PREVENT's impact in healthcare is scant, especially on the lived experiences of staff.

Aim The purpose of this study was thus to explore the experiences of dissenting NHS staff who have undergone PREVENT training.

Methodology This study examined individual interviews with 16 dissenting NHS health professionals who participated in mandatory PREVENT counter-radicalisation training.

Results Results reveal two themes central among dissenting health professionals. The first theme is the moralising discourse experienced within PREVENT training. This moralising discourse offers that criticism towards PREVENT may be perceived as paramount to sympathies for terrorism itself and is experienced more acutely by British Muslim healthcare staff who felt silenced. The 'morally correct position' then is to unquestioningly accept PREVENT policy. The second theme relates to the structures which extend beyond PREVENT but nonetheless contribute to the silencing of dissent: distrustful settings in which the gaze of unknown colleagues stifles personal expression; reluctant safeguarding leads who admit PREVENT may be unethical but nonetheless relinquish personal responsibility from the act of training; and contemporary socio-political conditions affecting the NHS which overwhelm staff with other concerns.

Conclusion This paper argues that counter-terrorism policy within the NHS may exacerbate the self-censorship of dissenting staff, unveiling novel concerns for medical ethics.

Parallel session – Critical Perspectives and Social Theory (22 March 11:30 – 13:00)

07 THE HOSPITAL IS NO LONGER AN OPTION: A CASE STUDY OF PREGNANT WOMEN GOING AGAINST MEDICAL ADVICE

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Background In the Netherlands, some women with high-risk pregnancies go against medical advice and protocol in their choice of place and mode of birth, and choose to birth outside the regular maternity care system with a 'holistic' midwife.

Aim To explore the defining moments for women choosing home birth in high-risk pregnancies and to determine if there was a general pattern in their experiences.

Methods The researchers in this study used a feminist approach informed by Critical Theory. The DESCARTE model (Carolan, Forbat, & Smith, 2016¹) was used in the design of this exploratory multiple case study. 10 cases were chosen based on 41 in depth interviews with Dutch women with a high-risk pregnancy who chose to birth at home against medical advice, their partners and their health care professionals (midwives and obstetricians). Within case (grounded theory) and cross-case analysis (based on propositions cf. Yin 2014²) of the cases was performed. The focus was on the negotiation of care during conversations with health care professionals wherein women with a high-risk pregnancy expressed their wishes.

Results Two patterns emerged. The dominant one was a trajectory of trauma, self-education, concern about paternalism, and

conflict during consultation leading to a negative choice for alternative/holistic care. Prior birth trauma often made consultations fraught with tension. The second pattern was a path of trust and positive choice for holistic care without conflict.

Conclusions For women to perceive the hospital as safe again, professionals will need to work on building a trusting relationship using continuity of care, true shared decision making, and an alternative risk discourse. Preventing initial birth trauma is a prerequisite.

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08

RE-THINKING 'MENTAL HEALTH' THROUGH FEELING: EMOTION CENTRED RESEARCH ABOUT FAMILY WITH LGBTQ+ YOUTH

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Background LGBTQ +young people experience disproportionately poor mental health outcomes compared to their heterosexual counterparts. Poor mental health is linked to family conflict about sexual orientation whereas supportive family relationships are correlated with mental wellness in LGBTQ +youth. However, little research focuses on family environments for LGBTQ +youth and to date there is no UK evidence on the topic. In addition, both 'family' and 'youth' remain under-theorised and mental health research typically uses a psycho-biomedical framework where emotion is pathologized. This limits our understanding of the complexity, relationality and meanings of youth mental health.

Aim/Objectives This methodological paper will explain the interdisciplinary critical mental health taken to researching LGBTQ+youth and family relationships in a small-scale study in England. Specifically, I will critically reflect on the epistemological and practical aspects of centralising emotion within this research project.

Methods Two phases of qualitative research with 13 LGBTQ +young people and 7 'family members' was conducted. Phase one involved family mapping and semi-structured interviews; and phase two used diary methods. Emotion mapping techniques were used throughout and an emotion-centred analysis conducted including through the development of 'I-feel poems'; and drawing on Hochschild's (1979) concept of 'emotion work.'

Results Our approach to researching LGBTQ+young people and their families yielded material that was saturated with emotion and highlighted myriad ways that LGBTQ+youth mental health is influenced by doing emotion work in their families for the purposes of becoming, belonging and survival.

Conclusions Our method/ology successfully captured emotion and facilitated an emotion-centred analysis of LGBTQ +youth/family relationships. Although it's likely much emotion remains hidden from view and its exposure presents ethical risks for researcher and participant, this methodological approach offers a valuable alternative perspective on mental health that attends to the meanings and relationality of LGBTQ +youth experience.