitating de-briefing following physical restraint. I became increasingly aware of this important area for exploration by listening to nurses’ accounts of physically restraining patients and comparing these to Paul’s experience of being restrained by nurses. Physically restraining patients is predicated upon nurses’ use of forced touch and I was curious to understand why we did not talk of touch in the context of physical restraint interventions. My sense of the importance of revealing nurses’ experience of forced touch grew and led me to the research question.</td>
</tr>
<tr>
<td>Foreconception</td>
<td>My preliminary sense of what counted as a question and what would count as an answer.</td>
<td>I wanted to know about the meaning that nurses give to their lived experience of using forced touch against patients during physical restraint interventions. I believed nurses’ accounts of their thoughts, feelings and perceptions of forced touch would count as an answer because these represent what it is to be human and use forced touch against patients in nursing care.</td>
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Working out the forestructures and laying them open in this way demonstrates for the reader the very earliest origins of the research study (Geanellos, 1998b, p.238).

3.7.2.2 Revealing my forestructures about the phenomenon itself

Having made sense of how my forestructures had orientated me towards my research question, I then answered the research question myself before proceeding with the study. I drew upon Geanellos’ (1998b, p.238) structured approach to illustrating the subjective personal lens through which I would interpret the data. This enables readers to judge the degree of subjectivity, and therefore, the legitimacy of the final interpretation, by illustrating how trustworthy
and authentic the data is (Speziale & Carpenter, 2007, p.97; Geanellos, 1998b, p.238).

Hence, I asked a doctoral student with a background in nursing and qualitative research studies, to conduct the interview using the interview schedule prepared for the study, thereby keeping the same focus for exploration. I provided the schedule prior to the interview to allow time for the interviewer to familiarise herself with the questions. A digital recorder captured the interview.

I transcribed the interview myself, staying true to the notion that this was an essential part of the interpretative process and would bring forth a greater understanding of my most strongly held beliefs (Geanellos, 1998b, p.241). Once transcribed, I returned the transcript to the interviewer to provide comment upon what she felt to be the most expressed and emphasised ideas. She then sent her comments on the transcript back to me. I then read and re-read the transcript, underlining repeating and common elements within the text. I constructed ten statements from these common elements to illustrate my superficial position, or those beliefs that immediately arose, because these were likely to be my most strongly held beliefs (Geanellos, 1998b, p.241). These are set out in Box 3.1.
Box 3.1: My superficial position: 10 statements about my beliefs about physical restraint and forced touch

1. Using touch in mental health nursing practice requires an emotional connection with the person to know how and when to use it. As a former general nurse, I am used to touching patients and I experience this as a natural part of my work.

2. If I can avoid having to use my bodily force against a patient, I will, because it is frightening and distressing for everybody.

3. The fear of not being able to grasp and hold the patient is what I am most anxious about because of the consequent risks to all involved.

4. Once I have a hold of the patient, I am so close to them that I can feel the patient’s heart rate and their tense body.

5. Holding patients who are very disturbed for a protracted time is physically tiring and stressful.

6. When I see any reddening of the patient’s skin where I have touched them forcefully, I feel embarrassed to have caused them harm and I am concerned about their impression of me as a nurse.

7. There is no dignity in grappling with patients. If nurses have to do it, then they should always do it professionally and with care and compassion.

8. Once you have used forced touch against a patient, your relationship with them can sometimes fundamentally change.

9. Nurses need to try to understand what escalates behaviour and talk with the patient about what we did or did not do to help us to understand what made them angry or distressed.

10. Using force with our bodies has remained a silent aspect of nursing practice.

From the ten statements, I engaged in a reflective process that clustered together those with similar meanings to form four summary interpretations (Box 3.2). Each interpretation now included my assumptions. Clearly, these interpretations could not bring forth all of my assumptions to consciousness (Ganellos, 1998a, p.155), but documenting the most superficial statements and making them public would help raise my awareness of my potential influence upon the data and therefore, the final co-constitution of the phenomenon. The four summary interpretations include how physical restraint
demeans, the frightening nature of forced touch and the importance of professionalism. Finally, I recognised my own silence about forced touch.

**Box 3.2: A summary of four personal dominant interpretations about physical restraint interventions using forced touch**

**Interpretation 1: Forced touch demeans**  
I always feel relieved if bodily force is avoided. I find the use of forced touch de-humanising for the nurse and the patient. Force can change the trust fundamental to the nurse-patient relationship. When physical or emotional injury to patients occurs, it assaults my nursing beliefs and embarrasses me. Nurses need to try to care-fully understand how to help the patient to work together to avoid the situation again. I assume that most other nurses also try to avoid having to restrain patients.

**Interpretation 2: Forced touch frightens**  
Physical restraint is often frightening, and my anxiety about not being able to grasp and hold the patient is high because of the consequent risk to staff and patients. In holds, I am aware of the patient's tense body and their increased heart rate. Holds may be protracted and afterwards I feel exhausted. I assume that most other nurses find physical restraint anxiety provoking.

**Interpretation 3: Forced touch demands professionalism**  
Nurses have to use forced touch at times, but I believe that when they do, they should always do so with care and compassion. The use of 'should' illustrates that I assume that at times, the standard of care from de-escalation approaches, through to spending time with patients following restraint, requires improvement.

**Interpretation 4: I have been silent**  
Using touch in daily practice on acute wards requires a connection with the person. I feel confident about using touch to comfort patients who are either physically or emotionally distressed as a natural and important part of my work. Yet, my experience of forced touch with my body has remained silent, as it has amongst other nurses. Therefore, I have taken-for-granted my use of touch as a normal part of my mental health practice and, I have not previously stopped to apprehend my experience of forced touch during physical restraint interventions.

Working reflexively between my superficial statements to develop my summary interpretations set out my position. Then, through a 'shuttlecock' movement back and forth, I developed my understanding against the broader context of the participants’ experience (Todres & Wheeler, 2001, p.4). Using Geanellos’ (1998b, p.243) structured approach in this way set out my forestructures about the phenomenon so that readers could make their own judgement about whether the participants’ voices stood authentically in the shared final interpretation.
3.7.2.3 Keeping a reflective diary

I believe that maintaining a reflective diary throughout the research process helped to capture and clarify my thoughts, feelings, ideas and interpretations, as suggested in the literature (Clarke, 2009, p.68; Kahn, 2000a, p.65). I reflected upon difficult questions, philosophical quandaries, and my reactions to the study process (Gough, 2003, p.25; Ballinger, 2003, p.70; Kahn, 2000a, p.66). The diary assisted my development as a researcher because it helped to clarify my thinking about the research process, as well the phenomenon of interest (Gough, 2003, p.25). A selection of these reflections is contained in the final report to illustrate to the reader my subjective position (Ballinger, 2003, p.70).

Hand writing entries into the diary facilitated the record without the need for equipment in the field. Time was set aside before and after each interview, and during each phase of my developing analysis, to capture my immediate perceptions (McKay, Ryan & Sumsion, 2003, p.62). Yet, my reflections also ebbed and flowed during busy working days. As McKay et al (2003, p.62) recognises, moments of insight and questions sometimes appeared at the most inopportune times, such as driving many miles as part of my job. A pad of sticky notes kept to hand helped to capture these for entry into my diary as soon as possible.

3.8 Ethical considerations for the study
3.8.1 Seeking a favourable opinion

The University of Portsmouth gave a favourable opinion to my application on June 8th 2009 (Appendix 4). The National Research Ethics (NRES) Committee gave a favourable opinion on 25th March 2010 (Appendix 4). I attended this committee to respond directly to questions about the proposal. The Committee
raised a concern that participants may feel coerced into sharing more than they wanted to about a potentially sensitive subject. Sensitive research subjects include studies that can engender powerful feelings such as anger, fear, anxiety, and embarrassment, and may harm the participants as well as causing distress for the researcher (Elmir, Schmied, Jackson, & Wilkes, 2011, p.12). Therefore, such subjects require thoughtful planning (Ashton, 2014, p.27). Inquiry into the possibly private sphere of forced touch could be sensitive, although it was important not to assume it a sensitive area because individual nurses maintain varying degrees of privacy about their world (Lee, 1993, p.5).

A committee member suggested asking participants to prepare personal scenarios of physical restraint and using forced touch that they felt comfortable sharing. The research study participant information sheet incorporated this advice (Appendix 5), thereby helping to address the balance between the participants’ freedom to participate and having choice over what they wanted to say.

3.8.2 Ethical underpinnings of the study

Ethical considerations followed Cerinus’s (2005, p.76) principle-based framework and drew upon the practical steps offered. This framework is underpinned by the four principles of beneficence, non-maleficence, respect, and justice (Beauchamp & Childress, 2001, p.39) universally recognised as a sound basis for ethical reasoning in research using human participants (Fulford, Dickenson & Murray, 2002, p.9). Each principle is set out to illustrate the practical steps taken to achieve an ethically sound study (Table 3.3).
Table 3.3: The ethical framework underpinning the study

<table>
<thead>
<tr>
<th>The ethical framework underpinning the study</th>
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<tbody>
<tr>
<td><strong>Beneficence</strong></td>
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<td><strong>Non-maleficence</strong></td>
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<td><strong>Respect</strong></td>
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Psychological distress

The nature of the potentially sensitive research topic meant that participants could feel upset during the interview process. To protect the participants as far as possible, each received details of the confidential Staff Support and Wellbeing Service (Appendix 6) as part of their study information should they wish to seek psychological support following the interview. The Head of the Staff Support and Wellbeing Service was aware of the proposed research study and the service prepared for any contacts from participants once the study commenced. Any participant who made contact would have their confidentiality respected in line with the local Staff Support and Wellbeing Service policy.

Confidentiality and anonymity

It is important to respect participants’ privacy and dignity throughout the research process (RCN, 2009, p.5). Using pseudonyms protected participants’ confidentiality. Generic terms such ‘acute ward’ contextualised the study whilst protecting the identification of specific work areas.
I reminded each participant that they were bound by their professional Code of Conduct (Nursing and Midwifery Council, 2008) and therefore absolute confidentiality could not be guaranteed. The consent form (Appendix 7) made specific reference to this for discussion during the verbal consenting process. The focus upon forced touch meant that there was potential for a conflict between my duty of care as a nurse and the ethical principle of justice (Mansour, 2011, p.29). I informed participants that, should they disclose any practice that placed, or may place, a patient at risk, I would abide by the same code and enact my duty to inform the participant’s Line Manager (Mansour, 2011, p.29). Only when I was certain that each participant understood was the informed consent form recorded and jointly signed.

In qualitative studies, guaranteed anonymity is not possible when the presentation of data includes thick slices of participants’ narrative (Speziale & Carpenter, 1999, p.38). However, I made clear attempts to protect anonymity. I informed participants that if they revealed any information that might breach their anonymity, this would be discussed with them, and an opportunity given to have the data removed, or changed. This included particular phrases or expressions, or different ways of speaking that may make them uniquely identifiable (Corden & Sainsbury, 2006, p.19).

3.8.5 Security of data

The principles of the Data Protection Act (1998) underpinned the steps taken to safeguard the security of the data. Digitally recorded data were transferred to a home computer immediately after collection. After the interviews, I deleted recordings from the recorder. The electronic data, including e-mail correspondence, were password protected on my home and work computer. During analysis, paper transcripts were stored in a locked cabinet in the
workplace. Following publication, and any potential need to re-visit the data, I plan to delete all copies of the transcripts and e-mail correspondence.

3.8.6 Research Governance

Indemnity was provided by the researcher’s employing NHS Foundation Trust (Appendix 8)

3.9 Method

3.9.1 The study setting

Acute mental health wards were the setting for the study based upon the research question. The setting was seven wards located across three adult mental health hospital sites in one mental health Trust in the South of England serving the adult population of two counties, each admitting patients between 18-65yrs from both urban and rural communities. The wards comprised five acute admission wards, one PICU, and one recovery ward. The five acute wards were single sex units. The PICU and recovery ward admitted both men and women. Male and female nurses staffed each ward.

3.9.2 Conducting research as an insider

Researching one’s own context can present both positive and challenging considerations. Staff may assume their practice to be under scrutiny by the researcher and therefore, access to the setting can be problematic (Roach, Duxbury, Wright, Bradley & Harris, 2009, p.67). Coupled with this, access can be particularly difficult when controversial findings may emerge, or the topic concentrates on private areas of an experience or fear (McCann & Clarke, 2005, p.8), such as the potentially sensitive nature of nurses’ use of forced touch.
To reduce potential anxiety, spending time in clinical areas can help to develop an unobtrusive familiarity and a sense of comfort and trust with the participants (Roach et al, 2009, p.67). As suggested by Bonner & Tolhurst (2002, p.9), my clinical role meant that I had a good understanding of the culture of the wards and importantly, an established professional relationship with many of the nurses there. My subjective experience of the phenomenon also formed the basis for generating knowledge through the study (Holloway & Fulbrook, 2001, p.544) and assisted the development of conversations about the topic. I believe that this enabled my access to the wards and helped to develop a sense of trust with participants to enable them to feel more comfortable about discussing their practice.

3.9.3 Sampling

A purposive sampling approach identified nurses who were likely to have the experience that I wished to understand (Mansour, 2011, p.29; Speziale & Carpenter, 2007, p.94; Holloway & Fulbrook, 2001, p.544; Steeves, 2000a, p.45). Qualified adult mental health nurses who were C&R trained, up-to-date with refresher training according to local policy, and who used it as part of their daily work, were invited to take part in the study. Local training records showed that there was a potential pool of 68 participants who were adult qualified mental health nurse working both full-time and part-time hours on night and day shifts on the seven wards.

The philosophical underpinnings of hermeneutic phenomenology determine that understanding the depth of people’s experience is the outcome of research, rather than generating large samples (Bryman, 2012, p.19). Therefore, there are no hard and fast rules about sample sizes and the focus is upon the richness of data (Tuckett, 2004, p.49). In phenomenological studies, ten participants are appropriate because this is large enough to gain an in-depth
understanding of a particular phenomenon (Smith, Flowers & Larkin, 2009, p.51; Speziale & Carpenter, 2007, p.106; Tuckett, 2004, p.49). Therefore, the aim was to recruit a minimum of ten participants.

Nurses were the focus of the study as they were the only professional group who restrained patients. When samples are this discreet with limited variability, information redundancy is more likely at lower levels (Bryman, 2012, p.19; Holloway & Fulbrook, 2001, p.544). In hermeneutic phenomenological studies, data collection reaches closure and information redundancy occurs when the repetition of discovered information confirms previously collected data (Mansour, 2011, p.30; Speziale & Carpenter, 2007, p.31 & Tuckett, 2004, p.56).

Yet, Heidegger believed that context was so important to our interpretations of the world that the place and time of the interviews, as well as the mood of the researcher and participants, could affect how the story was both told and heard (McConnell-Henry et al, 2011, p.29). Following this philosophical position, I understood that achieving complete closure of the data may not be possible, but perhaps more importantly, it may not be desirable since our interpretation is ever changing and never still. Nonetheless, I needed to hear enough of a shared understanding, amongst the nurses, to draw themes that illustrated the intersubjective nature of the nurses' understanding of forced touch during physical restraint interventions.

3.9.4 Recruitment

People are more likely to actively respond during recruitment, participate and share their experiences if they know you (Rubin and Rubin, 2005, p.89). However, knowing some of the ward nurses meant that maintaining the boundaries of the nurse-researcher was important to ensure the ethical considerations of the study. Therefore, recruitment took place on only seven
wards out of a possible nine wards because I was working on two wards intensively on service improvement projects and I had close relationships with the staff.

The nurses on the seven wards were invited to participate by electronic letter (Appendix 9). The letter, together with an information sheet (Appendix 5) was e-mailed to each Ward Manager using the internal system. The e-mail asked the Ward Manager to forward it to the registered nurses, in their team, who were using physical restraint as part of their work.

There was no direct contact with potential participants at any point to avoid possible feelings of coercion about a potentially sensitive study area. The letter included my contact details should the nurses wish to discuss the study. When Ward Managers responded to enquire about participating themselves, an invitation letter and information sheet was returned to them. Ward Managers intervene with physically restrain as part of their job, and they were therefore, suitable to take part in the study.

During recruitment, the nurses responded to the invitation to participate in two ‘waves.’ The second wave of four nurses confirmed much of what was contained within the first wave of 10 interviews. This increased my confidence that I had captured the essence of the experience. I therefore believed that I had enough data to reveal deep insight into the meaning of the experience of forced touch for these nurses, the goal of hermeneutic phenomenology (deWitt & Ploeg, 2006, p.217). Therefore, data collection concluded following interviews with 14 nurses.

The recruited 14 participants included six Ward Managers, two Deputy Ward Managers and six Staff Nurses. Within the sample, I knew three Ward
Managers and one Staff Nurse fairly well because we attended the same meetings and events. The remainder were relatively unknown to me.

**3.9.5 Procedure for gaining consent**

The information sheet (Appendix 5) detailed the purpose of the study, what participation meant for participants, the favourable ethical opinion, and the right to withdraw at any point. Also included were details of the Staff Support and Wellbeing Services should participation raise uncomfortable issues (Appendix 6). Consent was obtained verbally and in writing to record participants’ agreement to take part in the study (Corbin & Morse, 2003, p.341). The verbal consenting process provided an opportunity to answer any questions or concerns as well as documenting the participant’s willingness to take part (Appendix 7).

I returned a copy of the signed consent form to the participants to keep. It included my contact details should they wish to discuss their ongoing participation, or withdraw from the study. Informed consent is a dynamic process that remains under consideration throughout the research process. Therefore, I confirmed ongoing and informed agreement to take part at all stages, including the point of recruitment, interview, and return of the verbatim transcripts (Houghton, Casey, Shaw, & Murphy, 2010, p.16).

**3.10 Data Collection**

**3.10.1 Rationale for data collection using semi-structured interviews**

In Heideggerian phenomenological research, individual interview methods are highly appropriate for participants to express their experience through direct conversation with the researcher (Higginbottom, 2005, p.12; Creswell, 1998, p.124). Heidegger believed that language speaks man, and language
illuminates our experience of being in the world (King, 2001, p.111; Watts, 2001, p.70; Moran, 2000c, p.250 & 228; Kahn, 2000a, p.61). He maintained that talking is the basis of language and expresses the original sense we have of things (King, 2001, p.111; Watts, 2001, p.69). Talk includes the personality of the speaker and listener, the expression of experience itself, and the hearing of this experience (Watts, 2001, p.69). The participants’ spoken expression would provide insights into the meaning of the experience as it had been lived by them. The linking of my research aim, research question, philosophy and method in this way is the essential underpinning to my project (Procter, 1998, p.88).

The unstructured interview is seen as the best approach to allow participants complete freedom to speak for themselves (Savin-Baden & Major, 2013, p.221; Wimpenny & Gass, 2000, p.1490). However, open-ended, semi-structured interviews provide a more focused approach, yet also offer a flexible guide (Holloway & Wheeler, 2002, p. 82). Offering some structure was important to this study to help participants to focus specifically on their experience of forced touch during restraint interventions because the literature illustrated that nurses’ experience of forced touch appeared hidden within the wider phenomenon of physical restraint procedures. Semi-structured interviews would therefore be more likely to help to focus the conversation on the topic of interest (Curtis & Redmond, 2007, p.25).

Focus groups were also considered as these can enhance participants’ feelings of comfort because they are amongst others who may have similar experiences (Curtis & Redmond, 2007, p.27). However, it was essential to consider the sensitive nature of the research topic and potential group effects, including the impact of any power issues amongst various grades of nurses taking part in the study (Happell, 2007, p.23). There was a risk of dominance within the group, and therefore, the potential for feeling coerced into suppressing individual ideas,
or forming a consensus with which not all participants agreed. The data would then be unrepresentative of the experiences of individuals within the group (Happell, 2007, p.23; Curtis & Redmond, 2007, p.30). Given the sensitivity of the area under inquiry, providing individual space for exploration was not only a psychologically safer approach, but also one more likely to ensure representation of the participants’ individual experiences. I decided to digitally record the interviews to provide a high quality record on a device that minimised external noise to provide greater clarity (Fernandez & Griffiths, 2007, p.8)

3.10.2 The pilot interview

Pilot interviews help researchers move towards a practical, engaged sense of the phenomenon of interest through the hermeneutic circle (Kezar, 2000, p.385), and to begin to become experientially grounded in the context of the participants’ experience (Kezar, 2000, p.397). They also help to show whether potential errors exist in the interview process and schedule (Bowling, 2005, p.403).

One nurse, who met the inclusion criteria, agreed to participate in the pilot interview. Verbal and written consent were gained to digitally record the conversation for accurate transcription. The information gained confirmed my foreconceptions that nurses’ thoughts, feelings and perceptions of their experience would be likely to answer the research question (Leonard, 1994, p.57), although initially the nurse struggled to recollect her experiences. Therefore, there were no adjustments to the schedule.

Following the interview, I discussed with the nurse whether I could incorporate the data from the interview into the analysis because it had elicited information useful to the overall aim of the study, to which she agreed.
3.10.3 Analysing the pilot interview

Whyte’s (1982) Directiveness Scale provided a self-assessment of how much researcher regulation and prescription occurred during the pilot interview. Highly prescriptive styles undermine Heideggerian philosophy by dominating the conversation and inhibiting the shared understanding inherent within the philosophy (Wimpenny & Gass, 2000, p.1487). The scale is illustrated in Table 3.4:

Table 3.4 Whyte’s Directiveness Scale

<table>
<thead>
<tr>
<th>Level</th>
<th>Whyte’s Directiveness Scale</th>
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<tbody>
<tr>
<td>1.</td>
<td>Making encouraging noises</td>
</tr>
<tr>
<td>2.</td>
<td>Reflecting on remarks made by the informant</td>
</tr>
<tr>
<td>3.</td>
<td>Probing on the last remark by the informant</td>
</tr>
<tr>
<td>4.</td>
<td>Probing an idea preceding the last remark by the informant</td>
</tr>
<tr>
<td>5.</td>
<td>Probing an idea expressed earlier in the interview</td>
</tr>
<tr>
<td>6.</td>
<td>Introducing a new topic</td>
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</table>

*(1=least directive, 6=most directive)*

Analysis of the pilot interview was undertaken and scores set in the margin. This analysis considered the degree of balanced participation, the tone of the conversation, and the degree of interruptions to the participant’s expression. Relatively low levels of directiveness were evident in the analysis. Nearly all of my interactions with participants were at level three and below. This low level of directiveness reflects my professional training and my working alliances with patients and staff, as well as my methodological stance. In each, it is vital to allow the patient or the participant to express their subjective experience, if I am to understand the meaning of their world. There were no changes to my style of interviewing.
3.11 Interview techniques
3.11.1 Practical considerations

The nurses chose to participate in the interviews during work time and in their work environments. Two hours were set aside for each interview to allow plenty of time for them to share their experiences. Rooms were pre-booked to ensure privacy and prevent interruptions.

Prior to the interview, I allowed time to make a drink, talk about consent issues, discuss the recording equipment and answer any questions. Developing rapport in this way is essential to enter the life-world of the nurses and openly discuss their stories (Elmir et al., 2011, p.13). Discussing the consent issues also helped to reassure the nurses about confidentiality and promote their confidence to talk openly (Wilson, 2009, p.32). Some demographic data were collected at the beginning of the interview to provide part of the thick description of participants’ characteristics to aid transferability for the reader (Appendix 7). These details were ‘safe ground’ upon which we could start our conversation and to contextualise their experience, then lead into the interview (Doody & Noonan, 2013, p.31).

3.11.2 Minimising power asymmetry

Understanding and addressing the power asymmetry between my nurse-researcher role and the nurse participants was vital to enable them to speak frankly about their experience (Wilson, 2009, p.33). Qualitative interviewing can be both therapeutic and empowering (Clarke, 2006, p.19), providing people with the space to express themselves and gain insights into their experience. However, they can also be harmful (Clarke, 2006, p.19). My position of Consultant Nurse was senior to the ward nurses and my perceived status and influence could leave them feeling coerced into the interview or fearful of
judgment about their contribution (Wilson, 2009, p.4). As revealed in the review of the literature, the topic area also had the potential to re-present past episodes of emotionally and physically sensitive physical restraint situations for them.

To ensure that the power asymmetry was minimised as far as possible, I needed to ensure that the nurses felt that they had control over all aspects of their participation in the study. Once the nurses felt comfortable with their participation, this would also help to gain access to the private spheres of their experiences (Wilson, 2009, p.32). To do this, I used a ‘primer scenario.’ Prior to conducting the interviews, I asked the nurses to think about scenarios when they had used forced touch, and to come prepared to share their chosen experiences. This enhanced the autonomy and control they had over what they were prepared to divulge. Taking this approach helped to set out what the interview would cover, whilst accepting that participants have their own sense of agency and control about the balance of withholding information and revelation (Corbin & Morse, 2003, p.337).

Power asymmetry was also minimised as far as possible by taking a warm and friendly approach based upon interdependence to build a mutual trust (Speziale & Carpenter, 2007, p.36). Sharing some of my own experiences revealed a shared background and some commonality with the participants, which also contributes to building a sense of safety (Clarke, 2006, p.21; Rubin & Rubin, 2005, p.92 & p.116).

3.11.3 The hermeneutic interview
3.11.3.1 Orientating to, and seeing, the hidden phenomenon

The listening gaze refers to how we must stop in order to see the ordinary and extraordinary within nursing practice so that we may better understand the
phenomenon of our interest (Walton & Madjar, 1999, p11). By being open, compassionate and attuned to the nurses’ experiences, the depth and complexity of the phenomenon can be grasped (Walton & Madjar, 1999, p.11-12). It was therefore important for me to take time to orientate towards this still, listening state prior to each interview, most of which were undertaken during my working day. I allowed myself time to read my diary entries to re-connect my ‘self’ with the emerging lived experience, and entered each new moment with the nurses in a thoughtful and prepared manner.

3.11.3.2 The structure and style of the hermeneutic interview

The interview structure took a retrospective approach to access the nurses’ accounts about what they had already interpreted about physical restraint and forced touch from their past, remaining true to the hermeneutic tradition (Kahn, 2000a, p.61) (Appendix 10). The same broad opening question activated the discussion with each of the nurses and indicated my openness to their accounts (Kahn, 2000a, p.60). Using broad opening questions helped to put the nurses at ease and allowed them to test my responses to them tentatively as they worked towards their deepening stories (Corbin & Morse, 2003, p.342).

I asked questions to elicit deeper feelings and meaning once participants appeared more comfortable with the interview process (Rubin & Rubin, 2005, p.96). Once rapport was developed, I explored the depth and detail of the nurses’ experience to help to bring forth both vivid accounts and more subtle meanings (Rubin & Rubin, 1995, p.81). Sharing some of my experiences not only reduced power asymmetry, but also illustrated a relationship based in reciprocity (Elmir et al, 2011, p.14). Using reciprocity in this way illustrated the openness and honesty with which I would normally respond in my practitioner role. It was reasonable to assume that the participants might expect a certain
amount of reciprocity from me as a nurse with an experience similar to their own (Carolan, 2003, p.12).

At the end of the conversation, the emergence phase used questions to lighten the atmosphere and ensure that the nurses were in a calm emotional state before leaving to return to direct patient care (Corbin & Morse, 2003, p.343). This helped to show respect for the nurse’s contribution to the research, and to patient care, by ensuring the psychological safety necessary to cope with nurses’ emotional experiences in each arena.

3.11.3.3 The lived hermeneutic circle

According to Heidegger, people live and make sense of the world quite naturally in a hermeneutic circular movement between the parts of their past and their new experience (McConnell-Henry et al, 2009a, p.11). As the interviews progressed, this was illustrated when the nurses talked about forced touch by moving between their past, to their present experiences, in a dialectical manner back and forth, and then vocalising their re-interpretation. Although I had previously understood the theoretical tenets of the hermeneutic circle of understanding from reading philosophical texts, this was the first time I observed it in action. This was an important milestone in my development because phenomenologists believe that we can really only understand phenomenology by doing it; knowing the approach from an intellectual stance is entirely different to truly understanding it from within (Flood, 2010, p.7).

Box 3.3 illustrates how the participants’ hermeneutic circle manifested itself, exemplified by one nurse interpreting her present by dialectically relating to her past. The relatively short extract from the early part of our conversation revealed:
- How the research question enabled the nurse to enter the hermeneutic circle of her experience of using forced touch.
- The nurse’s dialectical comparison between her past experience of feeling that forced touch was mob-handed and disrespectful with her current interpretation of greater organisation and respect for patients.

**Box 3.3: An example of the hermeneutic circle of understanding lived during an interview**

**R:** ...so what is like for you to use forced touch?

**P:** ‘Well on [ward], it is seeing how staff members approach things here and how things have changed in a good way. You know, and how it is all organised.

**R:** So how people approach restraint now...?

**P:** Yeah, I just remember when I was a student in a big old asylum, not in this part of the country, it was mob-handed. Uuurrghhh... You certainly felt that some people really enjoyed it. You know, like afterwards it was, ‘that was cracking.’

### 3.11.3.4. Apprehending participants’ meaning

Using verbal probes helped to develop my understanding when participants’ initial meaning was unclear so that I could grasp the essential facets of their story. Box 3.4 illustrates how I tried to apprehend the meaning of ‘too compassionate’ because, at first, it was unclear to me:
Box 3.4: Probing to uncover meaning:

\[ \text{P: I guess I think sometimes I’m too much of a compassionate nurse. Well, compared to other people. And then I think, ‘No, I’m not actually.’} \]
\[ \text{R: And what is being too compassionate like?} \]
\[ \text{P: Too compassionate is that we accept the patient’s behaviour on that end [gesturing with hands to the extreme end]. I think maybe some people just switch off their compassion sometimes in a job like this because if they let it in, the feelings, then it would probably mess them up.} \]

I understood that the nurse believed that she was caring and empathic. She also believed that her PICU team members viewed her as soft and overly tolerant of hostile behaviour. She thought that by comparison, her colleagues cared in a detached way. Using verbal probes to inquire into meaning in this way helped me to ensure that both I, together with the participants, co-constituted our understanding.

3.11.3.5 Attending to body language during the interview

Paying attention to body language during the interviews was an important aspect of probing (Clarke, 2006, p.19). It helped me to understand the nurses’ non-verbal and emotional experience. In this example, Box 3.5 shows how, rather than encouraging the nurse to describe something that she clearly found difficult to put into words, I watched her re-enact her experience. She appeared embarrassed to have to demonstrate her meaning, rather than being able to articulate her experience, and she laughed awkwardly whilst she tried to convey what she meant:
I came to understand the nurse’s experience of holding the patient’s head to be providing a ‘frame of safety’ created by her hands. She demonstrated how she held the patient’s head with firm but gentle touch, whilst at the same time, providing protection from the hard floor.

Capturing and documenting the lived experience of the interview process helps illustrated the reality of the research experience for the participants and the researcher, contributing towards the representation of the entire research process, and therefore, enhancing rigor (Laverty, 2003, p.31).

### 3.12 Transcription

I transcribed all of the digital recordings myself because this provided a further opportunity to listen carefully to our conversations. Transcription is a protracted process and allows longs periods of orientating to, and sensitising to, the issues of importance (Holloway and Wheeler, 2002, p.236). Listening and re-listening to the recordings deepened my understanding as the nurses spoke their stories and I grasped their meanings (Flood, 2010, p.12). Language and articulation, intonation and silence all helped to convey the participants’ meaning. Third party transcription would have severely interrupted the analytic process because according to hermeneutic tradition, analysis commences during the interviews themselves.
3.12.1 Return of Transcripts

I returned the transcripts to the nurses within two weeks of each interview. This provided them with the opportunity to add comments or delete anything they wished to remove. Returning transcripts supported the ethical principle of non-maleficence because it gave the nurses further control over what they wanted included in the study (Houghton et al, 2010, p.17). It also allowed them to check both the accuracy (Kahn, 2000b, p.90) and the meaning of what they had said (Dearnley, 2005, p.24), affording them the opportunity to authenticate the transcript as a shared record of the ‘intersubjective understanding’ of their experience (Standing, 2009, p.25).

One risk inherent in returning transcripts about a sensitive subject is that it might distress participants when they see their experiences in black and white (Dearnley, 2005, p.25). I therefore returned them with a note offering the nurses to contact me should they wish to talk. None of the nurses made contact and each returned their transcript. Two nurses deleted small amounts of narrative, and although some of this data contained rich information, their autonomy was the most important consideration (Rubin & Rubin, 1995, p.94). Two nurses reiterated or emphasised what they had said during the interview. It seemed that the open duration of the interviews had allowed them to talk at length about their experience and capture what they wanted to say. The friendliness in the notes placed on the returned transcripts highlighted their sense of collaboration and participation in the research process. Box 3.6 contains one nurse’s humourful response to seeing her conversation for the first time, as well as expanding and emphasising her meaning:
Box 3.6: Participant’s comment upon return of transcript

*Hi Jill, I’ve read through and I didn’t realise how funny I sound in conversations! I don’t know if it helps, but the noticeable difference, other than strength, is that female skin feels smoother and softer.*

3.13 Reflexity during data analysis

3.13.1 Reflexive process throughout data analysis

Maintaining a reflexive stance was as integral to the analysis as it had been to the conception of the topic area, the influence upon the research question, the research approach, and the data collection (Carolan, 2003, p.8). Although definitions of reflexivity vary, it is widely agreed that reflexivity during analysis is concerned with researcher’s interaction with the data and therefore, the development of the findings (Carolan, 2003, p.9). Being aware of my responses to the nurses’ accounts was a critical part of the interviews, in which I had close emotional and physical proximity to the field in which the nurses worked (McGarry, 2010, p.10; Khan, 2000b, p.88). I used my reflective journal to capture these interpersonal dynamics and make reflexive decisions during the study. This approach adds depth and insight to the research process because it illustrates the inherent subjectivity of personal feelings and beliefs through a self-critical process (Carolan, 2003, p.10). A selection of these entries is now illustrated.

3.13.2 Reflexive response to philosophical questions

Conducting research can be an emotional experience (McGarry, 2010, p.11). Box 3.7, documented in my reflective diary after two interviews, illustrates my confusion and anxiety at not immediately hearing nurses’ experiences of forced touch:
Box 3.7: Reflection upon my early emotional response to the nurses’ stories

‘They [nurses] talk of ‘going into zones,’ a sense of detachment from patients, so it seems that they cannot describe grasping the [patient’s] body. Am I therefore trying to enquire into an unconscious, inaccessible nursing act? If nurses cannot remember the force they use, is it possible for them to articulate the experience?’

Box 3.8 shows how I felt a philosophical panic whilst reading the transcripts because I was worried that the nurses’ experience of forced touch could not be illuminated:

Box 3.8: Reflection upon the possible existence of a hidden phenomenon

As I re-read their [nurses’] narratives, I think of Schön’s swampy lowlands and the mess and complexity of what nurses do every day. Is the experience of forced touch lying in such a deep swamp that it is not consciously known? What if the phenomenon cannot be illuminated because the nurses cannot recollect it? Is there such a thing as an inaccessible phenomenon? And is that why forced touch is so silent?

Posing theoretical questions in this way was an important part of documenting my reflection and learning about the philosophy underpinning the study (Kahn, 2000a, p.66). I turned to the work of Reed (1994, p.340) to help me understand that, just because I was struggling to access the nurses’ experience, it did not mean that the phenomenon did not exist. Reed suggests that everyday knowledge is embodied within experience and becomes taken entirely for granted. Nurses then find trying to break down their wider experience (the whole physical restraint event) into the specific phenomenon of interest (forced
touch) difficult (Reed, 1994, p.338). Following Reed, I responded reflexively by asking questions directed towards connecting the nurses with their feelings about forcibly touching patients to attune them to their emotional experience, and to start to generate meaning (Reed, 1994, p.340).

Focusing on the nurses’ emotional response helped them to share how it felt to grasp and hold patients. Box 3.9 shows how I became aware of bearing witness to the nurses’ emerging awareness of their experience of forced touch, observing the phenomenon coming to light:

Box 3.9: Reflection upon my understanding of the nurses’ developing sense of the phenomenon

I have listened to nurses expressing the birth of their understanding and I have watched them almost falteringly learn to describe how they use their body forcefully, struggling to find the right words, moving their body as they speak to convey what they mean. And I have witnessed their increasing awareness of how much empathy they feel for the person they are using forced touch against, and of their human contact with them.

3.13.3 Reflexive response to personal experience of using force

Box 3.10 documents my powerful emotional response to the nurses’ feelings and it shows similarities with my first summary interpretation in which I had elicited how I felt physical restraint to be demeaning for the patient and the nurse. The reflection also documents my understanding of the nurses’ ordinary humanity and their ability to relate to the patient under their force:
Box 3.10: My summary interpretation and diary reflection upon the nurses’ accounts:

‘The nurses’ intense dislike of laying on hands is tangible and truly felt by me. These feelings have touched me. As I listen to each nurse express their repugnance about having to restrain, I am disgusted by what they have to do. Yet, I feel lifted by their empathy and the very ordinariness with which they relate to patients’ reactions towards them. One nurse put it quite simply, ‘I wouldn’t like it [forced touch] if it were me.’

Recognising my early subjective interpretations helped me to remain cognisant of my possible impact upon the data collection (McGarry, 2010, p.10; Kahn, 2000b, p.88 & Kvale & Brinkmann, 2009, p.166) and stay focused upon the nurses’ accounts. Throughout the analytic process, my early documentation helped to remind me to consider carefully the participants’ meaning to ensure that the final analysis represented the authenticity of their experience.

3.14 Approach to data analysis

Data analysis followed Cohen, Khan & Steeves’ (2000, p.71) phenomenological hermeneutic process of analysis to ensure that the analytic approach remained congruent with the methodology. In hermeneutic studies, demonstrating the phases of analysis is important whilst maintaining the fluidity essential to the philosophical approach (Flood, 2010, p.11). Approaching the non-linear, iterative phenomenological analytic process with as much rigour as possible is essential to streamline and clarify the interpretation of the data (Crist & Tanner, 2003, p.202). Cohen et al (2000, p.76) therefore offer a loose order of phases, reflecting the methodological assumptions of the dialectical process, comprising:
- analysis during interviews
- immersing oneself in the data
- data transformation
- thematic analysis
- writing and re-writing to develop a coherent narrative text that stands alone for readers

Each phase is discussed in turn and the rigour of the analytic process illustrated.

3.14.1 Phase One: Analysis during interviews

In the hermeneutic method, analysis of the participants’ meaning commences as the researcher listens during the interviews and begins to orientate to the interpretation (Speziale & Carpenter, 2007, p.96; Cohen et al, 2000, p.74). Recording early meanings helped me to grasp my immediate sense of the nurses’ experience. I visited and re-visited these meanings during the analysis and they contributed towards the final interpretation. Box 3.11, written as part of my notes after the ninth interview, captures my developing understanding of how important it was for the nurses to justify their use of forced touch, and how much harder it was for them to do so if they had not witnessed escalating behaviour:
Box 3.11: Early diary entry illustrating an analytic question raised during the interviews

‘Responding to emergency alarms on other units seems more disliked by nurses than physically restraining patients on their own unit. The nurses appear to need to convince themselves to a greater degree of the necessity for force with patients they do not know. Witnessing patients’ escalating behaviour perhaps helps to reassure them that their use of force is justifiable. They also seem to struggle to trust the judgment of the nurses’ next door to use the same criteria for intervention as they use themselves.’

I also recorded my experience of being an insider and my impact upon the research process. Box 3.12 shows my reflexive response to, how being known to some of the participants, resulted in frequent ‘you know’ responses (because you are you, and you know the experience too). I reflected that, for the purpose of the research study, I needed to try to facilitate clarity of expression to ensure that I reached a shared understanding with participants:

Box 3.12: One of the challenges of being an insider

‘I am conscious of how many ‘you knows’ I hear in the interviews. Being known as a nurse colleague means that there can be a lot of implied meaning. If I was an outsider, the nurses may be more likely to explain themselves more clearly. ‘You knows’ help towards a more relaxed interview but I have to try to summarise, clarify and reflect back more often to check meaning, and make it clear for the recorder. Yet, one benefit is that I am sure that being an insider means that I can interpret the ‘you knows’ fairly easily because we have a shared connectedness, a mutual trust, because we ARE mental health nurses who HAVE LIVED through forced touch.’
3.14.2 Phase Two: Immersing oneself in the data

Reading and re-reading the transcriptions helps to immerse oneself in the data and derive the essential characteristics of the stories (Cohen et al, 2000, p.76). I recorded these essential characteristics in single phrases. They included the nurses’ struggle to bring the experience to words, their dislike of forced touch and need to justify it, living through messy practice, understanding touch and coping. These early, essential characteristics were important because they were immediate and drove the subsequent coding (Cohen et al, 2000, p.76).

3.14.3 Phase Three: Data Transformation

Once accurately transcribed, verbal ticks, umms, and ers, were removed to add coherence whilst making certain that this did not detract from the overall meaning (Cohen, et al, 2000, p.76). Editing the data carefully was important to conserve the richness of the immediacy of the spoken word (Corden, 2007, p.20). The editing process did not remove minor amounts of colourful language in the transcripts because I felt that these conveyed the depth of the nurses’ feelings better than I could (Corden & Sainsbury, 2006, p.16). The nurses’ expressions did not reveal any significant personal characteristics, or their ethnicity, that may have warranted editing attention to avoid breaches in anonymity (Corden, 2007, p.20).

The data transformation process is important because it maintains the relevance of the data available for analysis (Cohen et al, 2000, p. 76). I believe that, as part of demonstrating the rigour of the study by opening it to scrutiny (deWitt & Ploeg, 2006, p.2003), the data not considered for analysis should also be made apparent. By doing this, I therefore illustrate for the reader my understanding of what did not constitute the phenomenon. Only a minimal amount of narrative was removed that appeared to drift away from the topic
area. Box 3.13 shows one extract that constituted a digression away from the topic because the nurse was talking about her experience of caring for a patient following self-injury:

Box 3.13: Minimising digression

**P:** … the main problem was after she’d cut quite deep, she’d refuse to go to hospital and we would do what we could in terms of patching her up. But it was more about speaking to her about what’s wrong with hospital and you’d spend the next few days coaxing, talking to her about trying to change her mind because they’d [wounds] get infected.

3.14.4 Phase Four: Thematic analysis

Each transcript was numbered (1-14) and pseudonyms allocated to protect participants’ confidentiality. The transcripts were line numbered and subject to line-by-line coding, whilst working to keep sight of the overall engagement with the individual statements and contextualising them within the whole conversation (Cohen et al, 2000, p.77). Important phrases and passages were highlighted and codes placed in the margin.

To enable straightforward location and comparison of the data, and to facilitate later analysis, details were typed using the comment facility in Word software against each piece of highlighted data (Illustration 3.1):

- the pseudonym of the participant
- the number of the interview
- the gender of the participant
- the number of years qualified
- the page number from the transcript
- the line number from the transcript
- the coding applied to illustrate meaning
Illustration 3.1: Coding and indexing narrative text

Many iterative revisions of the coding took place reflecting my changing understanding of individual experiences and intersubjective experiences, and vice versa. To illustrate these changing interpretations over time, Table 3.5 shows an example of early coding in which I split the textual data into smaller meaning units and coded them. During early coding, I first interpreted Andy’s understanding of the patient’s level of deterioration by their degree of self-neglect and the body odour that transferred onto his clothes.

Table 3.5: Early coding

<table>
<thead>
<tr>
<th>Line No</th>
<th>Verbatim text</th>
<th>Pseudonym, Interview No, Gender, Years qualified, Age, Line No.</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>375-377</td>
<td>They’re floridly psychotic and not looking after themselves and it’s just that kind of smell associated with it. And I cannot actually tell you what it was, but there is definitely a smell associated with that level of unwellness and it does rub off on you.</td>
<td>Andy 1, M, 3, p.33, Line 375-377</td>
<td>Patient fragmenting</td>
</tr>
<tr>
<td>378-379</td>
<td></td>
<td>Andy 1, M, 3, p.33, Line 378-379</td>
<td>Carrying the smell of relapse</td>
</tr>
</tbody>
</table>
However, Table 3.6 shows how my interpretation changed over time. By the final coding, I reconstructed the previously deconstructed text because I felt that the meaning had become fragmented. Set within the context of the wider, now situated narrative, and subject to numerous iterations, I now understood Andy’s experience of using forced touch against a floridly psychotic, self-neglected, odorous patient as a feeling of being contaminated. Being contaminated reflected more than a superficial transfer of odour to Andy’s clothes. It represented Andy’s deep understanding of the wretchedness of severe psychotic relapse and his subsequent disgust about using forced touch against disenfranchised and helpless people, symbolised by the lingering discomfort left by the smell on his clothing.

Table 3.6: Final coding – changing understanding

<table>
<thead>
<tr>
<th>Line No</th>
<th>Verbatim text</th>
<th>Pseudonym, interview, gender, yrs qualified, page, Line no,</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>375</td>
<td>They’re floridly psychotic and not looking after themselves and it’s just that kind of smell associated with it. And I cannot actually tell you what it was, but there is definitely a smell associated with that level of unwellness and it does rub off on you. And I can’t really describe it. It makes me uncomfortable thinking about it because it’s a smell that makes me feel bad for the people I’m looking after. It speaks to me of loneliness and desperation and being disenfranchised, and being picked up out of your life and being brought to a bare, stark unit where you’re quite scared and you have no control. And then three people come and sit on you and give you an injection. And all of that is summed up by that smell.</td>
<td>Andy 1, M, 3, p33, Line 375</td>
<td>Being contaminated</td>
</tr>
<tr>
<td>376</td>
<td></td>
<td>Andy 1, M, 3, p 33, Line 379</td>
<td>The smell of wretchedness</td>
</tr>
<tr>
<td>377</td>
<td></td>
<td>Andy 1, M3, p 33, Line 383</td>
<td>Perceived helplessness</td>
</tr>
<tr>
<td>378</td>
<td></td>
<td>Andy 1, M, 3, p33, Line 383</td>
<td>Forced touch</td>
</tr>
</tbody>
</table>
Once I felt that the codes accurately reflected the nurses’ experiences, individual statements or paragraphs of meaning were cut out of the text (Cohen et al, 2000, p.77). Similar code labels were placed into piles with constant comparison across the texts (Cohen et al, 2000, p.79). To handle the vast number of meaning statements, a large table was covered with brown paper to accommodate them (Illustration 3.2). Beside each pile, possible theme labels were written and re-written. On a practical note, paperweights secured the piles after each analytic session to avoid them inadvertently moving.

Illustration 3.2: Compiling piles of coded text to develop initial themes

Theme labels changed as the collective meaning of the piles of text evolved. Once the meaning, and therefore, the theme labels stabilised, any coded meanings on the pieces of narrative that did not ‘rest’ comfortably against the theme labels were re-examined against other theme labels and then moved. This sometimes occurred more than once, until the theme label reflected the meaning of each piece of text in the pile. When pieces of text were moved, a record was made in upper case on the paper itself to keep a clear audit trail of the decisions made.

The following example illustrates the movement of individual text between theme labels. During early coding, this text was tentatively located against the

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early theme label ‘Our bodies are in jeopardy’ that reflected the nurses’ perception of physical threat. As analysis continued, the text was re-aligned with ‘Being careworn’ because the meaning appeared to speak more of the nurse’s superficial humour used to cope with her feelings. ‘Being careworn’ as a theme label had developed over time to illustrate how the nurses coped with their experience of forced touch (Illustration 3.3).

**Illustration 3.3: Recording movement between theme labels as understanding develops**

Once all the individual statements clustered under the theme labels, the theme labels themselves were each reviewed for similarity and shared meaning (Flood, 2010, p.12). Five major iterative phases of interpretation of the theme labels took place, known as splitting and splicing (Dey, 1993, p.129). Splitting and splicing describes the way in which we apprehend the data set through a developing conceptual framework (Dey, 1993, p.131). Splitting the themes helps to illuminate the finer detail by sub-categorising data, and splicing them combines themes to provide a more integrated and coherent interpretation, demonstrating the breadth of the participants’ experience (Dey, 1993, p.139). I documented decisions about their movement in a table to provide the audit trail.

The iterative process of splicing gradually condensed overlapping themes until the final understanding emerged as three major themes and nine sub-themes to illustrate the phenomenon. Fewer themes in the final analysis helped to develop a more intelligible and coherent interpretation (Dey, 1993, p.139). Through this dialectical process, a greater understanding of meanings that penetrated across texts culminated in the final overall interpretation of the whole of the nurses’
experience, and of the parts. The major themes and sub-themes that best illustrated the co-constructed meaning were then described (Flood, 2010, p.12; Cohen et al, 2000, p.81; Leonard, 1994, p.57).

Table 3.7 shows the changing pattern of theme labels. The early phases show a high number of tentative smaller themes that revealed a fine-grained approach to my early conceptualisation, and significant splitting or deconstruction of the data set (Dey, 1993, p.132). The analytic decisions made about the labelling and movement of sub-themes is described beneath each phase of analysis. The table also sets out my decisions about splicing theme labels together into the final nine sub-themes that collected under three major themes.
<table>
<thead>
<tr>
<th>First Phase</th>
<th>Second Phase</th>
<th>Third Phase</th>
<th>Fourth Phase</th>
<th>Fifth and Final Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inarticulate familiarity</td>
<td>Lost in flight</td>
<td>Lost in flight</td>
<td>Lost in flight</td>
<td>Lived moral inconsistency:</td>
</tr>
<tr>
<td>I become automated and inauthentic</td>
<td>Only if I have to Justifying it to myself</td>
<td>Only if I have to Justifying it to myself</td>
<td>Only if I have to Justifying it to myself</td>
<td>Only if I have to Justifying it to myself</td>
</tr>
<tr>
<td>Getting it over and done with Messy work Hot ward atmosphere Vulnerable bodies Unfamiliar bodies Preferred body parts Intimacy Knowing the body in custody Necessary evil Justifying force to myself Relating to being forced Being a compassionate custodian Returning to the patient experience Reflection and coping</td>
<td>Messy work Hot ward atmosphere Vulnerable bodies The unfamiliar body Preferred body parts Abiding smell Knowing the body in custody Having affinity Being a compassionate custodian Returning to the patient experience Reflection and coping</td>
<td>Messy work Vulnerable bodies The unfamiliar body Knowing the body in custody Having affinity Being a compassionate custodian Returning to the patient experience Reflection and coping</td>
<td>Messy work Knowing the body in custody The unfamiliar body Having affinity Being a compassionate custodian Being careworn</td>
<td>Lived knowledge inconsistency: Lost in flight Messy work Knowing the body in custody The unfamiliar body</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lived care inconsistency: Having affinity Compassionate custodian Being careworn</td>
</tr>
</tbody>
</table>
Analytic decisions made regarding theme labels during the condensing of themes

<table>
<thead>
<tr>
<th>First phase</th>
<th>Second phase</th>
<th>Third Phase</th>
<th>Fourth Phase</th>
<th>Fifth and Final Phase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total data set split and 16 piles of text with similar meaning given tentative themes labels.</td>
<td>‘Inarticulate familiarity’ initially interpreted to mean being unable to describe the familiarity of forced touch. This was re-labelled ‘Lost in flight’ to reflect my understanding that the nurses could not capture or grasp their experience in order to articulate it.</td>
<td>‘Preferred body parts’ spliced with ‘Knowing the body in custody’ because the nurses preference for each body part was embodied within their knowing of the body.</td>
<td>‘Getting it over and done with’ spliced with ‘I just do it’ because being disconnected from the patient experience appeared to be part of the nurses’ way of getting through forced touch as quickly as possible.</td>
<td>Three major themes and nine sub-themes developed.</td>
</tr>
<tr>
<td>‘Necessary evil’ initially meant that the nurses understood that forced touch was sometimes essential however much they disliked it. This was re-labelled ‘Only if I have to’ to place emphasis on my understanding of the nurses’ developing tolerance, rather than acceptance.</td>
<td>‘Hot ward atmosphere’ spliced with ‘Messy work’ to incorporate the context specific aspect of the phenomenon with the nurses’ perception of escalating chaos and disorganisation that they interpreted as messy work.</td>
<td>‘Preferred body parts’ spliced with ‘Knowing the body in custody’ because body odour was something the nurses knew and understood about forcibly touching patients with their body.</td>
<td>‘Returning to the patient experience’ was re-labelled ‘Re-connecting’ because of the nurses’ desire to re-establish their emotional alliance with the patient, rather than simply going back to the patient.</td>
<td></td>
</tr>
<tr>
<td>‘Intimacy’ initially meant being in close bodily contact. This was re-labelled ‘Abiding smell’ to reflect how the patient’s odorous body lived with the nurses as the dominant aspect of lived intimacy.</td>
<td>‘Abiding smell’ spliced with ‘Knowing the body in custody’ because compassion threaded through the nurses’ corporeal connection with patients and their attempts to soothe and re-connect with patient relationship through their touch.</td>
<td>‘I become inauthentic’ re-interpreted and labelled ‘I just do it’ because the primary meaning concerned the nurses’ actions rather than their feelings.</td>
<td>‘Reconnecting’ was spliced with the ‘Being a compassionate custodian’ because compassion threaded through the nurses’ corporeal connection with patients and their attempts to soothe and re-connect with patient relationship through their touch.</td>
<td></td>
</tr>
<tr>
<td>‘I just do it’ spliced with ‘Lost in flight’ because both themes reflect the nurses’ sensory and emotional disconnection from the patient.</td>
<td>‘Getting it over and done with’ spliced with ‘I just do it’ because being disconnected from the patient experience appeared to be part of the nurses’ way of getting through forced touch as quickly as possible.</td>
<td>‘Messy work’ spliced with ‘Our bodies are in jeopardy’ because being involved in a messy restraint with a poorly contained body engendered fear of, and injury to, themselves and the patient.</td>
<td>‘Reflection and coping’ was re-labelled ‘Being careworn’ because I understood that rather than actively coping, the nurses were passively coping, too careworn to care for each other or themselves.</td>
<td></td>
</tr>
</tbody>
</table>
3.14.5 Phase Five: Writing and re-writing: The exhaustive description of the phenomenon

Analysis continued throughout the process of writing and re-writing. Presenting individual pieces of data from the main corpus of the data set that best captured the essential meaning of the themes provides supporting evidence for the reader (Holliday, 2002, p.113; Cohen et al, 2000, p.80). These pieces illustrate the depth of the experience through the nurses’ voices and present enough data for readers to judge the fairness and accuracy of the findings (Corden & Sainsbury, 2006, p.12). As well as the shared experiences, unique experiences illustrate the breadth of the experience, and how ever changing human experience in the world can be (Conroy, 2003, p.3).

3.15 Member checking

Having drafted the final interpretation, member checking was an important consideration. The literature presents an array of views about member checking. Some interpretative phenomenologists suggest that returning to the participants to check the interpretation reduces bias and enhances rigour, as well as offering the opportunity to further access more useful data (Kahn, 2000b, p.93; Koch, 1994, p.979), thereby validating the interpretation and enhancing the credibility of the study (Houghton et al, 2013, p.12).

I decided not to attempt to ‘validate’ my interpretation with member checking for two reasons. First, Kahn’s (2000b, p.91) suggestion is contradictory. His recommendation that checking the interpretative process with colleagues, panels of experts, students or researchers reduces researcher bias is set against his recognition that each of these people would also introduce their own interpretations into the study. Such attempts to validate the meaning co-constructed by the participants and the researcher are based upon the incorrect
assumption that the interpretation can be tested for truth independent of those who participated in the research endeavour (Geanellos, 1998a, p.157).

Second, some interpretivist researchers consider member checking completely redundant, a misguided attempt to confirm the findings entirely out of keeping with the values of phenomenology (McConnell-Henry et al, 2011, p.30). They suggest that interpretative phenomenology as an approach guided by the philosophy of hermeneutics should respect the concept of self-knowing, that no one truth exists, truth is plural, context specific and incomplete (McConnell-Henry et al, 2011, p.29-30; Geanellos, 1998a, p.157). Heidegger’s belief was that context was so essential to interpretation that when revisiting an experience, the meaning may have already changed based upon the different time, place and mood of the participants and the researcher (McConnell-Henry et al, 2011, p. 29; Bradbury-Jones et al, 2010, p.28).

Having made the ethical decision to give participants control over their contribution by allowing them to confirm the accuracy and meaning of their transcripts, and add or delete anything they wished to within two weeks of the interviews, the analytic process then took many months. Such a long period between the participants’ expression of their experience and returning with the first tentative interpretation, contradicts the philosophical stance entirely. Therefore, by remaining true to Heideggerian principles, the interpretation was jointly created by the researcher and the participants during the interview process, specifically, contextually and temporally, and therefore there was no attempt to ‘validate’ the interpretation through member checking.

3.16 Summary of methodology and approach to study

To answer the research question,

‘What is it like for mental health nurses’ to use forced touch during physical restraint in acute mental health inpatient settings?’
the philosophical underpinnings of Heideggerian hermeneutics guided the approach both theoretically, and in my practical, everyday world as practitioner-researcher. Employing a reflective diary throughout assisted the demonstration of balanced integration through congruence between philosophy, researcher and topic, and the inclusion of the philosophical tenets within the approaches taken (deWitt and Ploeg, 2006, p.224).

Examples detailing my experience illustrate the lived research process, commencing at the reflexive decision-making process during my orientation to the study, through an understanding of my forestructures, to the methodological decisions and consequent determinants of the approach, and finally to the findings as a co-constituted meaning of nurses’ lived experience of forced touch. The study approach therefore demonstrates openness through clear accountability for the decisions taken, and a systematic and understandable process (deWitt and Ploeg, 2006, p.224).

Having set out the approach, the findings of the research are in now presented in Chapter 4.
CHAPTER 4: FINDINGS

4.1 Introduction

The findings are presented following a process of writing and re-writing to develop a coherent interpretation and representation of the nurses’ lived experience of forced touch during physical restraint interventions (Cohen et al, 2000, p.73). The interpretation is represented through one overarching main theme, three major themes and nine sub-themes. Themes are clusters of similar meanings that form a unit of understanding during the analytic process (Holloway, 1997, 154). The final interpretation makes manifest the nurses’ truth from their disclosures and revelations because time is taken to carefully represent the nurses’ voices clustered together in sub-themes under major themes that sit under the overarching theme heading (Moran, 2000c, p. 229).

The final construction presents one interpretation, through my lens, of this group of nurses’ experience in their own context and at a specific time (Kahn, 2000a, p.57). Recognising subjectivity in this way acknowledges the potential for others, reading the data, to see differently through their own lens, offering the possibility for a range of interpretations. This is important to qualitative approaches because each reader is situated in a reality derived from their own subjective experience (Speziale & Carpenter, 2007, p.13), and the final interpretation is brought forth in light of this experience. Nevertheless, the findings were derived through a rigorous, systematic process of data analysis.

4.2 The study participants

Five males and nine females including Staff Nurses, Deputy Ward Managers, and Ward Managers from seven acute adult wards took part in the study. The nurses’ ages ranged from 28-59yrs with a mean of 38.7 yrs. The years qualified ranged between 1-30yrs. Three nurses had three years’ experience, or less.
The remainder of the nurses had been qualified in mental health nursing for five years or more. The Interviews took place over six months from May-October 2010. Table 4.1 describes the participants:

**Table 4.1: The study participants**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Male / Female</th>
<th>Role</th>
<th>Age</th>
<th>Years qualified as a Mental Health Nurse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ella</td>
<td>Female</td>
<td>Ward Manager</td>
<td>43</td>
<td>13</td>
</tr>
<tr>
<td>Paul</td>
<td>Male</td>
<td>Ward Manager</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>Flora</td>
<td>Female</td>
<td>Ward Manager</td>
<td>41</td>
<td>15</td>
</tr>
<tr>
<td>Cian</td>
<td>Female</td>
<td>Ward Manager</td>
<td>39</td>
<td>10</td>
</tr>
<tr>
<td>Saul</td>
<td>Male</td>
<td>Ward Manager</td>
<td>38</td>
<td>5</td>
</tr>
<tr>
<td>Rhiannon</td>
<td>Female</td>
<td>Ward Manager</td>
<td>32</td>
<td>7</td>
</tr>
<tr>
<td>Maddy</td>
<td>Female</td>
<td>Deputy Ward Manager</td>
<td>33</td>
<td>10</td>
</tr>
<tr>
<td>Tom</td>
<td>Male</td>
<td>Deputy Ward Manager</td>
<td>32</td>
<td>10</td>
</tr>
<tr>
<td>Jackie</td>
<td>Female</td>
<td>Staff Nurse</td>
<td>38</td>
<td>5</td>
</tr>
<tr>
<td>Andy</td>
<td>Male</td>
<td>Staff Nurse</td>
<td>33</td>
<td>3</td>
</tr>
<tr>
<td>Sarah</td>
<td>Female</td>
<td>Staff Nurse</td>
<td>30</td>
<td>5</td>
</tr>
<tr>
<td>Lizzy</td>
<td>Female</td>
<td>Staff Nurse</td>
<td>50</td>
<td>3</td>
</tr>
<tr>
<td>Adrian</td>
<td>Male</td>
<td>Staff Nurse</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Jane</td>
<td>Female</td>
<td>Staff Nurse</td>
<td>59</td>
<td>30</td>
</tr>
</tbody>
</table>

**4.3 Presentation of the findings**

As discussed, the hermeneutic phenomenological approach is inextricably linked with the idea that we express our lifeworld through language. Our spoken words express the meaning of our experiences as they have been understood by us (Moran, 2000c, p.234). Therefore, the nurses’ verbatim expressions of their interpretation of their experience are represented under each theme and sub-theme heading (Corden, 2007, p.17). This theme and quote method also
enhances clarity for the reader by distinguishing between the nurses’ data and the researcher’s interpretation (Steeves, 2000b, p.97).

Three further reasons underpin using the nurses’ spoken words in the final report. First, they convey the complexity, depth and richness of their reality (Corden & Sainsbury, 2006, p.13). Second, by documenting the nurses’ voices, the impact for the reader is likely to be greater (Corden & Sainsbury, 2006, p.13). Presenting the nurses’ own words may be more likely to resonate with other nurses because the language of nursing may be common to those who use forced touch with patients thereby enabling the reader to judge how fair and representative the interpretation is. Examples of the phenomenon presented in the nurses’ words also help to situate the reader concretely within the context of the phenomenon, thereby linking the reader’s lifeworld with that of the nurses’ lifeworld (van Manen. 1997, cited by deWitt & Ploeg, 2006, p.225).

In the presented findings, selecting which quotes to use is important; a greater number of quotations illustrate the analytical perspective where the majority of the nurses expressed similar views (Corden & Sainsbury, 2006, p.15). More than one quote also helps to portray subtle differences between perspectives. To ensure the breadth of the experience is represented, minority views are also presented, but with fewer quotations (Corden & Sainsbury, 2006, p.15). Phrases and single words woven into explanatory text provide the particular emphasis heard in the nurses’ expressions. Longer passages provide exemplars that sum up many of the nurses’ experiences. Entire paragraphs also contextualise the nurses’ beliefs, feelings, perceptions and the chronology of events illustrating the complexity of some of the nurses’ understanding (Corden, 2007, p.15). Each nurse from the sample is represented in the findings as well my voice, thereby illustrating the shared interpretation of using forced touch (Corden, 2007, p.14).
Square brackets provide clarity to illustrate what the nurses were referring to during the interview in instances where this was not explicit in their spoken words, yet understood by the researcher (Corden, 2007, p.21). They are also used to show when silence occurred [silence], when there was a pause [pause], or the when the participant laughed [laughs] because in spoken language, silence, pauses and mood affect meaning and it is important to reflect the influence of these on the interpretation (Clarke & Iphofen, 2006, p.69).

In some instances, the nurses used colourful language that represented the depth of their feelings. These words are included in the report to help portray the vividness and forcefulness of their views (Corden & Sainsbury, 2006, p.16). The nurses did not use any language that was likely to offend readers, such as racist, sexist, or homophobic language.

Finally, and in keeping with the chosen framework for the expression of rigour (deWitt and Ploeg, 2006, p.223), Heidegger’s philosophical tenets are woven into the findings where I feel they emerge naturally as part of the interpretation. This is an essential aspect of balanced integration in which Heidegger’s main philosophical tenets are presented in my interpretation of the nurses’ accounts (deWitt & Ploeg, 2006, p.224).

4.4 Robustness of the themes

Table 4.2 illustrates the number of nurses contributing to each sub-theme to provide a clear picture of the contributions made across the study. It helps to establish the relative robustness of the themes, as well as revealing possible patterns of experience (Kahn, 2000b, p.97). Each voice is represented in the findings to ensure that every participant contributed to the final interpretation (Corden, 2007, p.16). Other demographics such as the roles and the setting in which the nurses worked are discussed.
Table 4.2: Number of participants contributing towards each theme and sub-theme

<table>
<thead>
<tr>
<th>Major theme</th>
<th>Sub-theme</th>
<th>No of nurses</th>
<th>Gender</th>
<th>Participants (Pseudonyms)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lived moral inconsistency</td>
<td>Only if I have to</td>
<td>14</td>
<td>5 Male, 9 Female</td>
<td>Andy, Sarah, Tom, Maddy, Jane, Ella, Flora, Jackie, Paul, Lizzy, Rhiannon, Saul, Cian, Adrian</td>
</tr>
<tr>
<td></td>
<td>Justifying it to myself</td>
<td>13</td>
<td>4 Male, 9 Female</td>
<td>Andy, Sarah, Maddy, Tom, Maddy, Jane, Ella, Flora, Jackie, Paul, Rhiannon, Saul, Cian</td>
</tr>
<tr>
<td>Lived knowledge inconsistency</td>
<td>Not knowing: Lost in flight</td>
<td>14</td>
<td>5 Male, 9 Female</td>
<td>Andy, Sarah, Maddy, Ella, Flora, Jackie, Paul, Rhiannon, Saul, Cian, Tom, Jane</td>
</tr>
<tr>
<td></td>
<td>Not knowing: Messy work</td>
<td>12</td>
<td>5 Male, 7 Female</td>
<td>Andy, Sarah, Tom, Maddy, Jane, Ella, Flora, Jackie, Paul, Rhiannon, Saul, Cian</td>
</tr>
<tr>
<td></td>
<td>Knowing: The body in custody</td>
<td>14</td>
<td>5 Male, 9 Female</td>
<td>Andy, Sarah, Tom, Maddy, Jane, Ella, Flora, Jackie, Paul, Lizzy, Rhiannon, Saul, Cian, Adrian</td>
</tr>
<tr>
<td></td>
<td>Knowing: The unfamiliar body</td>
<td>8</td>
<td>2 Male, 6 Female</td>
<td>Andy, Sarah, Maddy, Jane, Flora, Jackie, Cian, Adrian</td>
</tr>
<tr>
<td>Lived care inconsistency</td>
<td>Being caring: Having affinity</td>
<td>13</td>
<td>5 Male, 8 Female</td>
<td>Andy, Sarah, Tom, Maddy, Ella, Flora, Jackie, Paul, Lizzy, Rhiannon, Saul, Cian, Paul</td>
</tr>
<tr>
<td></td>
<td>Being caring: Compassionate custodian</td>
<td>13</td>
<td>4 Male, 6 Female</td>
<td>Andy, Tom, Sarah, Maddy, Jane, Jackie, Ella, Flora, Paul, Saul, Cian, Adrian, Rhiannon</td>
</tr>
<tr>
<td></td>
<td>Being careworn</td>
<td>13</td>
<td>5 Male, 8 Female</td>
<td>Andy, Sarah, Tom, Maddy, Jane, Ella, Flora, Jackie, Paul, Lizzy, Rhiannon, Saul, Cian, Adrian</td>
</tr>
</tbody>
</table>

4.5 The construction: an overview of the whole experience

The nurses were encouraged to talk freely to tell their stories in their own words. Initially, they struggled to articulate their experience of forced touch because they said that they had never thought about it before. It appeared that the nurses had not connected physical restraint interventions and touch in their minds. Yet, with time and exploration, they began to recall and tell their stories.
At the culmination of the analysis, I understood the central meaning or overarching theme of the nurses’ experience of forced touch during physical restraint interventions, to be lived inconsistency. The central meaning reflected the inconsistency in the nurses’ beliefs and feelings that threaded through their accounts, although these were not strongly dissonant.

The major themes are set out sequentially to reflect how the nurses’ told their stories. These nurses had lived through physical restraint procedures and forced touch many times and exploration of these events brought forth their experience of lived inconsistency in three areas. First, they set out their moral position and their stories expressed how they lived with uncomfortable moral dilemmas and inconsistent thoughts and feelings about their nursing role in physical restraint. Second, their accounts then illuminated their inconsistent beliefs about whether they knew their sensory experience of forced touch well enough to describe it, or not. Initially, the nurses said they could not recollect what it was like to use forced touch, but this appeared inconsistent with their vivid accounts of how they touched the patient once they had successfully restricted their movement. Third, it appeared that, having attuned to physical restraint interventions as forced touch, they then recalled further stories of using touch with compassion during the calming phases of their intervention. They illuminated their feelings of affinity and their deep care for those under their force, and they recounted how they touched patients to express their care. Yet, they did not always feel cared for themselves.

Three major themes represent these lived inconsistencies: (1) lived moral inconsistency, (2) lived knowledge inconsistency, and (3) lived care inconsistency. Table 4.3 presents the themes, the sub-themes, and a summary of the interpreted lived inconsistency:
Table 4.3: Theme labels, sub-themes and summary contributing towards the central understanding

<table>
<thead>
<tr>
<th>Theme label</th>
<th>Sub-themes</th>
<th>Summary of lived inconsistency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major theme 1</td>
<td>Lived moral inconsistency</td>
<td>• Only if I have to&lt;br&gt;• Justifying it to myself</td>
</tr>
<tr>
<td>Major theme 2</td>
<td>Lived knowledge inconsistency</td>
<td>• Not knowing: Lost in flight&lt;br&gt;• Not knowing: Messy work&lt;br&gt;• Knowing: The body in custody&lt;br&gt;• Knowing: The unfamiliar body</td>
</tr>
<tr>
<td>Major theme 3</td>
<td>Lived care inconsistency</td>
<td>• Being caring: Having affinity&lt;br&gt;• Being caring: Compassionate custodian&lt;br&gt;• Being careworn</td>
</tr>
</tbody>
</table>

4.6 Major Theme 1: Lived moral inconsistency
4.6.1 Introduction

The first major theme, *lived moral inconsistency*, illuminates the nurses’ thoughts and feelings about their role in physical restraint procedures. I felt their emotional discomfort at the outset of our conversation as they articulated their conflict about having to restrain people about whom they cared. Their desire to express this discomfort appeared to delay access to accounts of their experience of forced touch, as well as signifying the strength of the moral distress. Although the nurses spoke of not wanting to engage in physical
restraint, they felt able to defend their actions on the grounds of safety for patients and staff because they believed they had no other choice. This first major theme had two sub-themes. First, *Only if I have to* revealed the nurses' negative feelings about having to use physical restraint procedures and how these negative feelings intensified over time. Second, and on the other hand, *Justifying it to myself* revealed how, even in light of their acute dislike, they felt justified using physical restraint on the professional grounds of safety.

### 4.6.2 Sub-theme. Only if I have to

The moral discomfort felt by the nurses is exemplified by the sub-theme *Only if I have to* because it describes their reticence to intervene with physical restraint with patients in their care unless it was absolutely necessary. Yet, they revealed how, in their early professional lives, they had more easily accepted physical restraint as part of their work. Adrian, a newly qualified staff nurse, epitomised this acceptance of *‘doing’* restraint:

*‘If I’ve been told I need to do it [restrain], or I’ve made that decision, then I go ahead and do it. You fall into that role and that place.’*

Similarly, Maddy, a Deputy Ward Manager, reflected upon her early professional socialisation in a matter-of-fact manner:

*‘Yeah, you just did it then. Before we went on the wards, we had two weeks Health and Safety. The second week was C&R. They talked about it as a necessary part of the job. It wasn’t something that happened frequently, but it was a necessary part of the job.’*

As the nurses gained more experience of the impact of physical restraint upon themselves and people in their care, their apparent acceptance seemed to
reduce to tolerance of what they described as the worst part of their job. They cared deeply about patients, and they felt increasingly conflicted as they became more aware of patients’ suffering at their hand. Maddy reflected her changing interpretation over time through her use of ‘now,’ and how her attitude shifted from matter-of-fact acceptance during her induction, to her present practice:

‘Honestly, it’s the worst part of my job. I don’t like doing it now because of their [patients] reaction to it. It’s distressing to have to do it.’

Similarly, when asked about having used physical restraint many times since starting his career in PICU, Andy also said, ‘I know now it’s not to be taken lightly when you put your hands forcefully on somebody. It’s wrong really. It’s like the opposite of therapeutic touch.’

Paul illuminated similar views. However, he believed that it was his growing mastery of the requisite technical skills that had increased his confidence sufficiently to open the psychological space to think about the negative impact of physical restraint:

‘I don’t think I was aware when I was first doing it - how the patient felt about it, that wasn’t on my agenda. Higher on my agenda was making sure that I did it right. But when you know that you can do it [techniques] right, then you start to think about it…what it’s like for patients.’

The nurses’ use of overt force against patients in their day-today work was extremely uncomfortable for them. Andy clearly detested it:
‘You feel like an arsehole because you are planning to take them to the ground, pick them up in a thumb-wrist lock, then take them somewhere and give them an injection.’

Some nurses had to search for words to articulate the intensity of their disgust. Jane lost eye contact with me, put her hands to her face and muttered, ‘It is so horrible, horrible [silence].’ Similarly, Jackie reflected that it is ‘heart-breaking.’

The nurses spoke about trying to negotiate with patients to avoid restraint. When Andy failed to achieve a new position with the patient, he described the consequences as ‘crap,’ and reflected how dehumanising it was for patients and him:

‘So the only choice I can offer you [patient] at this moment is whether we do this [compulsory medication] in a manner that promotes your dignity, or in a manner that takes it away [pause]…And it’s really crap when that’s what their choice boils down to, whether you get them into a restraint or not.’

Similarly, Jackie felt ashamed at having to give intramuscular medication into a patient’s buttocks:

‘We’re not only putting you down on the floor, we’re also forcing you to have medication that you feel you don’t need. And it’s uncomfortable, very uncomfortable for me as a nurse and for the patient [silence].’

The nurses’ believed that if they had time to get to know the person, this improved their chances of avoiding physical restraint because they could recognise the patient’s unique escalation signature:
'When you know your patient and the triggers that someone’s becoming highly agitated, you can work to eliminate those before it reaches that point. Because restraint isn’t nice.’ (Tom)

Flora, a PICU Manager, was the only nurse to talk about colleagues who refused to participate in physical restraint interventions. She described how a small number of her older, female team members took an informal stance against its use. Flora recognised that this placed an extra burden on other staff. However, she believed that their advancing age, motherhood, and grand-motherhood infused practice wisdom that they used to settle patients’ behaviour:

‘They [older staff] don’t get involved. They think it’s a load of nonsense and they manage to calm things in different ways when people are getting a bit revved up, like having a cup of tea, because they’ve got that older, maternal thing going on.’

No other PICU nurses mentioned this, so their views are unknown.

The nurses’ profound moral objection towards using physical restraint meant that for them, it was ‘always the last resort’ (Saul). They said they would ‘try everything else first’ (Tom). Cian encapsulated the nurses’ insistence that they intervened only when everything else had failed:

‘It can be frightening and it can be distressing, and it’s really not a pleasant part of the job. I don’t think I would go in there if there was any, any, any possible alternative.’

In summarising this sub-theme, the nurses’ early socialisation into mental health nursing appeared to commence with their unquestioned acceptance that
physical restraint procedures were part of their job. Yet, as they became more familiar with the impact of their force upon patients, they became more aware of the contradictions inherent in their caring role. They then found using physical restraint more degrading for themselves and patients. Their stories brought forth how their attitudes moved towards a position of tolerance, believing firmly that physical restraint was their last resort.

4.6.3 Sub-theme. Justifying it to myself

The clusters of meaning that underpinned the sub-themes Only if I have to and Justifying it to myself drew naturally together to form the first major theme because they were inextricably linked through the centrality of the nurses’ experience of moral inconsistency. On one hand, they emphasised their intense dislike of using physical restraint against patients in their care, and on the other hand, they justified their actions to themselves, seemingly to dampen their moral discomfort.

The nurses justified their actions on the grounds of safety including the immediate physical threat to patients or staff, destruction of the ward environment, and nursing patients who were severely self-neglecting. Maddy and Andy both described restraint as a rare, but ‘necessary evil.’

Ella’s metaphor of a road traffic accident illuminated her belief that her role in physical restraint procedures protected patients from other patients:

‘In that situation [patients fighting], something has to be done. It’s like the car is going to roll over someone. You have to quickly do something to the car, to stop it [pause]. All you’re thinking of is just holding them from doing any more of that. So I think of it as if it were a child going into a road, because you’d hold them wouldn’t you?’
Similarly, Flora felt justified in protecting staff:

‘I wasn’t going to let him get up and do what he wanted, because I didn’t want him to, hitting everyone...[staff]. It just felt like it was the safest thing to do at the time.’

Rhiannon felt that C&R training improved her confidence to protect her colleagues:

‘It is difficult, but when you need it you’re glad you trained and you can support your colleagues. I can think of nothing worse than not having your training and I couldn’t help them [staff].’

Yet, although the nurses felt justified in their use of physical restraint interventions to protect patients and staff at times, their justification appeared more complex in two specific areas. First, when they undertook personal care, and second, when they had not observed the patients’ escalating behaviour themselves.

Andy spoke about providing personal care for a severely self-neglected man. His exemplar revealed the inconsistencies in his thinking between the importance of personal care for wellbeing and his heavy discomfort about forcibly handling a physically and mentally vulnerable man:

‘The whole time he’s spitting in my face and calling me all the names under the sun. So for me that is the most beneficial type of restraint. You can’t leave a man in his own faeces. So you clean them up and that’s good, clean nursing. But it doesn’t feel like that. You know you’re doing it for the best but after a couple of days he starts bruising. The man looks like a battered peach.'
And your choices are clear choices because when you go in and pick him up he’s covered in poo. The other choice is to leave him floundering around the floor in his poo.’

When the nurses had not observed patients’ escalating behaviour, justification felt more difficult. When emergency alarms sounded on other wards, the nurses recalled how they often arrived to find physical restraint interventions underway and they felt compelled to assist to keep the situation safe. Tom oscillated between feeling both reassured and uncertain about the necessity for physical restraint:

‘It provokes a lot of anxiety when you lay hands on, but in particular when it involves people [patients] from other wards that you don’t know...When you respond, I’m not sure if they’ve [other ward staff] done everything they should have done, but I’m sure they probably did everything they should have done to de-escalate.’

Similarly, Paul was not always convinced:

‘Well you’re responding to another ward’s situation. You arrive and something has already half kicked off. You don’t know whether it is the most justifiable thing to go and do. It’s never a nice situation to be in.’

Two discrepant cases illustrated situations when the nurses felt unable to defend the decision to physically restrain a patient, or the techniques used. First, Flora felt guilty about the inadequate communication amongst her team that culminated in its use:

‘I hesitated to let him have his money because of the community meeting and the boundaries thing [patient was required to attend meeting in order to access money]. Then we found out that the community meeting hadn’t
happened, so I felt awful. At this point, he got really upset and he started arguing and following the staff nurses, and he was taken down [by the team]. If I'd just found out the information first, and the HCA had done what she needed...I just felt so sorry for him.’

Second, Sarah felt contempt for colleagues’ use of excessive flexion:

‘You can restrain somebody and keep them safe without having to apply extra pain. It might just take a bit more verbal de-escalation, but sometimes I see nursing staff using flexion to get people to comply, and I don’t agree with that.’

Sarah’s account revealed how, although all nurses trained in the use of flexion to the joints, they made different decisions about whether to use this technique.

4.6.4 Summary of Major Theme One: Lived Moral Inconsistency

This major theme represents the nurses’ thoughts and feelings about their role in physical restraint procedures, rather than their experience of touching patients during physical restraint interventions. Their accounts are full of moral dilemmas and inconsistencies. Their stories recalled their early socialisation and acceptance of physical restraint procedures as part of their job, but their attitudes moved towards a position of tolerance as they became more aware of the impact of their human force upon patients.

The nurses spoke of their distress about physically dominating patients and this appeared to conflict with their caring selves. Heidegger believed that human beings are fundamentally caring. Yet, our care for others (solicitude) can take the form of either authentic solicitude or dominating, inauthentic solicitude (Watts, 2001, p.47). I felt that these nurses experienced a state of inauthentic
solicitude when they intervened with physical restraint, and according to Heidegger, this is inconsistent with our innate, authentic, caring state of being (Moran, 2000c, p.240; Polt, 1999, p.79; Inwood, 1997, p.27). However, the nurses lived through their intense moral discomfort many times as part of the expectations of their role as ward nurses.

Whilst the nurses tried to avoid physical restraint interventions, at times they felt they had no choice. Another inconsistency manifested itself because even though the nurses’ caring selves felt conflicted, they also justified their use of forced touch on the grounds of safety to patients and staff. The nurses seemed to find it easier to justify when they knew the patient, or they had observed escalating behaviour, and they believed that physical restraint was their only option. They reported that having to respond to other wards was less comfortable because they had no influence upon their colleagues’ decisions to intervene. When they perceived others to be using excessive force, the nurses felt guilty and worried about colleagues’ actions.

4.7 Major Theme Two: Lived knowledge inconsistency
4.7.1 Introduction

The second major theme, *lived knowledge inconsistency*, illuminated how, from their accounts, at first the nurses did not seem to have previously connected physical restraint interventions as forced touch. They found it difficult to bring to words what it felt like to touch patients when they intervened to grasp the patient. The nurses associated this difficulty with the necessary speed of their intervention and the chaotic nature of restraint events on wards. They described not knowing their experience. However, with time and space, the interview process with its specific focus upon forced touch, appeared to provide an opportunity for the nurses to recall their vivid experiences of using forced touch and listening to the patient’s body.
The second major theme is comprised of four sub-themes. The first two sub-themes labelled, *Not knowing: lost in flight* and *Not knowing: messy work*, illustrate the nurses’ struggle to apprehend, and convey through talk, their experience of grasping the patient to restrict their movement as they initiated forced touch. Their need to respond immediately, often in disturbed and chaotic situations, appeared to suffocate their experience.

Heidegger suggests that ontology, or dwelling in our everyday world, precedes epistemology, our beliefs and knowledge about what is to be-in the world and engaged in the tasks of everyday life (Polt, 1999, p.47-48). Therefore, from a phenomenological perspective, although the nurses could not articulate their subjective knowing of forced touch at first, it did not mean that that it did not exist (Reed, 1994, p.340) because the nurses had not yet become aware of their understanding.

The third and fourth sub-themes labelled ‘*Knowing the body in custody and Knowing the unfamiliar body*, illuminate how, once the nurses took time to reflect upon what it was like to be in physical contact with the patient, they gave vivid accounts of their experiences of using forced touch. Thus, the second lived inconsistency manifested itself because although the nurses believed that they did not know their experience of forced touch, their stories were infused with vivid accounts of touching patients forcefully with their body.

**4.7.2 Sub-theme. Not knowing: Lost in flight**

*Not knowing: Lost in flight* describes the nurses’ exclusive focus upon the technical procedures required to grasp and hold the patient during the initiation of forced touch. Consequently, they believed that they could not apprehend their sensory experience. They described altered bodily states as they entered
the restraint situation, amidst disturbed ward atmospheres, and they expressed their palpable desire to get through the procedure as quickly and safely as possible.

During early exploration of the nurses’ experience of forced touch, they said they ‘hadn’t really thought about forced touch’ (Andy) and ‘had never even thought about what it is actually like’ (Jackie). Andy recognised that he ‘hadn’t connected the two really’ and Saul seemed surprised at having never having made the connection saying, ‘It’s strange that I’ve never looked at it or analysed it before.’

Flora believed that she only became aware of touching the patient, ‘if they’re a bit clammy, or whatever, but I don’t think it’s something that comes into play.’

Having not previously reflected upon their experience, the nurses found it difficult to bring to words, saying ‘It’s fairly difficult to describe’ (Lizzy) and, ‘it is quite hard to articulate what it feels like’ (Cian). Recollection felt difficult because ‘it happens so quickly’ (Lizzy), ‘too quickly to be able to think’ (Jackie), so ‘it is lost during the intensity of the incident’ (Maddy). The nurses’ focus on their technical skills dominated their initial description of their experience:

‘you’ve got your hip or your leg into them to make sure you’ve got a steady base. You know that part isn’t really going to hurt them, so you’re not thinking how it feels for the patient, you’re just thinking, ‘Am I strong in my base?’(Maddy)

Paul described how his fear of losing control kept him focused on his holds:

‘I think it’s about adrenalin kicking in and it can make you very focused [pause]. We’re concentrating on, ‘I can’t let this patient go.’ It’s on getting the
grip and most importantly, not letting the patient go. I don’t think it’s much beyond that.’

Similarly, Rhiannon pinpointed safety as her only focus:

‘At the time, all is that you want everything to go safely.’

During the initiation of forced touch, the nurses also described feeling as though they were in altered bodily states, entering ‘zones’ (Ella) and ‘modes’ (Saul), and becoming ‘robotic’ (Adrian) in order to engage in frightening and physically forceful contact with patients. Adrian spoke of grasping patients in ‘an automatic way’ and Paul described early intervention like ‘a mechanical task.’

The nurses talked about not being their normal selves. Ella said that nurses deliberately adopted ‘different personas’ in order to undertake the task and she dissociated from her usual self:

‘It’s the nature of it. People’s voices change. You’ve been trained to do it. And you don’t restrain and smile at the same time, do you? At that time you’re in your zone, and you just know that you have to do it. It’s just a job. It becomes just a job at that minute.’

The nurses’ automated, detached state whilst they grasped the patient was common amongst them, yet Andy’s sense of familiarity and ease with which he forcibly touched patients unsettled him:

‘There’s a few of us who’ve been doing it so long, it’s almost like sleepwalking and that’s a bit disturbing. It is as if you’ve become so used to restraining people that somebody swings a punch at you and you step back out
of the way, catch the arm as it goes past and rotate it. Before you know it, you’re working towards a thumb wrist lock.’

Woven into the nurses’ stories were images of rapidly deteriorating situations and escalating behaviour that disturbed the ward milieu and signalled an impending crisis. The nurses spoke of a sudden tension saying they could ‘feel the high expressed emotion’ (Andy) and they recognised the ‘charged atmosphere’ (Tom). They understood that when ‘it [tension] reaches that crisis point, it is about to snap’ (Saul). At this critical point, the nurses described their swift response and their intent to complete their intervention as quickly as possible.

When the nurses intervened, they wanted to get through the intervention and withdraw their force as soon as possible. Jane reflected her need to contain both hers, and the patient’s distress:

‘You get a team and you go in and you get the person down to the floor and into position, and if you have to medicate, then somebody comes in to medicate them. And that’s it, finished, for everybody.’

The nurses’ felt need for swift intervention and resolution seemed to further their belief that they could not recall their experience of forced touch. Andy illuminated how, once nurses grasped the patient, there was a risk that the patient’s behaviour may escalate further:

‘Once you put hands on a patient, you cement that risk’

Andy recalled using the element of surprise to try to minimise this risk. He spoke about a secluded patient with an extensive history of actual bodily harm.
against nursing staff. Andy confines his narrative to his procedural actions, with no reference to his emotional or sensory experience of forced touch:

‘We made our decision that the best thing to do was to go in, not mess around. We went in. He was laid on the bed wrapped in a blanket and it was a good time to go in [early morning] because he’s going to take a few moments to get up off the bed. So we made the decision to go in and close it down as quickly as possible. And that’s how it worked.’

Similarly, when giving personal care, the nurses shared their concern about intruding on the patient’s privacy and compromising their dignity. Flora felt it important to keep her intrusion brief:

‘Where you need to give personal care, everyone’s going, ‘I don’t want to do it’ and, ‘Oh, he won’t like it.’ And I’m like, we know he won’t like and we’re not going to like it, but we have to do it, so let’s say that we’re going in to do it at such and such a time, you, you, and you, and we’ll kind of go in to get it done for him as quickly as possible.’

Busy wards also appeared to drive the nurses’ desire to get physical restraint procedures finished because they were acutely aware of the needs of other patients. Saul summarised this saying, ‘you come in and you get the job [forced touch] done. We have 23 others to worry about too.’

The nurses’ experience appeared to reflect Heidegger’s notion of taken-for-grantedness that describes the way in which they responded by physically restraining the patient in their usual and immediate way without becoming open to, and aware of, the experience of their body touching the patient’s body (Watts, 2001, p.55). However, Maddy recognised and seemed to appreciate the space created by the interview for reflection:
'It feels nice to have the chance to go back and think about it now. You don't have the chance to go back and think about it then.’

The ontological authenticity of a study occurs when the study helps participants, as well as the researcher, to understand their social world through greater insight into the phenomenon under inquiry (Holloway & Wheeler, 2002, p.256). Maddy seemed to recognise that new possibilities existed for understanding what it was like to use forced touch based upon her preliminary understanding of being in physical restraint with patients. According to Heidegger, such recognition reflects that all learning is circular (Watts, 2001, p.40).

In this sub-theme Not knowing: Lost in flight the nurses’ spoke of being unable to apprehend and give voice to their experience of forced touch because they believed that their focus on the technical procedure inhibited any accommodation of what was happening to them. They described using forced touch in a detached and automated manner, remaining task-focused, and getting bodily contact with patients finished as swiftly as possible to ensure safety, reduce patients’ experience of humiliation and return their dignity, and to discharge their own unpleasant emotions. Rapid, effective intervention also meant that they could return to care for the remaining patients on the ward. I therefore understood that their focus on efficient technicality meant that their sensory and emotional experience of forced touch eluded them.

In the next sub-theme, the nurses’ desire for a swift, effective intervention appeared to stand in sharp contrast with their accounts of the often messy and unpredictable daily reality on the ward.
4.7.3 Sub-theme. Not knowing: Messy work

Following their classroom-based PMVA training, the nurses believed they knew how to use forced touch effectively. However, when they returned to face real life situations with large, disturbed patients on busy, furnished wards, they believed it was much more difficult to effectively use the skills. The nurses' accounts of these messy situations appeared to contribute towards their belief that they could not apprehend, and therefore, did not know their experience of forced touch.

The nurses described their classroom-based training C&R experience as ‘a clean procedure’ (Jackie) where ‘it all goes very nicely there’ (Andy). However, they said that the reality on wards could be ‘a bit of a wrestling match’ (Paul), or ‘a bit of a frenzy’ (Saul), and situations would sometimes ‘go all pear shaped’ (Jane). Sarah summarised this stark contrast:

‘When you get trained, it all goes very well and people go down to the floor and it’s all done perfectly. But when it comes to the actual situation, it’s a completely different matter…[silence].’

The nurses talked about struggling to contain patients and of feeling out of control, frightened, and vulnerable to injury. They spoke of situations unravelling and feeling suddenly helpless. The nurses struggled to grasp patients and restrict their movement as they worked in complex ward environments that were filled with furniture and other objects. Andy reflected that, ‘We only ended up being able to restrain this gentleman because he got his leg caught in the sofa’. Flora used the metaphor of stars as she spoke of the chaos of a ward restraint amidst a constellation of chairs, tables and other patients on Christmas Day. Her humour appeared to defend her against her perceived absurdity of the situation:
'He [patient] was almost like a star shape, and we [nurses] were all like stars lying on top of him, and I remember thinking I really didn't think I'd be watching the Queen’s speech like this [laughs]. We had to be in the TV lounge because we couldn’t really move anywhere else.’

The nurses believed that the way in which they learned to hold the patient’s specific body parts (head or their arms) did not always go smoothly in practice. However well they planned their three-person intervention, their plans could sometimes disintegrate and nurses were shocked and injured:

‘I was meant to be on the head and I ended up on an arm. I had a colleague on the floor with a bloody nose, and you just think, ‘Oh my goodness.’’ (Maddy)

Sarah reflected upon how difficult it could be to hold the patients’ head ‘particularly when you get sweaty heads. That makes it difficult to hang onto them.’ She recounted how being unable to quickly restrict head movement could be ‘frightening because I’m going to get bitten or I’m gonna get a head butt.’ Her story, together with her demonstration, conveyed her panic at needing to keep her hands away from the patient’s mouth and their head at arm’s length to protect them from bulldozing her breasts. Sarah’s story brought forth the complexity of attempting to use correct techniques to restrict the patient’s movement whilst defending her own body.

Both the male and female nurses felt intimidated by the patient’s stature and perceived strength, and under-confident about the effectiveness of classroom techniques. Patients who were very fit and agile frightened them. Andy admitted, ‘people who’ve been in the armed forces, you don’t want to go near them.’ Yet, he felt that the instructors ‘all just constantly reinforce techniques over strength’ and he believed that this negated nurses’ fear of failure. They
therefore felt vulnerable and believed their bodies were often in physical jeopardy.

The nurses described feeling inadequate and out of control when they could not effectively restrict movement, regardless of their size. Tom, a nurse of short stature said, ‘If they’re tall, I get flung around a bit.’ In contrast, Andy, a well-built nurse, also portrayed how small and insignificant he felt when, ‘after 20 minutes or so it stopped, most of us in our twenties, relatively fit young men, were being thrown around like rag dolls.’

The influence of illegal drugs, such as amphetamines, sometimes worsened the situation:

‘It was all quite messy. As soon as we were touching him it was like an electric shock. He was flinging his arms everywhere, as if he knew what was coming, and it didn’t feel particularly wonderful because it was really difficult to get a hold on. He tried to flick you off, and all you’re thinking at the time is we need to get him down because people are going to be at risk.’

The nurses’ language conveyed their fear about the resistance they met. Sarah expressed this as ‘fighting:’

‘You don’t know whether it’s going to be a smooth restraint or whether there’s going to be a lot of fighting before you can actually get somebody in control.’

Ella also recalled thinking, ‘Oh God, he’s really strong and I’m going to the floor now with him.’
When patients had a history of assaulting nurses, they talked about how their fear intensified:

‘[We had] a lad who was awaiting court appearance for ABH against two nurses. On two separate occasions, they’d gone to offer him medication and he’d smacked them in the face, he’d gone and knocked their teeth out.’ (Andy)

Sometimes, the nurses faced patients armed with items used as weapons. Flora said, ‘We had this lady and she had this vase and you get this sixth sense, there was something about the way she was holding that vase. We had just had the unit done up…and then there was a hole in the door and a great big hole in the wall, and we were upset [silence].’ She then masked her distress by talking about the damage to her ‘lovely new ward’ that previously, had not been decorated for years.

One nurse worried about the potential for catastrophic harm if the intervention did not go according to plan:

‘I think we worry about what if something goes wrong? Someone ends up with a broken hand or a spinal injury? Or breaking a bone? Or something that the person may have to live with for the rest of their life? And they have to deal with it. Or maybe they will be injured or die and it will have a lasting impact upon the team.’ (Jackie)

To summarise, in this sub-theme Not knowing: messy work, the nurses often experienced trying to use the taught technical holds as messy, difficult, dangerous, and unlike their experience in the classroom, regardless of their gender or stature. They believed that the taught skills were inadequate in real ward situations. The nurses feared that both their bodies, and patients’ bodies, were in jeopardy and they described how injuries occurred.
The sub-themes *Not knowing: lost in flight* and *Not knowing: messy work* represent the nurses’ perception of the speed and automation with which they intervened, often in chaotic and frightening situations. These meanings appeared to contribute towards their belief that they did not know their experience of forced touch during physical restraint interventions, and therefore could not bring it to words.

### 4.7.4 Sub-theme. Knowing: The body in custody

In contrast, the sub-theme *Knowing: the body in custody* begins to reveal the nurses’ inconsistencies in their belief that they did not know forced touch, by presenting their recollections of forced touch. These memories revealed how they understood which part of the patient’s body they preferred to grasp. Once they had contained the patient safely in their bodily custody, they described a corporeal connection with patients, sensing through their body the necessary degree of force to use, and at what point to start relaxing their force. The nurses’ also illuminated the meanings they gave to the different qualities of touches they used, including both forceful and gentle touches, and how they used these in juxtaposition. When the nurses were in intimate physical with patients, they found smell the most powerful aspect of their experience, and this lingered with them for some time. Thus, a second inconsistency became evident because their stories contained vivid details of their experience of using forced touch against the patient’s body.

Each nurse asserted their preference for which part of the patient’s body, head or arms, they preferred to touch. All except two of the fourteen nurses preferred to take the patient’s arm because they felt that the patient’s head confronted their use of force. Thus, the nurses’ preference for touching different parts of the patient’s body also seemed to illuminate their feelings about the parts of the body that they disliked touching.
Grasping the patient’s head provoked strongly negative emotional responses. In particular, the nurses described that using forced touch on the patient’s head whilst in the prone position engendered feelings of repulsion:

‘I especially don’t like it when the person is prone because they can’t see you and your hands are covering half of their head, with their face to the floor. They’re looking at you with one eye, and you’re looking down at them, and I really don’t like that.’ (Paul)

Similarly, Flora said:

‘If I have to hold somebody’s head I would find that uncomfortable. I don’t know whether it’s because you can’t see their face. It just appears a bit [pause]...inhumane [pause]...’ (Flora)

Jane reflected upon how touching the patient’s head and face breached normal personal boundaries because ‘the head is more unsafe, more personal than the arms’. Maddy identified at a personal level with the intrusion into a private part of her body:

‘the head feels like quite a personal thing, and an arm is their body part, but on the head you’re pressing your hands on their face and I don’t know about other people, but I don’t like my face being touched. It’s personal. I don’t mind an arm, but my face, that’s really personal.’

The two youngest staff nurses expressed a preference for taking the head. Their duration of qualification did not appear to influence this preference. They put their preference down to having the confidence to communicate effectively with the patient and lead the team through the procedure. Yet, Sarah’s concern about being seen to avoid the risk of taking the patient’s arm is evident:
‘I prefer to be a head person because I want to be the one who’s interacting with the patient. That’s one of my areas of strength and I can use my communication skills...communicating with the patient and trying to de-escalate. I definitely prefer that. It’s not because I am chickening out of the doing the physical stuff though [laughs].’

Similarly, Adrian, a newly qualified nurse, discovered during his C&R training that, ‘I was better at the front [head] end because some of the team found it difficult to communicate.’

Once the nurses were in close physical contact with the patient, they recalled vividly the intimacy of forced touch. Cian also recognised the degree of uninvited intrusion saying ‘we do it without asking.’

Saul’s remembered how the degree of physical intimacy meant nurses came into contact with body fluids:

‘You invade their personal space. I feel that my personal space is being invaded also. Somebody [patient] is in the armpit so close to you, to your chest, and sometimes you’re talking and they’re talking and saliva is splashing into your face. You forget how intimate that is.’

The nurses found the smell of the patient’s body powerful because it transferred onto their nurses’ clothes, and reminded them of how close they had been to the patient. Paul recalled that the patient’s odour ‘lingered in my nostrils and on my clothes,’ a seemingly poignant reminder of the incident:

‘It was a struggle and he wasn’t wearing a shirt so there was a lot of physical contact....and just the smell; it seemed to be forever be on my jeans. I wouldn’t say it was BO but it was quite strong. And no doubt stronger because
he was struggling and he was sweating more. It wasn’t offensive but I was conscious of just how intimate it kind of was.’

The nurses wore their own clothes on duty rather than uniforms and this may have heightened their feelings of contamination:

‘that smell stays with you for the rest of the day. You can’t just pop and wash that off. Obviously, you will go and clean yourself and sanitise your arms with alcohol gel but you can’t change the fact that you were in person to person contact, so your own clothes smell of that person, and that doesn’t shift’ (Andy).

For Andy, the smell of the patient’s body also appeared to evoke his perception of the abject wretchedness of relapse, and projected an image of patients’ illness trajectory from home and independence, to conveyance by the Police to the ward and nurses’ use of forced touch.

‘They’re floridly psychotic and not looking after themselves and it’s just that kind of smell associated with it. And I cannot actually tell you what it was, but there’s definitely a smell associated with that level of unwellness and it does rub off on you. I can’t really describe it. It makes me uncomfortable thinking about it because it’s a smell that makes me feel bad for the people I’m looking after. It speaks to me of loneliness and desperation and being disenfranchised, and being picked up out of your life and being brought to a bare, stark unit where you’re quite scared and you have no control. And three people come and sit on you and give you an injection. And all of that is summed up by that smell.’

In one discrepant case, Jackie described how the team felt so repulsed by patients’ odorous bodies that this inhibited their normal, caring response and they avoided administering medication into the buttocks:
'You see the person differently. You just don’t want to go in. Poor personal hygiene puts you off. There’s a patient we should be administering a depot to. But his personal hygiene is really poor and nobody is being proactive and saying, ‘Well, let’s just go and do it.’

The nurses’ dislike of the odorous body also spoke of their hope for a clean body, but this engendered feelings of guilt because the nurses’ believed that caring for the patient, clean or self-neglected, was integral to their nursing role. Sarah’s embarrassment was evident as she said, ‘I think about really silly things like, I hope the patient is clean and stuff like that because it sounds like a really bad thing to say, but you want that when you’re putting hands on somebody.’

The nurses’ phenomenological knowing of the physical, emotional and sensory experience of forced touch manifested through their stories of their preferences for touching the patient’s arms or head, their felt intimacy, their repulsion of odorous bodies, and their hope for a clean body. Their subjective knowing was also manifest in their accounts of how, once they were able to hold the patient in their bodily custody, they could judge the right amount of force to use. They described sensing the patient’s response to their forced touch, and assessing how much pressure to employ.

Once the patient was physically contained, the nurses attuned to the patient’s body and sensed how much force to employ by responding to the patient’s body. They understood the degree of pressure needed. Maddy emphasised that, ‘by just feeling alone, you know how it’s going,’ and Ella perceived that, ‘some restraints need just a light touch.’

The nurses said they did not rely on verbal responses from the patient and the patient’s body guided them. Adrian reflected that, ‘rather than going by what they [patients] say, you actually go by the sensation of their movement, their
body.’ Similarly, Ella believed that nurses’ knew too much force because, ‘although the patient may not scream, their body tells you.’

The nurses articulated how, once the patient became still, they remained in a state of gentle readiness, carefully poised to react immediately to any renewed aggression. Rhiannon depicted how she ‘would have kind of a light touch above the ear where, if I needed to apply a bit more force, then I could, so it would be secure.’ She described how she sensed the patient’s response saying that, ‘you’re feeling through your hands and you go for a gentle touch, but if you’re getting a lot of resistance, then you would have to put a kind of more firmer hold on.’

Cian summarised the nurses’ perceptions of these different qualities of touch that they used in juxtaposition:

‘You don’t move so that you’re ready to respond if you need to. I think you do relax, but when it is a situation that is quite challenging your hold is firmer but within a context of still being gentle.’

Saul’s account illuminates how he relaxed the degree of force and started to provide comfort for the patient:

‘Once you feel that release of tension after the initial burst of adrenalin they experience, you feel it dissipating and you just gradually start releasing the flexion [pause]. And then you start putting their head in a more comfortable position.

To summarise this sub-theme, it illustrates the nurses’ recollections about which body part they preferred to hold, how they understood their experience of
intimacy with the patient, their phenomenological knowing of the amount of force to use, and their tacit knowing of patients’ responses to their forced touch.

4.7.5 Sub-Theme. Knowing: The unfamiliar body

In the sub-theme Knowing: the unfamiliar body, the nurses’ stories illuminated how they understood how to use forced touch more carefully with patients’ bodies that were unfamiliar to them, either through age, gender, physical form or disability. They talked about their experiences with a pregnant woman, older people, young anorexic women and patients with diseased or deformed bodies. The nurses expressed how they worried more about harming these patients, and they appeared more morally conflicted about using forced touch with patients they perceived to be physically vulnerable.

Andy’s account presents his understanding of having to bring a pregnant woman to the ground backwards. His was visibly upset and found the experience abhorrent. His use of ‘girl’ to describe the patient underlined his perception of her fragility. His narrative also epitomised his moral conflict between using his taught skills to stop a heavily pregnant woman from engaging in self-destructive behaviour and his compassion for her:

‘She was cutting herself and she had big bandaged arms and she was escalating and escalating, and it was just like, Oh my God!...we have no choice but to lay hands on this pregnant GIRL [emphasis]. You’re horrified. It’s awful, and you’re like, hang on a sec, she’s quite pregnant. I can’t describe the feeling of knowing that you’ve almost taken a pregnant woman to the ground. Uuurrrgghh, that is really horrible because you know you needed to do it to prevent her from escalating further and self-harming, and you know because of what you’ve been taught that you should take her down backwards to protect the baby and [pause], uuurrrgghh.’
Similarly, when considering forced touch with older adults, the nurses took ‘account of how frail the patient is [anorexic patient]’ (Sarah), and ‘you need to be a lot gentler with an older patient’ (Jackie). Jane, herself close to retirement, identified with an older woman and she expressed her repugnance. She said, ‘she was an elderly lady who was quite manic, and we tried all sorts to medicate her, to let her be calm, but nothing was working. In the end, we had to hold her to medicate her…and it felt REALLY [emphasis] horrible. She was about 60yrs old.’

Jackie recalled the possibility of having to use forced touch with patients with inherited conditions and brittle bone disease. She said, ‘It is different if it is someone who is able bodied. This patient was disabled. His limbs were deformed. He has one shortened arm and the other is normal, but his fingers are deformed and he’s got prosthetic legs so we need to be careful.’ She remembered another patient about whom the team were particularly worried saying, ‘he had brittle bone disease and everybody was quite conscious about having to restrain him’

Maddy recounted how she had learned to take account of individual patient’s responses over her career. When she reflected upon her early learning about forced touch, she described how she had made incorrect assumptions about the patient's youth and strength:

‘The first place I worked, we did a lot of restraints. The majority were on men and I thought naively that this would be fine, it’s a young girl, it’s not gonna go badly. The female body was unfamiliar to me in its strength. We were used to restraining men. It felt different because it was a young girl. But she was quite scary. That one will always stand out for me because it was my first lady. And I learned.’
The nurses’ accounts illuminated how they thought about their use of force with patients with different bodies more carefully, using gentler touches with older people. They described how they had to anticipate physical restraint and think about the type of holds and the degree of force because the patients’ bodies were unfamiliar and they worried that they would cause harm. One nurse recollected how she learned not to make assumptions about the patient’s response based upon gender.

4.7.6 Summary of Major Theme Two: Lived Knowledge Inconsistency

In summarising this major theme of *lived knowledge inconsistency*, the nurses brought forth inconsistencies in their beliefs about whether they knew forced touch as an aspect of physical restraint interventions, or not. First, they believed that they did not know their experience because they had never given it any thought, nor stopped to try to apprehend it through any conscious process because it happened too quickly for them to do so. They described how they initiated forced touch in an automated way using technical holds and how the incidents often felt messy and out-of-control. The nurses wanted to complete their work as soon as possible to minimise the perceived degradation for the patient and them, and to re-stabilise the ward environment. Therefore, the nurses’ meanings about forced touch appeared to be taken-for-granted as part of their usual experience of physical restraint.

Yet, the nurses’ sense of not knowing about forced touch contrasted clearly with their accounts of using forced touch against the patient’s body. They gave vivid descriptions of their preference for which part of the patient’s body they wished to hold, their understanding the body’s response to their forced touch once the patient was contained in their bodily custody, and how they used both forced and gentle touches in juxtaposition as the patient became still in their bodily custody. When the nurses were in intimate physical contact with patients, they
found smell the most powerful aspect of their experience, and this lingered with them for some time. Patients whose body was unfamiliar provoked the nurses to think more carefully about how to use forced touch, and they worried about causing patients harm.

4.8 Major Theme Three: Lived care inconsistency

4.8.1 Introduction

The final major theme, *Lived care inconsistency* illuminated the third inconsistency in the nurses' experience of physical restraint and forced touch. This theme has three sub-themes. The first, *Being caring: Having affinity* describes the nurses' sense of personal connection with, and empathy for, patients under their force. The nurses' descriptions revealed how their feelings of affinity with patients influenced their touches in a deliberate and authentic way, based upon their subjective experience of forced touch during C&R training and what they would want for themselves or their family. The nurses' described how they used their touches to protect the patient's body from harm.

In sub-theme two, *Being Caring: Compassionate custodian* the nurses revealed an unexpected finding from the study. This sub-theme brings forth how the nurses' used compassionate touches to express how much they cared about the patient. They spoke about how they touched patients to try to reassure, comfort, and soothe them following the event. Yet, sometimes, they felt unable to establish a caring connection when patients were angry with them.

Heidegger suggests that our manner of caring varies in response to the situations we meet (Watts, 2001, p.47). In the first two sub-themes of this major theme, the nurses' stories seemed to speak of moving out of their early dissociative state to a closer emotional connection with the patient to express their genuine care. Heidegger describes this expression of care as authentic
solicitude (Watts, 2001, p.46), reflected through the nurses’ identification with the patient’s feelings and the meanings they gave to their touches.

The third sub-theme, *Being careworn*, represents the nurses’ stories of how emotionally and physically exhausted they felt after physical restraint procedures, leaving few emotional reserves to care for themselves or colleagues. They did not seem to be care-less, nor did they express any intentional lack of care towards each other, but they appeared to lack the emotional energy necessary for reflection with peers, or to offer mutual support.

### 4.8.2 Sub-theme: Being caring: Having affinity

In this sub-theme, *Being caring: having affinity*, the nurses shed light upon the affinity they felt with the patients against whom they used forced touch. They identified with patients’ experiences of being forced from their own experience of role-play during their C&R training. They believed they shared a common understanding of what it was to be forcefully touched and this sense of affinity appeared embodied in protective touches to prevent patients from harm or discomfort.

Adrian had experienced colleagues as overzealous during his training. He described how he responded to patients with touches intended to protect, prevent pain and provide comfort:

‘When you have it practised it on you, there is nothing worse than having your head screwed into the ground, so I’m a bit wary. I put my hand right beneath their [patient] head so they’re nice and comfortable.’

As she maintained force against the patient’s body, Cian’s parallel sense of protection seemed to arise from her feelings of deep compassion:
‘It feels very precious. I think part of feeling protective is a feeling of compassion… And it makes me feel quite protective.’ (Cian).

The nurses’ accounts illuminated how they would want to be cared for themselves. Adrian said, ‘You’d want that sort of care if you were in that position’

Similarly, Sarah described how her experience of flexion generated greater sensitivity:

‘When you’re trained you get to know what it [flexion] feels like. I don’t like having to do it and I don’t like having to be restrained because I find it quite painful actually, and that’s quite a useful thing to know when you’re doing it.’

Maddy expressed her fear of being forced to the floor without regard for her body. She expressed her need to be cared for as a sentient person, not the object of a technical procedure:

‘I’m led by how it makes me feel rather than ‘let’s get them onto the floor’ and not caring how that person is feeling. I am very much aware of that because I guess that I wouldn’t like it, so I wouldn’t want to do something to somebody that I wouldn’t like.’

The nurses also connected with patients as family members. This understanding of the patients as people with family outside of the psychiatric ward seemed to reinforce their belief in trying to avoid forced touch:

‘We’ve got a patient in at the moment and he’s very ill. It’s not a nice experience. You think it could be a member of your family. I have nursed lots of
youngsters and as a mother; I would hate it for [pause]...you tend to think it could be your child. And that is awfully upsetting.’ (Jane)

Even when the nurses felt intimated by the patient, they described how, as they touched patients, they connected emotionally with how apparently defenceless and powerless patients appeared to feel:

‘There was this huge man and we needed to give him medication and he was very unwell and he was very threatening. In the end, the only thing we could do was to restrain and medicate him. But as soon as we touched him, that big man who was six foot something, and I don’t know how many stones became a baby. He screamed, ‘Please don’t hurt me.’ That will always stay with me...[silence].’ (Ella)

In a discrepant case, Flora said that when she was heavily pregnant, she tried to help the patient to have some affinity with her own situation through her touch. Her reflection exemplifies her belief in the importance of ordinary humanity and reciprocity:

‘In the end everyone [staff] was really frightened of him and I just couldn’t bear it, so I was about seven to eight months pregnant at the time and I said, ‘C’mon, let’s get him down to his room, your legs over his legs so he could only kick a bit. And I said, ‘Can I just tell you something?... I’m really tired...Give me your hand and I’ve got to tell you about my big baby.’ And I put his hand on my stomach and he asked what it was. And I said, ‘That’s a baby in there and we’re rolling around in here with you [laughing]. And I asked him if we could just sit, and we’d sit for ages, and I’d say to him that we can’t keep doing this all afternoon. So I was trying to get him in touch with me. I said to him, ‘I’m going to cry if I have to do this one more time with you today.’ Then you could go back
and then if he started messing around I’d say, ‘Remember, it’s me. Remember I’ve got this baby.’ And he’d go, ‘Oh, yeah.’

Flora informed me that pregnant nurses no longer work on acute wards because of the potential risk to their unborn baby.

The nurses described how their affinity with patients endured throughout their injuries. Lizzy’s acceptance of the patient’s illness meant that, as a human being in the same situation, she recognised that she, too, might retaliate against staff:

‘At the time, I was not happy about being bitten. But seeing how distressed he was, you think I would have done the same thing if I was in his position because it can’t be a very pleasant experience having one, two, three people grabbing hold of you. When people are distressed they can do quite a lot of awful things, but they are distressed and you have to make allowances for it.’

Summarising this sub-theme Being caring: having affinity, the nurses expressed how their affinity with patients arose from having experienced forced touch themselves during their C&R training. Heidegger believed that our past is responsible for our meaningful present, and it shapes our future actions (Watts, 2001, p.17). These nurses revealed how their meanings of being forced themselves were embodied in their practice in an authentic manner, using protective touches to safeguard the patient and prevent them feeling pain. The nurses’ touches reflected what they would want for themselves, or for their family members.

In the next sub-theme, the nurses revealed how they expressed their compassion through their body and their subsequent care.
4.8.3 Sub-theme: Being caring: Compassionate custodian

This sub-theme *Being caring: compassionate custodian* describes an unexpected finding from the study. The nurses recounted how, after using forced touch, they expressed their human kindness and compassion through gentle, caring touches. They recollected how they wanted to provide the patient with emotional and corporeal sanctuary in which they could begin to recover from the incident. The nurses expressed how they used their body as a form of refuge to try to reassure patients that they cared. These narratives of compassionate caring touches also contained descriptions of how the nurses remained emotionally present with patients once the situation calmed. Again, this contrasted significantly with their stories of detachment during the initiation of forced touch.

Cian believed that, ‘by being still and just holding someone, and being calm and sort of solid and secure, helps them sort of gather themselves and contain themselves.’ Cian recognised her way of being with patients as ‘a sort of presence’ during which her physical contact helped to soothe the patient after a traumatic time. Similarly, Lizzy felt that ‘physical contact with patients creates some calmness so they can start getting their head around things.’

The nurses spoke of remaining in close contact with patients in different positions. Flora reflected, ‘I’m using my whole body. Sometimes it is just not saying anything at all. It’s just sitting there being very quiet and just holding,’ and Ella described ‘lying on the floor, resting my body alongside them [patient] hoping it is reassuring, my body against theirs.’

Flora believed that her empathy flowed into the patient’s body through her touch, and she hoped they felt her care:
‘By touching you [patient], I’m giving you something in my head and I’m giving you something positive, and you can feel it coming out of my fingers and you’ll know that I care. There are times when I’m conscious of it and I hope they are too. Just sitting there and holding them, and being quiet. And I don’t know whether that presence goes through but I’d like to think that sometimes it does.’

Similarly, Adrian described ‘stroking the patient’s head to calm her,’ telling her that it was over.

Cian recounted her attempts to convey her empathy for the patient’s position. Her worry about sounding ‘ridiculous’ seemed to reflect her sense of awkwardness about articulating her use of touch for the first time:

‘I’m trying to reassure them and express compassion and empathy through my hands which perhaps sounds ridiculous, but you do.’

Jane spoke of wanting to convey a renewed sense of psychological safety:

‘You’re trying to reassure them through your body that they’re safe, and you are with them, and they are safe.’

Once the nurses withdrew their touch from the patient, they tried to convey their ongoing care. Flora described how she relinquished her touch gradually and tried to leave her caring in the room, saying, ‘you go gently, move your hand down them, then move it away, then the other hand. There have been a few occasions when that has just felt right.’

Maddy remembered sitting next to a young woman ‘and chatting about the normal things in life like her soft skin...and we discussed body lotion, and things
like that’, attempting to reconnect with the patient as a woman, and the patient with her femininity.

Yet, having allowed time for the patient to recover, the nurses spoke about how they sometimes found it difficult to re-establish their relationship. They felt the patients’ anger, which left them feeling unfairly rejected and frustrated because they believed that they had tried everything to avoid using force:

‘It’s normally like, ‘Well, you [nurses] didn’t give me a chance.’ And I just try to explain that we did give you lots of chances and this is where it led to…. They [patients] never like discussing the incident that led up to it. They say, ‘This is normal, this is normality.’ They question your normality at the same time. Is it running around, kicking stuff around [furniture and doors]. Well, it’s not normal. You’d expect to be arrested and charged at the station’ (Saul).

Two nurses spoke about how patients had told them that they experienced the nurses’ touch as caring. This appeared, to them, to affirm their good intentions. Cian reflected with a sense of achievement that, ‘I’ve had feedback that they felt safe, and they felt contained, and it’s been helpful for them to be able to contain themselves.’ Similarly, Paul emphasised how concerned nurses felt about re-igniting patients’ past trauma and his relief at a female patient accepting that he meant her no harm:

‘One patient needed a depot and we had to put hands on her and there were issues about it reminding her of her abuse. It was really unpleasant because we knew that we were doing something that she regarded as a violation of her body. And we were kind of feeling that we were in the same class as the violators. We weren’t, but that was the dynamic. The positive thing was that we talked to her afterwards. She didn’t bear a grudge because she recognised that we had tried to do it sensitively.’
Being able to re-establish their relationship with the patient felt important to the nurses. They considered returning warmth as a signal of recovery because ‘*when they are better they are a totally different person*’ (Jackie). Having a sense of the person in recovery brought feelings of celebration and re-connection. Flora explained how memories of forced touch signified for both her and the patient signified their sharing of their worst day of her hospital stay:

‘*When she got better, she was just gorgeous. She said, ‘Do you remember that black Wednesday. ‘And I said, ‘Yeah.’ And she said, ‘What did I do?’ And I said. ‘I’ve never ever seen you like it before.’ And she said, ‘My face changed didn’t it?’ And I said, ‘Well, I wouldn’t go that far.’ But it was like that.*’

Maddy expressed her satisfaction with her recognition of the uniqueness of each person she had restrained:

‘*I don’t know how many restraints I’ve done but I’m glad that they don’t all merge into one and I can pick out things about them. I am pleased about that; that I haven’t got blasé.*’

To summarise this sub-theme, *Being a compassionate custodian*, revealed how for this group of nurses, their practice embodied compassionate touches. Their innate caring manifested in their corporeal presence with patients. After the forceful touches of the initiation of restraint, the nurses wanted to provide bodily sanctuary, a place of physical security and psychological safety for patients. They deliberately remained in bodily contact with them to convey their care and understanding, and to provide comfort. The nurses used their touches to convey compassion and they hoped that the patient knew that they cared. They withdrew from patients with gentle touches to try to project their message of care into the future. The nurses’ celebrated patients’ recovery, recognising forced touch as the worst phase in their relationship with the patient.
4.8.4 Sub-theme: Being careworn

In the final sub-theme, Being careworn, the nurses shed light on the inconsistencies between their feelings of compassion for patients and their apparent lack of care for each other. Following withdrawal from the patient, the nurses appeared physically and emotionally worn. Their accounts lacked caring responses towards each other and they seemed ambivalent about de-briefing together. This lack of sharing together meant that the nurses did not seem to openly acknowledge the emotional impact of the event, or share amongst themselves their experience of the different ways in which they had touched the patient.

The nurses described using humour to cope. This appeared to help them to distance themselves from the gravity of their experience. Two nurses recalled how they emotionally compartmentalised their feelings about forced touch as they went home. This compartmentalisation showed similarities to the nurses’ descriptions of the emotional zones and modes evident in the sub-theme Lost in flight during the initiation of forced touch.

The nurses reported that de-briefing did ‘not happen very often and we don’t discuss our feelings very much’ (Jackie). They spoke of poor commitment to attending saying ‘sometimes we reflect on the situation to see how we could have approached it differently. Others send apologies’ (Tom).

Saul tempered his frustration about his team’s avoidance of de-briefing because he believed that his team did everything they could, and they did not want to ‘pick over’ the event:

‘We don’t ever de-brief in a systematic way. It’s just like, ‘You [nurse] had trouble on that hand, didn’t you?’ Or, ‘Oh, God! That was problematic.’ And, ‘he
[patient] was resistant, wasn’t he? They never sort of say, ‘My technique was awful.’ But it’s because they’ve done the best they can.’

The nurses’ spoke of how their apparent taken-for-grantedness of physical restraint as part of their job meant that, only after exceptionally challenging encounters, did de-briefs seem to take place:

‘We probably should do a de-brief after every one. If there’s a particularly difficult incident, or if there were issues about people say, not being where they should be, we’d have a de-briefing afterwards’ (Rhiannon).

The nurses provided an account of their limited experience of caring amongst themselves. Andy spoke about how the macho culture and hierarchical atmosphere in PICU constrained opportunities to care for colleagues, leaving him feeling exasperated. His attempt to convey simple caring is expressed through his use of ‘just’ to show that he did not consider this to be an exceptional nor professional activity, but a fundamental act of human kindness:

‘You try and get people together to get a bit of expression and see if everybody’s alright. Even if you’re not involved in it, you want to check on the staff. Sometimes it’s difficult because I’m the Staff Nurse and I’m in charge of the shift and someone more senior did the restraint but I just want to check if they’re alright. I just want to say to them, ‘Are you alright? Everything OK?’ Just caring...It is a simple and caring thing to do.’

Sarah confirmed Andy’s account that PICU nurses avoided de-briefs to defend themselves from becoming overwhelmed by their emotions, saying that ‘maybe some people just switch off their compassion in a job like this because if they let it in, the feelings, then it would probably mess them up.’
The nurses’ humour also appeared to create some distance from the emotional gravity of their experience.

‘By just making fun of it, it just makes it lighter to deal with. It is really stressful. It’s not only stressful for the patient; it’s always stressful for us as well. But we just laugh it off and make it light.’ (Jackie)

Two Ward Managers illuminated how they used humour with their teams. Saul found that laughter was cathartic for his team, saying that it ‘dissipates that adrenalin shot.’ He said his team joked around with him and laughingly resisted his attempts to bring them to a still, reflective state:

‘you try to get to ‘is everybody OK? Does everybody feel comfortable?’ they don’t want to do it in that serious manner. It’s a joking manner, not in a derogatory way, but joking and releasing.’

Rhiannon used light humour to confront the team’s performance and minimise any sense of criticism:

‘I say to them, ‘Why weren’t you there then?’ What were you doing in the middle of that then? Were you off to make a cup of tea, or something?’ [laughs] (Rhiannon)

The nurses also laughed about their injuries, apparently negating the impact:

‘Well, the bruises go on for a bit [laughs]. I think I still have one. Yes! [laughs]. I still have one bruise there [pointing to a large bruise on her thigh] where I restrained somebody from upstairs TWO [emphasised] weeks ago!’ (Jackie)
Even following a more severe injury Andy joked, ‘*colleagues on the day were very supportive and they gave me time to go away [to the general hospital] and get my thumb put back in [laughing].’*

The nurses’ use of humour appeared to masquerade as coping, the superficiality of it disguising their true feelings about forced touch. Yet, after leaving work, two nurses seemed to compartmentalise the event and the impact upon them. Lizzy described her sense of isolation at home and she appeared to shut down her emotional response before leaving the ward saying, ‘*You can’t discuss it at home…so it’s not something I go home and think about constantly.*’

Jackie believed that being able to compartmentalise feelings was a positive coping mechanism. She described divorcing herself from the experience through a vigorous defence of her personal life, and an attempt to create positive psychological space for herself at home:

‘*I’m lucky, I don’t know if there are some people who can’t switch off but the minute I leave the office, that’s it.’* I switch off. And I will see it tomorrow when I come back to work. If you don’t, then it just impacts on your private life, which it shouldn’t.’

The nurses found completing the incident forms tedious. Adrian felt that the emphasis upon paperwork snuffed opportunities for caring responses recalling that, ‘*the only thing we had was, ‘Come back and fill in the paperwork whilst ‘How was it for you?’ ‘Fine, OK, see you later.’* When I asked him what helped him to cope, he reflected how simple things provided comfort, saying, ‘*Just going home and being able to relax, and de-stress with a cup of tea.*’
4.8.5 Summary of Major Theme Three: Lived care inconsistency

In concluding this final major theme of *Lived care inconsistency*, the nurses painted a picture of deeply compassionate care and a binding affinity with patients arising from their own experience of forced touch. The meanings the nurses gave to their own experience of forced touch appeared to influence the way they used their touches to protect the patient’s body, and express their compassion and empathy. The nurses described feeling present with patients, and they conveyed how much they cared, corporeally and emotionally, for the person in their custody. They withdrew gently from their bodily contact and they wanted the patient to feel cared for, even after they had left. Yet, these strongly caring responses towards patients appeared inconsistent with care for each other. The nurses expressed ambivalence about exploring their experience together in de-briefs. They revealed how they used humour as a catharsis and a way of coping in the aftermath. At times, the nurses described feeling uncared for by their colleagues.

The research question focused upon nurses’ experience of forced touch. Yet this theme describes how, when given time for reflection and recollection, these nurses’ gave unexpected, vivid accounts of a range of touches. The meanings they gave included being protective and being compassionate. Although at times, the nurses felt they had no other choice but to use forced touch, the calming phase included time in which the nurses expressed their deep compassion for the patient.

4.9 Summary of findings

These nurses reflected on their experience of physical restraint procedures. At first, the nurses believed that they did not know their experience of forced touch and it appeared hidden. However, during the interviews, they recalled their
memories and gave vivid accounts of their forced touch encounters with patients. Therefore, it seemed that this aspect of these nurses’ experiences of physical restraint interventions had lain latent in the everydayness of their work. Their recollections appear to shed new light over our understanding of the phenomenon of physical restraint.

Running through the nurses’ accounts were inconsistent thoughts and feelings about their moral experience, their beliefs about whether they knew forced touch, and their experience of being both caring and cared for, all expressed through their individual narratives and across the collection of stories. Therefore, I understood the final co-construction of the whole of the experience to be lived inconsistency. This interpretation, or overarching theme, comprised three parts, each described as a major themes, representing inconsistency in these nurses’ experiences of physical restraint and their forced touch encounters.

The first major theme revealed inconsistency in these nurses’ beliefs about the morality of physical restraint procedures. During early professionalisation, they appeared to accept their role in restraint procedures, but their acceptance changed to tolerance as they gained more experienced of the impact of their force upon patients. They expressed how using forced touch stood in stark contrast to their caring selves and that they would only intervene if it were the last option available to them. The nurses felt that it caused both them and patients distress, and they tried to avoid it. Yet, when they used forced touch, these nurses justified their actions on the grounds of safety for the patient, themselves and others, and the apparent lack of alternative options.

The second major theme revealed inconsistencies in these nurses’ phenomenological knowing of forced touch during physical restraint interventions. They spoke of entering automated and detached emotional states
to face the initiation of forced touch. The nurses felt that, because of the speed, their fear, and the chaotic ward situation, they struggled to apprehend and articulate what forced touch felt like. Yet, set against this apparent sense of not knowing were the nurses’ recollections of using forced touch once the patient was safely contained in their bodily custody. These nurses expressed how they understood the different qualities of their touch, ranging from forced touches to applying firm but gentle touches in case of renewed aggression, and how they used both forms of touch in juxtaposition. They recalled how they sensed the patient’s response to their touch and adjusted their degree of force accordingly. The nurses also expressed their clear preference for grasping the patient’s head or arm, and their understanding of the intimacy of their bodily contact with patients including the powerful impact of body odour and body fluids upon them. When the patient’s body was unfamiliar to them, the nurses appeared to think more carefully about how to touch them. Thus, a second inconsistency appeared because these nurses believed that they did not know force touch during initial intervention, whilst simultaneously expressing their phenomenological knowing of forced touch during early and later phases of physical restraint interventions.

The third and final major theme brought forth inconsistency in these nurses’ experiences of caring. The nurses expressed feeling a close affinity with those against whom they used forced touch because they had experienced forced touch themselves during their C&R training. They wanted to provide human sanctuary for the patient once the patient had calmed and relaxed in their holds, and the nurses described using protective touches to prevent the patients feeling pain or discomfort. The nurses’ stories illuminated how they felt a corporeal connection with patients. Unexpectedly, they brought forth accounts of how they used compassionate touches to express how much they cared, attempting to soothe and comfort the patient. Yet, this caring for patients appeared inconsistent with their accounts of the care they experienced amongst
themselves. They spoke of feeling too careworn to confront the gravity of their own emotions about their intervention, or to reflect on the incident. The nurses believed that de-briefing was poorly attended, inconsistently available, and an unreliable source of support for them. They appeared to cope by using humour to distance themselves from the emotional event or compartmentalise their feelings.

The discussion chapter now takes forward the findings in Chapter 5, drawing upon the main insights to consider how the human condition can be understood further by linking them with the contemporary literature (Steeves, 2000b, p.98).
CHAPTER 5: DISCUSSION AND IMPLICATIONS

5.1 Introduction

The aims of this study were to (a) explore acute adult inpatient mental health nurses' lived experience of physical restraint procedures, and specifically (b) to enquire into nurses' experience of forced touch during physical restraint interventions. During physical restraint interventions, nurses use forced touch to grasp and hold patients, and restrict their movement. In this research study, forced touch refers to the forceful quality of nurses' touch during physical restraint interventions.

The review of contemporary literature located no recent UK studies of nurses’ experience of physical restraint procedures, nor any that enquired into nurses’ experience forced touch. It was therefore important to explore the meanings nurses give to physical restraint and, specifically, to their experience of using forced touch, to understand how these may inform nursing practice.

I took a qualitative approach, employing a Heideggerian hermeneutic stance to study the phenomenon. This approach studied the experience though the eyes of the nurses and discovered the meanings they attached to their lived experience (Welford, Murphy & Casey, 2011, p.40). Semi-structured interviews were used to help focus the conversation on forced touch as part of physical restraint procedures, whilst giving the nurses as much freedom as possible to tell their stories (Holloway & Wheeler, 2002, p.82; Holloway & Fulbrook, 2001, p.543). Analysis followed Cohen et al’s (2000, p.71) phases for hermeneutic analysis, commencing with analysis during the interviews and culminating in a coherent narrative text that stands alone to illustrate the nurses’ lived experience. A clear decision trail illuminates how my interpretation developed.
My overarching interpretation of the whole of the nurses’ experience was lived inconsistency. Three major themes of lived inconsistency, each with sub-themes, underpinned my interpretation (Steeves, 2000b, p.96). Table 4.1 presents the themes and sub-themes:

Table 5.1: Themes and sub-themes

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<tr>
<th>Overall interpretation</th>
<th>Major theme</th>
<th>Sub-theme</th>
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<td>LIVED INCONSISTENCY</td>
<td>Lived MORAL inconsistency</td>
<td>Only if I have to</td>
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<td>Justifying it to myself</td>
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<td>Lived KNOWLEDGE inconsistency</td>
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5.2 Thinking with the data: Relation to previous research and literature

The current study addresses a gap in the contemporary literature by providing up-to-date evidence of UK adult acute mental health nurses’ subjective experience of physical restraint in NHS adult wards. Specifically, the study enquires into nurses’ experience of forced touch, not evident in previous studies of physical restraint. The current study also contrasts from a number of methodological perspectives. It appears to be the first study of nurses’ experiences of physical restraint to employ a hermeneutic phenomenological approach. Taking this approach helped me to develop a deep understanding of nurses’ experience during physical restraint by attending to their language and meaning of bodily contact with patients (Allen and Jenson, 1990, p.241). Explicit descriptions of the study setting and the participants also assist readers’ decisions about its relevance both in and outside of UK mental health services.
The discussion commences with commentary on the paucity of touch studies in mental health nursing through an exploration of why an apparently controversial form of nursing touch has previously been of such limited interest. The discussion then sets out the major themes and sub-themes sequentially to reflect the flow of the nurses’ conversations about their experience of physical restraint procedures and their intervention with forced touch. The major themes and sub-themes are contextualised within what is already known, remaining congruent with the hermeneutic approach (Steeves, 2000b, p.98; Speziale & Carpenter, 2007, p.97). The discussion also draws upon the wider literature thereby enhancing the significance of the nurses’ stories as human experience (Steeves, 2000b, p.98).

The main findings that differentiate this research from previous study findings, and therefore inform the discussion, arise from the nurses’ experience of forced touch during physical restraint interventions as more than a series of technical holds and procedures. The discussion explores their experience of their feelings of closeness and intimacy with patients, and their reactions to body odour and body fluids. It also considers the nurses’ meanings of the touches they used at different stages of their restraint intervention and the changing quality of their touches, including their juxtaposition of both forceful and gentle touches. The discussion concludes with a summary of the meanings the nurses gave to the touches they used throughout their physical restraint intervention.

5.3 Touch: An under-researched topic in acute inpatient mental health nursing.

Studies into touch are not available from the earliest origins of the psychiatric profession but anecdotal evidence suggests that touching mental health patients has long been a taboo (Autton, 1989, p.90). Commentary on the development of the profession offers two main reasons for this. First, the
psychiatric profession developed during the Victorian era with its prim attitudes towards sex and intimacy (Mintz, 1969, p.367). Freud’s psychoanalytic work included the development of sexual theories and his early work documented stroking and massaging the head and neck of distressed patients, as well as allowing patients to touch him, a practice that his opponents considered a sexual perversion (Hunter & Struve, 1998, p.53; Autton, 1989, p.90). It is thought that this had a profound effect on the developing profession, resulting in psychotherapists avoiding the use of touch altogether (Hunter & Struve, 1998, p.52). Freud eventually rejected the use of touch as seductive and dangerous (Autton, 1989, p.90).

Second, anecdotal evidence suggests that the early psychoanalysts wished to establish themselves as scientists who objectively studied the mind (Mintz, 1969, p.367). They did not consider the body integral to their healing approaches (Burton & Heller, 1964, p.125). This reportedly contributed adversely towards professionals’ fear and guilt about touching patients, stifling its use in practice (Burton & Heller, 1964, p, 128).

A third possible reason relates to changes in inpatient populations of adult mental health wards. Gleeson and Higgins’ (2009, p.382) suggest that many adult psychiatric inpatients today are physically self-caring and the need for nurses to touch them is reduced, thereby reducing researchers’ interest in touch. Yet, in my experience nurses are not discouraged from touching patients whether patients are self-caring, or not. Touch is very much part of the mental health nursing relationship, albeit that nurses use touch following assessment of the patient’s likely response.

A fourth potential explanation relates to the apparent lack of inclusion in undergraduate literature. Few subject indexes of contemporary undergraduate mental health nursing texts index the subject of touch. Where the topic is
addressed, the principles of maintaining the balance between safety and intimacy (Lakeman, 2003, p.510), and using touch with great care (Stacey, Felton, Bonham & Holland, 2012, p.256) is emphasised, yet exploration of the topic is brief. This suggests that mental health nurses’ use of touch has not only been neglected by researchers, but also by nurse authors. Therefore, it seems that mental health nurses’ learn about touch experientially, from patients and colleagues in practice.

A final possible explanation for the paucity of studies arose during this research. The study nurses initially found their experience of forced touch difficult to articulate. The words to describe their thoughts, feelings and perceptions appeared to elude them until they had taken time to recall them. Previous interview studies (Bigwood & Crowe, 2008, p.215; Sequeira & Halstead, 2004, p.3; Bonner et al, 2002, p.465) and focus group studies (Moran et al, 2009, p.599) of nurses’ experiences of physical restraint have not described nurses’ difficulty in expressing their experiences of physical restraint, but neither have they focused upon forced touch. The specific study focus upon forced touch may be an area that is difficult for nurses to express.

Others have also found that nurses find it difficult to talk about how they care for patients’ bodies. Lawler (1991, p.19) observed and interviewed 34 expert general hospital adult nurses, believing that more experienced nurses would be able to articulate the subtleties of caring for patients’ bodies. Having observed the nurses in practice, Lawler found she still had to prompt the nurses during the interviews to think through, and put into words, what they knew about their experience of body care because they had apparently taken so much of what they did for granted (Lawler, 1991, p.11). The study culminated in Lawler defining ‘the problem of the body’ following her understanding that society and nurses find talking about body care difficult. Thus, a final explanation, seemingly supported by my practice experience during de-briefing meetings, may be that
mental health nurses’ meanings of touching patients during physical restraint intervention exist in a silent, taken-for-granted way. Therefore, it has not previously grasped researchers’ interest. Thus, this appears to be the first study to enquire into the phenomenon of forced touch during physical restraint interventions. Each major themes and sub-theme is now discussed sequentially.

5.4 Lived moral inconsistency

The major theme of lived moral inconsistency represents the study nurses’ descriptions of their moral conflict about using forced touch against patients they cared about, and their belief that it was always their last resort.

5.4.1 Only if I have to

The study nurses believed that physical restraint procedures were their last resort and they would try all other alternatives first. Other studies in acute settings have found similar findings. Nurses in Bonner et al (2002, p. 470) and Moran’s (2009, p.601) studies described restraint as a ‘last resort,’ and nurses in Bigwood & Crowe’s (2008, p.219) study recounted their attempts to avoid restraint by utilising negotiation and calming skills. Similarly, in forensic settings, nurses report their dislike of restraint (Sequeira & Halstead, 2004, p.6), and how demeaned they feel by it (Lee et al, 2003, p.437).

Although they disliked physical restraint procedures, the study nurses viewed them as part of their role on adult acute wards. Other studies have also described how nurses view physical restraint as part of their job (Bigwood & Crowe, 2008, p.219). In two previous studies, nurses reported that they became hardened after many restraints as a self-preservation strategy (Moran et al, 2009, p.602; Sequeira and Halstead, 2004, p.9). Yet, the study nurses, rather
than hardening, recalled how their attitudes had changed from early unquestioned acceptance of physical restraint procedures as part of their role, to a changed position of tolerance because they had witnessed many patients' distress. In the current study, rather than becoming hardened, the nurses appeared to become more sensitive to the patient's experience.

The study nurses had all participated in C&R training or refresher sessions during the previous year with ex-patients like Paul, and had listened to their subjective experiences. Patient participation in C&R training may therefore help to influence nurses' emotional connection with patients when they use forced touch against them. The DH (2014a, p.35) recently determined that corporate training strategies must include competencies relating to patients' experiences, although it is unclear whether this means learning directly from patients themselves during training. From this study, it is recommended that patients' subjective experiences of forced touch should form a fundamental and integral component of classroom learning to help nurses relate to the patient's experience from qualification, and throughout, their professional lives.

5.4.2 Justifying it to myself

When the study nurses felt they had no other option but to use physical restraint, and by extension, forced touch, they justified their actions upon their professional duty to provide safety for the patient and others. These beliefs conflicted with their feelings of care for patients. Other studies have found that nurses feel conflicted in both adult settings (Moran et al, 2009, p.601; Bigwood & Crowe, 2008, p.220; Bonner et al, 2002, p.468) and forensic settings (Sequeira & Halstead, 2004, p.8), suggesting that nurses’ feelings of conflict do not vary whether they work in open or secure environments.
Similarly, nurses also feel conflicted when they apply mechanical devices, across different patient age groups, and in a range of settings and countries. Goethals, Dierckx de Casterle & Gastmans (2012, p.1198) meta-synthesis of qualitative studies (N=11) of nurses’ decision-making about using mechanical restraints with adults and older adults in general (n=8) and psychiatric settings (n=3) found that nurses based their primary decisions on their professional duty and liability for patient, staff and environmental safety. These justifications presided over the nurses’ personal values of beneficence, dignity and autonomy, leading to inner conflicts (Goethals et al, 2011, p.1204).

It is clear that nurses feel conflicted about their role in restraint regardless of the patient population, the country, care setting, or type of restraint used, and this was first identified in relation to physical restraint in 2002 (Bonner et al, 2002, p.465) and mechanical restraint in 1993 (Quinn, 1993, p.148, cited in Goethals et al, 2011, p.1198). This study therefore builds upon these earlier findings because these nurses clearly expressed feeling conflict in relation to performing physical restraint.

Of importance to practice is that nurses in the current study and two previous acute adult ward studies (Bonner, 2007, p.155 & Bigwood & Crowe, 2008, p.220) spoke of how, when they knew the patient well and had been able to try alternatives such as de-escalation first, their moral discomfort was ameliorated. By contrast, the study nurses reported a greater degree of discomfort when intervening with patients who were strangers to them, e.g. when they responded to the alarm on other wards. Given these nurses’ negative feelings about physical restraint, using forced touch against patients they do not know may add to nurses’ sense of conflict and degradation. Frequent requests for assistance on poorly staffed wards also causes system-wide disruption to nursing care on both the receiving and responding wards.
Previous qualitative studies designed using prolonged observation and interviews (Delaney & Johnson, 2006, p.198; Johnson & Hauser, 2001) to understand knowledge embedded in nurses’ stories of de-escalation practice have found that nurses need to know patients well to able to ‘read’ them, to know their unique needs, and to be able connect with them in the moment, to diffuse the situation. Current guidance for mental health nurses also recognises that knowing patients well, providing consistent and individualised approaches to care, whilst minimising blanket restrictions, helps to prevent challenging behaviour (DH, 2014a, p.20). The significance of well-staffed inpatient teams to allow nurses time to get to know patients is therefore important if they are to reduce the use of forced touch and their consequent feelings of moral discomfort, as well as avoiding the potentially negative impact upon their therapeutic alliance with patients.

5.5 Lived knowledge inconsistency

The major theme of lived knowledge inconsistency represents the contradiction between the nurses’ belief that they did not know their experience of using forced touch as part of physical restraint, and their vivid accounts of the touches they used and the meanings they gave to them.

5.5.1 Not knowing: Lost in flight

The sub-theme Not knowing: Lost in flight illustrates the nurses’ struggle to articulate their experience of forced touch during the initiation of physical restraint interventions. They believed that their experience was lost to their consciousness during the immediacy of the situation. Thirteen nurses described being unable to focus on their own feelings or to connect with their feelings, during the inception of their physical restraint intervention whilst they focused exclusively upon applying technical holds and restricting the patient’s
movement. They recounted being on *autopilot*, and assuming a different *persona* to confront and manage their fear.

Other studies have also described nurses’ emotional absence during physical restraint procedures although unlike this study, they do not always make the duration of nurses’ emotional absence clear. The studies have described nurses actively suppressing unpleasant emotions and disconnecting from the patient (Moran et al, 2009, p.601; Sequeira & Halstead, 2004, p.9), simply getting on with restraint without thinking about it (Bigwood & Crowe, 2008, p.218) and being on auto pilot during the incident (Bonner, 2007, p.148). Sequeira & Halstead’s (2004, p.12) forensic nurses (n=17) also described ‘automatic responding’ for a period during restraint and a quarter of the nurses explicitly reported emotional absence throughout the entire restraint and afterwards (Sequeira & Halstead, 2004, p.9).

Studies also show that nurses experience an absence of feelings whilst using mechanical force. A Swedish study of nurses’ (n=8) perceptions of administering forced medication in locked wards described how six nurses felt nothing during the restraint procedure, and five felt nothing afterwards (Haglund, Von Knorring & Von Essen, 2003, p. 71). Similarly, older adult general ward nurses (n=12) in a Taiwan qualitative study said that they applied mechanical restraints without any hesitation or feelings at all (Chuang & Huang, 2007, p.489).

Researchers discuss two possible reasons for emotional absence during physical restraint. First, nurses may emotionally disconnect to defend themselves from the psychological impact of the event (Bigwood & Crowe, 2008, p.218; Sequeira & Halstead, 2004, p.12) and second, highly trained emergency responses have to be procedurally focused to deal with situations effectively and efficiently (Sequeira & Halstead, 2004, p.12).
In contrast to previous studies, the nurses in this study all clearly described feeling emotionally dissociated whilst initiating forced touch and restricting the patient’s movement, but none recalled feeling emotionally absent throughout the entire physical restraint intervention. Following early feelings of automation, they became aware of the touching patient’s body once they had established holds. The nurses then experienced a sequence of different meanings associated with their touches including forced, gentle, protective and compassionate touches as they worked on the patient’s body until they withdrew from them. Therefore, nurses’ emotional disconnection from their feelings during the emergency inception of technical restraint procedures may be a necessary defence against the psychological impact of a frightening experience. However, this study casts doubt over the merit of this argument as a total explanation for the experience of automation given that the nurses’ experiences of emotional disconnection did not necessarily persist throughout the entire physical restraint intervention.

These findings create an important opportunity to review how nurses learn to touch patients during current training approaches. Locally, C&R trainers employ role-play to help nurses to rehearse their competence in the technical holds and positions used. Other UK training courses feature similar approaches. Following a review of the literature, Farrell, Shafei & Salmon (2010, p.1646) concluded that programmes include a ‘smorgasbord’ of content (i.e., environmental factors, skills acquisition, communication, self-awareness) focused upon the technical skills necessary to provide physical containment. The authors recommend incorporating content on emotional and attitudinal responses to using physical force (Farrell et al, 2010, p.1647), although the recommendations do not extend to nurses’ experience of their bodily contact with patients.

In the local training programme, a de-briefing follows the role-play of different scenarios and techniques, an approach popular in simulated approaches.
(Dufrene & Young, 2014, p.372). De-briefing is orientated towards a review of the effectiveness of nurses’ application the technical holds and procedures, but gives little attention to nurses’ experience of touch. Recent DH (2014a, p.34) recommendations for training now include an exploration of nurses’ feelings about exposure to disturbed behaviour and the importance of trauma informed care. Unfortunately, these do not explicitly include addressing nurses’ experience of forced touch. Yet, as Green (2013, p.250) suggests, when given the opportunity for reflection, nurses understand how their touches connect them with the patient’s experience in a direct and immediate way, as these nurses in this study revealed in their accounts. Therefore, the study nurses’ initial lack of connection between touch and physical restraint perhaps reflects the current training emphasis upon the requisite cognitive and psychomotor skills for C&R, with little opportunity to explore and reflect upon their sensory and emotional touch experiences.

It is recommended that training courses develop a clearer conceptualisation of physical restraint interventions as nursing touch involving the whole body to support nurses to reflect upon the qualities of touches they use throughout the intervention. In the first instance, the classroom offers a good place for opening the nurses’ experience of the way they use touch through guided reflection because it provides opportunities to freeze and reflect upon the situation, rather than attempting this amidst disturbances on wards (Johns, 2013, p.10), especially when wards feel as messy as these nurses described. The participation of patients in this reflective space will further open for exploration the patient’s experience of being touched in different ways by nurses, including, gentle, protective and compassionate touches. Only by opening this shared reflective space will nurses be able to articulate their embedded knowledge of the phenomenon of forced touch, and develop a shared understanding of how their touches influence patient care.
5.5.2 Not knowing: Messy work

*Not knowing: Messy work* describes the study nurses’ perceptions of how their classroom-based training felt straightforward in contrast with their ward experiences where things felt chaotic and out of control. They described feeling under-confident, intimidated, frightened of strongly built patients, and of feeling as if they were rag dolls when they could not satisfactorily restrict movement. The nurses talked of struggling to hold onto sweaty bodies, working amidst furniture and other patients, being fearful of harming patients and of being injured. At times, they said patients damaged the ward environments. Amidst this perceived chaos, the nurses believed they could not apprehend their experience of forced touch.

Other studies have also described the mismatch between nurses’ training and the reality of their ward practice. Nurses in Bigwood & Crowe’s (2008, p.220) study described how violent events left them feeling inadequately prepared and out of control. Similarly, in Southcott, Howard & Collins’ (2002, p.34) interview study of PICU nurses’ (n=19) experiences following physical restraint training they described establishing holds and getting patients to the floor as a messy and uncoordinated process. The current findings also provide evidence to support Lee et al’s (2003, p.427) argument that environmental issues such as confined spaces and working amongst furniture add to the messiness of physical restraint.

Nurses’ comparison between the realities of physical restraint interventions in messy ward environments and their classroom experiences in cleansed spaces requires recognition and legitimisation if nurses are to feel supported, confident and properly prepared for practice. During a recent visit to East London NHS Foundation Trust, similar issues encountered by nurses has driven the implementation of ward based trainers as part of a wider restraint reduction
programme (Lingard, Cruickshank & Warren, 2014). This study suggests that the provision of a PMVA trainer to every acute adult ward could be beneficial to staff by ensuring that each trainer has contextualised knowledge of the ward environment, local patient populations and ward staff skills to facilitate specific and relevant advice and support.

5.5.3 Knowing: The body in custody

The study nurses held clear preferences for grasping the patient’s head or arm, and twelve nurses preferred the patient’s arm. The nurses found it inhumane to hold the patient’s head forcefully. It reminded them of the patient’s vulnerability and the vulgarity of their force. They spoke of their feelings of intimacy whilst working on patients’ bodies, their contact with patients’ body fluids (sweat, saliva), and how the patient’s body odour lingered on them. Smell appeared to be the most powerful aspect of their experience. One nurse spoke about how body odour inhibited the team’s administration of medication. The nurses shared a common hope that a patient about to be physically restrained had a clean body, although this also engendered feelings of guilt because it seemed to conflict with their caring role.

The nurses expressed how they tried to communicate with the patient through their hands whilst they held the patient still, and they listened to how the patient’s body responded to them, adjusting their degree of force accordingly. Once the patient calmed, the nurses articulated how they maintained firm holds but they juxtaposed these with more gentle touches to convey calm containment and their presence. The nurses spoke of knowing when to reduce their degree of force as they sensed the patient relaxing.

It is recognised that nurses’ work on others’ bodies is frequently only inferred in the nursing literature, and nurses and patients’ proximity has to be imagined.
because nurses' bodies, and their embodiment in care, have been taken-for-granted (Shakespeare, 2003, p.48). This is certainly true of physical restraint because although it is acknowledged as a highly interpersonal and intimate nursing experience (Winship, 2006, p.60), previous research studies have only inferred that nurses touch patients, thereby assuming that the reader understands the experience beyond the written page.

This research differentiates itself from previous studies through recognition that physical restraint involves nursing touch, and it inquires about this inferred experience. This study viewed physical restraint through a new lens, and consequently the nurses shed new light upon the complex range of touches they used during restraint and the meanings they gave to them.

The nurses’ strong preferences for which part of the patient they preferred to grasp and hold, is not evident in previous studies. Twelve nurses, all with more than three years’ experience, expressed strong dislike for holding the patient’s head. During presentations of this research to trainers across three other mental health providers, this overt dislike resonated easily with the trainers, albeit that they could give no reason other than they believed that nurses disliked the leadership role associated with taking the patient’s head. This was not however, the view expressed amongst the nurses in this study, who described their emotional response as the most powerful influence over their choice.

Through their accounts, the nurses objectified the patient’s body, describing how they took ‘the head’ or ‘the arms.’ As previously discussed, the nurses’ objectification may reflect the content and language of their C&R training. Yet, mental health nurses’ objectification of the body is also evident in other studies of body care in mental health. In Van Dongen & Elema’s (2001, p.154) Netherlands interview and participant observation study, older peoples’ nurses
spoke of how, during care procedures, they touched patients’ bodies objectively without feeling any emotions. Yet, when the patient responded to their touch, the nurses were unable to remain emotionally detached and they reacted subjectively to the patient. Similarly, the current study nurses revealed how they could not maintain their objectification of ‘the head’ because seeing the patient in a prone position on the floor trying to look up at them reminded them of their feelings of overt power and inhumanity. This strong emotional reaction seemingly influenced their preference for grasping the patient’s arm because the patient’s arm could not confront the nurse’s emotions in the same way.

By contrast, in a study of staff (n=19) perceptions of C&R training, nurses gave technical reasons why they preferred taking the patient’s head. Five nurses believed their stature influenced the effectiveness of the intervention, two female staff believing that small female nurses should have a specific role in taking the patient’s head (Southcott et al, 2002, p.34). In the current study, only two newly qualified nurses (one male, one female) preferred holding the patient’s head because they felt confident in their communication skills to lead the intervention, in contrast to the aforementioned views of local trainers. The nurses’ preference for taking the patient’s head may also represent the nurses’ sense of the patient’s humanity, holding their head whilst conveying their messages of care. Stature did not seem to influence the study nurses’ preference as both nurses were tall. Thus, although Southcott et al (2002, p.34) provides some evidence that technical reasons may influence nurses’ choice about which body part nurses prefer, the current study also suggests that nurses have strong emotional reactions that influence their choice of which part of the patient they prefer to touch.

It is unclear whether any of the study nurses’ emotional reactions to holding the patient’s head meant they actually avoided the leadership role in their daily practice. Should staff feelings influence their choice to such a degree, pressure
may be felt by other nurses to take the lead, whether they are experienced in leading the procedure, or not, with potential consequences for patient and staff safety.

In addition to nurses’ emotional reactions to the body, this study also brought forth nurses’ strong reactions to patient’s body odour, not illuminated in previous studies of physical restraint. However, similar findings are evident in studies of care work in general settings. Agency careworkers who wash and bathe disabled older people at home have described smell as the most difficult thing to bear because, like the study nurses, it lingers on them for some time (Twigg, 2000, p.389). Similarly, a phenomenological study of general nurses (n=12) day to day experiences of interacting with patients and their bodies reported that odours notoriously elicited strong reactions, and many of the nurses avoided patients with offensive bodies (Picco, Santoro & Garrino, 2010, p.43), a position also described by one nurse in this study. The nature of psychiatric deterioration and the self-neglected, offensive body reminded the nurses of the patient’s humanity, and most of the time, they were able to respect the patient and overcome their feelings.

Although this study did not set out to explore nurses’ use of forced touch to provide intimate or personal care, the nurses volunteered information about this aspect their work. Previous studies of physical restraint provide scant information about this sensitive area of nursing practice. Intimate touch involves touching parts of the body normally considered private (Williams, 2001, p.663). When undertaken using forced touch during physical restraint, these nurses felt conflicted and wanted to get their task completed quickly for themselves, and to restore the patient’s dignity. Nursing work undertaken directly on the body comprises bodywork (Twigg, 2006, p.85), and perhaps bodywork is never as blatant as when giving personal care using forced touch, with all the inherent violations of the body and social norms. Talking directly about what bodywork
really involves is critical to nurses’ understanding of the central issues that they face in practice (Twigg, 2006, p.11). This study has provided in part, some understanding of nurses’ direct talk about cleaning soiled patients using forced touch, dealing with the odorous body and the intimacy of physical restraint interventions. In particular, there is an urgent need for greater understanding of nurses’ experience of using forced touch to provide personal care and the meanings they give to it given the heightened potential for re-traumatisation in this challenging area of nursing practice.

5.5.4 Knowing: The unfamiliar body

The study nurses recounted their experiences of restraining patients who were physically vulnerable or whose bodies were unfamiliar to them. Previous studies of nurses’ experiences of physical restraint have not shed light on this aspect of care, the inference being that the patients mental health nurses restrain on adult wards are physically fit and fully mobile. Yet, patients on mental health wards also present with a wide range of physical health presentations and problems. The study nurses worried about harming these patients and felt disgust at using physical restraint against them. They planned carefully how to use restraint with these patients should they need to.

Given the complexity of forcibly handling patients with physical vulnerabilities, there is little discussion on the topic or available evidence of how much training or support nurses receive to intervene safely, and with confidence. Lee at al’s (2001, p.157) survey of C&R training across 63 randomly selected PICUs and RSUs in England and Wales found that 23% staff were taught how to restrain people with ‘physical handicap’, and 14% covered the topic during refresher sessions. However, the definition of physical handicap and the content of the training are unclear. Stubbs, Knight & Yorston’s (2008, p.11) discussion on using restraint in patients with physical conditions suggests that a specialist
physiotherapy assessment and advice on adaptive restraint techniques should be available to all ward teams. Given the study nurses’ anxieties about handling patients with unfamiliar bodies during physical restraint, it is important that nurses have access to appropriate expertise at all times to ensure that they feel confident to handle patients safely and effectively.

5.6 Lived care inconsistency

The major theme of lived care inconsistency represents the inconsistency in the nurses’ experience of their feelings of care for patients against whom they used their force when set against their experience of feeling a lack of care amongst their colleagues.

The nurses described a close affinity and deep compassion with patients under their force. They wanted to provide them with a sense of bodily sanctuary and they used their touches to protect them from pain through their corporeal connection with them. Once calm, the nurses touched patients to express their compassion for them. However, the nurses’ caring feelings for patients seemed inconsistent with the care they experienced amongst the nursing team. In the aftermath of restraint, they appeared too careworn to confront the gravity of their emotions, and they reported that de-briefing was inconsistent. The nurses spoke of using humour after the incident, and this seemed to distance them from the emotional intensity of restraint. They wanted to re-establish relationships with patients because they viewed their involvement in restraint as harmful to their working alliance.

5.6.1 Being caring: Having affinity

Being caring: Having affinity illuminates the nurses’ feelings of affinity with the patient under their force. They accepted patients’ aggression and behavioural...
disturbance as a symptom of illness. The nurses identified with patients’ apparent vulnerability and the physical impact of their holds and positions because they believed their experience during their C&R training was similar. Their accounts reflected how they used their touches to try to protect patients from unnecessary force or discomfort.

There appear to be no studies of C&R training that inquire into the emotional impact of experiential learning approaches upon participants’ relatedness with patients and the subsequent influence upon nurses’ practice of forced touch. Previous forensic studies have investigated a comparison of incident numbers pre and post C&R training in a medium secure forensic unit (Parkes, 1996, p.525) and a survey of C&R course content including safety, de-escalation and restraint techniques in PICUs and RSUs (Lee et al, 2001, p.151). As previously mentioned, Southcott et al (2002, p.33) explored PICU staff (n=19) perceptions of the effectiveness of C&R training focusing upon techniques.

In this study, the nurses’ spoke of the influence of role-play in their C&R training, and they believed that having experienced forced touch themselves strongly influenced how they wanted to care for patients during physical restraint. It also influenced their desire to use touches that avoided pain and protected the patient from unnecessary discomfort. This study therefore suggests that, although the nurses did not believe that the course prepared them for the reality of ward scenarios, the simulated learning approaches of C&R training did help them to learn experientially what it is like to be forced, and this strongly influenced their subsequent attunement to patients’ in practice. As Carlsson et al (2000, p.543) conclude in their study of positive encounters with violence and aggression, educators who facilitate nurses’ learning about violence cannot omit the body. Therefore, from this discussion, courses need to include significant attention to the subjective experience and what it is to
experience physical restraint to expand nurses’ perceptions, and therefore, their knowledge.

5.6.2. Being caring: Compassionate custodian

Unexpectedly, the study nurses revealed their use of compassionate touches to express their authentic caring once they felt sure that the patient was safe in their bodily custody. In contrast to their early intervention when they described their touches as forceful and automated, their accounts also revealed moments of embodied compassion, when they spoke about holding patients, lying alongside them, stroking and patting them, and remaining in bodily contact for some time to try to reassure them with their caring presence. They said they wanted their care to stream into the patient through their body because they understood that patients felt vulnerable. Afterwards, they apologised to patients for using physical restraint, and they wanted to re-connect and reconcile with them to reduce any emotional distance and dissipate mistrust.

In previous studies, nurses have not substantially illuminated compassionate touches during physical restraint interventions, except for minor mention. In Haglund et al’s (2003, p.65) aforementioned Swedish interview study of forced medication, one nurse described trying to make force more gentle by stroking the patient’s face, although this is not discussed further.

In Carlsson et al’s (2000, p.539) study of positive encounters with aggressive patients, caregivers (n=5) understood how they used their touch with aggressive patients as ‘inner knowledge.’ However, Carlsson et al’s study contrasts with this study by its specific focus upon positive encounters with aggressive patients. Yet, there are some similarities with the current study findings. The nurses in Carlsson et al’s study described how, once their initial fear subsided, they moved to touch patients to ‘tend’ to their psychological wounds (Carlsson
at al, 2000, p.539). They believed that holding and comforting the patient released the patient's physical and mental tension and they hoped that they had given something good to patients through their touch (Carlsson at al, 2000, p.539), similar to the current study. Thus, both studies illuminated how nurses use opportunities for touching with compassion to try to comfort patients once they perceived hostility to have passed.

This study did not inquire into the patients’ experiences of receiving nurses’ touches, including their compassionate touches, and their perceptions are therefore unknown. Patients’ experiences of physical restraint in adult wards has received little attention, and where studies exist, anger, fear, anxiety and re-traumatisation (Bonner, 2007, p.211; Sequeira & Halstead, 2002, p.13 & Bonner, 2002, 468) have been described, although these studies did not focus upon patients’ experience of touch. Salzmann & Eriksson’s (2005, p.843) phenomenological study of adult mental health outpatients with psychosis (n=4) described how patients with severe mental illness feel weak and yearn to be touched by workers because, when hospitalised, they miss the physical comfort from relatives. They find that gentle touch is comforting, connecting them with others through a sense of belonging and kinship, and acknowledging them as human beings, thus creating a deep sense of affinity (Salzmann & Eriksson, 2005, p.850). The study reveals that patients, like nurses in the current study, experience feelings of affinity through physical human contact. However, patients’ also spoke of their feelings of inferiority, fear and annihilation when touch was unwanted or they did not know the person (Salzmann & Eriksson, 2005, p.849). Given the study nurses' narratives of forced, protective and compassionate touches, as well as their dislike of using forced touch against patients they did not know, it is important to understand adult mental health patient’s perceptions of these types of nursing touches during restraint interventions to understand how this aspect of nursing care is experienced through their body.
The nurses’ accounts of their caring touches are also important not least because the public image of nurses’ roles in restraint is generally negative (MIND, 2013). The current Nursing Strategy and Vision (DH, 2012) urges every nurse to include the 6Cs (care, compassion, communication, competence, courage and commitment) in everything they do. These nurses revealed how they tried to express their care and compassion at a time when they also felt conflicted, frightened and needed courage to care for patients. If, as previously suggested, most mental health nurses appear to learn how to touch patients in practice rather than through their undergraduate training, or their C&R training, then these findings are important in starting to reveal how nurses use the 6Cs in their physical restraint practice.

Other studies have reported how, in the absence of training on the use of touch, nurses learn their art in practice. In Estabrooks and Morse (1992, p.448) grounded theory study of female Intensive Care Unit (ICU) nurses (n=8), none recalled any teaching about touch during their training, but they described becoming ‘enculturated’ into the clinical arena and internalising touch practice. Enculturation involved adaption to the new environment, learning how to touch patients from colleagues they observed and admired, and as their confidence grew, learning from patients (Estabrooks & Morse, 1992, p.452). Unfortunately, the study presents very little raw data to illustrate the nurses’ accounts of how they learned to touch patients, limiting the trustworthiness of the findings regarding nurses’ enculturation.

It is important to understand how mental health nurses learn to use touch in their daily practice because it may influence how nurses touch patients during physical restraint and therefore, patients’ experiences of being restrained by nurses. Through this study, bringing forth this new understanding of compassionate nursing touch during physical restraint procedures has
highlighted the importance of understanding the source of nurses’ learning and its subsequent influence on care.

5.6.3 Being careworn

Following physical restraint procedures, the nurses described feeling tired and careworn. They sometimes felt uncared for by colleagues and unable to care for their emotional selves. They reported that gathering together for a de-briefing was irregular and they appeared ambivalent about its usefulness. The nurses were also aware of having to return their attention to other patients on the ward. They seemed to cope by using humour. Two nurses spoke of compartmentalising their feelings and leaving them at the ward door before they went home.

As described in this study, physical restraint generates a range of uncomfortable emotions that nurses have to manage. This regulation of feelings is understood as emotional labour. Emotional labour concerns jobs that require workers to manage the feelings of themselves and others (Hochschild, 1983, p.147). It relies on people using their inauthentic self to do their work. The study nurses restrained patients as part of their job and they illuminated how they managed their feelings of moral distress, their fear during the intervention itself, and their emotional response in the aftermath.

The nurses’ ambivalence about de-briefing may reflect their way of avoiding the enormity of their emotions or their ongoing management of their feelings after the event. Specifically, the PICU nurses described detachment in colleagues who were unwilling to share feelings. Similarly, in Sequeira & Halstead’s (2004, p.10) study, forensic nurses believed formal de-briefs were important to share feelings, but they also described how the macho culture of the environment inhibited them, leaving them to cope without support. By contrast, in Bonner et
al’s (2002, p.470) study, most adult acute nurses found de-briefing useful, but the perceived effectiveness depended upon the skill of the facilitator and the proximity to the restraint incident. Nurses therefore appear to have to manage their feelings about restraint against a range of factors including their ward culture, workload and availability of skilled support.

The nurses’ stories reflected how they had to manage a wide range of feelings about using physical restraint procedures. They described having to balance their moral dilemmas as an integral part of their role, how they would swing rapidly from the adrenalin-fuelled initiation phase to compassionate care during the calming phases of the procedure, and their need to return calmly to work other patients. The recent DH (2014a, p.22) guidance appears to recognise that nurses and patients need time to adjust following physical restraint. Recommendations include post-incident reviews to acknowledge the emotional responses of those involved once they have recovered. Successful implementation will depend upon the development of more open cultures on wards where nurses feel able to talk openly about their experience including the wide range of emotions they feel during physical restraint interventions.

It appeared that to cope with the burden of their emotional labour, the nurses recalled laughing and bantering following withdrawal from the patient. The use of humour extended across all grades of the study nurses including Ward Managers. The senior nurses understood how humour helped to minimise staff distress, and it helped them to confront their team’s effectiveness. The study nurses’ humour appeared to provide a sense of camaraderie and a way of sharing their emotional burden.

A narrative review of the literature on nursing humour suggests that humour is primarily a coping mechanism, and that laughing at highly stressful situations
helps nurses to deem certain work events as ridiculous, thereby making them less threatening (McCreaddie & Wiggins, 2008, p.589). In Page & Meerabeau’s (1996, p.322) study of nurses’ experiences of cardiopulmonary resuscitation, Zijderveld (1983, cited in Page & Meerabeau, 1996, p.322) suggests that laughter helps to reduce the cognitive dissonance between nurses’ ideal theorised practice and their real lives on wards, thereby reducing the emotional impact of the event. Given the study nurses’ expressed dissonance between their classroom experience and their ward experience, this may help to explain the nurses’ response.

Other studies of physical restraint have also found that nurses laugh afterwards, joking around to make themselves feel better (Bigwood & Crowe, 2008, p.221), to defend against anxiety, or to get rid of stressful feelings (Sequeira & Halstead, 2004, p.9). Similarly, other types of clinical teams have also been shown to employ humour under stressful situations to help them to cope with their work including emergency personnel (Scott, 2012, p.355), critical care nurses (Dean & Major, 2008, p.1090), acute psychiatric staff (Sayre, 2001, p.669), and nurses in health and social care (Ästedt-Kurki & Liukkonen, 1993, p.187). A study (Thornton & White, 1999, p.275) of intensive care nurses’ use of humour suggests that the more serious the situation perceived by nurses, the more likely they are to use dark or gallows humour. The current study nurses clearly described their perceived physical and emotional gravity of the restraint incidents to which they responded and this may have fuelled their humour response. Yet, it is also conceivable that the nurses’ laughter was a coping mechanism in response to faulty or inadequate support in practice. The nurses’ dissonance between their classroom and ward experiences, their perceived messiness of the incident, having to respond frequently to other wards request for assistance with physical restraint, their moral discomfort, and their anxiety and fear, all suggest that significant practice-based support is essential for nurses who use forced touch.
Previous studies of the use of humour in clinical teams have also described staff’s understanding of the importance of professional boundaries and sanctioning behaviour to protect patients from the nurses’ wit (Scott, 2007, p.357; Sayre, 2001, p.682; Ästedt-Kurki & Liukkonen, 1993, p.187). The current study did not explore the nurses’ whereabouts when they laughed, the type of they humour used, whether they regulated their behaviour, or whether they were in the ward area or had gone to a staff-only area. However, an important practice issue was identified in Sequeira and Halstead’s (2004, p.9) study in which patients witnessed nurses laughing after restraint and believed that nurses were laughing about them, causing them feelings of resentment and anger.

Laughter appears to provide an important catharsis following physical restraint procedures. However, regardless of the source of the humourful response, nurses who laugh to cope should be neither visible nor audible to patients. Should they do so, they may be in breach of their ethical code by failing act to promote the trust and confidence of patients, and to act with integrity (NMC, 2015). Whether laughter provides a catharsis for psychological stress in response to patient care, or a way of coping with faulty support systems, ethical leadership is essential to role model professional practice and challenge behaviour that dehumanises or insults patients’ dignity.

These study findings therefore reinforce previous recommendations for the introduction of ward-based C&R trainers, ensuring that trainers work amidst the reality of ward life, both to prevent or minimise the idealisation of classroom practise, and to support nurses to reflect on the event and to cope with the gravity of the situations they face.
5.7 Summary of the meaning of nursing touches during physical restraint interventions

The themes represent these mental health nurses’ meanings of forced touch during physical restraint interventions and the categories of touches they described. The findings present new information about both the touches that nurses’ use with force and those that nurses’ use to convey different meanings. Shakespeare (2003, p.51) suggests that restraint touch, or ‘violent touch’ has not been assimilated into nursing touch categorisations because research studies have rested upon the idea that nursing touch is benign. This study challenges the notion of a single category of ‘violent touch’ to encapsulate nursing touch during physical restraint, and provides evidence of a much more complex range of touches used by mental health nurses.

Similar to Gleeson & Higgins’ (2009, p.387) study of mental health nurses’ perceptions of touch, these nurses did not explicitly name the categories of touch they used. This may be because they had not previously apprehended their experience, but also as previously discussed, there is little literature on the topic in mental health nursing. Yet, they described vivid scenarios that clearly illustrated the meaning of the touches they used.

Previous studies categorising nursing touch have named 27 different forms, including many that have similar meanings, causing some confusion (Routasalo, 1999, p.845). During the 1970s, Barnett (1972, cited by Routasalo, 1999, p.844) simplified the categories of nursing touch to necessary and non-necessary touch. Necessary touch includes deliberate touch to perform a task, and non-necessary touch is spontaneous and affective, and not necessary to perform a task.
The study nurses revealed how they touched patients during physical restraint using necessary and non-necessary categories. They described necessary touches to grasp and restrict patient movement, whilst using gentle touches in juxtaposition with forced touch to convey stillness and security whilst they waited for the patient to relax. The nurses also used protective touches in juxtaposition with forced touches to prevent patients from harm or discomfort. Protective touch does not appear to have been previously documented in a mental health setting. Estabrooks (1989, p.395) previously described this category in general intensive care settings where nurses used it to protect patients from physical harm by restraining them to safeguard medical treatment (i.e., to prevent self-extubation), and to prevent patients striking nurses during care.

Once the study nurses felt the patient begin to relax, they described using non-necessary touches to convey their reassurance and compassion, expressing tenderness by lying against the patient on the floor, sitting against them, patting and stroking them. Thus, the nurses described their embodied knowledge about touch during physical restraint interventions, drawn from their subjective experience of forced touch on their training course and their experience in practice.

These nurses described how they experienced corporeal connections with the patient’s body during physical restraint intervention. This new knowledge contributes not only towards our understanding of nurses’ experience of forced touch during restraint, but also to our knowledge of the categories of touch used by nurses in mental health settings.
5.8 Strengths and limitations

Language, and in particular talk, underpins the hermeneutic method (Watts, 2001, p.69). A strength of this study was selecting semi-structured interviews because this enabled the nurses to tell their experiences of physical restraint procedures whilst also keeping a clear focus upon the particular phenomenon of interest, nurses’ intervention with forced touch. The nurses appeared to recall and then unveil their experiences of forced touch for the first time as part of the research process. Listening to them beginning to articulate their stories reflected how they incorporated and made sense of their experiences (Conroy, 2003, p.3).

However, the interviews also introduced some weakness because the nurses’ initially struggled to put their experience into words. At the outset, and without exception, the nurses all said that they had never thought about forced touch and they said they did not know what it felt like. This meant that early in the interviews, different conceptions between the participants and the researcher made the phenomenon more difficult to access (Reed, 1994, p.336). In addition, practical non-verbal knowledge such as touch can be difficult to unpick and to talk about (Eraut, 1994, p.42; Meerabeau, 1992, p.110).

Allowing plenty of time for the interviews opened the space for the nurses to reflect and articulate their stories. It is not clear whether the nurses’ narratives about forced touch would have emerged had they not participated in the study. However, their vivid and detailed accounts suggest that their understanding of forced touch was latent and the phenomenon clearly existed for them, albeit that they had not given voice to it before.
5.8.1 Sampling approach

I used purposive sampling to approach all adult acute ward nurses who lived the experience of physical restraint to get the widest possible range of information for analysis (Tuckett, 2004, p.51). However, this strategy did not recruit nurses that fully represented the inpatient nursing population. Nurses of all ages, length of qualification, males and females, full time and part-time staff, all shift patterns, across three geographical service sites in two counties comprising seven wards, were invited. Despite this, only one nurse held less than three years’ experience in mental health nursing. Therefore, most of the voices were those of experienced nurses, rather than recently qualified nurses.

It is unknown whether nurses with less experience have different stories to tell. Senior nurses may have joined the study because of their greater confidence to talk with the researcher, who is herself a senior nurse in the organisation, or their greater experience of participating in sensitive conversations about complex experiences as a normal part of mental health nursing. Junior nurses may have felt less confident about discussing their limited experience of physical restraint.

5.8.2 Being an insider-researcher

In hermeneutic phenomenology, it is argued that expert knowledge of the phenomenon is of benefit because it brings added meaning (Ranse & Arbon, 2008, p.40). As a Consultant Nurse working within the same care group as the nurses, I brought the benefit of understanding the context, cultural norms, the language of the setting and the phenomenon (McGarry, 2010, p.9). Many of the nurses knew that I had also lived the experience of physical restraint and this seemed to enable them to explore their thoughts and feelings with me. This was
apparent by their willingness to stay and explore with me a topic that, at first, they believed they did not know about.

Given that the phenomenon seems to have been an unrecognised part of practice experience, there are a number of interesting points in respect of my impact upon the findings. By deliberately exploring forced touch, I offered the nurses the opportunity to reflect openly upon their experience and create a chance for me understand their nursing care (O’Lynn & Krautsheid, 2011, p.25). However, whether this familiarity assisted better access to this phenomenon, or whether an outsider researcher would have heard more or less, is unknown. Being an insider may have also brought some disadvantages. Potential participants may not be willing to talk with somebody who is part of their social group (McEvoy, 2002, p.49). Less experienced nurses may have been concerned about judgement by a more senior nurse. Some nurses may have also avoided sharing their experiences about this sensitive subject because of the potential emotional cost of participating (McGarry, 2010, p.11).

A further consideration is whether power imbalance may have influenced the completeness of the nurses’ stories, including their decisions to remove certain pieces of text from their transcriptions. Although only two participants withdrew text (and only minor amounts), the removed texts showed some commonalities that reflected anxiety about sharing the information. However, the ethical principle of non-maleficence and my duty to protect the participants took precedence and the nurses’ requests were honoured.

During my planning, I considered whether to recruit from an outside organisation, but this presented other challenges. First, access to participants may have been more difficult because nurses in other organisations may not have trusted sharing information about a potentially sensitive subject with a stranger. Second, managers act as ‘gatekeepers’ of services that can enable
access and provide internal 'approval' (Ramluggan, Lindsay & Pfeil, 2010, p.63), or deny researcher access. Support from managers in external organisations may have been more difficult if suspicion arose about what a study inquiring into forced touch may reveal. Conducting the study ‘in-house’ met with the support of senior managers and nurses alike, and there were no issues with access to the study setting. I considered the issues of familiarity carefully and although they posed potential problems, being an insider contributed towards achieving a sufficient sample for the study.

5.8.3 Reflexivity: The impact of the researcher on the research process

Although definitions of reflexivity vary, it is generally agreed that reflexivity during analysis is concerned with researchers’ interactions with the data and therefore, the development of the findings (Carolan, 2003, p.9). Being aware of my responses to the nurses was important because my usual role was both emotionally and physically close to the field (McGarry, 2010, p.10; Khan, 2000b, p.88). I used my reflective diary to capture my thoughts, feelings, ideas, interpretations and decisions (Clarke, 2009, p.68; Kahn, 2000a, p.65). This added depth and insight to the research process because it documented my inherent subjectivity through a self-critical process (Carolan, 2003, p.10).

A strength of this study is the excerpts included in the final report that illustrate my thought processes and feelings throughout the research process (Ballinger, 2003, p.70). These include reflections on the experience of engaging in the hermeneutic approach and the questions that emerged during the analysis, thereby providing an audit trail of decisions for the reader (Koch, 1994, p.134).

A further strength is the balance of interpretative text and the nurses’ narratives in the report. A wide selection of verbatim text illustrate their feelings and beliefs about the phenomenon (Corden, 2007, p.15), and the report ensures that the
voices are heard and readers can judge, as far as possible, how my interpretation was made.

The findings appear to illustrate the nurses' first expression of the phenomenon, revealing the temporality of their understanding, and their situatedness at the time of the interviews. This situatedness also applies to my temporal understanding and background at that time. Should I have the opportunity to talk again with the nurses in the future, both the nurses’ interpretations, and mine, may be different. That said, some of the findings support those of previous of previous studies suggesting a more general ‘truth.’

5.8.4 The expression of rigour

de Witt & Ploeg’s (2006, p.215) framework guided the expression of rigour to ensure that readers can judge the specific quality of this hermeneutic endeavour. The five expressions were openness, balanced integration, concreteness, resonance and actualisation. Openness and balanced integration were reflected in the research process, whilst concreteness, resonance and actualisation concern the outcome of the research (deWitt & Ploeg, 2006, p.226).

5.8.4.1 Openness

Openness is the ‘opening of the study to scrutiny’ (deWitt and Ploeg, 2006, p.225). It includes the orientation to, and attunement with, the nurses’ lived experience (deWitt & Ploeg, 2006, p.224). My orientation to the phenomenon commenced with personal exploration and documentation of my foreconceptions, and answering my own research question. These expressions of openness are contained in this thesis at pp.76-80.
Attunement with the nurses’ experience was enhanced by ensuring that plenty of time was given to listen to their stories during the interviews as they reflected and put their stories into words. The nurses had the freedom to explore their experience in an unhurried way using a loosely framed interview structure. The recordings lasted up to 61 minutes and each concluded in the nurses’ own time. Highly structured interviews using standardised questions and sequencing may have constrained my attunement to, and revelation of, the phenomenon (Newell, 1994, p.15).

Each nurse chose to participate at work in paid time. They therefore may have felt under pressure to return to their clinical environment thereby limiting their contribution. However, their choice of environment, rather than another place or their home, suggests that this was the most comfortable arrangement for them to talk openly. Given the way that the nurses dealt with their emotional experiences following restraint, they may have felt more comfortable containing this area of practice and keeping it at work.

Openness also includes systematically and explicitly documenting all philosophical and analytical decisions for inclusion in the final report (deWitt & Ploeg, 2006, p.215). This thesis documents evidence of the philosophical quandaries and decisions made. One particular quandary concerned whether the phenomenon even existed. The report details my emotional response and my consultation with the literature that underpinned my decision. This explicit accounting of the research process opens this study to scrutiny and allows readers to judge its honesty through representation of the lived experience of the researcher and the research process itself.

One of the great challenges of the hermeneutic approach is the analytic process. Cohen et al (2000, p.76) suggest it is a process of steps taken to provide a coherent interpretation. Yet, the reality was not as neat as it sounded.
Following Heidegger’s circular process of interpretation, the movement between individual pieces of text and whole transcripts, individual transcripts and clusters of transcripts, over many months, in a dynamic process reflecting my changing understanding over time, demanded considerable attention to, and documentation of, the decisions made along the way. Again, transparency in this process was essential to express openness (deWitt & Ploeg, 2006, p.225). High diligence, rigorous labelling, and documentation, captured the changing interpretation. Records were made of the movement of text between theme labels, and the splitting and splicing of data sets. Documenting these records in the thesis (pp.113-114) helps to record an open and transparent decision trail for the reader to decide whether rigour has been an applied throughout the analytic process.

5.8.4.2 Balanced integration

Balanced integration is expressed through clear articulation of the chosen philosophy and its fit with the researcher and the topic, intertwining these philosophical concepts in the methods and findings, and balancing the participants’ voices and the researcher’s voice (deWitt & Ploeg, 2006, p.224).

Heidegger’s philosophical notion of temporality suggests that our meaning is forever changing (Geanellos, 1998a, p.157). Following this notion, participants’ meanings are likely to change between their interview and the final interpretation. Therefore, prompt transcription and return of copies to participants allowed them to respond with any additions or deletions (Houghton et al, 2013, p.14) at a time when their reconnection with their stories was as close to their interview as possible. Prompt transcription also enabled my immersion in the data to be as close to my experience of collecting the data as possible, thereby commencing my interpretation close to context of the stories
Field notes taken after each interview also reminded me of each experience to preserve the uniqueness of each story.

Remaining true to the notion of temporality underpinned my decision not to return to the participants to check my final interpretation. This philosophical position brings a challenge to those who adhere to traditional criteria such as Lincoln & Guba’s (1985, p.301) criteria of credibility. The credibility of a study is said to be enhanced when the researcher returns the final interpretation to the participants to ensure that they recognise it as their own (Houghton et al, 2013, p.14). Proponents of traditional criterion might therefore suggest that my final interpretation lacks rigour. It is important to acknowledge that once participants had read and commented upon the transcripts, they had no further influence on the final interpretation because I remained true to Heideggerian philosophical tenets.

Balanced integration is also expressed by ensuring that Heidegger’s main philosophical tenets are evident in the interpretation (deWitt & Ploeg, 2006, p.226). de Witt & Ploeg describe this as a potential limitation of their framework because, as in this study, researchers without an expert understanding of this substantial and complex philosophy may overlook some aspects of Heidegger’s work (de Witt and Ploeg, 2006, p.226). In this study, where Heidegger’s tenets appear naturally (i.e., the hermeneutic circle, temporality, authenticity and inauthenticity), they are woven in for the reader based upon my reading during this thesis, and without claim to philosophical expertise. I also shared my analysis and findings throughout with my supervisors to ensure that the tenets in the findings arose from a thorough analysis.
5.8.4.3 Concreteness

Readers recognise concreteness when the findings firmly contextualise the phenomenon as part of everyday life and they can connect them to their own world (deWitt and Ploeg, 2006, p.225). Within the findings, the participants’ narratives about forced touch are contextualised within their everyday lifeworld of physical restraint on wards. For example, Box 5.1 shows an excerpt from the report that situates the nurse’s experience in the public area of the ward amongst other patients and furniture:

**Box 5.1 Firmly contextualised phenomenon**

> ‘He was almost like a star shape, and we were all like stars lying on top of him, and I remember thinking I really didn’t think I’d be watching the Queen’s speech like this [laughs]. We had to be in the TV lounge because we couldn’t really move anywhere else.’

Concreteness is also expressed though the contextual information provided. Details about the clinical areas, the participants’ ages, duration of qualification and role help the reader to judge the relevance of the findings to their own setting (Holloway and Wheeler, 2002, p.225). The study describes the policy, practice and clinical context at the time of the study to give a rich impression of the setting.

5.8.4.4 Resonance

Resonance occurs when the reader understands the meaning of the text and experiences feelings of resonance with the participants’ accounts (de Witt & Ploeg, 2006, p.226). As well as readers, resonance might also occur when the
findings are presented in practice and at conferences. The findings have been presented across three Trusts to trainers in physical restraint. This has stimulated conversations amongst practising nurses and PMVA instructors and the findings have resonated with, and touched them.

5.8.4.5 Actualisation

Actualisation occurs through the continual interpretation by readers over time, an expression that is difficult to demonstrate (deWitt & Ploeg, 2006, p.226). I have not yet published the findings, but dissemination in a peer-reviewed journal may provide ongoing reinterpretation to build upon the findings. Again, it would seem that once people have heard the findings, continual interpretation might also occur amongst them. It is also likely that in my everyday practice, I will continue to interpret the findings. Those who participated in the study may also continually interpret and give voice to their experiences having spoken their lived experience for the first time.

5.9 Summary of the study in relation to previous research, relevant literature, policy and practice

This research has achieved its objectives. It appears to be the first qualitative study into adult acute mental health nurses' lived experience of physical restraint procedures and specifically, forced touch interventions. It builds upon sparse interest in the topic, including the limited knowledge of forced touch, which was either absent, or only inferred, in the literature. Previous studies have inferred forced touch within the broader phenomenon of nurses' experience of physical restraint procedures, thereby losing the richness and complexity of nurses' experience.
This research makes an original contribution to nursing and provides empirical knowledge in two areas. First, it provides an up-to-date exploration and interpretation of nurses’ lived experience of physical restraint procedures in acute adult wards in the UK. Second, the inquiry into nurses’ experience of forced touch confers that the phenomenon of forced touch exists for these nurses.

Third, the intellectual contribution is evidenced through the identification and explication of the gap in the research literature, ignited through practice-based knowledge, and the development of the subsequent approach to the study. The theoretical contribution includes the expansion of our previous understanding of nurses’ experience of physical restraint to firmly contextualise ‘forced touch’ within the wider phenomenon. Taking a new theoretical stance and viewing physical restraint interventions as touch interventions shed new light over a previously only partially understood phenomenon.

For the first time, the findings also highlight the nurses’ vivid accounts of the range of both non-necessary and necessary categories of touches they used. The findings describe how their range of nursing touches was more than simply restricting movement using a series of technical holds and procedures. They suggest complexity beyond a single type of touch applied in physical restraint. The nurses’ meanings revealed further categories of touch used beyond that described as forced touch, including protective, gentle, and compassionate touches. The study nurses also shed light upon previously silent nursing moments of embodied compassion and feelings of close affinity with the patient following initial hostilities and this has afforded a new opportunity to consider how this may influence current practice, education and research. Given the negative perceptions of physical restraint in mental health settings, the study has demonstrated how deeply these nurses cared about the patients against whom they used forced touch as part of physical restraint. These findings help
to re-orientate us towards a new conceptualisation of physical restraint as nursing touch, and urge us to develop further our understanding about how nurses learn to handle and touch the patient’s body during physical restraint interventions.

Fourth, the study provides an empirical contribution and useful methodological approach through the application of the hermeneutic phenomenological approach guided by de Witt & Ploeg’s (2006, p.215) framework for expressions of rigour. The approach culminated in a new interpretation of the phenomenon developed through a well-documented, rigorous and systematic approach. Employing a framework for the expression of rigour that strongly reflects the specific underpinning philosophical notions of hermeneutic phenomenology ensured appropriate methodological alignment and guided decisions about method throughout the research study.

Finally, the findings make a structural contribution to the nursing profession’s approach to training nurses in physical restraint interventions and the application to practice. They suggest that the way in which the profession has traditionally conceptualised, taught and implemented physical restraint interventions may benefit from some reconsideration. The findings suggest that re-conceptualising physical restraint interventions as forced touch enables nurses to express their experience of what it is to be in restraint with patients and to illuminate the touches they use. This is important to the profession and to daily practice for a number of reasons. First, it illuminates the nursing contribution to care beyond restraint holds and techniques at a time when patients are extremely vulnerable. Second, the study findings included nurses’ preference for taking the patient’s arm, their experience of intimacy, their felt affinity with patients, and their awareness and response to patients who have a past trauma. These findings help to inform training approaches to nurses’ conceptualisation of restraint as touch, and encourage the verbal expression of
forced touch and physical restraint interventions as body care, thereby developing our nursing discourse. Only when nurses are supported to bring their experience of being in forced touch with patients to consciousness and give it a voice, can they learn from their practice, learn from patients’ responses to their touches, and adapt to patient needs, thereby enhancing nursing care and the nursing experience.

5.10 Recommendations for future research

The findings present the experiences of one group of nurses working in adult acute mental health wards in a large mental health provider in the UK. Further studies directed towards nurses’ experiences of forced touch are needed in other contexts, such as older adults, young people and forensic services. This may provide a more comprehensive understanding of nurses’ lived experience of forced touch and reveal different meanings in other nursing cultures. It is important to understand how nurses in other settings react to patients’ bodies during physical restraint, whether they also have preferences for touching and holding specific body parts, and how their responses to the body may influence patient care during restraint practice. It would also be interesting to formally evaluate the impact of including discussions about touch in C&R training upon nurses’ and patients’ experience of physical restraint. New knowledge from these studies will help to inform the provision of future training by incorporating and reflecting upon the human complexities of this nursing intervention.

There is a particular need for studies directed towards nurses’ experience of using forced touch to provide personal care. The findings may help to open direct talk about the challenges of maintaining privacy and dignity in this silent and challenging area of adult mental health care.
The current study interpretations reflect the nurses’ memories of forced touch, and not directly observed events. The direct observation of physical restraint incidents presents researchers with a range of ethical challenges including informed consent, maintaining privacy and dignity, and safety. However, approaches such as ethnography may be helpful to understand the cultural influences that affect how mental health nurses learn to touch patients by illuminating ward teams’ shared beliefs and knowledge, and its influence upon the way they use touch. Observational approaches may also help conversations during interviews because nurses may not think to tell researchers about aspects of care they take for granted (Field & Morse, 1985, p.75), although as others like Lawler (1991) have shown, nurses can still struggle to articulate body care.

This study included only qualified nurses. Studies of support staff who also restrain would contribute towards learning about similarities and differences across different roles in teams. Thirteen study nurses had three years or more ward experience. Recently qualified nurses with limited experience of physical restraint may also bring different perspectives.

The absence of adult acute mental health patient voices in the research literature demands attention from researchers. As previously discussed, it is plausible that the experience of patients restrained by nurses has remained unsayable because the experience, or the perceived suffering of patients, seems too difficult to articulate (Makaroff, 2012, p.481), and this may be for a number of reasons. However, researchers have a conscious choice about whether they attend to, or turn away, from people who are suffering, or for whom talking about the experience may be difficult (Makaroff, 2012, p.488). Researchers therefore need to confront the ethical and practice complexities to bear witness to patients’ experience in physical restraint, be present in the
aftermath, and to listen to both what patients find sayable, and that which is not expressed through language, and seems unsayable (Makaroff, 2012, p.488).

As nurses, we have a moral obligation to understand the meaning of our practice for patients in order to develop our practice and promote patients' wellbeing (Strout, 2010, p.417). Therefore, significant impetus amongst researchers is necessary to develop our understanding of patient’s perceptions, however challenging, to help us to understand patients’ experience of being under nurses’ forced touch and develop nursing practice.

5.11 Conclusion

The aims of the study were firstly to provide an up-to-date exploration of nurses’ lived experience of physical restraint procedures including their thoughts, feelings and perceptions of forced touch during physical restraint interventions, and second, to provide a critical reflection of the notion of ‘physical restraint’ and ‘forced touch. This study provides unique empirical knowledge about nurses’ experience of physical restraint procedures and specifically, their experience of forced touch during physical restraint interventions in UK adult acute wards. The nurses’ meanings also revealed the categories of touch they used, including both necessary and non-necessary touches. Necessary touches included forced touches, and gentle touches and protective touches that they used in juxtaposition. Non-necessary touches included compassionate touches to convey their deep care to the patient. The explication of the gap in the research literature, and the inquiry into nurses’ experience of forced touch presents a critical reflection of forced touch, and necessarily contextualises it within the broader phenomenon of nurses’ experience of physical restraint.

This study builds upon the sparse and sporadic interest in touch in mental health nursing and may kindle further interest in this important topic. The findings open a new discourse about the phenomenon of forced touch, for
nurses and amongst nurses, to increase nurses’ knowledge of embodied understanding of touching patients forcefully with those in their care as part of the job.
CHAPTER 6: REFLECTION ON MY PROFESSIONAL DOCTORATE JOURNEY

6.1 Introduction

In the final chapter, I take a reflective stance to my personal growth and independent learning during the Professional Doctorate Programme. I reflect upon my choice of programme, my experience of the research process and most importantly, the influence of doctoral training upon my professional development.

6.2 Choosing the Professional Doctorate Programme

As a Consultant Nurse in Adult Mental Health, I wished to pursue my clinical leadership career and the Professional Doctorate Programme attracted me for many reasons. The defining feature of the Professional Doctorate is its focus on the work of the professional and elevating work-based learning to the highest award (Scott, Brown, Lunt & Thorne, 2004, p.22). Programmes focus upon the generation of knowledge from practice (Rolfe & Davies, 2009, p.1266) and developing expertise or new phenomena that influences practice (Fulton, Kuit, Sanders & Smith, 2011, p.130; Gonzalez & Esperat, 2011, p.19; Lee, 2009, p.12; Yam, 2005, p.566). Professional Doctorates can also help to confirm professionals’ identities as practitioner-researchers (Fulton et al, 2011, p.130) and assist them to assert the importance of undertaking nursing research as integral part of their working life (Campbell & Gavaghan, 2005, p.41). I had researched a practice-based topic for my part-time MSc (Mental Health) (Addis & Gamble, 2002, p.452), and although it was challenging, I thoroughly enjoyed the focus upon the complexities of my lived world of work. It was important for me to continue to embed research into my Consultant Nurse role to ensure that
I could research the world that I inhabited where I understood ‘wicked’ nursing problems, and could generate knowledge from my practice.

In comparison to traditional PhD programmes, the Professional Doctorate programme at the University Portsmouth, in common with other programmes, contained elements including a taught range of research skills in both qualitative and quantitative methods, and taking a cohort approach to encourage multidisciplinary learning (Scott et al, 2006, p23). Following completion of my MSc, I understood that the clinical field is filled with research complexities. I therefore decided to apply for a doctoral programme that included a range of taught research skills to build further upon my knowledge and confidence. Finally, my role includes working with large, multidisciplinary clinical teams. The cohort approach to learning attracted me as these offer diversity and enhanced opportunities for learning across a range of disciplines.

Many Consultant Nurses in the UK view the Professional Doctorate programme as the finale of their professional life (Carr & Galvin, 2012, p.614). Although, I envisaged that the programme might signal the culmination of my formal education, I also saw the programme as an exciting developmental phase in my professional life. Throughout my career, I have needed to feel challenged, and like those who have previously undertaken Professional Doctorate programmes, I also need to learn to feel vital and engaged with my profession (Scott, Brown, Lunt & Thorne, 2004, p.60). Like others, I also believed that the programme would provide clear evidence of my commitment to nursing (Yam, 2005, p.568). Yet, I knew that doctoral level study whilst working in a demanding role with long hours and a family, would take huge commitment.

Commencing the programme was both exciting and daunting. Having left school at sixteen and entered nursing at seventeen, I clambered my way into university for the first time during my thirties and I have steadily progressed towards
doctoral level education. At the outset of the programme, I included in my professional portfolio a quote from a favourite novel (Box 6.1). It represented my doubts about being ready for the programme, juxtaposed with excitement about my forthcoming endeavour:

Box 6.1 Portfolio entry

“In the street, the front door of number thirteen is swinging gradually open, a young boy who can barely reach the door handle is peering around the door, his hair is sticking up and he is still wearing pyjamas. He climbs onto a bright red tricycle that is waiting for him on the front path, he pushes all his weight onto the pedals and he creaks out of his garden and onto the main pavement. He looks back at the still open front door, he looks ahead of him to the main road, he puts his head down and he pedals, slowly at first, bumping and wobbling over loose paving slabs, picking up speed.”

Jon McGregor (2002, p.32) If Nobody Speaks of Remarkable Things

6.3 The challenges of working in full time healthcare whilst undertaking the Professional Doctorate Programme

Having reached submission at the conclusion of Stage 2 of the Programme, I am mindful of the frequent and unpredictable changes in my role that have often unsettled my journey. Research in practice is often complicated by constant instability in health environments (Rittel & Webber 1973, cited in Fulton et al, 2011, p.133) and dramatic changes are an inherent challenge for many healthcare researchers (White, 2012, p.17). Since commencing the programme, I have experienced six major changes of focus in my Consultant Nurse post following service change and re-design, different managerial demands and perceptions of the role, changes in line managers, and changing service needs. This constant change has required considerable tenacity to stay engaged with
my studies, and at times, it has threatened my completion for both practical and emotional reasons.

During my Professional Doctorate, these roles have included:

- Consultant Nurse and Professional Lead in Adult Mental Health focusing upon inpatient units and Crisis Response and Home Treatment Teams
- Consultant Nurse and Operational Lead for Crisis and Home Treatment Services
- Consultant Nurse and Service Manager for Inpatient Units and Crisis Services
- Consultant Nurse for Service Improvement (productivity)
- Consultant Nurse and Organisational Lead for Safer Care Team (patient safety)
- Head of Patient Safety, Academic Health Science Network Patient Safety Collaborative and Consultant Nurse and Organisational Lead Patient Safety

Simultaneous to the changes in my role, the number of Consultant Nurses employed in the organisation over the course of the programme has reduced from five to one, leading to significant feelings of professional isolation. This situation also frequently stifled the psychological space I needed for study whilst I felt preoccupied with my professional survival. As Murray (2002, p.41) recognises, having to use most of my annual leave for study also left me feeling enduringly guilty about my self-enforced exile from my family and social world, not to mention feeling professionally weary at times. As previously stated, I really enjoy complexity, challenge, and wicked problems to address but I could never have predicted how much challenge I would face.
6.4 Reflection on the doctoral research process

I now reflect upon my development as a researcher and a nurse, and set this against Level 8 Descriptors (Doctoral Level) (SEEC, 2001) (Appendix 11) to evidence the standard achieved.

6.4.1 Level 8: Knowledge, understanding, cognitive and intellectual skills

Level 8 cognitive and intellectual descriptors incorporate advanced analytic and synthesis skills to develop areas of knowledge and advance practice.

My personal and professional suspicion that an unrecognised phenomenon might exist acted as a stimulus to enable me to begin this exploration of forced touch (Johns, 2013, p.61). Before I began the study, I needed to gain a comprehensive understanding of the methodology relevant to my study. The starting point was to reflect upon my personal ontology and epistemology in the context of my lifeworld to set out my philosophical stance. This phase of self-questioning was enlightening because it facilitated understanding of how my personal philosophy about the nature of being in the world strongly influenced the research questions, paradigm, methodology and method that I chose for the study. This early exploration of my subjectivity was also pivotal in encouraging me to maintain a reflexive stance throughout the study, and ensuring that my decisions and personal experience as a researcher were evident in the final report.

Having determined a phenomenological approach, grappling with complex Heideggerian and Husserlian philosophical tenets was challenging. I read of the importance of developing my philosophical understanding to ensure the key tenets underpinned the study remained congruent throughout (Dowling, 2012, p.26). Yet, once I started reading phenomenological studies, I realised how
discordant the literature was, a point emphasised by Dowling & Cooney (2012, p.26), with a vast range of sometimes contradictory philosophical approaches and opinions, leading to many confusing moments about how to conduct a hermeneutic inquiry.

I read extensively and developed my confidence about making difficult philosophical decisions. Making the decision not to member check my interpretation with participants is an example of my synthesis of many different perspectives on Heideggerian approaches. Having explored Heidegger’s notion of temporality, I felt able to defend my decision not to return to the participants, supported by the selection of a specific framework to ensure the rigour of this hermeneutic study.

The hermeneutic analytic process tested my analytic skills as I became increasingly aware that, not only is it not a series of clearly defined sequential steps (Cohen et al, 2000, p.71), but the underpinning notions of the circularity of understanding created endless questions of the data. As predicted by Cohen et al, it was ‘tricky’, and demanded that I document the process very carefully. Recording my changing interpretation was critical to illustrate my decision trail. I documented every movement of text, and the splitting and splicing of the themes, to hold on to the many threads of my interpretation. Capturing my rationale in this ongoing way enabled me to illustrate my analytic decisions in an open and transparent manner.

The aforementioned inconsistent study time meant than I experienced a rather staccato journey through the analytic phase of my study. Therefore, before recommencing each session with the data, I carefully re-read my reflective diary to re-connect with my previous interpretations and musings. Re-connecting in this way was critical to re-immersse myself in the process, and, as Heidegger suggests, recognise that my interpretations were ever changing. A useful
adjunct to this was Dr Rowena Murray’s Freewriting Workshop that helped me to write my diary without censor, capturing my interpretations as they came to me, using arrows, simple words and phrases, questions and queries, to record my flow of thinking. This newfound academic freedom was personal, creative and free from judgement, thereby stimulating my thinking each time I studied. Months of iterative questioning of the data, and moments of what felt like a muddle, eventually culminated in a sense of what I can only describe as the ‘settling down’ of the interpretation into a lucid and cohesive representation of the nurses’ experience. Undertaking a hermeneutic approach taught me to take time to dwell in uncertainty, to listen to and to be with the data, making sense of emerging interpretations, just as I take time to understand patients and staff in clinical practice. I have learned that hermeneutic analysis is a lived relationship with many voices, rather than a process that one performs on the ‘data.’

Level 8 also includes handling ethical dilemmas and formulating solutions. My experience of handling the ethical issues of a sensitive study was a parallel process of academic supervision to provide critical reflection on my progress (Etherington, 2004, p.29) alongside a reflexive dialogue with my internal supervisor. As a mental health nurse, this is a familiar dialoguing voice that guides my ethical decisions during patient care (Johns, 2013, p.10). My internal supervisor dwelled in the space between the participants and me and guided my decisions about minimising any sense of coercion. This ethical stance culminated in decisions to remain distant from the potential participants until they had self-selected themselves for the study and to respect their right to withdraw data they wished to remove.

Listening to my internal supervisor also ensured that I was sensitive to the moral issues of equal representation of the participants’ voices (Etherington, 2004, p.32). The issue of equal representation and co-existing word limitations meant making some difficult choices that sometimes caused some
consternation, not least because I felt morally obliged to present an interpretation worthy of the nurses’ stories of part of their lives that they had shared with candour. The final report is an open account underpinned by deep respect for those who collaborated with me.

6.4.2 Level 8: Key transferable skills

Level 8 requires the nurse to have an overview of complex and specialist contexts at the forefront of knowledge and to demonstrate transferable and practical skills, not only during the completion of the research project, but as an autonomous consultant in the workplace. The nurse is also expected to continue her own professional studies with others, both inside and outside the discipline.

6.4.2.1 Research development

The most striking aspect of my professional growth has been the way in which I learned to compartmentalise my study and work life for much of the programme. I learned to separate my identity as a senior nurse and that of a student to cope with the demands of both worlds. For a long time, there was little interaction between the two. However, in the last year, as I have developed greater confidence to merge these identities, I have received growing recognition as a research active nurse and, together with the unswerving support of the Director of Nursing and Clinical Standards who passionately believes in the role of Consultant Nurses, my Consultant Nurse role is now on a new trajectory.

In 2014, I participated in a collaborative service improvement grant application for £375 000 between the local Trust and two universities to the Health Foundation to study and extend my suicide prevention work in crisis resolution and home treatment teams. This harm reduction work using improvement
science approaches (understanding variation, human error, systems thinking, improvement methodology and psychology) (Langley, Moen, Nolan, Nolan, Norman et al, 2009, p.75) was a finalist project in the Health Service Journal and Nursing Times Patient Safety Awards 2013. The research aimed to replicate my harm reduction approaches across five mental health teams and undertake a qualitative study of professionals’ experiences of learning and implementing improvement science approaches. The research team comprised the Trust CEO and Director of Nursing and Clinical Standards, and senior academic staff from three local universities.

Writing for a substantial grant meant that I had to draw heavily upon my learning from the doctoral programme and my developing improvement science skills. Although we were unsuccessful, a second application to the Health Foundation is planned this year to extend current work on the development of inductive coding systems to improve learning from serious incidents and complaints. I am currently involved in testing the software in the second pilot site. Participation in these projects symbolises my growing confidence in preparing applications for funding with other professionals.

Also in 2014, in collaboration with the Clinical Research Unit and the Research and Development Department, we established for the first time a ‘pipeline meeting’ to review undergraduate and graduate research projects planned within the organisation. A panel now reviews each project for policy and organisational alignment, the appropriateness of the study setting, the ethical considerations, and the likely benefit to the patients or staff, before granting organisational permission to commence. Panel members are also available to provide advice to students where needed. This new panel process has helped to identify early problems such as ensuring senior oversight of studies in clinical areas, confirming the researcher’s clinical skills to conduct the proposed study, the quality of questionnaire designs, and recruitment strategies. Participating on
the panel affords me the opportunity to use my research skills in a practical and supportive way whilst helping to ensure that the quality of proposed studies is high.

I have also agreed to be the clinical supervisor and part of the supervisory team for a nursing colleague who is applying for a National Institute for Health Research Grant next year to research family experiences of teenage suicide. Joining a research supervisory team will also contribute towards developing my research skills further.

**6.4.2.2 Leadership and autonomy**

Over the past year, I have also developed as a more autonomous leader at an inter-organisational level, seeking support and development from a wider group of colleagues. In November 2014, I represented our organisation as an invited guest of Dr William Lo Tak-lam, Chief Executive, and Betty Ku, General Manager (Nursing), Kwai Chung Hospital, Kowloon, Hong Kong, to lecture on quality, safety and strategy in mental health nursing. The visit provided an exciting opportunity to engage with senior nurses working in a different culture and establish an ongoing professional friendship to exchange ideas and learning. A further visit is planned this year to review progress together.

As the trust lead for patient safety and quality improvement, I am now an invited faculty member of the South of England Mental Health Safety Collaborative working with thirteen NHS Trusts using Institute for Health Improvement approaches to reduce harm in patient populations. I am also an Associate Faculty Member on the local acute hospitals Patient Safety Academy. Sitting on both faculties affords me the opportunity to influence the delivery of patient safety training and collaboration across the region.
In 2014, I was appointed to lead patient safety at an Academic Health Science Network (AHSN). This new role offers truly exciting opportunities to bring organisations together work at the forefront of national and regional patient safety initiatives to reduce harm across the entire patient pathway. As a significant part of this national development work, I have been nominated to participate in the Health Foundation’s Q Initiative founding cohort to design and test programme content and the leaning approach for future cohorts.

To conclude, the Professional Doctorate programme has provided a bricolage of moments that have felt exhilarating, fun, frustrating, and lonely. It has helped to shape who I am as a nurse and developed my confidence as a researcher of the swampy world of healthcare that I inhabit. Consequently, I have worked to stretch my Consultant Nurse role through enhanced leadership and autonomy. Most importantly, I believe that I continue to grow in a profession of which I am always immensely proud to be a part.

6.4.3 Dissemination

I presented my research findings to the Three Counties Restraint Collaborative Conference in September 2012, attended by C&R instructors and educationalists who are experts in physical restraint training. The research has been presented at local instructors training days to develop nurses’ exploration of their experience of forced and compassionate touch. What has been striking is that at each event, nurses have confirmed that they had not previously reflected upon their experience of touching patients during physical restraint. Yet, the findings also resonated deeply with them. This resonance opened new, direct talk about their experience of forced touch and compassionate touches, an essential aspect of developing and articulating shared their understanding of their work.
The demands of my work and study have constrained the time to write for to publication during the programme, leading to feelings of considerable disappointment. I plan to write for publication in an internationally peer reviewed journal as a dedicated activity following the completion of the programme. During the publication and dissemination module, I revised a previous lengthy publication (6 500 words) of my earlier published qualitative research (Addis & Gamble, 2002, p.452) to reduce the wordage. Permission to publish the paper was given by a generous editor! Learning to write more concisely is likely to enhance my choice of journal for future publications.
References


Chambers, N. (1997). ‘We have to put up with it – don’t we?’ The experience of being the registered nurse on duty, managing a violent incident involving an elderly patient: a phenomenological study. *Journal of Advanced Nursing, 27*, 429-436.


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Quinn, C.A. Nurses' perceptions about physical restraints. *Western journal of Nursing Research, 15*(2), 148-162.


Roles of the Three-person Team

“Staff have a responsibility to prevent situations which increase risks to service users, the public, and staff.” (PMVA Policy).

1. To ensure the level of intervention applied is justifiable, appropriate, reasonable and proportionate to the specific situation.
2. Ensure that only recognised and approved techniques are used.
3. To commit to and ensure cohesive teamwork occurs throughout all procedures.
4. Ensure that any physical intervention be brought to an end at the earliest opportunity.
5. To remove from their person any items that may cause injury to themselves or others such as pens or watches.
6. It is the responsibility of all team members to assess and monitor the patient’s physical state and wellbeing and react immediately to any life threatening emergencies.

The role of the lead person (number 1)

1. It is recommended that the individual staff member who undertakes this role is the person who knows the patient best.
2. Assess the patient’s mental state, physical well-being, and compliance.
3. Maintain observation of the patient’s life signs throughout the Physical Intervention procedure.
4. To support, protect and secure the patient’s head ensuring the patient can see, hear, breathe and communicate throughout the physical Intervention.
5. Communicate with the patient, giving an on-going explanation of staff actions throughout.
6. Communicate with the team members and the incident co-ordinator, other Number 1’s and any additional staff attending.
7. Be aware of any advanced directives, care-plans and clinical risk assessments relevant to the situation.
8. Provide skilled leadership to the team members and co-ordinate their movements.
9. Allocates numbers to the team as necessary.
10. Commit team members either verbally or non-verbally (except when the patient commits the team).

Roles of the limb persons (numbers 2 & 3)

1. Maintain observation of the patient’s life signs and degree of compliance throughout the Physical Intervention procedure.
2. To isolate and secure an arm in co-ordinated movements as instructed by the Number 1.
3. Identify any concern/ need they may have to the number 1.
4. As instructed by the Number 1 will undertake their role during de-escalation.
## Studies on nurses' lived experience of physically restraining adult patients

<table>
<thead>
<tr>
<th>Authors</th>
<th>Title of Study</th>
<th>Research Question or Objective</th>
<th>Setting / Context</th>
<th>Participants</th>
<th>Method and Data Analysis</th>
<th>Findings presented in study</th>
<th>Methodological Strengths and Limitations</th>
</tr>
</thead>
</table>
| Moran, Cocoman, Scott, Matthews, Stanislavene & Valimaki (2009) Republic of Ireland | Restraint and seclusion: a distressing treatment option? | To explore the emotions and feelings experienced by psychiatric nurses in relation to incidents of restraint and seclusion. Study presents an account of nurses’ emotional distress gathered during a funded European study to understand nurses’ emotional and educational needs in respect of physical restraint. | 4 general wards in psychiatric hospital that used restraint and seclusion | 23 Nurses | Three focus groups (6-9 participants) Tape-recorded and transcribed verbatim. Supplementary field notes taken Interpretative analysis | Three themes were created: 1. The last resort 2. Emotional distress 3. Suppressing unpleasant emotions | Strengths  
Research aim clearly identified.  
Study focus described: restraint and seclusion  
Purposive sampling employed to recruit nurses with the experience under study  
Data collection and interpretative analytic approach congruent  
Steps to achieve rigour are described including agreement amongst researchers of the interpretations made  
Participants’ voices from each focus group reveal rich narrative and enhance authenticity | Potential limitations discussed:  
1. Risk of censoring and conforming in focus  
Discussion explores important implications of nurses’ distress for the nurse-patient alliance |
|   | Bigwood & Crowe (2008) New Zealand | ‘It’s part of the job but it spoils the job’: A phenomenological study of physical restraint | To answer the question: How do mental health nurses perceive the experience of the physical restraint of patients in the acute mental health service? | 20 bedded PICU and 2 acute wards | 7 Registered nurses | Descriptive phenomenology Semi structured interviews. Taped and transcribed verbatim Thematic analysis | 1. Major theme: ‘It’s part of the job’ constituted by the sub-theme of ‘Control’. Control had two sub-themes: 1. Conflicted Nurse 2. Scared Nurse | Strengths Research gap clearly identified Context clearly described Philosophical position is clear. Van Manen’s descriptive research process clearly described. Purposive sampling employed to recruit nurses with the experience under study Nurses’ restraint experience clearly described as full or partial |

2. Purposive sampling, sample size and methodology preclude generalisation of the findings

Funding declared

**Other limitations**
Philosophical position unclear

Context lacks detail regarding type of ward and patients admitted which impacts upon transferability

No recommendations for research stated
| 3 | **Bonner (2007) (Thesis) United Kingdom** | The psychological impact of restraint in acute mental health settings. The experiences of staff and patients. | To answer the questions: 1. What is the psychological impact of restraint for staff and patients in acute mental health settings? 2. Does the experience of restraint reawaken memories of earlier encounters for staff and patients? 3. Does a structured Post Incident Review serve a purpose in the examination of experience of restraint for both staff and service Acute psychiatric wards including PICU 30 nurses and nursing assistants (17 female, 13 male) Mixed methods. Grounded theory underpinned qualitative approach. Quantitative approach included Trauma Screening Questionnaire (TSQ) and evaluation of interview experience of questionnaire to test applicability of interview structure for clinical post-incident review Focus group with 12 staff using semi-structured | Major theme of antecedents included 8 sub-themes: 1. Mental state worsened 2. Behavioural disturbance 3. Intuition 'just knew' 4. Unclear / assisting other clinical area 5. Not taking medication 6. Use of illegal substance 7. Earlier minor incidents 8. No incidents noted. Findings also detailed: Emotional consequences for staff of having to restrain range from anxiety, distress, anger and guilt to Post Traumatic Stress Disorder. Restraint is distressing for staff and patients. Restraint reawakens past trauma | partial to reflect the degree of force used. Participants’ voices reveal rich narrative and enhance trustworthiness Rigour enhanced by identification of the researcher’s preconceptions, returning transcripts for comment and member checking the findings **Limitations** No recommendations for future research stated |

**Strengths**
Research gap clearly identified.
Sample size for quantitative analysis is recognised as small and larger numbers would be needed for robust examination
Nurses’ restraint experiences described as ranging from gentle guidance to C&R techniques in the prone position.
Evidence of participants voices provides rich data and enhances trustworthiness
Clear recommendations
| **users?** | interviews structured interviews and quantitative data collection  
30 patients interviewed using same approach as for staff | such as rape and assault for patients and staff.  
Clinical framework to help staff and patients discuss antecedents and psychological effects can help to identify early identification of trauma symptoms. | arise from findings:  
1. Restraint learning programmes should include the psychological impact, post-incident review and the identification of early trauma.  
2. Research recommendations include large multi-site study to extend the findings, evaluation of the post Incident Review Framework used in the study, and wider exploration of the phenomenon of awakening trauma.  
3. Practice recommendations include consideration of the psychological impact of restraint, documentation and communication of trauma history, support for staff including referral to specialist help for trauma symptoms. |

**Limitations**  
Study context not described in detail.  
Handling of researcher's preconceptions is unclear.  
Patient evaluation of the interview experience using a questionnaire
| 4 | **Sequeira & Halstead (2004)**
**United Kingdom** | The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital: 'When I go home, it's then that I think about it.' | What is the experience of physical restraint reported by nursing staff? (focus on psychological responses)
**Aim:** To document new insights into participants’ psychological experiences | 5 secure wards in private hospital | 17 Nursing staff (8 Registered and 9 nursing assistants plus the 14 patients who were restrained or secluded and 5 patients who witnessed the event) | Grounded theory and thematic analysis
Semi-structured interviews within 12 hours of the restraint.
Computer software used to facilitate coding and categorisation of data. | Ten themes presented:
1. Anxiety
2. Reduction in anxiety through familiarity with restraint
3. Anger
4. Anger and abuse of interventions
5. Boredom, frustration and low moral
6. Conflict with role as a nurse
7. Distress and crying
8. Coping with strong emotional reactions
9. Automatic responding – no feelings
10. Ambivalence about support | Strengths
Research gap clearly identified
Context clearly described
Clearly stated that all restraint types were included in study involving between 2-8 members of staff
Attempts to reduce sampling bias made by randomly selecting restraint events over the 24hr day
Data analysis clearly described and congruent with methodology
Nurses’ responses are triangulated with patients’ responses to enhance understanding
Participants’ voices reveal rich narrative and enhance trustworthiness
Discrepant cases included to illustrate breadth of responses
Recommendations for future studies arise from was not undertaken and the findings therefore reflect only staff experiences
| 5 | **Lee, Gray, Gournay, Wright, Parr & Sayer (2003)** England and Wales | Views of nursing staff on their last use of C&R techniques in the context of training in physical restraint | Have the following occurred during the last restraint episode? 1. A positive outcome 2. Patient injury 3. Staff injury 4. A negative outcome 5. Other concerns | 63 Regional Secure Wards and PICUs | 338 nursing staff of whom 269 completed this part of the questionnaire | Mixed methods. Postal questionnaire Quantitative analysis using SPSS Qualitative analysis using coding and categorisation of written narrative into themes | Eight areas of the experience were described in a combination of quantitative and qualitative findings: 1. Injury 2. Negative outcomes 3. Organisational issues 4. Concerns about the use of the procedure 5. Staff attitude 6. Alternatives 7. Reason for use 8. Post-restraint management | **Strengths**  
Aim of study clearly stated  
Authors attempted to gather information about a sensitive topic using the anonymity of a questionnaire. Study highlights areas of poor practice that may be difficult to gather using face to face approaches  
Restraint type clearly focused upon full C&R techniques | **Limitations**  
Representation of individual voices in report is unclear. Numbers contributing to each theme demands further clarity  
Development of theory not addressed |
Recommendations arising from findings are made for policy, education and practice.

Limitations
Random sampling process of wards for study not documented
Approach to qualitative analysis is not made explicit and themes are not well developed
Some use of extracted words and phrases to describe staff injuries and staff attitudes but presentation of raw data extremely limited reducing trustworthiness

<p>| 6 | Bonner, Lowe, Rawcliffe &amp; Wellman (2002) | United Kingdom | Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. | Pilot study to: 1. Establish the feasibility of using semi-structured interviews with patients and staff during and in the aftermath of untoward incidents involving physical restraint 2. Gather information on factors patients and staff found helpful and unhelpful, during and in the aftermath 3. To explore the | Adult psychiatric wards | 6 incidents involving 12 staff and 6 patients | Qualitative Semi-structured interviews. Taped and transcribed verbatim Data analysis employed coding and development of themes | Semi-structured interviews assisted effective data collection Three major sequential themes presented: 1. Antecedants 2. In the midst of conflict 2. The aftermath Other issues: Patients: 1. Fear of restraint 2. Restraint and re-traumatisation 3. Agency staff Other issues: Staff: 1. Ethical issues 2. Re-traumatisation | Strengths Aim of study clearly stated Restraint type described as manual physical restraint used during untoward incidents Purposive sample sought nurses and patients who had lived through a physical restraint by means of daily phone call to wards. Analytic steps described. |</p>
<table>
<thead>
<tr>
<th>Subjective lived experience of restraint</th>
<th>Attempts to enhance rigour made through consensual coding of data between researchers</th>
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<tbody>
<tr>
<td>Participants’ voices reveal rich narrative and enhance trustworthiness</td>
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<tr>
<td>Clear recommendations arise from findings and include health policy, workforce planning, training and research. Research recommendations highlight need to study staff and patients’ traumatic re-living during restraint</td>
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<tr>
<td><strong>Limitations</strong></td>
<td></td>
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<tr>
<td>No philosophical stance stated to underpin study</td>
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<tr>
<td>Representation of individual voices in report is unclear. Numbers contributing to each theme demands further clarity</td>
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### Studies into adult mental health nurses’ experience of touch in their daily work

<table>
<thead>
<tr>
<th>Researcher Date Country of origin</th>
<th>Title of Study</th>
<th>Research Question / Objective</th>
<th>Setting / Context</th>
<th>Participants</th>
<th>Method and Data Analysis</th>
<th>Findings Presented in Study</th>
<th>Strengths and limitations</th>
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<tbody>
<tr>
<td>1. Gleeson &amp; Higgins (2009) Republic of Ireland</td>
<td>Touch in mental health nursing: an exploratory study of nurses’ views and perceptions</td>
<td>To explore psychiatric nurses’ perceptions of physical touch with people who experience mental health problems</td>
<td>Range of adult inpatient admission units.</td>
<td>10 registered psychiatric nurses with 10-20 yrs experience (6 men, 4 women)</td>
<td>Descriptive exploratory design.  Semi-structured interviews. Tape recorded using interview guide and transcribed.  Burnard’s 14 stage-by-stage process of coding and categorisation</td>
<td>Four main themes:  1. ‘It’s a very powerful tool’ – an essential aspect of practice  2. ‘Honouring their personal space’ – using touch with sensitivity  3. ‘The verbal part is only a small percentage’ – using touch in practice  4. ‘Making me feel uncomfortable’ – being cautious  Summary suggests touch is integral to mental health nursing.</td>
<td><strong>Strengths</strong> Study aim clear  Participants’ voices provide rich data and this enhances trustworthiness  Recommendations for future research are clear and include:  1. Studies with diverse groups  2. Studies of clients’ views of touch  3. Inclusion of touch in educational curricula  <strong>Limitations</strong> Rationale for random selection of 10 consented participants is not stated, nor the potential impact upon saturation of data.  Sample included only experienced nurses with 10-20yrs experience.  Researcher subjectivity and potential influence on data not discussed  Burnard’s (1991) criteria for achieving ‘validity’ (colleague and participant</td>
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<td></td>
<td>Keogh &amp; Gleeson (2006) Republic of Ireland</td>
<td>Caring for female patients: the experiences of male nurses</td>
<td>To describe male nurses' experiences of caring for women with a particular emphasis on interventions that involved physical touch</td>
<td>Not described</td>
<td>5 male general nurses 6 male psychiatric nurses</td>
<td>Descriptive qualitative design. Semi-structured interviews Burnard's 14 stage-by-stage process of coding and categorisation</td>
<td>Three themes developed: 1. Fear of sexual allegations when caring for persons of the opposite sex 2. Factors influencing caring interventions with the opposite sex 3. Learning about caring interventions for the opposite sex</td>
</tr>
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check of coding) are not evident in the analytic process
<table>
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<tr>
<th>3.</th>
<th><strong>Carlsson, Dahlberg &amp; Drew (2000)</strong></th>
<th><strong>Encountering violence and aggression in mental health nursing: a phenomenological study of tacit caring knowledge</strong></th>
<th><strong>To explore the phenomenon of positive encounters with aggressive and violent clients</strong></th>
<th><strong>Acute psychiatric clinic</strong></th>
<th><strong>2 Nurses and 3 Nurse Assistants (4 female, 1 male)</strong></th>
<th><strong>Descriptive phenomenology</strong></th>
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<td><strong>Written narrative of a positive encounter (positive impact upon staff and patient) to set the scene followed by audio taped interviews. Written narratives typed in full and interviews transcribed verbatim.</strong></td>
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<td><strong>Thematic analysis</strong></td>
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<td><strong>Positive encounters with aggression are an embodied moment including a pattern of seven themes:</strong></td>
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<td>1. Respecting one’s fear and respecting the client</td>
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<td>2. Touch</td>
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<td>3. Dialogue</td>
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<td>5. Stability</td>
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<td>6. Mutual regard</td>
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<td>7. Pliability</td>
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<td><strong>Findings reveal that within the theme of touch, encounters with aggressive clients that had a positive outcome were characterised by touch. Non-procedural touch is very much part of psychiatric inpatient nursing practice.</strong></td>
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<td><strong>Strengths</strong></td>
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<td><strong>Participants self-selected as willing to take part.</strong></td>
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<td><strong>Philosophic position Husserlian and Giorgi’s method followed to search for essences</strong></td>
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<td><strong>Analytic approach described. Attempts to enhance rigour included shared agreements between researchers to agree meanings.</strong></td>
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<td><strong>Participants’ voices reveal rich narrative and enhance trustworthiness</strong></td>
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<td><strong>Clear recommendations include:</strong></td>
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<td>1. Research into caregivers’ openness.</td>
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<td>2. Education to include the development of caregiver’s awareness of their subjective body through reflective learning.**</td>
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<td><strong>Limitations</strong></td>
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<td></td>
<td><strong>Sample very small (n=5) including one male</strong></td>
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| | | | | | | **Potential influence of researchers’ subjectivity is described as being open and receptive to participants’ accounts without clear evidence of researcher assumptions.**
<p>|   | Tomassini (1990) USA | The use of touch with the hospitalised psychiatric patient | To identify and describe the ways in which registered nurses use non-procedural (purposeful) touch in the inpatient psychiatric setting. Excluded procedural touches including assistance with medication, physical restraint, taking vital signs and changing dressings. | Two adult inpatient units and one adolescent unit. | 13 Registered nurses, (12 female, 1 male) and 17 patients | Descriptive non-participant observer in natural setting (ward common areas) for 27.5hrs with nurses blind to the study focus, followed by focused interviews to understand the nurses’ decision-making and their intentions when touching. Content analysis | Five decision-making categories: 1. Patient characteristics 2. Patient needs 3. Knowledge of the patient 4. Role expectations 5. Cognitive / emotional states Five intention categories: 1. Patient needs 2. Communication 3. Patient assessment 4. Establishing contact 5. Non-illness focus | <strong>Strengths</strong> Use of researcher field observations helped to facilitate the interview with participants Support from traineeship declared <strong>Limitations</strong> Nurse participants described as experienced practitioners (mean 6.7yrs in psychiatric nursing), although sample included nurses with only 8 months experience Limited discussion of power asymmetry and impact upon study Limited information regarding analytic process Study lacks sufficient raw data to support findings in relation to nurses’ intentions to touch Nurses were unaware of study focus raising ethical concerns Broad recommendations made for further research into touch from both nurse and patient perspectives. Minimal touch used in middle aged adults is a suggested area for further study |</p>
<table>
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<tr>
<th>5.</th>
<th>DeAugustinis Isani &amp; Kumler (1963) USA New Jersey</th>
<th>Ward study: the meaning of touch in interpersonal communication</th>
<th>What are the various meanings of touch gestures that occur in patient-ward personnel dyadic relationships in the psychiatric settings, and are these meanings to the initiators and recipients similar or dissimilar?</th>
<th>Four wards caring for chronically ill patients</th>
<th>9 staff and 9 clients All female non-professional staff working with female patients with chronic mental illness</th>
<th>Non-participant observation, interviews and questionnaires.</th>
<th>Caregivers initiated touch with patients in 79% of the observations. They described 55% as automatic and less than 32% as thoughtful. (Thoughtful meant ‘I thought about touching before I touched’). All the caregivers thought about being touched by patients afterwards. Most commonly, touches were described by caregivers as intending to convey tender feelings, gaining attention and instigating an action. Incidental findings revealed that staff and patients recognised restraining actions as touches. One staff member recognised also being touched by the patient when restraint was used.</th>
<th>Strengths To enhance rigour, the researchers agreed the classification of the observation and interview data. Recommendations were made and include: 1. Further studies on touch 2. Further studies on the types of patients who touch and who are touched. 3. Greater education for nurses on the use of touch</th>
<th>Limitations Approach to understanding meaning lacks philosophical underpinnings to guide study Interview and questionnaire design includes a number of closed questions that may have limited responses. The researchers acknowledged: 1. Sample of patients and staff was all female 2. The presence of researchers the ward affected the patterns of interaction 3. Limited number of staff reduced the sample size 4. Period of data collection was too short to pre-test the approach</th>
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5. The participants knew the researchers’ background (University Nurses) and this may have influenced the answers given during the interviews.
**FORM UPR16**
Research Ethics Review Checklist

Please include this completed form as an appendix to your thesis (see the Postgraduate Research Student Handbook for more information)

<table>
<thead>
<tr>
<th>Postgraduate Research Student (PGRS) Information</th>
<th>Student ID:</th>
<th>353915</th>
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<tbody>
<tr>
<td>Candidate Name:</td>
<td>Jillian Bailey</td>
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</tr>
<tr>
<td>Department:</td>
<td>School of Health Sciences and Social Work</td>
<td></td>
</tr>
<tr>
<td>First Supervisor:</td>
<td>Dr Ann Dewey</td>
<td></td>
</tr>
<tr>
<td>Start Date: (or progression date for Prof Doc students)</td>
<td>28.05.2009</td>
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<tr>
<th>Study Mode and Route:</th>
<th>Part-time</th>
<th>MPhil</th>
<th>Integrated Doctorate (NewRoute)</th>
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<td>Full-time</td>
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<td>Prof Doc (PD)</td>
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| Title of Thesis:                                   | A hermeneutic inquiry into adult mental health nurses’ experience of physical restraint procedures and their intervention using forced touch with patients |
| Thesis Word Count: (excluding ancillary data)     | 48,416    |

If you are unsure about any of the following, please contact the local representative on your Faculty Ethics Committee for advice. Please note that it is your responsibility to follow the University’s Ethics Policy and any relevant University, academic or professional guidelines in the conduct of your study. Although the Ethics Committee may have given your study a favourable opinion, the final responsibility for the ethical conduct of this work lies with the researcher(s).

**UKRIO Finished Research Checklist:**
(If you would like to know more about the checklist, please see your Faculty or Departmental Ethics Committee rep or see the online version of the full checklist at: [http://www.ukrio.org/what-we-do/code-of-practice-for-research/](http://www.ukrio.org/what-we-do/code-of-practice-for-research/))

  a) Have all of your research and findings been reported accurately, honestly and within a reasonable time frame? **YES**
<table>
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<th><strong>b)</strong> Have all contributions to knowledge been acknowledged?</th>
<th>YES</th>
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<tr>
<td><strong>c)</strong> Have you complied with all agreements relating to intellectual property, publication and authorship?</td>
<td>YES</td>
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<tr>
<td><strong>d)</strong> Has your research data been retained in a secure and accessible form and will it remain so for the required duration?</td>
<td>YES</td>
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<tr>
<td><strong>e)</strong> Does your research comply with all legal, ethical, and contractual requirements?</td>
<td>YES</td>
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*Delete as appropriate*

### Candidate Statement:

I have considered the ethical dimensions of the above named research project, and have successfully obtained the necessary ethical approval(s)

<table>
<thead>
<tr>
<th>Ethical review number(s) from Faculty Ethics Committee (or from NRES/SCREC):</th>
<th>NRES 10/H0504/12</th>
</tr>
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</table>

**Signed:**

(Student) Jillian Bailey

**Date:** 19.07.15

If you have *not* submitted your work for ethical review, and/or you have answered ‘No’ to one or more of questions a) to e), please explain why this is so:

**Signed:**

(Student)

**Date:**
Appendix 5
1. Study title: Mental health nurses' lived experience of using forced touch

2. Invitation to take part
You are being invited to take part in a nursing research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Please contact me if there is anything that is not clear, or if you would like more information. My telephone number is: . Take time to decide whether you wish to take part.

3. What is the purpose of the study?
The researcher has fully reviewed all the available literature on what it is like for inpatient nurses to use force to hold patients during restraint. There is very little information available and this aspect of nursing appears to be poorly understood. Therefore, the study aims to understand this aspect of practice in more detail. The study is in part fulfilment of a Professional Doctorate in Nursing at the University of Portsmouth.

4. Why have I been invited to take part?
You have been invited because you work on an inpatient unit and as part of your role you may have restrained patients. The researcher anticipates that about ten people may participate in the study. If many more wish to take part, it may not be possible to include everybody. If this is the case, you will be offered a copy of the executive summary. If the required data is not obtained, the researcher will invite more people to participate.

5. Do I have to take part?
No. The research is voluntary. It is up to you to decide whether, or not, to take part. If you do decide that you would like to take part, you will be given this information sheet to keep and be asked to sign a consent form. The researcher will explain the purpose of the study and answer any questions that you may have before you participate. You are free to withdraw at any time and without giving a reason.

6. What will happen to me if I take part?
If you decide to participate, you will be invited to an interview with the researcher. You will be asked to reflect on your experience of using forced touch during a restraint incident before you attend. The researcher will then ask you about this experience. The interview will be recorded on a very small digital recorder. The interview is likely to last between an hour and two hours, but you will be able to determine how long you wish to talk. Once your interview is transcribed, you will receive a copy of the transcript to read. You will be able to add, change or delete anything that you do not want included in the study. The interview phase of the study is likely to take about three months to give time to interview all the people who agree to take part.

7. What do I have to do?
The researcher will transcribe the interview. No other person will have access to the information that you provide. You will receive a copy of your transcript to you so that you can check it for accuracy, add or delete anything that you do not want to be included in the study. Your age, gender, grade, time since qualifying and place of work (ward type only) will be noted to assist the researcher with the analysis.
8. What are the other possible disadvantages and risks of taking part?
Restraining patients can be a challenging part of practice. Talking about such experiences may be uncomfortable or upsetting. You retain control over what you wish to share. Should the interview cause you to feel upset, you can end it at any time. If you need further support, the researcher can direct you to the Staff Support and Wellbeing Services. This service is aware that the study being conducted, and the possibility that staff may want support from them. Details of the service are provided with this sheet.

You may either take part outside of your work hours or during your paid employment time. The researcher will be flexible in her approach to meeting when it is most convenient to you and the needs of patients. If you wish to participate on Trust premises, the interviews will take place in a mutually convenient room. It will be pre-booked to ensure that no interruptions take place.

9. What are the possible benefits of taking part?
Taking part gives you the opportunity to participate in a research project. The project will contribute towards filling a current gap in nursing knowledge through proposed publication. It is envisaged that nurses and help to inform current practice through support, supervision and training will read the study.

10. Ethical Research Practice
Research practice follows ethical guidelines in a similar way to clinical practice. It is important that you know that should you disclose evidence of malpractice, the researcher would be obliged to report this.

11. What if you think there is a problem?
If you have any complaint about the way you are dealt with during the study, or any possible harm you might suffer as a result, this will be addressed. Contact number for research conduct complaints:

(Name): Research and Development Coordinator: Tel:

12. Will my taking part in the study be kept confidential?
Your participation in the study is entirely confidential. The researcher will not discuss your participation, or the information that you give, with anybody except her academic supervisors as part of the research process. Your interview transcript will held on a computer that is password protected. Your transcript will be coded with a pseudonym to ensure that it cannot be related to you. Any details that you give that may identify you, such as names or places, will be removed to protect your anonymity as far as possible. Hard copies will be kept in a locked filing cabinet. Audio recordings will be deleted at the end of the study, and paper copies shredded.

The final analysis presented for publication may contain the actual words that you have used during the interview. You will need to be careful to protect patients’ names and take care not to reveal their identities during the interview.

There is no intention to save the data or to use it for any other purpose except for this study. The handling of research data in this way conforms to the Data Protection Act 1998.

13. What will happen to the results of the research study?
The findings of the study will be examined during the viva voce as part of the Professional Doctorate at the University of Portsmouth. They will also be written up for publication. A summary of the results of the study will be provided to all participants. The consent process will make this clear before you participate.
14. Who is organising and funding the research?
The research is sponsored by the (Trust). The project does not have external funding and there are no external interests. The University of Portsmouth provides academic supervision for the researcher.

15. Researcher Details: The researcher is Jill Addis. Contact Tel: e-mail:

Thank you for taking the time to read this information sheet and considering whether you would like to take part in the study.
Information for staff following a serious incident, e.g. suicide or assault at work

Such events are rare but they do happen. When faced with such a crisis, practitioners usually function to the very limits of their ability. It is only afterwards that the emotional impact hits. An acute reaction can follow a suicide or death or other serious incident at work and last for a week to a month. Whilst professional failures are seldom found, feelings of blame, responsibility and self-doubt are common. This can be exacerbated by the necessary reviews of cases and reports demanded by the Serious Untoward Incident process.

Factors such as pre-existing stress, the existence of other problems, the nature of the relationship, and the issues in one's own life that the event may trigger can increase the impact.

Participating in opportunities to learn more about the facts of the situation is important, and formal and informal consultation with colleagues is one of the most helpful actions to take. It is also a way of bringing a close to the shock of the death and dealing with any difficult feelings you may have around the incident.

Reactions

These vary; some people may not be affected in any of these at all, but effects can include:

- Upsetting memories, images or thoughts
- Trouble controlling a range of emotions
- Sleep disturbances
- Concentration and memory difficulties
- Feeling agitated or tense
- Avoiding situations that might cause association or memory of the event
- Drinking too much, or shutting down emotions
- Having less enthusiasm for usual social activities.

All of these reactions are normal and natural responses, and usually settle down within four to six weeks.

A few tips for coping

- Do allow yourself to accept that it is normal to have an acute response to such an event, and that any feelings or emotional reactions typically fade.
- Don't bottle up feelings. Talk to someone, or to colleagues who will fully understand what has happened.
- Working or keeping active may help. Equally, some people may just need time alone to reflect. We all experience things differently and it is important to let others know what you need rather than allowing them to assume.
- Don't forget to look after yourself. Accidents are more common after an event, so be extra careful when driving, and around the home.
- Spend time with family and friends who make you feel at ease.
- Do participate in the Trust's review process. This is an opportunity to learn from traumatic events and to achieve closure and understanding.
- Meet regularly with your manager for a while. There should be plenty of opportunities to let them know if you need anything, and how things are going.
Appendix 7
CONSENT FORM – Version 2

Title of Project: Mental health nurses' lived experience of using forced touch

Name of Researcher: Jill Addis

Please initial box
1. I confirm that I have read and I understand the information sheet dated .......... (Version 2) for the above study.

2. I have had the opportunity to consider the information, ask questions, and I have had these answered satisfactorily.

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

4. I agree to audio recording of my interview.

5. I have discussed the issue of anonymity and I understand that anonymity cannot be fully guaranteed.

6. I understand that the interview data may be shared between the researcher and her supervisor as part of the academic learning process.

7. I understand that the researcher would be obliged to report evidence of malpractice.

8. I understand that the study will be published and may include the actual words that I use during the interview.

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

________________________   ______________   _______________________
Name of Participant       Date             Signature

________________________   ______________   _______________________
Chief Investigator        Date             Signature
## Participant Demographics

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<th>Category</th>
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<td>Band..................</td>
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<td>Gender</td>
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<tr>
<td>Duration of qualification</td>
<td>....................yrs</td>
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<tr>
<td>Acute / PICU /</td>
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(Trust Name and NHS logo)

R&D Manager  
Nursing and Clinical Governance Department  
14th July 2009

Ref: R&D/jm

To Whom It May Concern:

Re: PI: Jill Addis
Study Title: A Heideggerian hermeneutic inquiry into nurses’ lived experience of forced touch

I can confirm that ..........NHS Foundation Trust will act as research sponsor for the above study and will comply with the Department of Health Research Governance Framework for Health and Social Care 2005. As sponsor, the Trust will also provide indemnity for the above study.

Sponsorship is confirmed subject to formal approval from a Research Ethics Committee and the understanding that should any substantial amendments be submitted to the Ethics Committee, these would also be copied to the Trust R&D office.

Yours sincerely

R&D Manager
Date:

Dear Nurse on (Ward Name)

I am writing to invite you to participate in a research study entitled:

**A Heideggerian hermeneutic inquiry into nurses’ lived experience of forced touch during restraint interventions in acute mental health settings.**

You have been identified as a qualified nurse working in an acute inpatient setting who has used restraint interventions as part of your work. Therefore, you may wish to take part in the project. The study forms part of my Doctoral thesis leading to the qualification of Professional Doctorate in Nursing at the University of Portsmouth.

I am interested in the experience of using forced touch from nurses’ perspectives who work on day shifts, night shifts, or those who rotate between days and nights.

I attach an information sheet for you setting out the reasons for the study and what it means should you to participate. Should you decide that you would like to take part, please contact me on , or you can e-mail me at . I will then explain the study to you and answer any questions that you may have. I will then ask you to sign a consent form and make arrangements for us to meet for the interview. If you have more questions about the study, please call me and I will discuss the project with you.

Yours sincerely,

Jill Addis
Consultant Nurse
(Trust Name and NHS logo)

Interview Schedule

Mental health nurses’ lived experience of using forced touch - v1

You have now had some time to reflect upon your experience of using your bodily force to restrain patients..........................

Experience Questions

Can you tell me what is it like to use forced touch when you are restraining patients?

Can you describe what it is like when you apply force to the head or limbs during restraint?
- ask for detail on moving in, initial grasping, holding, releasing
- ask for exemplar or follow up on any highly charged summaries
- ask for PRECISE descriptions through clarification of broad statements about touching the patient

Feeling Questions

What does it feel like when you know you are going to have to lay hands on a patient?
How do you feel whilst you are using the force of your own body to restrain a patient?
What does the patient feel like to touch?
What does it feel like once you take hands off / move your body away from the patient?

Knowledge Questions

How do you know how much force to apply?
How do you know if you are causing pain?
How do you cope with using force in this way?

Toning Down the Emotional Level Before Closing

Now that you have talked with me and answered my questions, is there anything else that you think I should have asked, or wish to share with me?
How do you feel now that you have shared your experiences with me?

Close and Confirm a Calm State

How are you feeling about returning to your duties now?

Thank you for taking part. Your contribution is a highly valued part of the study.
Level 8 (Taught Doctorate)

1.0 Development of knowledge and Understanding
The Learner

.01 Knowledge Base: has great depth and systematic understanding of a substantial body of knowledge. Can work with theoretical / research knowledge at the forefront of the discipline at publication-quality / peer reviewed standards.

.02 Ethical Issues: can analyse and manage the implications of ethical dilemmas and work proactively with others to formulate solutions.

.03 Disciplinary Methodologies: has a comprehensive understanding of techniques / methodologies applicable to the discipline (theory or research-based).

2.0 Cognitive and Intellectual Skills
The Learner

.01 Analysis: with critical awareness can undertake analysis, managing complexity, incompleteness of data or contradiction in the areas of knowledge.

.02 Synthesis: can undertake synthesis of new approaches, in a manner that can contribute to the development of methodology or understanding in that discipline or practice.

.03 Evaluation: has a level of conceptual understanding and critical capacities that will allow independent evaluation of research, advanced scholarship and methodologies. Can argue alternative approaches.

.04 Application: can act independently and with originality in problem solving, is able to lead in planning and implementing tasks at a professional or equivalent level.

3.0 Key /Transferable Skills
The Learner

.01 Group Working: can lead / work effectively with group. Can clarify task, managing the capacities of group members, negotiating and handling conflict with confidence.

.02 Learning Resources: Is able to use the full range of learning resources.

.03 Self-Evaluation: is reflective on own and other’s functioning in order to improve practice.

.04 Management of Information: competently and independently can undertake innovative research tasks.

April 2001 Revised Draft level Descriptors
.05 Autonomy: is independent and self-critical as a learner; supports the learning of others.

.06 Communication: can communicate complex or contentious information clearly and effectively to specialists / non-specialists, understands lack of understanding in others. Can act as recognised and effective consultant.

.07 Problems Solving: independently can continue own professional study, professionally can make use of others within /outside the discipline.

4.0 Practical Skills
The Learner

.01 Application of skills: can operate in complex and unpredictable / specialist contexts that may be at the forefront of knowledge. Has an overview of the issues governing good practice.

.02 Autonomy in Skill Use: can act in a professional capacity for self /others, with responsibility and largely autonomously initiative in complex and unpredictable situations.

.03 Technical Expertise: has technical mastery, performs smoothly with precision and effectiveness; can adapt skills and design or develop new skills / procedures for new situations.

Revised Levels Descriptors, SEEC 2001