JYU DISSERTATIONS 369

William James Vennola-Stover

Forced Care Directed at Psychiatric Clients

A Study of Emotional Suppression in Psychiatric Seclusion

UNIVERSITY OF JYVÄSKYLÄ
FACULTY OF HUMANITIES AND SOCIAL SCIENCES

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Esitetään Jyväskylän yliopiston humanistis-yhteiskuntatieteellisen tiedekunnan suostumuksella
julkisesti tarkastettavaksi yliopiston vanhassa juhlasalissa S212 toukokuun 28. päivänä 2021 kello 12.

Academic dissertation to be publicly discussed, by permission of
the Faculty of Humanities and Social Sciences of the University of Jyväskylä,
in building Seminarium, old festival hall S212 on May 28, 2021 at 12 o'clock noon.

JYVÄSKYLÄN YLIOPISTO
UNIVERSITY OF JYVÄSKYLÄ

JYVÄSKYLÄ 2021

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Permanent link to this publication: http://urn.fi/URN:978-951-39-8589-9

ISBN 9978-951-39-8589-9 (PDF)
URN:ISBN:978-951-39-8589-9
ISSN 2489-9003

ABSTRACT

Vennola-Stover, William James
Forced Care Directed at Psychiatric Clients: A Study of Emotional Suppression in Psychiatric Seclusion
Jyväskylä: University of Jyväskylä, 2021, 279 p.
(JYU Dissertations
ISSN 2489-9003; 369)
ISBN 978-951-39-8589-9

The aim of this PhD dissertation in social work is to understand mental health clients' individual and social rights and bring about a broader understanding of client-centered treatment. This study will seek to gain phenomenological insight into the experience of clients and their understanding of seclusion in a psychiatric hospital setting. The research question is: What kind of experiences do mental health clients have with psychiatric seclusion?

The data consist of semi-structured individual interviews with six adult mental health clients in one psychiatric hospital in Finland, using a bio-psychosocial and narrative qualitative research design. This study aims at client centered meaning making of the subjective experience of seclusion and generating of social philosophical theory about this process.

This study revealed that the absence of talk therapies and forced medicine results in helplessness, a lowered motivation often leading to defenseless disorientation or high affect agitation and indirect aggression culminating in frequent seclusion. Through the lack of opportunity to voice emotional trauma, clients develop socially learned adaptations. Preparing and delays and pauses in interviews around treatment terms suggest suppression and emotional regulation as a defense against trauma associated with psychiatric seclusion. Premotivational and pre-cognitive contributions were made in delay, stuttering, sudden stopping, total disappearance of words, and long pauses around objects of trauma in recall of seclusion.

Based on the findings, it is recommended to the psychiatric care system and professionals working with mental health clients, to recognize only voluntary status. Clinicians are advised to bring patients into consensual treatment, and willful participation, by providing comprehensive talk therapies on demand. Furthermore, by the lack of talk therapies and inaccessibility of social support, clients may become endangered in the inpatient setting and community. The reluctance of psychiatric clinics to further provide acknowledged assisted refusals, educated informed consent, and participatory volunteering, ignores the basic human needs of an already vulnerable group of people.

Keywords: seclusion and restraint, psychiatric forced care, emotional suppression

TIIVISTELMÄ

Vennola-Stover, William James
Psykiatrisen hoidon asiakkaiden pakkohoito: Tutkimus tunteiden tukahduttamisesta psykiatrisessa eristämisessä
Jyväskylä: University of Jyväskylä, 2021, 279 s.
(JYU Dissertations
ISSN 2489-9003; 369)
ISBN 978-951-39-8589-9

Tämän sosiaalityön väitöskirjatutkimuksen tavoitteena on ymmärtää psykiatrisen hoidon asiakkaiden henkilökohtaisia ja sosiaalisia oikeuksia ja korostaa hoidon asiakaslähtöisyyttä. Tutkimuksella tavoitellaan fenomenologista ymmärrystä asiakkaiden kokemuksista ja käsityksistä psykiatrisessa hoidossa tapahtuvasta eristyksestä.

Tutkimusaineisto koostuu kuuden aikuisen asiakkaan puolistrukturoiduista yksilöhaastatteluista yhdessä suomalaisessa psykiatrisessa sairaalassa, käyttäen biopsykososiaalista ja narratiivista laadullista tutkimuksellista lähestymistapaa. Tutkimus tarkastelee eristyskokemuksille annettuja subjektiivisia merkityksiä ja pyrkii rakentamaan sosiaalifilosofista teoriaa tästä prosessista.

Tulokset osoittavat, että keskustelumahdollisuuksien puute ja pakollinen lääkitys johtavat avuttomuuteen, alentuneeseen motivaatioon ja edelleen puolustuskyvyttömään hämmennykseen tai voimakkaasta tunnereaktiosta johtuvaan levottomuuteen ja epäsuoraan aggressioon, joka kärjistyessään johtaa usein eristämiseen. Kyvyttömyys ilmaista eristyksen aiheuttamaa traumaa ja välttää pakkotoimia saa asiakkaat kehittämään sosiaalisesti opittuja taitoja kuten tunnereaktioiden hillitsemistä, ja tämä voi johtaa jopa asiakkaiden eristyneisyyteen. Tauot haastatteluissa hoitotermejä mainittaessa, niihin valmistautuminen ja puheen viivästyttäminen kielivät tunteiden säätelystä ja niiden tukahduttamisesta. Se toimii puolustusmekanismina psykiatrisen eristystoimenpiteen aiheuttaman trauman muistamisessa.

Tuloksiin perustuen on suositeltavaa, että psykiatrinen hoitojärjestelmä ja asiakkaiden kanssa työskentelevät ammattilaiset toimisivat vain vapaaehtoisuuden periaatteilla, pyrkien yhteisymmärrykseen asiakkaiden kanssa sekä asiakkaiden tietoiseen ja harkittuun osallistumiseen tarjoamalla kattavia psykoterapiapalveluita ja mahdollisuuksia keskusteluun. Psykiatrisen hoidon haluttomuus tarjota keskusteluapua, hyväksyä hoidosta kieltäytymistä, pyrkiä tietoon perustuvaan suostumukseen ja vapaaehtoisuuteen, jättää entisestään haavoittuvaisessa asemassa olevan ihmisryhmän inhimilliset tarpeet huomiotta.

Avainsanat: Eristäminen ja rajoittaminen, psykiatriset pakkokeinot, tunteiden tukahduttaminen

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ACKNOWLEDGEMENTS

I would like to thank all the people who have helped and inspired me during my doctoral studies and who have helped make it so rewarding for me. First and foremost, I would like to thank my supervisor, advisor, and mentor Professor Mikko Mäntysaari for his outstanding support and encouragement in writing this thesis. His steadfast support, patience, and guidance have made this effort possible. He has always been accessible, giving generous support and a willingness to help me in formulating and broadening my perspectives. He has enlightened me through his wide knowledge of social science and his deep intuition about where it should go in the future and what is necessary to get there. I wish also to express my sincere gratitude for the kind support of my committee member Professor Jukka Aaltonen from the University of Jyväskylä. He has been supportive in providing feedback and advice throughout the process and has provided valuable ideas for the plan. I owe a debt of gratitude to my other supervisor Professor Marjo Kuronen for her careful editing and gracious assistance. I am very grateful for this support. I am thankful for the pre-examiner and opponent, Professor Janet Anand and pre-examiners Associate Professor Kris Clarke and Professor Emeritus Pauli Niemelä for their generous contribution to the development of the ideas of this study.

I am greatly appreciative of the support of Dr. Jyrki Heikkilä. This research would not have been possible without him. He was instrumental in providing the facilities and support to conduct the interviews. I owe him humble thanks for allowing his staff and mental health clients the time to participate, for providing places to conduct the interviews, and for the nursing staff's valuable cooperation and support.

I am also grateful to Sanni Suvila who assisted in the interview process by setting up a safe environment for the study subjects and for conducting the interviews in a pleasant and effective way and with professionalism.

I owe thanks to David Kivinen, who made a great contribution in transcribing. His professional and diligent work helped to translate the vast amount of interview data according to the research goals and without delay. I owe a special thanks to Nick Kirkwood who offered excellent proofreading. I owe thanks to Mark Pelt for formatting for preparation for the publisher. Several people in the Social Science and Philosophy Department at the University of Jyväskylä have assisted me in various ways, among whom I particularly wish to mention the study advisor of social work, Aino-Riitta Pöllänen.

My most heartfelt thanks are due to my closest relatives, to whom I wish to express my gratitude for their support in various ways throughout my time doing this important research. I would like to thank my family for all their love and encouragement, for the way my parents raised me to have a love of science, and for the way they supported me in all my pursuits. I owe great gratitude to my sister Ellen Coloccia for her presence and support in my life and to my supportive and encouraging mother for her help in translations and in the final stages of this process. In addition, I would like to thank Jennifer Jones MSW for

the inspiration to accomplish this small contribution to physically disabled and mental health clients. This book is dedicated to the memory of Antti Brotherus.

The cover picture is an allegorical female figure striking a pose in masque costume, with a stork or crane. It is a Woodcut by T. Stimmer, 1580. I want to thank and credit the Wellcome Collection for making the picture public to use.

Looking back on this long journey, I am very appreciative for all I have received throughout my years in Finland. It has certainly shaped me as a person and led me to where I am today. This thesis is further dedicated to those mental health clients who do not always get their voices heard, and to the wellbeing of people. It is also dedicated to my family here in Finland, particularly Sinikka Vennola, who taught me that even the largest of tasks can be accomplished if it is done one step at a time.

Turku, March 17th, 2021
William James Vennola-Stover

CONTENTS

I INTRODUCTION

1.1 Purpose of the Study

I began this journey, as part of a community activist committee in California in the mid- nineties. That committee consisted of friends and family of victims of police brutality, and it helped to organize in order to bring more liability, for many of the fatal shootings of mental health clients by police in that community. It became a concern for us when we began to see mental health patients who, unable to conceal their symptoms in public, when confronted by police had frequently fallen victim to police shooting simply for being emotionally expressive. An example of such expression was bereaving. Bereavement being the open display of sadness due to grief and loss. Among the most dedicated, committed, gifted, and effective activists I found, were the mentally ill themselves, working around the self-help movement. When I came to Finland I found a similar self- help movement, which was also concerned about deaths due to restraint and other social-control methods, employed on mental health patients. I decided to explore this lethal practice in the "belly of the beast", and ask psychiatric clients themselves in the inpatient setting, how they process these methods of forced treatment. In graduate school, we discussed the importance of clinical social work fighting for jobs assisting psychiatry, in direct competition with the multi-approaches of psychological and behavioral disciplines, in order to maintain its credibility as the best guardian of client centered treatment. We acted to build the confidence of mental health clients, pointing towards their own membership, as leaders in this field. My hope is that practitioners may use this research to identify what generates trauma recall memory and find new motivational and cognitive theories that build on preventive strengths. Such preventive praxis will help mental health clients avoid being admitted as in-patients to psychiatric hospitals.

This dissertation explores the use of seclusion among psychiatric clients in Finland. It was thus necessary for this research to observe a population where restraint and seclusion are practiced frequently; and a psychiatric inpa-

tient facility in Finland provided the ideal place. The use of forced care practices, such as seclusion among clients with intellectual capabilities, is greater in Finland than in other countries (Hansson, 1999, p.99), (Bak, Aggernaes, 2016, p.298). Forced care in recent years has not decreased, despite the additions of control and instructions praxis, and the duration of seclusion has increased threefold (Keski-Valkama, 2010, p.1). Disregarding a mental health client's request for treatment on demand, and enforcing forcible seclusion is a practice that is on the rise (Korkeila, 2002, p.339).

This clinical social work research explores seclusion and how displayed emotions are met with repeated seclusion. It was carried out by in situ direct inquiry of inpatient mental health clients. I asked clients to describe and recall their experiences inside the constrictive and restrictive environments around and within the seclusion room. Indirect aggressive behavior, acting in an exited way, disorientation, and quick evaluations as safety demands are theoretically the most accepted justifications for coercive measures. Välimäki, Taipale, Kaltiala- Heino (2001, p.5) suggest that paternalistic actions are justified, when a mental health client is incompetent. However, the authors say that competence can be measured by ability to make a choice, understand relevant information, appreciate the current situation and its consequences, and manipulate information in a rational way. The authors maintain that overriding mental health clients' wishes must follow the guidelines of the long-term values and goals of mental health clients, not those of the treating professionals (Välimäki, Taipale, Kaltiala- Heino, 2001, p.5).

I am a mental health and substance abuse clinical social worker, who is very interested in seeking to strengthen the alliance between clinical social work and psychiatry. I am a Finnish-American who has limited skills in Finnish, so my research had to rely on an interpreter under my direction to conduct these interviews and to transcribe the data, presented by the mental health clients of my study. I acknowledge my own subjectivities in this study because, if services are being reduced through the practice of coercion on one proportion of the population, professional positions employing bio-psycho-social cognitive therapies will be affected. People have subjective biases and see the world through a perceptual personal view. I believe it unnecessary to subject my report to an impartial judgment, because of the general negative sentiment toward coercive practice among the mental health population. I possess subjectivity that empathizes with the client's well-being. I understand clients so called "non-adherence" to be the medical profession's justification for seclusion, and not necessarily in the patients' best therapeutic interest. Thus, patients are in a dire situation when they say "No", to compliance with what can be poor treatment – effectively lack of meaningful patient choice over outcomes. I believe that everyone has subjective biases; these need not get in the way of a deepening understanding within research, as long as they are brought to the forefront and suitably contextualized.

I am not a student of anti-psychiatry because I suggest clients enact an alternate re-approach to talk therapies. I strongly believe that non-adherence

(Morris & Schulz, 1993. 603) does not necessarily imply resistance to any treatment, nor does it mean the inability to make a treatment decision (Fenton, Blyler & Heissen, 1997, p.637). Being naturally suspicious, of substandard treatment can be due to an evasive treatment program that enforces self-responsibility, under the overall state of declining care. There exists a devastating potential: the role that unsupervised and over prescribing by psychopharmacology can play before arriving at an assisted, renewed, informed, educated consent. This can have a direct impact on legal or social institutions, family, marriage, financial, health, and collaboration with other service providers. Clients that are over or under medicated for example, interact with these client systems every day. The challenge for our discipline is to intercept behaviors such as agitation, and chemically induced sedation caused by over prescribing by psychopharmacology, and to not misunderstand them. I hope that alternatives to punishment of agitated instances can come into shape and be expanded, such as the development of de-escalation techniques to offset the criminalization of the mentally ill.

This research is not a psychological thesis that tests and manipulates variables to arrive at quantitative findings. It is not evidence-based medicine research, but explores phenomena occurring partially due to the inpatient structural design of the seclusion room, and the area around it. This is also not a comparative literature study of psychiatric writings; discovery of protected archives and documents or quality assurance reports, to confirm clinical deception. This research is a clinical social work PhD dissertation, combining social science, sociology, clinical social work, and uses philosophical research findings and theories, about specific types of restraint and seclusion. It approaches clinical social work as a field that can be developed, in strict coordination with psychiatry, in the interest of protecting and treating at-risk mental health clients. It has a clinical social work approach, because psychiatry often presents psychopharmacology alone as a magic bullet. It is clinical social work research, because we, in social work research, work in collaboration with psychiatry, and with multi-discipline approaches to mental health, to provide research that benefit both clients and service providers. This research hopes to generate theoretical findings in order to help practitioners assist clients, and to avoid hospitalization in the context of clinical in- and outpatient individual and group therapy sessions.

1.2 The Danger of Forced Care

This study focuses on seclusion. There are many forms of combined practices, which can be considered under the term seclusion. The practice of seclusion may have profound effects on mental health clients; in fact these are high risk practices when used on mental health clients. There are many places in our communities that practice seclusion and restraint. Spitz (2002, p.26) indicates that face down prone restraint in the street or dangerous psychiatric take downs

toward seclusion rooms can turn deadly. While most clients do survive these actions, some vulnerable others do not. In many situations: in health practices, in policing, and elsewhere in contemporary society, these practices are used every day. There are dangers within coercion, from many different possible health complications: agitated or excited delirium due to restraint, positional asphyxia, and risk to respiratory capacity. Cardiac arrhythmia induced by medicines including phenothiazines, and complications can affect the abdominal cavity or small or large body mass (Parkes, 2002, p. 24). Practicing restraint on those who take medicines that cause fatigue or weight gain can contribute to shrinking or enlarging the heart: it can affect diaphragm breathing due to a prolonged duration without oxygen, in combination with other variables at the scene during psychiatric or public restraint. Long-term complications after hyperventilation and other adverse outcomes may be unpredictable, and include vomiting, increased agitation (Chan, Vilke & Neuman, 1998, p.202), thrombosis, sudden death, the danger of which may be elevated by restraint and seclusion. Other lethal and further disabling complications can result from restraint, such as hypoxia (insufficient oxygen in the blood) or a disturbed heart rhythm (Stratton, Rogers & Brickett, 2001, p.187).

In seclusion, within a hospital setting, a mental health client can be: fixed with a restraint mechanism, chained to a bed, or within the matter of a few seconds made subject to a quick violent take down, then restrained, face-down on their stomach for hours and days along with forced chemical restraints. All this can result in serious, permanent, or fatal injury. Sudden death can be caused, for instance through anoxic encephalopathy ending with anoxia due to positional asphyxiation (Stratton et al., 2001, p.187). Face-down restraints, chemical restraints, or injections either scheduled or unscheduled, whether used for social control in public or used in a clinical diagnostic process, while restraining or already having been restrained, can result in respiratory compromise due to sedative medicines. Unmonitored medicine can cause relaxation of the pharynx, and respiratory obstruction in restraint which progresses to cyanosis, hypoxia, and cardiac arrhythmia or arrest due to combined causes. Medicines, including phenothiazines, contribute to complications affecting the abdominal cavity. Large body mass (Parkes, 2002, p. 24) can make restraint positions lethal.

A four or five point quick violent take down, face down with stomach to the floor restraint, used on a mental health client to the length where they lose oxygen for a number of seconds, and in combination with other medical factors can rapidly progress to the point where any resuscitation efforts, can fail. The attempt to restore timely cardiopulmonary function may easily fail. A person can suffer an anoxic brain injury and may lapse into a coma due to resultant respiratory compromise, due to sedation or agitation and physical combativeness. A quick violent take down or face down, stomach to the floor restraint can cause asphyxiation and cardiac arrhythmia associated with trauma, from the restraint procedure itself. However, combined with both sedative or agitated effects of poorly monitored psychotropic medicine, and the level of health of

the person, can lead very quickly to injury and death based on body size, enlarged heart, or other medical factors (Stratton et al., 2001, p.187).

Long-term medicine and lack of combined talk contributes to increased health factors that can make just one or two restraint efforts lethal or very dangerous, due to the need to resuscitate from lack of oxygen. Adding other factors into the equation such as age, or other health factors like immediate prior physical activity (e.g. running from staff or struggling against attempts to restrain) make being restrained face down in a hospital or public setting, even more lethal. Restraints already in place during long-term neuroleptic treatment, involving extra pyramidal symptoms (EPS) over thousands of movements in smaller limbs, can seriously complicate coercion. A particularly problematic instance is when a taser is employed by police on an individual in a public take down. A taser is a device, often used in restraint procedures, that delivers electric shock. Needless deaths have occurred from restraint, primarily from positional asphyxiation (PAI, April 2002). Other causes of death have resulted from how a restraint was used, such as on the extremities; or lack of observation, which has failed to deal with patients slipping and twisting between the bed rails; fire; poor design of various restraint devices, such as restraint vests; incorrect patient manipulation leading to strangulation; therapeutic holds; thrombosis, and asphyxiation.

All these institutionalizing factors (particularly the effects of many such violent take downs) in multiple clinical systems over a lifetime, can medically socialize a person as deviance upon mental health patient roles that they are kept from having enough agency to give a confidential social expression of trauma. These methods employed on the most vulnerable are fatal, but even resuscitation from unconsciousness, may lead to increased mental disability. For instance, active psychosis and other mental states are the third most disabling conditions in the world, after paraplegia and delirium (Ustun, 1999, p.111). Restraint methods can bring further mental health and physical complications to those who have already been disabled for years. This dissertation commits itself to explore how strengthened assisted consents and refusals, can be instrumental in aiding clients to make safe treatment decisions to prevent forced measures from occurring, within in- and out-patient communities.

1.3 Clinical Social Work Research

One feature of the clinical social work sub-discipline is that by monitoring mental health clients' medicine for side effects by providing confidential talk therapies to understand the person in situ it is helping other medical professionals (Sands, 2001, p.69; Maguire, 2002, p.18). This praxis justifies the sub-discipline in holding a position of service to mental health clients. By simply talking to mental health clients, trauma prevention can be practiced by avoiding psychiatric encounters, as therein are social institutions in place that enforce involuntary

treatment upon the ill. Aside from human expressions arising from illness; a medicine induced state, and an isolated social environment, can create high or low affect that can contribute to high-risk situations. These affect modifying interventions have been clinically observed. Among many side effects clinical social workers look out for, high affect created by medicine is one. It is usually manifested by agitation. In contrast, low affect can be created, which renders a client incapable of responding to threatening conditions, by sedation. Low affect can be present with distrust in clinical and social situations, although compromising social situations can induce low or heightened affect. Affect is a clinically observed feature of illness, and a defensive measure that the human species utilizes as protection from harm. This can manifest: in heightened visible high motivational affect such as in an agitation confrontation; and low motivational or low affect, such as during sedation retraction. Lack of medicine monitoring or talk therapy can endanger the affect process, in risky social environments. Agitation created by medicine alone, can make a mental health client more prone to assault, and other risks. Medicines alone can rule the cognitive and motivational processes such as: attention; memory; action monitoring; and measures of planning that can set into motion cool or hot executive functions in the brain, that involve the regulation of affect and indirect aggression.

Agitated behavior is the most frequent antecedent of seclusion, and some studies have justified seclusion as a way to interrupt the mental health client's progressive disorganization, which may end up in nonviolent behavior. However, Brown and Tooke (1992, p.713) say nonviolent agitation is the justification for seclusion, and more experienced staff can usually calm most agitated mental health clients by providing human interaction. Brown and Tooke (1992, p.713) also say that mental health clients differed from staff by citing either noncompliance and refusal to take medication, or participation in an activity and requests to see a doctor as reasons for seclusion. Clients may believe that seclusion is used as punishment. Whaley and Ramirez (1980, p.14) say that 30% of staff felt that seclusion served as punishment, and Heyman (1987, p.11) says 58% to 75% of secluded mental health clients they surveyed felt punished. Recall of seclusion as a consequence of prior activity, and the actions leading to seclusion as a sanction and sequence of events may be skewed, or highly proficient in the traumatic memory of clients. Executive function in trauma recall carries out sequential events and can be affected by inhibition and emotional regulation due to structural, spatial and social relational distance, in recall of the trauma of seclusion. Confidentiality often conceals cause of death from public view, and there may be no professional liability for inadequate monitoring of treatment or lack of social or material support. This lack of accountability directly influences the culture of consequences of client behavior, which leads up to a restraint seclusion episode.

When a client is visibly agitated, these psychiatric trauma expressions seek the confidence of the therapeutic alliance. Inadequate outpatient supports contributing to unwanted side effects due to increasing levels of half-life in medicine, may serve to pre-dispose a person to a health condition, or that ade-

quate help was supposed to have been there but was not, may answer for endangering clients to traumatic high-risk settings (Summers, 2003, p.39). Half-life is the time that half to quarter of the full amount of medicine, is still in the system after discontinuing a prescription. Medicines, spatial distance from help, an unknown knowledge of time away from social support, unassisted, mid-educated consents or refusals can make a mental health client more susceptible, to certain agitated or low motivational vulnerable behavior in the community, or in the inpatient setting. A simple miscalculation of dosage by lack of comprehensive talk support can contribute to the risk of death, injury, or create affect that is traumatically confrontational, or defenseless.

A good introduction to my social work research was to discover immediately that clients recall isolation and sparse talk with long pauses. Clients in my study exhibited traumatic narratives, fighting and fleeing from submersion and re-surfacing of terrifying remembrance of seclusion, accompanied with suppression as a current state of mind. Lapses in traumatic narratives has been said to be an indicator of extreme long-term trauma (Cassidy & Mohr, 2001, p.292; Breslau et al., 1991, p.217; Loftus & Fava, 1985, p.280). This research is about the psychiatric setting where clients face, inside general psychiatric and outpatient mental health client settings, voluntary or involuntary, restraint and seclusion. In many places across contemporary societies the police-force, with the blessings of a coroner, doctor, or psychiatrist, are allowed to enforce this deadly practice carte blanche. Due to confidentiality and protections of the professions there is often no accountability and they are not liable for the consequences of inappropriate application, thus in many places in public there are people who practice take downs to seclusion. However, mental health clients may be among those especially vulnerable who cannot survive such restraint and seclusion and are severely injured and traumatized in this process.

Over-medication in order to simply sedate mental health clients can complicate this process as well, as it can have effects on weight and breathing and also when a person struggles. Mental health disorders with the combination of coercion can contribute to an extra-ordinary physical strength, which is countered through struggling, which can be fatal. The heightened affect may also disrupt the ability of mental health clients to express traumatic frustration. These dangers may be brought about by oppressive medicines and lack of social supports, before arriving at informed educated consent with a client, as in the case with involuntary committed clients. Clinical social workers also help clients to arrive at beforehand, during and after assisted educated informed consents and refusals and comprehensive knowledge of medicine, precipitating a low or high affect emotional outburst. It may be that psychiatry indirectly exonerates itself by producing evidence of consent, after an event of in-direct aggression though the client may have simply not knowingly, trusted the doctor complying with a non-supervised medical regimen, unable to issue a refusal, unassisted with vital talk support. It can be that a client may finally issue consent or refusal in a medicine induced state, after the medicine had been enforced without talk support. Seaver (1998) reports cases of unnecessarily medi-

cating people before arriving at an informed consent with powerful anti-psychotic drugs that impair judgment and induce sedation in jails not monitored by clinical social workers. Enforced medication interferes with mental health clients' ability to defend themselves in court and is a problem that is "true and very real" Meyers (1998, p.1). Chemical restraints that keep people sedated before and during legal trials frequently happen.

Seaver (1998) states even though all were over-medicated, only 1 out of 44 members placed on sedative medicine, had actually been diagnosed with psychosis or severe depression, in cases involving serious offenses. "Continual medication altered the way they thought, felt and acted and because the drugs diminish assertiveness, made them less capable of defending themselves and consulting with attorneys" stated a one of the 44 Women Prisoners Convicted by Drugging and that "We are our best witness, and it is tampering with a witness" (Meyers, 1998, p.1). This group launched a legal claim forcing legal liability of the profession that had violated these women's basic human rights. It is possible for a psychiatrist to administer a drug or medicine and neglect supervision of the medicated mental health client. This medication can then contribute to that client becoming susceptible to being taken advantage of in an arrest; this is one way how deviance and mental health labels can be socially constructed (Searle, 1995, p.175). Regardless of whether a so-called crime took place or not, it culminates in the social construction of mental health and deviance labels. Oppressive psycho- pharmacology (Foucault, 1989, p. 79) and extra-legality (Szasz, 1994, p.2) may socially construct labels of deviance and mental health by restraint and seclusion, and this process can be highly traumatic to clients meaning of experience. I define clinically attributed deviance labels enacted to mental health ascription, as subtle infractions to self-sufficiency that is conceptualized as agitation or disorientation. These expressions are transformed into justification for restraint. The emotional expressions contribute to a compromise to decision through sedation, in low affect or indirect aggression, through forced medicine and long periods of time without talk therapies that is met by the sanction of seclusion. They may result in inpatient endangerment and motiveless crimes in an outpatient setting.

1.4 Social Rights and Agency

Social rights suggest clients must be encouraged to exercise their free reign of ability to accommodate to a trying environment, not to fall back due to the constraint of incapability that limits participation in care. Social work must encourage protection from the violation of human rights (Healy & Link, 2011, p.30) of vulnerable individuals and groups. This includes from oppressive structural limitations, which inhibit free maneuverability of action. Psychiatry often falls short in explaining when it comes to an accurate evaluation of the participatory ability of a client. There can be a falling short of capability of agency in problems with life, which are affected by the social environment rather than a cli-

ent's inherent competency. One reason for this failing may be due to the lack of social scientific and philosophical training, within the discipline. For instance, the Social and Occupational Function Assessment scale only takes into consideration impairment, that must be a direct consequence of the mental and physical health disability of a client; therefore the effects of lack of opportunity and other social environmental limitations, which are not explicitly required, are not often considered (DSM IV TR, 2003, p.818) when assessing everyday functioning as agency. The Diagnostic and Statistical Manual of Mental Disorders (2003) is a standard classification of mental disorders used by psychiatry and clinicians. It is designed to be used across clinical settings including inpatient, and outpatient with community populations. It utilizes a multi-dimensional approach to mental health including biological, psycho-social, cognitive, behavioral and family systems when making a diagnosis. When a person cannot affect change through participation (Rapp, 1992, p. 56); (Runyan & Faria, 1992, p. 37) because of illness it is a very different limitation than constriction if a person has little to no-choice options due to the social environment. Often a client cannot be in control of the consequences of their actions or reactions, such as when they are compromised in regard to self- discipline and personal command, so that rather they are restricted by structural surveillance (Payne, 2014, p.352). Among these structurally oppressive power relations social rights are compromised.

An excellent definition of the loss of personal agency is, to be driven into a social process, not under our own choosing (Archer, 2003, p.122). This loss is as a result of pressure under social environmental structures that encompass the casual efficacy, of power, to transform collective agency. Archer says that real discoveries are not made about the self as an agent, but about the social environment and objective status as combined agents (p.123). A mental health client can deliberate upon the objective status as a social agent, talking about agential placement, of what may be contended to be an objective awareness of driven agency. Capable agents are often compelled by social environments, through inefficacy, not of their own choosing; for example, involuntary placement of many clients. There are situations, where adverse conditions as inefficacy affect outcomes, which are beyond the client's control as oppressive fixed systems of power (Gray & Webb, 2009, p.82). In such situations a person can begin to attribute one's own self-control (Howe, 2009, p.152) as not the predominate force, both in terms of success and failure within broader social environments. Awareness of a no-fault-of-your-own for seclusion; presence or absence of a way to communicate seclusion injustice; and the mechanism of manifestation of a strong objective structural social force that creates poverty of maneuverability, are all factors which impact on outcomes of success or failure among mental health clients, in environments not of their own choice. Coercion may set into motion a revolving door process where, due to little or no social support before admittance and during residential care, a client is admitted, discharged and then and re-admitted repeatedly. In such circumstances we therefore can speak of re- admittance as well as de- hospitalization.

Re-admittance and de-hospitalization are trends seen over recent years in treatment regimens where mental health clients have begun to be pushed out from inpatient facilities (Alanko, 2017, p.2) to become outpatient members of the community. Social work must aim to provide direct assistance to persons affected by oppression (Morgaine, Desyllas, 2015, p.2) in at-risk environments, while simultaneously acting to change oppressive systems of care that those environments engender. The process of assigning oppressive lower tier help within hospitals, that encourage a person's release, may be a structural functional attempt to take resources away from both in and outpatient care. This redirection of resources toward a revolving door of re-admittance exposes clients to criminalization and increased vulnerability to death from restraint, rather than contemporary societies reluctantly providing full lifetime quality care. This process may have less to do with failure to recognize clients' rights (Bentley &Walsh, 2001, p.71) and more to do with an institutional function reducing resources.

There is a difference between general and forensic psychiatry. The small population of people with major mental health disorders, such as schizophrenia and depression are among the most nonviolent and very far apart from any kind of deviant ascription. The general population is more violent and more engaged in real deviance. The correlation between violence and mental illness is misleading and substantially untrue, as supported by the best empirical evidence (Parry & Drogin, 2001, p.135). False residential commitment and false imprisonment may not be the result of the client's agency or omission of actions, but instead may be due to the clinician's inaccurate assessments (Parry et al., 2001, p.162) of the environmental factors. This carries a danger for this most vulnerable population themselves, as to how they view mental health illness and deviance, and the accurate distinction between them.

More research is needed in order to fight the stigma of mental illness being associated with deviance, to protect mental health clients and to challenge the tactics of psychiatry. Such psychiatric praxis that utilizes the leverage and pressure of overemphasizing blame for motiveless crimes, due to agitation and disorientation, to increase coercive methods such as seclusion should be opposed. The result of this can be resources are taken away, such as cash assistance, that compulsory programs are created out of voluntary ones, and a deterioration in carefully monitored, mutually supervised consensual medicines from the international mental health communities, where they are vitally needed. Lack of a confidant might affect the communication of psychic and traumatic pain from past seclusion thus creating the incapability of stating reasoning for a current placement, and the in-authenticity of refusals and consents. This is a study of emotional suppression that might be due to seclusion, as either visible or temporarily hidden, among clients voicing trauma demanding to be heard. I am interested in studying patient's phenomenological experience of seclusion. The high incidence and prevalence of this phenomenon in a city in Finland, provided the ideal place. This study can also help researchers to un-

derstand clients' adaptions to seclusion in other countries where restraint and seclusion are applied.

1.5 Patterns of Forced Practices in Finland

The Council of Europe (2009, p. 2) stipulates informed consent to mandatory in-placement must be obtained freely, without threats or improper inducements. The client is afforded appropriate disclosure of adequate and understandable information in a form and language understood by the client on: The diagnostic assessment; the purpose, method, likely duration and expected benefit of the proposed treatment. The client should also be given information on alternative modes of treatment, including those less intrusive; possible pain or discomfort, and risks and side-effects of the proposed treatment. Only two criteria out of a combination of five must be met in order to subject a person to involuntary placement. The first criteria for involuntary placement is the presence of a mental health problem. The second criteria is the existence of a significant risk of serious harm to themselves or others, this thus justifying involuntary placement. Involuntary placement and involuntary treatment, in situations not linked to any emergency, generally follow a two-stage procedure: a risk assessment, or an observation period, is first undertaken; and then a decision confirming the placement and the treatment is handed down (Mental Health Act. 1116-1990 sec.8).

In Finland, the law requires more than two medical opinions. In the process of ordering a person to be involuntarily treated on the basis of the Mental Health Act, the assessments of three independent physicians are decisive. Opinions are sought from the referring physician, the physician in the hospital giving the treatment and the physician in charge of the hospital. In addition, when a person has been referred to observation, and before the observation has begun, a physician considers whether the requirements for involuntary treatment are likely to be met. The number of physicians involved (up to four) is supposed to properly secure the patient's rights. The final decision on involuntary treatment, which requires involuntary placement of a person after the initial four-day observation period, must be taken by the hospital's leading psychiatrist. This decision is valid for three months. For a further extension, which is valid for up to six months, a second decision is taken, which is immediately subjected to confirmation by the administrative court. Then, initial reviews of involuntary placement or treatment take place after a short period of time. Once the initial review has confirmed the placement measure, a time frame for regular review of the decision is prescribed every six months. A core origin of the de-hospitalization policy has been the ideology of avoiding unnecessary seclusion, which is seen as harmful to mental health. However, the trend of avoiding psychiatric hospital care stems from the breakthrough in treating mental health patients outside asylums, which began in the 1950s internationally including Finland (Alanko, 2017, p.22).

In order to find out what is happening in the inpatient facility, the recent history of what is contributing to produce the suppression phenomena around seclusion, I first turn my attention toward older research in order to establish what kind of trends have appeared. Recently however, Bak and Aggernaes (2016, p.297) report Finland uses more seclusion than 10 other European countries. The Finnish Institute for Health and Welfare (2020) reports that the number of ended care periods, where forced measures were used 2006-2018 were affected in the way in which data was collected (Sotkanet.fi database retrieved 21.12.20). The statistical collection methodology was changed in 2017, so numbers before and after 2017 cannot be fairly compared. More recent statistics on forced care, restraints and number of seclusion or forced injections, even if they are documented after each instance in the clinic, are not available. However, forced injections doubled from an approximate incidence of 500 in 2012 to 1000 in 2013. Restraint episodes (whether they took place in conjunction with seclusion is unknown) reduced from around 1500 in 2006 to 750 in 2016. Seclusion incidents were more frequent, formerly occurring at 2500 lowered in frequency to 1500 in 2016.

Based on previous research, in Finland in 2001, up to 32% of psychiatric mental health clients were subject to seclusion and restraints. This figure is 2 to 5 times higher than has been reported in research elsewhere (Välimäki et al., p.5). As these early studies are from the 1990's, it is advantageous to observe whether the situation seclusion has changed for the worse, the better, or not at all. Kaltiala-Heino, Tuohimäki, Korkeila, Lehtinen, Joukamaa (2003, p.139) carried out a study at three Finnish university hospitals in Finland of (n = 1543) 18–64-year old, during a six-month period in 1996. Hospital databases, seclusion records, personal medical charts, medication schedules, and nursing files were all evaluated. The data detailed the use of seclusion and restraint, number of episodes during a treatment period, motivation for each episode as documented by staff, total time spent in seclusion and restraint, and type of admission and diagnosis. Description of the variables is necessary here. Violence was categorized as predicting violence or a threatening act or attacking or breaking property. Agitation or disorientation as a motivation for restraint, and seclusion was characterized as being behavior that includes being agitated, excited or restless, pacing, and reacting in a strained way, but excluded being verbally violent, or committing actual indirect violent acts. The motivation for seclusion was differentiated to include disorientation, acting in a confused, chaotic or irrelevant, noisy behavior, soiling clothes, undressing publicly, or uncontrolled sexual behavior. Kaltiala-Heino et al. (2003, p.145) found that the main motivation for seclusion and restraint was agitation and disorientation in 43.6 % out of 482 episodes, and less often due to violence directed to people rather property, and this effect was more frequently the reason for restraint, 16.1% versus seclusion 11.8%, in the cases presented (p.143). Kaltiala-Heino et al. discovered that actual violence was only the case in 11.1% of seclusion cases; however, the target of violence was not reported.

In Finland, from 1999 to 2005, 50 to 57 persons per 100,000 of inhabitants were secluded in psychiatric care (Tuori, 2007, p.24). Compared to legislation in other Nordic countries, the use of coercion is high in Finland (Kaltiala-Heino & Korkeila, 2000, p.217). Earlier research has stated that in six-month samples of the psychiatric admissions of 1543 mental health clients 32% had coercion applied (Kaltiala-Heino & Korkeila, 2000, p.215). In a study by Korkeila, Tuohimäki, Kaltiala-Heino, Lehtinen and Joukamaa (2002) the team set out to determine the rates of coercive measures among municipalities, specifically Turku and Oulu. The study was comprised of a retrospective chart review and studied 1543 admissions. The results suggested that Oulu had the highest population-based level of restraints, 39.21%, and that Turku had the highest level of seclusion 42.91% (Korkeila et al., 2002, p.341). Additionally, Kaltiala-Heino et al. (2003, p.145) claims that among Finnish mental health clients newly and involuntarily admitted, agitation and disorientation was the primary reason for seclusion and restraint in 72.2 % of the cases. However, in the first to tenth episode of seclusion during a treatment period, the motivation to apply coercive treatments ceases to be agitation and disorientation, and the staff's motivation for applying coercion then became threatening violence toward staff in 47.8% of these cases (p.146). Kaltiala-Heino et al. (2003, p.146) reports that after the eleventh episode of seclusion or restraint, a large proportion of the motivation to use these measures ceases to be agitation, and instead becomes threatening staff, that is in 54.1% of cases.

The author makes a contention that seclusion and restraints are used in response to visible agitation and aggression toward property, not violence upon people, and therapeutic interventions, rather than coercive approaches, should be used in these situations. Kaltiala-Heino (2003, p.144) reports that of 482 seclusion or restraint episodes in Finland, the mean or total time spent in seclusion during the treatment period was 35.8 hours, and the median total seclusion time was 13 hours. Factors predicting the overall use of seclusion and restraints may be partly explained by population demographics, within urban areas in Finland. Seclusion is used more often than restraints or forced medication, however, each procedure is poorly documented. In Finland in 2000, about 8% of all mental health clients were isolated against their will (Salokangas, 2004, p.53). Also, Finnish law does not define the rights of involuntary mental health clients to participate in treatment planning (Kaltiala-Heino, 2005, p.72).

In recent studies, Keski-Valkama (2010, p.23) reports that among patients in general psychiatric hospitals in Finland 34.9 % of the total hospitalizations were due to agitation and disorientation. Keski-Valkama (2010, p.49) says a high incidence and prevalence of seclusion at 89.4 per 100,000 inhabitants was reported in Finland. Schizophrenia was a high predictor at 44.4% and mood disorder at 44.6% for agitation disorientation that culminated and accounted for 44.2 % of all seclusions. The agitation itself can be brought on by medicine alone, and absence of beforehand social supports. Keski-Valkama et al. (2010, p.49) reports no informed consent in seclusion among general psychiatry, and mental health clients reported that a low occurrence (53.6%) of discussions dur-

ing seclusions were insufficient. A lack of conversation in general psychiatry can be a problem in the first place. Keski-Valkama (2010) signifies that agitation among general psychiatry, mental health clients were self-reported by 63.4 % clients, who stated that seclusion had a negative effect on psychiatric conditions. Unclassified reasons were over-reported, as understandably, when agitated or angry anyone will want to talk, or because the structure creates exclusion, and this can create a revolving door cycle.

Laiho et al. (2014, p.1) writes that there are conflicting views on what aggression is, the main justification for seclusion on a psychiatric ward, among psychiatric professionals. This might suggest aggression might be a rational response to impoverished, non-communicative settings. The clients' behaviors interpreted as aggressive, were characterized as communicative by many psychiatric professionals among other negative connotations, each professional having their own perspective, to interpret the most frequent reason for seclusion. Aggression may have many outward expressions, to suggest the main reason for seclusion is quickly judged by personal bias. The authors say that individual judgment might be explained by a lack of collective training, of how to understand client behavior (Laiho et al. 2014, p.6). Clients exposed to non-communicative environments might aggressively demand talk, and this can prove justification among many professionals to seclude.

Mental health client rights groups in Finland have consistently resisted the use of coercive measures, suggesting that they are solely an instrument of control and subjection, without any treatment effect. Carrying out this coercion in a take-down can cause death or injury to the client and to staff, and violent and dangerous take downs call into question, any real practical safe way to carry it out. Disregard for nutrition, fluid balance, hygiene, and the threat of somatic complications, further deteriorating while in seclusion are all considerations that can agitate an already intense situation. Keski-Valkama, Koivisto and Kaltiala-Heino (2016) sought the views of secluded patients (n= 106) shortly after seclusions at two general and forensic hospitals and re-interviewed them half a year later. The authors questioned if patients knew the reasons for seclusion in their self-reports, and if this differed from their psychiatric file (p.452). They also acted to discover whether clients regarded seclusion as a positive or negative experience, and whether clients were satisfied with their interaction with staff, during the seclusion. As the main reasons for seclusion were agitation and disorientation, disagreement between self-reported and staff reasons occurred among 23.6% of cases. Of the patients that regarded seclusion at least partly harmful, 63.4% stated reasons for their opinion: 38.5% stated they were secluded for a negative effect on their psychiatric condition, suggesting they may have felt they were secluded for their psychiatric symptoms (Keski-Valkama et al. 2016, p.453).

Other reasons surfacing was the experience of stigmatization or ostracization (34.6%) negative attitude to treatment (11.5%) loss of acquired permissions (11.5%) and fear of re-seclusion (3.9%) further suggesting they felt they might be secluded for psychiatric behavioral reasons in the first place. In addi-

tion, to the subjects perceiving seclusion as punishment, 42.1% self-reported the seclusion was done, because of bad behavior. Self-reported reasons for seclusion differed from the file, suggesting a lack of agreement and interaction in the process. One third of patients did not remember the episode at one and a half years later at the follow up. 68.7% still remembered the reasons for seclusion, others had no memory. Of those who recalled, 88.2% viewed seclusion as punishment. 51.9% felt resting in one's room, 46.3% perceived de-escalation and 40.7 % stated better medicine were better alternatives to seclusion. The authors also reported that the mean time in seclusion in 2016 was 38.5 hours (Keski-Valkama et al. 2016, p.453).

Lack of preventive care might pre-dispose clients toward seclusion, more than those who do not receive social support. Withholding supportive care resulted in the increase of seclusion, as Putkonen et al. (2013, p.850) found in two inpatient wards housing the small amount of clients of the major mental health disorders, engaged in real violence with a high and low level of seclusion restraint (n= 88 beds) depending on beforehand preventive care. These patients were evaluated to test the efficiency of an effort to eliminate seclusion. These efforts included improved leadership, staff development, consumer involvement, seclusion restraint reduction tools, among many progressive preventive devices. Seclusion and restraint was significantly reduced, implementing these interventions. Furthermore, these coercive measures increased for the control group from 133 to 150 hours, where these interventions had not been applied (Putkonen, 2013, p.852). Among strategies to eliminate seclusion with the intervention group, the control group did not respond to a reduction of seclusion and restraint hours.

Bak, Aggernaes (2016) compared coercive measures applied across Europe. As Finland has the highest use of seclusion in Europe, the divisions between forensic and civil groups to whom these measures are applied are unknown (p.301). The authors report Finland uses more forced admissions, that the other EU countries, 218 per 100,000 inhabitants (p.298) in 2016. Whether the use of seclusion and forced medicine used before seclusion is used to precipitate the event, to distinguish forensic and civilian commitments is unknown. Finland uses more short-term medicine or forced injections as the authors report, and how this can progress into an agitated or disoriented composer that culminates into seclusion is also unknown. Despite efforts to reduce the incidence of seclusion, Steinert, Lepping, and Bernhadsguitter et al. (2010) state that in Finland, seclusion was applied to 89.4 inhabitants per 100,000 in that same year, and the mean duration of time in seclusion was 22.8 hours (p.893). These authors stipulate the percentage of admissions applied forced measures - specifically seclusion, was 8.3% of 713 admissions (p.893). Soininen (2013b, p. 49) found that the mean duration of time in seclusion in 2013 was up to 16 days, and Soininen (2013a, p.10) reports the mean time in seclusion was 57.22 hours. This figure is up from previous years.

Soininen et al. (2013b, p.52) presented a survey where secluded patients voiced the experience from their perspectives after the seclusion. Clients were

able to relate that their opinions, were not included in treatment planning (Soininen, 2013b., p.52) and a similar lack of connection may have led up to the event of seclusion. Clients also felt they could voice their concerns and arguments, but that they were not taken into account (Soininen et al. b.). This might indicate that there is a contention of views before the seclusion incident, that clash and are taken down, which escalates toward the seclusion room. It was recommended by the authors, to allow clients to voice their needs, be heard and understood, to consider client's wishes as active partners before a seclusion incident takes place. The authors also point out that, considering combined participation in planning for crisis situations, so that client's wishes are taken into account before becoming overwhelmed by coercive paternalism would be good practice. Soininen et al. (2013 b.) forwarded a study to collect citations related to seclusion. Comprising of two collections, both were from Finland, one qualitative and the other quantitative. 32 studies were included to study methods employed in obtaining the patients' perspective of seclusion, 14 qualitative and 18 quantitative. Patients' refusal was reported in 37% of both kinds of studies. In five of the qualitative studies, the refusal to participate was maintained, and of the quantitative studies 8 included refusals (Soininen et al. 2014 a.). The authors also reported that of the qualitative studies, when 3 patients refused, the consent to participate in research was directly asked or a verbal indication was given. One other patient refused, when informed consent was asked for by a researcher. 18 patients refused, when asked for written consent by a researcher, and another 18 refused when informed consent was merely asked for by a researcher. 16 patients refused when informed written consent was asked for by staff. This might indicate that the more a patient is explained to and assisted in giving refusal, the more they tend to refuse. The authors suggested that researchers should assign credibility to a refusal, and make sure there is active participation for informed consent.

The result of failure to implement such measures may cause psychological harm, and mental health clients thus will often conceptualize restraint as punishment and associate it with negative emotions (Brown & Tooke, 1992, p.718). Presuming competence to make a decision among psychiatric mental health clients establishes the extent and direction of proof, much like the presumption of innocence. Reamer (1987, p.427) says that mental health clients who either refuse or withdraw consent to treatment, should be considered prime facie legally and mentally capable. Regarding an involuntarily admitted mental health client capable of consent and participating in research, as well as their own treatment, furthers a client's rights.

In Finland, patients' perspectives of seclusion practices, have received insufficient attention during the seclusion and restraint process, and improvements and alternatives to seclusion and restraint as suggested by the patients, focused on essential parts of clinical nursing, have not been extensively adopted (Kontio, 2011, p.1). Nursing and medical personnel thought that patients' subjective perspective received little attention, as personnel proposed a number of alternatives to seclusion and restraint. They however, expressed a need for edu-

cation and support to adopt these in clinical practice. Often the presence of an agitated non-adherent client, simply reacting to dire conditions, may be viewed as justification for coercion. Their refusal, reduced to be an aspect of disease or implausible to the listener, can be used in order to rationalize a strong paternalistic tendency to label. This labeling could be a subtle deviance label which then can lead to a retrograde step in the level of care provided.

1.6 Research Question

My research question is: What kind of experiences do mental health clients have with psychiatric seclusion?

This research gives voice to those not often heard, by considering their experiences regarding self-determination and respecting the dignity, and uniqueness of individual and social rights and needs. This study will bring about a broader understanding of client centered treatment and will seek to gain insight into the perceptions and values of mental health consumers regarding their understanding of seclusion, in the inpatient psychiatric setting. I will explore the client's perspective of involuntary intervention, and expect that clients hold views consistent with a loss of self-determination, liberty, and encroachment of civil rights when faced with involuntary hospitalization, and potential vulnerability to social control measures in the outpatient setting. The research question asks clients' level of social empowerment concerning the protection of individual rights, and instances of forceful interference with treatment. I hope that clients' knowledge of their civil liberties may impact on their level of resilience and this in turn, may engender a higher level of mental health care. This qualitative research will seek to explore the understanding clients have of self-advocacy, and the measure of empowerment that is attained through the partnership of the client and care providers. I hope this can help make clients more self-sufficient and encourage avoid multiple commitments.

This dissertation is a means to bring forward from silence, the voice of involuntary mental health clients. Whether in public or private, open or closed door inpatient mental health client hospital settings, I explore how long-term psychiatric mental health clients are affected by seclusion and restraint. I examine how mental health clients have been, are, or will be affected by repeated seclusion. An important goal of this research was to explore how clients voice opposition to, the methods they are subjected to. I aimed to generate an understanding of their navigation around a constricted and restricted social environment; the psychiatric inpatient setting that enforces restraint and seclusion. The constricted area refers to the space around the seclusion room, and the restricted environment refers to the seclusion room.

My emphasis is on clinical social work to understand the construction of mental health and deviance labels, to demonstrate that the rights of clients can become threatened, by simply not talking to clients before carrying out clinical treatment on them. In addition, clients are in danger of increased risk due to re-

admittance, de-hospitalization and criminalization. Below I explore emotional expression and its toll or advantage on the motivational systems. This research has an element of professional development action based research; I refined my own skills as a researcher studying traumatic content by carrying it out. I hope to help further protect oppressed populations from increasing harm. Another task of this study is to understand and explore how long-term psychiatric mental health clients withstand repeated seclusion, and how it may foster mistrust among the mental health therapeutic alliance's failure to provide initial stabilizing talk-therapies. I hope that this research contributes to helping clients into collaboration with doctors; including mental health clients into voluntary participation in the therapeutic alliance. I hope to further understand psychiatric clients' reluctance to rely on the therapeutic alliance. This study draws on both motivational and cognitive contributions to communicated thought, in recalling the experience of seclusion.

Forced seclusion, it has been told, is a part of the health profession's duty to serve the interest of safety for staff. How the clients themselves process this labeling of alleged deviance to, or in place of treatment and illness, is crucial to this study. A subjective process is a level of awareness of the generation of social reality existing to oneself, and an objective social process is a level of shared awareness of the construction of social reality between the self and others. It may be that clients that have been alienated from support are forced to accept incomplete explanations of illness and compulsory treatment. This may be justified by the failure or success of ability of the hospital, to both create and formally or informally process deviant claims that constitute social control, that can ascribe non-adherent mental health categories again and again, as seclusion revolving door cycle.

II METHODOLOGY

2.1 Phenomenological Orientation

My dissertation makes use of some key concepts in a phenomenological approach to qualitative scientific research, in order to more deeply understand the experience of clients. It was important to be up-front with my personal subjectivities, of my feelings of importance toward furthering an emancipatory approach, for client's well-being. My own biases are that people experience the social world in subjective ways and these must be brought to the forefront, made known, and compared with others' objective experiences. I explore how this is done in order to find similarities of impressions of the world, that are intuitive and grounded as realist (Patton, 2002, p.128) both augmenting and differing from one's own told biases and truth. The phenomenological approach of studying the patients' perspective in the interviews on site at the hospital where I carried out my research, worked well with some conversation analysis methods in my study. Phenomenology is the study in depth, of how things, like social interaction appear in human experience (Phillip, 1987, p.205). Mental illness, for example have both biological, socially constructed and motivational biased knowledge manifestations of what people expect to encounter with so-called ill behaviors, and how they view them as such. Crying, as displayed by one client for example, can be both induced due to: a reluctance to disclose by becoming exposed to disparaging environments; an inability to carry out motivational suppression. Emotions can become worse when asked to shroud or shake them off, or appropriate to limited situational circumstances when it is accepted (by social mores or clinical staff) to make them pronounced and visible.

Differences exist in psychosocial dimensions including many common gender expectations, for instance of how to socially regulate emotions, according to biological and socially constructed pathways. These common, personal perceptions, and the ontological process of acquiring knowledge about others' situated interactive processes (Turner,1987, p.44) make up phenomenology, that

is the study of social phenomena of both the subjective and objective (Rubin & Babbie, 2001, p.389) experience of human reality. The aim of phenomenology in my approach is to explore the clients knowing of self-meaning, and how their actions are received by widely-held conventionally, already arrived at, ideas of what make up so-called acceptable commonly held, normatively perceived actions. Edwards (2007, p. 34) enlightens me with the understanding of how psychological states, including communicated subjective motivational dispositional biases, attend to talks' situated practices. The author takes up the theme of how people process the emotional accountability of dispositions, and other non-verbal features of talk. In managing clients' told subjectivity, I noticed an effort among them to maintain a claim about treatment existing in the social world. Ways of managing my reported subjectivity, include seeing a particular social interaction as ordinary, and developing a rational accountability at time of recall, and bias in the "here and now" occasion (Edwards, 2007, p.34) when questioning clients. I discovered a helpful perspective whereby the author points out extreme case formulations as a methodological tool that helps to identify subjective utterances of clients such as "no" never, everybody, "nobody", and short, concise, "end of the continuum" expressions, then long periods of silence when describing self in the environment. These cancellations of further explanation about self and its situated social context, often cited by clients in my texts, point to a long- term pre-motivational element, governing the told traumatic experience and recall of seclusion. I adopt the author's view of one way of managing subjective told bias in displaying experience, is to speak of the components of prejudice of one's own presumptions, of what suits you to believe what you do, defending oneself from a possible contrary accusation of pre-judgment, insisting the experience is common, not apart from oneself. A clients' compliant of medical treatment, for example might involve some kind of personal or public transgression, making relevant a motivational dispositional position (Edwards, 2007, p.37). This clarifies for me objective factualities, solidifying how aggrieved, and long suffering the complaint had been endured. Conversation analysis, inspired by authors such as Peräkylä & Vehviläinen (2003, p.734) and Sacks (1972a, p.46, 1972b, p.56), provides me with substantive tools to pointing out often missed, "between the lines" social interaction and non-verbal interaction, such as motivational low affect in recall of a little to no interaction setting.

My experience working with an interpreter (Sanni) allowed me to turn the spotlight on what was happening between the inquirer and client. In interviews, to my surprise, the inquirer/interpreter was engaged in a natural process of executing the downward enforcing of an authority, suggesting agencies sense of self-responsibility to take credit for one's (clients') actions in the setting. This was weighed and considered by the client, and they both battled for a focus in the interview, to assign the most influential impact on successful outcomes: the social environment or agency. I acted to see the interviewer's world, for a time excluding the central figure (client) (Denzin & Lincoln, 1994, p. 500) and notice the clients' insistence as the bare environment, the predominate force in shaping their experience.

I politely guided the interpreter toward allowing the clients to point to an evaluation of the external environment as being the predominate impact as a paradigm, competing with a version of reality (Denzin & Lincoln, 1994, p. 500). I became aware of myself noticing the surroundings shaping the clients' situational self. They relied on a description of a constant, neutral setting that the clinical context provided, a central impact on the individual. I made an effort to hold back the interpreters imposing questioning of the client, that was biased that the agency of the client, or a responsibility of self-agency, a prevailing factor to shape success in outcomes. Clinical inquiry provided me with a method of listening to the client, noticing the motivational systems regulating the emotional experience of losing perception of agency, as a predominate force contributing to their lived (Holstein, Gubrium, 1994, p. 262) world of their social reality.

2.2 Clinical Inquiry

Individual clinical inquiry uses human attributions skills in a micro system-based approach that integrates macro advanced systems and employs a methodology of clinical observances, with empirically validated techniques of inquiry in an eclectic framework (Maguire, 2002, p.2). Clinical inquiry attempts to shed light on how the threat of seclusion by simply being around the room, may create a low motivational affect. Questions propose a preservational defense that assumes a low posture, and emotional composer due to suppression of expression, and how its experience, short and long-term impacts on human beings, is important to me. Clinical inquiry relies on me interpreting nuances of talk that may bring to the surface formally suppressed items that had been previously discarded, treated dispassionately or possibly which the client was unaware of at the time of seclusion, that are now visible and relevant to my research. I expect to respectfully "tread softly" as a professional, be wary of exacting dominant values of agency the predominate impact on outcomes, and instead am favoring interpretations of social reality emphasizing the social environment, so to combat the imposing of personal responsibility for trauma, often imposed by psychotherapists. These pre-suppositions may require a mental health client to adopt denial, suppression, and illusion as part of normal psychological functioning. I respect Winnicott (1986, p.33) who emphasizes the need for some people to organize a false self-front to cope with the world, this false front being a defense designed to protect the true self that has been traumatized, and must never be found and wounded again. Coercive measures may act as suppression of evolutionary pathways of adaption, of coping within a hostile world (Ekman, 1972, p.207; Hochschild, 1979, p. 551). Resistance and reaction are present in the conversation, telling of defensive coping with trauma, as my own interpretations of mental health client worlds may transgress the bounds of the normal illusion of healthy denial. A delusion is not far from a normative illusion, or common assumptions about the world in which we live.

Many times a description of trauma encompasses the everyday understandable workings of society, assumptions about social institutions and social arrangements that often occur, and really are a part of everyone's dominant behavioral script.

A question from me, illuminating the clinical-sociological workings of the inpatient setting, might be damaging to self-report and skew descriptions of an unaccommodating setting. These self-views of illness can include intersubjectivity of a client as responsive or non-compliant to treatment, as an isolated individual, and as an illusion of feeling or being alone for example. These self-identity perceptual accounts as told to me by an individual respondent, can construct selves as incapable of living with illness, or identifying common solutions that are tested, and more so easily transmuted by social learning in a process within group settings keen of a group identity, for example. However, the inquiry commits itself to exploring a foundation of illusion or meaning making of trauma, the mental health client must be protected, as they have to build a defense against the traumatic world. In the inquiry I must be sensitive to the unstated standard, assumed, imposed individuation process of the therapeutic community imposing dominant behavioral scripts of absolving the social environment's impact by isolating a person and dissolving agency. This resultant institutional constructed departure, from embracing same group membership collective experience, may not take into account those living with an illness stage of mature development that relies on restructuring (Maguire, 2002, p.251) and deconstruction of the inefficacy of transgressing responsible agency. In preparation for the inquiry, I expect this social process includes rejection of the dominant, illusion, firmly fixed in the mind of convention of what it is to be so-called ill and labeled a deviant individual, so-called unresponsive to reform, and abiding toward supervision. A long-term client may not attribute discouraging conditions for an accurate level of created non-productive agency. Deconstruction involves taking back the emotional expression so vitally needed, the gaining of awareness in shared approximation of real agency power.

The social construction of deviance labeling is a process that I struggle to understand, phenomenological unduly experienced by clients that may be made visible, and socially expressed in subjective awareness. This initial partial realization of the social world, verified by others' elementary realization of objective reality, can be understood, by exploring social scientific inquiry. Under dominant behavioral scripts an individual may be stripped of defining normative behavior and norms as a member of a population and may be forced to accept perceived vulnerability as a self, within the hospital setting. Clients' reluctance to accept individual helplessness and vocalizing social power may be more often misunderstood as non-adherence. Moreover, clients in my research may resist institutional definitions of so-called deviance, illness, and treatment. The effort to describe these infractions of conduct, comes with a defense that expresses itself through hesitations, pauses, stuttering, and an incapability to utter a word associated with trauma. These firmly fixed biases were communicated to me with motivational abrupt conclusion with lowered self-reports of

individual human agency, when I saw a constricted social environment such as around the room imposed on clients.

The subjective bias of a client can come to the surface, then be observed by me, as a consequence of formally suppressed cognition of external conditions. In this study using social scientific inquiry I, as the researcher, rely on everyday ordinary talk, in order to provide a way for mental health clients to adopt a definition of their own social reality. This at times is not readily possible, in clinically communicating long-term trauma. Long-term exposure to a constrictive and restrictive environment, may help me to notice a mental health client is temporarily unresponsive to friendly cues and unwilling to talk, and reasons for such can be articulated by them about the external social reality. A clinical context serves to create a neutral setting, where the self is hypothetically set aside from the impact of the environment, so a persons general functioning capacity can be ascertained. My expected clinical observation of a client's recall of isolation is that it is an exclusive outcome of a constricted setting, it issues a source of blame - experienced as construed to force mental health clients to collaborate to predefined treatment solutions- which are enforced by a professional definition of illness and deviant conduct. Professional dominant patterns of retracting interaction, may influence people's subjective bias, disregarding client's preferences in treatment decisions, as conventional ideological constructs of self-sufficiency and axioms of self- responsibility, and the diversion from these, might affect the way mental health clients understand themselves, and others.

I must be careful to catch what is said or not, in relation to specific distancing or objectifying conversational items, that may be temporarily out of reach that have been suppressed. Mental health clients' need to talk is then retrieved in clinical research into attention, telling of practices of individual and institutional denial (Becker, 1973, p.145) and suppression, as counter transference objects. Traumas associated with the central trauma are weighed, against an exchange value of the emotional labor of recalling and telling as well. A seclusion room may represent an absence of the therapeutic relationship, avoidance of punishment, repression and suppression of projection of larger systems' inability to provide for needs. The spatial placement around the room may not provide a social setting, reciprocal to interacting to scheduled cues that may not be adopted, and quickly rejected by mental health clients. This assumed efficacy in the constricted environment around the room may be reported by staff as a dominant taken for granted (Bourdieu, 1993, p.2) collective assumption, or commonly held as normative. Then a client's infraction of expected conduct can lead to attribute blame to the client, not to their efforts to exert agency within the design parameters of a constricted area. Bringing out ideological analysis is important to my research, because we seek to explore what ulterior social interest is served, by employing suppression upon persons and groups. This involves recovering hidden meanings, showing why the "natural" may not be quite so natural, and why absence of talk may carry underlying sociological presumptions (Billing, 1999b, p. 552). It requires examining beyond what is

said, to explain significant absences. Absences such as exemplified by pauses, emphasizing seemingly distended subject matter, may relate to the relevance of the trauma objects described by the person. This depends on being aware of where the client is, how their experiences are shared, why human beings position themselves as unwilling to express vital emotions, the consequences of this when they are brought to surface, and then cannot be contained any further.

I expect clients to tell me very sensitive personal experiences associated with traumatic memory of a violent event that they hold as not their fault. I can be sensitive to the told experience of seclusion that can represent lack of talk, infractions to this correction or failure to suppress a cry for help, for example might be assigned an individual ascription of blame of lack of self-sufficiency. Told recall of long-term limited or no conversation, whether constructed by isolating structural ethnography, or scarce mental health professionals, is repressive as well as suppressive. I estimate encountering recall of shared patterns of actions as take downs toward a seclusion room, might be preventing other social patterns from occurring. Expecting institutional harm, I can venture clients telling me of oppressive power being reproduced within interaction or withholding it without the participants explicitly discussing it (Billing, 1999b, p.556). When mental health clients raise an issue, I can notice they are likely to be challenging patterns of power, rather than reproducing it by either agreeing with the transmitted knowledge and institutional created absence of participation, or rejecting the imposed suppression created by the area around the seclusion room. Critical analysis of me as a researcher, involves seeking to uncover patterns of unawareness or socially produced unconsciousness, of inactive made active routes of communication. I am informed by Billing (1999a, p.18) explaining that it involves becoming aware of the disappearance of the accompanying motivational affect, working through the memory of the traumatic event, and how this is made known by formally reaching a threshold of tolerance of the problematic emotions, and in the clinical recall of the event.

In the institutional setting, I must be very careful of the way clients are speaking to me. I can notice the individual may bring to the surface a rejection of seclusion by distancing short utterances of the experience, in recall that can be a result of treatment given before the trauma. Because short utterances are closely linked to items of psychiatric coercion, Billing (1997, p.152; 1999a, p.142; 1999a, p.547) argues that skills of repression are related to the skills of talk. The emphasis for myself, as a researcher, is to move away from attending to the features of talk that are readily observable, and necessarily dis-attend to what people see as activities, to uncover the underlying organization from specific examples of the interviews. This is one reason for why my emphasis in my clinical research refers to structural suppression, rather than repression, as well as institutional and contemporary societies' imposed denial of the predominance of agency within mastering constraints in social environments, even in constricted non-reflexive settings. These methodological tools for research inquiry are vital for me to capture clients' understand-ability of themselves and environment, and how easily they relate to their experiences in the interviews.

2.3 Studying Trauma Recall

Critical to my method is to explore how to define the recall of coercion as it exists as a present, traumatic suppressed mental state. Sanctuary harm refers to a definition that applies to events that do not meet the DSM-IV-TR(2003) criteria for trauma, but that invoke insensitive, inappropriate, neglectful, or abusive actions by staff and associated figures and structure within and around social institutions, and invoke in clients a response of fear, helplessness, distress, humiliation, and loss of trust in psychiatric staff. Mueser, Goodman, and Trimletta (1998, p.496) in a study of an adult population in an inpatient mental health setting found, that 98% had experienced DSM-IV-TR's definition of trauma. The DSM-IV-TR definition of trauma, along with other diagnostic manuals, includes a re-experiencing of the event and among other criteria, persistent avoidance of stimuli associated with the event (DSM-IV-TR, 2003, p.463). Poor treatment outcomes may precipitate an agitated or sedative incident, and may be the result of institutional trauma, whether inflicted in the outpatient or inpatient setting. Robins et al. (2005, p.1130) researched psychiatric institutional use of seclusion among adult mental health clients, by exploring perceptions of traumatic or harmful events, that occur in these settings by measuring adverse experiences, not meeting DSM-IV-TR criteria for trauma, with mental health clients reporting harmful incidents of treatment.

In other studies of clients' experiences with coercive treatments such as seclusion, interviews occurred during and one hour after an episode of restraint (Outlaw & Lowry, 1994, p.72). However, the results I consider to be unreliable, as the researchers were asking questions of mental health clients in such an uncomfortable setting. Also questionable, are the methods they employed to obtain consent, as the client was in restraints at the time or one hour after the event, and the consent was verbal, rather than written informed consent. Asking long-term treatment clients about lifetime experiences within psychiatric facilities questions reliability for me, as autobiographical memory is equivocal. Narrative (Holma, 1999, p.9) recall is thought to be the best way to achieve an accurate account. Neugebauer (1983, p.378) writes that lifetime experiences were unreliable, but the reliability of more recent accounts, within the last 6 months, yielded better recall among inpatient mental health clients.

Barsky (2002, p. 983) notes that anxiety and depression facilitate recall of unpleasant events, and pleasant mood helped provide greater success in recall than unpleasant mood, as negative mood makes illness related memories more assessable. I must be careful that recall of pain can prompt the recall of similar pain. Persons and mental health clients currently in pain, report of past pain more intensely than when questioned after the pain has subsided, as then they report that the pain was milder. However, Croyle & Sande (1988, p.483) indicate informing healthy volunteers in an experiment that they have tested positive for a disease, causes them to recall symptoms that they had previously been told characterize the disease, and recall behaviors described as risk factors. Barsky (2002, p.982) helps me understand a way to proceed that mental health

clients' recall of symptoms depends on how severe present symptoms are at inquiry, how anxious or depressed they are at the time of the interview. I incorporate in my interviews that information variance should be minimized, by obtaining the mental health clients' stories in their own words, asking to clarify and taking note of mental health clients' current state of illness, pain, and discomfort (Barsky, 2002, p.982).

Making a mental health client's recall more reliable, by breaking down memory retrieval into smaller units is done in this study, by asking clients in clinical interviews to recall events before, during, and after seclusion. Allen (1995, p.86) reports that memory for recall of recent events, can be considered more accurate than remote events in the past. A study by Christianson & Loftus (1990, p.127) where 400 subjects were asked to report their most traumatic memory, and answer questions about their chosen memory, suggests that there was a significant relationship between rated degree of emotion, and number of central details, not peripheral details the subjects believed they remembered. The authors associate intense emotion, with better memory retrieval. In conducting the interviews, I must be sensitive to the idea that under the long-term effects of suppression, a person struggles with allocation of peripheral and central recall (Ellis & Ashbrook, 1988, p.38); (Webster, 1993, p.270) of trauma objects brought from dis-attention, into partial primary awareness. Then, I must be aware of how these uncomfortable items surface, and how they are told.

The source of the terrible, includes the balance of inhibition and expression of trauma, such as the told staff's explanation of seclusion. The ascribed deviant sanction to labels of un-intelligibility of a client's insistence to talk, can force a client in my interview to accommodate to a recalled bizarre ecology of enforced silence when the need to talk is suppressed, such as around the seclusion room. I must be ready to depend on the adaptive low affect development of an erratic rationale in the recall of cessation of expression of trauma, as part of a long- term mental state. In abstaining from expression or articulation of adverse conditions, I must be careful that a person can adopt an irrational motivational ability to immerse into the setting, and its justification to motivationally withstand an irrational ecology. I must be sensitive that recall of an avoided take down and seclusion can be due to a failure to dispel a balanced affect, it might result in irrational motives that can be compelled by eccentric conditions. These conditions might be contributing to make a person unjustifiably exhibit agitated and disoriented behaviors around the seclusion room. These high and low affect expressions balancing fear in refusing to self-suppress refusal of the restraint and subsequent seclusion is re-ascribed, constructing a self- fulfilling prophecy, that (Lemert,1951, p.76) spoke of in the 1950's, into seclusion's door. This might create an irrational (Sutherland & Ball, 1992, p.6) justification that can falsely force a client, to admit and deny infractions to personal involvement and fabricate neglect of someone else's (other clients') responsibility. This culminates in the prisoner's dilemma, in not knowing the time of the ongoing seclusion, and in its release, the threatening ultimatum for emotionally anguished expression, pitting one client against another, each unaware of the time of other

clients exit from seclusion. As the deviant claim scientifically resides outside a common description of this small population, the client might reject and oppose the auspiciousness of deviance. I must be conscious to observe that the undeserving punishment may be imposed upon the client, in order that a mental state would enable the person to withstand a bizarre ecology, thus making the personal identification one not of deviance, but of mental health illness.

I conducted the interviews with preparation for receiving traumatic stories. These social expressions may be controlled, by creating trauma and a fraudulent claim of deviance expression of legitimate problems with treatment, misrepresenting the clients' more serious primary reason for a visit to the clinic. I must be careful that the unresolved problem with treatment may be transfigured and substituted for the therapeutic alliance, severing a long-term relationship with clients and family systems. Socially constructing the seclusion trauma into a re-definition or transference of clients' problems with living, resisting the seclusion take down, and transforming life's trauma into trouble with coercion and treatment, may be a functional counter-transference mechanism, designed to quickly take away description of long-term treatment of trauma suffered from illness. Whether the seclusion creates heightened demands or low affect helplessness is not so much an issue. What is missing is an account of what illness and treatment means to the client, which may become misrepresented by incomplete explanations by staff, and suppressed due to multiple seclusion. Around a client's descriptions of problems with treatment may be suppressed accounts of real issues that have been diverted from, and may be communicated with trauma sensitively received, possibly because these issues have not been addressed previously in conjunction with a full mental health treatment team.

It is important to be receptacle to clients' emotional demeanor. These conflicted laden social accounts of problems with living, may exist with more intensity, because objectified low affect composites of formally unexpressed trauma re-surface, and may increase pressure of opposing inability to control emotional regulation. The ability to self-suppress and maintain composer, relies on strengths to harbor, and release motivational disengagement of current commitment to investigate alternative paths, and formulate bias seeking no other position to persuade. Suppressed trauma may not seek to uncover underlying fear, and may rely on a misrepresented problem such as problems with treatment, to replace therapeutic exploration of own analysis. Definitions of illness may more describe adaptability to constricted poverty conditions, such as appearing disheveled and motionless (DSM- IV- TR, 2003, p.300-301) as a source of trauma. This appearance is due to the expression of endurance of self-suppression and low motivational affect in-action. I must be sensitive that this may testify to the impact of poverty upon an individual and resources that limit treatment, and cast inadequate care upon the individual. Adaptation may be by loss of motivation to seek solutions from illness through trauma treatment, and an awareness of social environmental forces overwhelmingly shape agencies effort.

If the trauma communication is too much for the client to bear, changing the subject may serve to promote transference in the taming of terror (Becker, 1973, p.145). The transference object or isolation room may control and suppress emotional expression, attempts to restore order for professionals, or a mental health client. Becker (p.145) says the object is the biological forces of nature for the individual, to which the ego binds itself emotionally to its fate, as individual constraints can be controlled by a negative transference object. The seclusion room is widely known to this population, and may be not so much blurred by repression, rather suppression even when simply around it, if the effect is visible whether partially aware of it at all times as not suppressed, and it can be a traumatic event to speak of in memory recall. The alternative, the human face or therapy may be denied for routine purposes (Becker, 1973, p.147) and coercion can bring to light the repression and suppression of the individual, as well as that of the professional. Becker (p.148) says the stronger the transference object, the more powerfully the traumatic object embodies itself in the self, the natural power of the social world, the more terrifying it can be, in reality, without any imagination on our part (p.148). I can be ready to apprehend that the client's social world is embedded within, and externally as a social expression of words, can also be suppressed. An individual may be aware of external social constructions and structures impacting on the self, as an idea of common views about trauma, to adapt to the clinical and social world.

As terms we all use such as "understand", "think", "intend", "believe", "feel", find definite actions in the external social reality linked to internal or mental states, these words in public language give the deed meaning. Coulter (1979) helps me to understand the gathering of knowledge includes understanding that is perhaps most often used, to close specific topics. Rather, than for example, representing a verbal external proxy for descriptive "cognitive" or normative closure (p.13) of expressing and determining little or no choice; to be unable to express traumatic fear. Exclusion sets out to show that mapping referentially, and universally internal cognitive phenomena, contradicts the possibility of public communication that emphasizes contexts, that are important to socially shared and communicated external social forces, shaping our lives. It is possible for me to expose self-repression that can also be in progress in a mental health client, concurrently with suppression that can be more so created by sparse conditions and distant social relations, imposing silence. I will be compassionate and recognize that expression of desperation about the social environment, may be dismissed by its listener as implausible, therefore configured deviant, and quickly find justification in psychiatry and staff, turning away requests for help. In the succeeding chapters, I present theoretical claims of mental health clients as reliable, to convey how they perceive, understand, and make meaning of the process of seclusion and its motivational and cognitive consequences. I then make assertions about how this revolving door can shape any human being's socially learned ontological worldview as conscious congruent understanding, and explore how this shared reality is socially constructed, sustained, and reproduced.

2.4 Data Collection

This study is based on qualitative interviews with six adult mental health clients, in a psychiatric hospital in Finland. I carefully explained to all clients, through an interpreter, the appropriate forms, along with the limits of confidentiality, before any interviews were carried out. Mental health clients were made aware of the research project by announcement forms posted on the inside of the ward, that they were requested to consent to engage in research that would take place only inside the locked facility. They after consenting then had to wait a few days to do the interview, and then we met them in a suitable interview room there, where under no discomfort they conveyed their experiences to us. A short description of the research environment tells of a constricted area, where patients are able to frequent with other patients and a restricted area or seclusion room, where clients are forcibly isolated individually for long periods of time. The subjects were recognized as capable of expressing consent and had the capacity to make a decision to participate in research. As clients held and recalled that ability, a question arises as to why they have been inside the involuntary, rather than a voluntary setting in the first place. The inpatient facility is a place, where one is not often brought into participation when it comes to consenting to treatment. During the interview mental health clients were asked many times if they felt strong enough to continue, if they felt comfortable. The questions were about recent seclusions, and they were given time to recall, and retrieve qualitative experiences. It was agreed with my interviewer, a Finnish speaking assistant (Q1) (Sanni) in the interviews to ask open ended questions and give the mental health clients time to respond in preceding briefing meetings. The questions were broken down into three parts, about experiences before, during, and after seclusion episodes in recent memory.

2.5 Description of the Sample

These mental health clients no longer viewed staff as helping them move toward expressing their own agency in treatment. All the mental health clients had been secluded over the years, either many times or seldom as recently as from one day, to six weeks before, and potentially could have been led to either seclusion or restraint or both, during or after the interview. They were being treated for major mental health disorders, bi-polar disorder and schizophrenia. None reported addiction to drugs or alcohol, and all reported a current medicine regimen. It was easy for clients to arrive at reports of trauma recall, as it is associated with seclusion and clients' perceptions were conveyed, without difficulty or discomfort. Screening respondents who did not meet the research criteria was done by myself within the same boundaries of confidentiality. Clients that did not meet the criteria, were simply too traumatized to comfortably speak about this process, and were immediately dismissed to the care of a nurse

on the ward, who helped them peacefully restore calmness. Clients either heard of the study via recommendation of their doctor, or from a nurse or through the inpatient governing board, made up of fellow clients.

Clients ranged from middle aged, to elder adulthood and were familiar with the hospital's procedures, as they had all been recently re-hospitalized. All had experienced recent seclusion and had been secluded multiple times in previous hospitalizations. All had recent placement as outpatients, and at least one had been recently voluntarily committed, although all reported current involuntary status. All reported current medicine regimens and were under professional supervision. One client was Swedish speaking, which accounts for 5% of the population, in the region. None reported any other trouble with accessing treatment, and all thought of themselves as "good patients". All received disability pensions and were only eligible to be treated at the city hospital. The sample is reflective of the sub-population, because all reported the experience of seclusion as unjust punishment, already assumed as common to most patients. A small individual unit of analysis was chosen, because individuals in this sub-population frequently go without preventive out and in-patient individual therapy, have known seclusion as individuals and are each subjected to lower tier, lower modality treatment. The sample size studied yielded more than enough information, emerging to reflect the social phenomena affecting the sub-population of mental health clients frequently secluded, hospitalized, and taken from the outpatient to inpatient area. Some had been hospitalized for a long and some a short time. Further description of the sample is not possible, because of the hospitals and ethics committee's refusal, to provide access to all documents, and charts of the clients.

2.6 Conducting the Interviews

Mental health clients were interviewed while keeping in mind respect for human dignity, personal convictions, privacy, and sensitivity to recalling harmful events. Before the interview was conducted, I provided information of the nature of the study, and attempted to remove all misconceptions that may have arisen. All efforts were made to minimize the degree and duration of discomfort, or stressful questions. Because of my lack of skills in Finnish, I had to use an interpreter. In this study, suppression and seclusion is recalled and relayed by mental health clients in Finnish or English to me alone, or in combination with the interviewer in the Finnish language, and at times relayed to me in English. If I had a question it was relayed in English, translated by the interviewer into Finnish, and asked of the mental health client in Finnish, sometimes they understood and answered the English, but as it happens they felt better to answer in Finnish, then it was sometimes translated back in English to me (Q2). The research setting for the interviews was a room provided both just outside the front gate, and a room provided within the walls of the inpatient area. There was a couch where clients could rest and talk if physically and mentally tired.

Clients were enthusiastic to relate their experiences and did so without greatly expended effort. Sometimes the interpreter took occasion, and initiation to interrupt and ask questions or complete mental health clients' statements by themselves, as this happens in naturally occurring talk. The interpreter was a Finnish-English speaking professional with an academic and professional background in social science, who was briefed before each interview on how to conduct the clinical inquiry procedure with sensitivity. However, the interviews relied somewhat on social scientific inquiry, which sometimes unfortunately interrupts to illicit information.

We both cautioned each other by briefing beforehand, to sensitively allow the mental health clients time to respond attentively, and with active listening paying attention to their conversation and silence. This allowed the mental health client to listen to themselves as well. We sat in silence as sometimes the interviewees were lying down on a couch out of exhaustion, and we told them that we would stay with them, to help us understand the mental health client experience. We listened to the mental health client speak, trying to avoid the role of what essentially could be expected, yet again two psychiatric professionals asking questions, and rather developed rapport immediately and delicately with care, listening carefully and cautiously to the clients. Taking up to 10 to 15 minutes, we carefully assisted and informed of the consent and refusal, explained, asking the mental health client for permission to engage in research, and explaining when the recording started, we asked "Do you fully understand the consent form?" In addition, we stated that this interview is, "To help mental health clients and the disabled help each other". We explained to the mental health client, "Please help us learn or better teach us to understand treatment in the inpatient setting and seclusion and you, as a client, can make treatment better for the benefit of mental health clients and that at any time if it were too difficult, we would remain there with you in support". We then got the signature for the consent form, and then recording started with the mental health client. We asked them to recall past treatment decisions. We professionals carefully waited and stayed with the mental health client in supportive silence to listen and support, while gently probing and listening. Being still with the client allowed them time to respond and to tell of seclusion and confinements within the constricted area. The time is indicated on the recording when the interview started and periods of silence and location of interviews.

This study of seclusion and suppression narrowly focuses on the social processes in depth, looking for detail and context. Human interactive phenomena can never fully understand the full experiences of all people, but can focus on a smaller number of people to more specifically understand what the consequences are to the individual, as the unit of analysis. As we dealt with seclusion, the inpatient mental health client setting, and the process of constructing deviance, I interviewed a small sample of volunteer respondents consistent with the description of the sub-population as withstanding life-long major mental health disorders, clinically eliciting largely open ended questions, from long-term mental health clients. This small sample has provided credible partici-

pants, which allowed us to draw specific inferences that are reliable and valid for the small population of the mentally ill, who are only a part of the general population. This focus of narrow data collection is to succinctly discover, what is happening to people as individuals in the psychiatric setting, and how people are affected by the setting. A partial explanation may come from listening to clients about the seclusion, and how they are affected by this process. As we side with the claim of the clients, if the clients say that they have been put in seclusion for no reason at all, we cannot claim that is has happened as they describe it, although we cannot disclaim it as well. We just present what they are saying, and whether or not their description is true or untrue, is another matter which you cannot resolve here with this data. We focus on how the client makes meaning through their own process and development, after being applied these forced measures. The interviews in my study with mental health clients were recorded, with the expressed consent of the respondents. The interviews were transcribed and translated from Finnish to English, with conversation analysis markings in the transcribed text. In the transcribed interviews, Q denotes a question from Interviewer 1 (Sanni), Q2 denotes a question from me, and fictitious names represent the mental health clients' responses. These are some of the ethical concerns and theoretical approaches used in the collection of my data.

2.7 Research Ethics: Obtaining Informed Consent with Involuntary Patients

Recognizing my own empathetic position of how people feel, I along with the interpreter and clients will interpret individual's everyday experience, deeper meanings, and what their subjective view is, within closed social environmental contexts. This study will be satisfactory only, if research acknowledge its practicality both clinically and socially, in better seeing the social world through the clients eyes. I see this as an emancipatory approach to ethics, because we must inform the mental health client that the refusal of any beforehand consent to treatment, not just the consent to participate in research, must be recognized and be addressed from the beginning. As Padgett (1998, p.37) emphasizes, special care should be taken to assure respondents are free to refuse participation in research, and to withdraw from the study at any time. Clients are assured that further expression of present or future refusal to consent to research and treatment is a credible decision, without the loss of any other services to which they are entitled. Refusal is an important question because involuntary patients must be able to point out mistreatment in care, and not be simply told that they had the ability to refuse it but did not.

Concerning research ethics, consent or refusal to participate in research, or issue an assisted refusal in this study is not unlike consent or refusal to participate in treatment. As consent to participate in treatment need only be verbal,

research subjects can give consent orally or in writing, or their behavior can otherwise be interpreted to mean that they have given consent to participate. For example, agreeing to a polite request for an interview or responding to a questionnaire or request for a written response, indicates that the subject has consented to be studied. Subjects have the right to withdraw from a study at any stage, but this does not mean, however, that their prior input (interviews etc.) cannot be used in the study (The Finnish Advisory Board on Research Integrity (TENK p.49). I am informed by the Finnish Advisory Board on Research Integrity (TENK, p.51) that states the fundamental starting point of research with human participants is the participants' trust in researchers and science. Trust can only be retained if the human dignity and rights of the people participating in the research are respected, and this is the most important goal that I achieved with these clients reporting sensitive information. The same research situations or topics may cause different reactions in different people, and I looked for similarities and objective experiences. These Finnish ethics guidelines manual confirms to me that research situations can and may include mental strain and emotional experiences similar to treatment situations of everyday life. I naturally protected the client in order to avoid causing unnecessary harm to research participants and the communities they represent. It was important to me that I familiarized myself with the community I was researching, and its community's culture and history in advance, especially the self-help movement in the town I was studying.

Recall of a sparse interaction, and an unresponsive environment as it is told in these congenial interviews, might have resulted in a client becoming agitated, publicly expressive, thus prone to criminalization as well. The code of ethics of Talentia Union of Professional Social Workers in Finland (2019, p. 28) says that Finnish social workers should inform the client, so that the mental health client can make his or her own decisions. Because the clients might have been denied participation in talk and placed away from interaction, does not negate their ability, to refuse coercive treatment in the current or long-term, and this does not make incapable their ability to participate in this research. In this study, the client must also be heard as credible and reliable when reporting psychiatric oppression. It can often be told by clients, that a doctor before a researcher is on the scene had done an incomplete job, informing the mental health client of these two basic rights to refuse. Also, no one can assume that a patient's treatment consents, carries another consent to research, or one refusal carries another in this study.

Datz and MacCarthy (1989, p.229) asserts that a mental health client's obligation to submit is not absolute; even people representing or misrepresenting a mental health client's presentation of mental processes can be a requisite, to establish nothing adequate or factual about the mental health client. Any form of treatment may affect a mental health client's ability to present anything in interviews of themselves to be addressed, and anybody representing the mental health client is no less than protected under any contemporary law, by legal right to protect the mental health client. This is especially true when the mental

health client themselves refuses any kind of treatment or research, and in so doing gives a full indicated voluntary refusal as no the first time, and furthermore a second, informed rejection of consent again.

In terminating or withdrawing consent or refusal of participation in research, a mental health client in this study must be presumed to be of full capacity and heard of expressed concern. There must be a presumption in this study that anybody can make testamentary capacity to make and break a valid contract, such as recognizing consent and refusal even if there be a lucid interval (Parry and Drogin, 2001, p.9) before a person becomes however temporary unsound. A will, for instance must remain valid, so can a pre-decided termination to participate in research, and a pre-decided refusal and consent to treatment, of any kind. The lucid interval can be brought on by simple exposure to trauma, and there may be no elaborate detailed explanation, other than the refusal. This lucid interval may also be brought about, by degrading conditions.

Clients approached these interviews with a self- understanding of exerting their basic human rights and explored ethical concepts such as ability and capability to refuse a non- responsive inpatient environment, and right to have a say in what kind of treatment is best. Every mental health client must be informed of their human right to, on the basis of education about the research, be able to refuse, and bid no consent to participate to professionals. Clients in this study had created a contract, whereby refusal or consent of any kind is recognized, in the case of inability to refuse consent, under certain or uncertain conditions in the future. In Finland and internationally, clinical social workers fight for the official medical recognition of the beforehand wishes of a person deemed credible if, at a time in the future the person proves incapable to execute a decision. In my study, mental health clients by scheduling the appointment and waiting time to cancel at any time, must be held as credible and reliable, as much as a legal recognition of a Ulysses contract, in order to promote mutual participatory refusal or consent with doctors, in any participation of research. A Ulysses contract is a free decision that is designed, and intended to bind oneself in the future, sometimes in the person's absence. The term is used in medicine and often accepted in mental health, especially in reference to advance directives. A decision when made by a person in one state of health, must be considered binding upon that person, when the client is in a distinctly different, possibly worse, state of mental health.

A Ulysses contract can be accepted as a sound decision, held as credible, when the person is unsound, or unable to make decisions for themselves or others. The client's decision to cancel participation in research was held credible for three years, after the interviews were carried out. At that time, all documents concerning the interviews were kept under lock and key, as long as the thesis was examined. In any time during that three years, clients with some measure of decision ability understanding the basic elements of a will, for example is more than enough to make the presumption they must be assumed to be able to refuse participation, in this study at any time. Clients' decisions making to participate in research are not unlike a Ulysses contract, where the person

was consensual or incapable to make a decision and dignify its recall in the recent past. It may not deal with mental health treatment at the time, but of decisions in the future existing in the present as an antecedent motivation in this study, for example. If a mental health client can make a Ulysses contract, they hold above and beyond the ability and capability to refuse to engage in this research, or participation at the time as well, and it only requires rudimentary levels of awareness that mental health clients have, above, and beyond.

2.8 Obtaining Ethics Committee (IRB) Permission

My in-depth qualitative research asks inpatient mental health clients, suffering the torment of illness their experience with seclusion, assumes involuntary status does not imply non-compliance or incompetence, and values the client's perspective first in order to study vulnerable groups of people. The lead psychiatrist and colleague on the closed ward and the ethics committee, granted access to post announcements to participate in research, and asked psychiatric nurses to hand out leaflets to patients during meetings, eliciting informants. The clients' who met specific criteria, were asked to participate by simply asking to talk about seclusion at a certain time determined by them. They were not excluded by virtue of mental health illness, and they were chosen with an equal ratio of male and female. Clients living with illness for approximately ten years were recruited and came forward to participate. They were invited to participate by means of flyers posted in the inpatient setting, staff handing out flyers, and announcements in ward meetings and staff meetings. The mental health clients volunteered, and scheduled time that was convenient for them.

An application and the appropriate forms were sent to obtain permission from the psychiatric hospital ethics committee, for a social scientific and philosophical PhD dissertation at the University of Jyvaskyla to be carried out. Originally, all data and records concerning this population and seclusion, including client records as well as policy documents, internal reviews of quality assurance were requested. Permission to view any documented data, such as client's charts concerning patients, or files of statistics on forced measures, was denied by the Ethics Committee. I was then granted access to the facility to simply talk with clients on the hospital grounds, where their recollections are more ready, available, hard earned, valid and reliable. Permission to conduct medical research (Medical Research Act 1999) among long-term inpatient mental health clients, simply asking questions of involuntary patients on the hospital grounds was then granted. Research carried out, abide by the strictest confidentiality protecting the client rights to self-determination and elicited, informed, and voluntary written consent was given by the mental health clients. The entire study was done without deception. A key informant approach (Rubin & Babbie, 2001 p.586-587) was used in order to produce knowledge from people who have special experience about the target sub-population, and common hazards of service delivery to the population. The sample sub-population possesses quali-

ty, in depth information, and holds insider knowledge about the difference between non-treatment phases or baseline and treatment phases and knows if the service is effective. This research seeks to discover experiences of interaction that are reflective of the target population, that are frequently constricted of non-reflexive environments.

2.9 Safe-guarding Confidentiality

Participants in this study were interviewed in person and audiotaped. These participants were informed of the limits to confidentiality, if the participant reveals they are a danger to self or others, or in the event that information regarding elder or child abuse emerges during the interview. Transcribers and interpreters agreed to ensure the confidentiality of the audiotapes and transcriptions. Second, participants will be informed of the general types of questions that will be asked. In addition, they will be informed that the interview may elicit from them, self-revelatory information of a personal nature. I have altered the client's names in the finished dissertation. Participants will be made aware of this when the review and sign the consent for research participation form. Participants will be assured that they may withdraw from the interview at any time, for any reason, and that the data gathered up to this point will be destroyed, at the time they withdraw. Transcribers and interpreters had access to audiotapes of the interviews, but where required to keep all data confidential.

All audiotapes where erased after transcription. Transcripts and the background questionnaire where shredded five years after publication. Participants were informed that their background questionnaire, audiotape of their interview, and transcripts made of the interview where stored in a locked file cabinet. They were informed that only the interviewer will have access to identifying information that would link their name to their data. Participants were informed that although their names will be kept confidential, fictitious names may be referenced in the dissertation. This study will involve in-depth interviews dealing with highly personal and potentially self-revelatory information. Participants were made aware of the general types of questions that were asked and will in return, gave informed consent to participate in this research study. Participants were given the opportunity to withdraw from the study at any time, and for any reason without penalty. Participants were informed that if they experience any undue stress or anxiety related to their participation either during or after the study, they would be given the name and telephone number of the researcher's supervisor, who will discuss their reaction to the study over the telephone. Participants who desired further consultation would be referred to a conveniently located psychotherapist. Participants were informed that only the initial phone consultation to schedule the interview, at the facility will be paid for by the interviewer. There were no benefits to participants in this study. Participants will gain insight into their experience of treatment, within the psy-

chiatric communities. Participation provides them an opportunity, to understand the role treatment plays in their lives.

Clients were asked repeatedly throughout the interview, the that if they did not feel well enough at any time during the talk, or felt that a question invoked psychological harm or mental discomfort, distress, or if they anticipate feeling as such up to two weeks after the interview, it would move to closure. Before termination, the mental health client and a concise account of their concerns would immediately be referred to a nearby staff member on the ward, in this case. Specific safeguards to protect confidentiality of each client's identity, and respect for other professional groups such as interviewer and myself, were maintained by the highest standards abiding by the code of ethics of clinical social work practice, and social scientific qualitative inquiry. Mental health clients were at all times recognized to be of full capacity of decision making regarding the welfare of self and others, even in the compulsory setting that may socially construct non-abidance to non-collaborative decision. Equally so, mental health clients were assumed to be of full capacity to affect influence of choice, and an accurate account of recall of experience with seclusion. During the interview process, the mental health client ideas and visions for creating alternative treatment, was regarded as an invaluable contribution, for recommendations for future research and professional improvement of service delivery.

Before and after each interview with mental health clients, the interviewer and I briefed each other about whether there were any concerns that would mandate reporting and compel us to do no harm. We were each made aware to be receptive to any report of abuse, neglect, harm of clients or harm of the institution. None were talked about. No one's legal liability, by virtue of any association with this study, was reported. The research proposal was submitted as a social science and philosophy study, and approved as medical research by the Ethical committee according to the Medical Research Act (1999), as this presumably protects the hospital and any association with this academic study (and myself) from any legal or copyright liability, in the future. This study extended itself to both involuntary inpatients, to freely express ideas with treatment. As the right to participate in research for a mental health client is voluntary, they might be considered able to carry out decision and make a choice about treatment as well, and could move to be of voluntary status immediately showing the ability to voice these concerns and carry it out.

2.10 Data Analysis

I arranged the data in a storyline (Goldsmith, 2007, p.1) format in order to arrive at central categories that captured the patients told, subjective phenomenological experience, found to be common and objective to others. This helps to organize the phenomena occurring in the data according to central themes that reflect ordinary experience, happening to everyday people. The data was ar-

ranged according to highlight the most frequently occurring social phenomena, happening to the clients. The interviews were all approximately a recorded hour long, and all yielded 20 to 30 pages each of printed transcribed and translated material. Organizing of the data was done to draw similarities among the clients, and so that we can draw assumptions that these phenomena happen, really to ordinary people in the everyday social world. After the interviews, with transcribed data in hand, the phenomena of patients being ignored and its cognitive utterance, distinguished by pauses and sudden stopping in its recall, practically jumped off the page to alert me. I set about to arrange the most significant places where the distant relationship between patients, and the helping professions is remembered, within a suppressive state. The criteria to select data extracts from the clients' interviews are based on founding a thematic base, where constructionist sociological theory, phenomenology, and conversation analysis can be explored. Clients may pause around words to identify both anticipated unacknowledged help, and its suppressed remembrance. Using abduction in understanding how details of a traumatic event such as seclusion can emerge out of suppression provides a view of what exists as an interaction void in the setting, in order to take away important areas about treatment that the client needs to address. When the client listens to their own articulation about valuable information about self in the situation, then pauses between traumatic content, I can through abduction, be partially aware of the effect and might be able to be aware of the cause, then notice the client develop a pre-motivational emotional regulatory affect retreat and advance, in order to adapt.

Selection of the data extracts was made by me, according to be consistent with the reported experience of the participants pausing (Westen, 1991, p.436); (Kunda, 1990, p.482) (time) or (…) or sudden stopping, stuttering and emotional hesitation phenomena, as a symbolic substitution for participation and as a common representation of seclusion, in recall. Analyzing the phenomena of pausing before and after objects of treatment trauma, and the social construction of seclusion as deterrence, was chosen because of its frequent occurrence in the written transcripts of clients recalling this process. Data extracts are presented in chronological order of time. The pause occurring throughout the data is discovered to been caused, due to the motivational recall of the seclusion environment, or to prepare for its description in recall, and this became an exciting question for me to investigate. The suppressive effect indicated by pausing around items of coercion, suggested to me that the clients might have already arrived to the interview, in a long-term pre-motivational suppressive emotional state as a direct result of recent and past seclusion, and simply in lowered motivational affect residing around the room, constantly living with the threat of forceful treatment. I follow the pause backward in critical places in the interviews, in order to get an idea of what is happening with the client in the motivational system, to understand more about low affect. There may be multiple reasons to maintain composer, as a pre-motivation to avoid loss of traumatic expression containment in uncertain, unyielding social environments.

In exploration of this, I must be concerned with the irony that clients were very willing to talk about coercion, yet the abduction method may allow me to understand that the suppression affect ensued by seclusion, inhibits current and recalled expression similar to a long-term mental state such as shock, fear, phobia, or desire. The abduction method allowed me to examine the interconnection of the low affect motivational system, and descriptions of structural constraints, as it is displayed before and after the pause, but leads me to understand that it is not an intentional defense mechanism. Rather the pausing phenomena, yielded valuable suggestions re-occurring around themes of descriptions of clients' agitation, helplessness, constructed supervisory, non-participatory non-deserving status, and the creation of involuntary care. This suppressed anger around rationalization for seclusion, and how a long-standing unaware protective strength utilizes opposite manifestations surfacing into visibility, such as anger confrontation into hesitation retraction, or expression delivery, into no acknowledged retreat, and emotional non-expression and conspicuous composer, became important in the analysis of the clients talk, in formulating how clients can prevent seclusion.

Upon investigation of the pauses, I considered that they might suggest the beforehand attentive attitude, and peripheral counter expression that can be opposing motivational forces, acting to pressure each other in repulsion, gathered around trauma treatment testimony. These counteracting emotional efforts of retraction and assertiveness are often canceling each other out, or growing at the temporary absence of each other, into long-term containment or expulsion into some other expression, and strength to contain frustration of a non-responsive social environment. These motivational powers of agitated despair might suggest clients develop to dull affect, as it is employed to the un-open environment around the room that the client interacts with, and tells of its expectation of low treatment outcomes. These motivational pausing recollections and the description around them may entail a mental state, and psychic impact on the self-concept of the client, and a level of understanding of commonality of other's perspectives as emerging social identity, and experiences among them.

Low affect motivational pauses and items of trauma around them, form evaluations of past, present, and future anticipated action of emotional regulation, in the form of external reasons (Tuomela, 2002a, p.157) for concealment of expression, and knowledge of causes for doing so. These causes are in regard to perceived and known impact of the unaccommodating social environment on self and others and help to understand the clients experience avoiding seclusion as socially learned. These pauses surfacing in recall can be communicated as an attempt to value uncertainty in unstable social environments, before and after the use of social institutional terms. As Duranti & Goodwin (1992, p.20-21) stress, miscommunication (recalled with pausing utterances) is strongly influenced by the social context in which it occurred, and could tell of a matrix of activity lacking social dimensions, that explains away the cessation of emotional expression of mental health clients, as a construct of the institution.

Duranti & Goodwin (1992, p.6) help explain the process of my research indicating communicative inactivity as a challenge to me to redefine the situation, where the context of a mental health client's behavior can be socially constituted, interactively and structurally. I, as an interviewer might hold a conventional view of what client behavior is, rather than critically attend to emotional communicative regulation that depends on a client capacity to spend time, to mourn these constricted situations of few alternatives. Inquiries of trauma around these pauses can help me to bring to the surface, formally suppressed psychic pain endured in treatment that its listener can allow, for clinical methods to patiently wait for the client to express sometimes hidden, made visible descriptions of range of emotions. Emotional regulation employed to speak of the process of seclusion was also chosen, to evaluate substantial thematic items around trouble uttering traumatic objects, because of its consistency throughout the data. The data indicating the initial development toward social identity maintained after seclusion, and in recalling isolation and accompanying pausing around items of trauma, was also selected because it frequently occurred throughout the data. The client's awareness of the social construction underway to create error at reform, and institutional non-specific guidelines to abide by non-correction and its remembrance with pausing, as a function of the institution, was additionally highlighted to bring out consistencies of client's interviews.

Analyzing the data brought about six themes of how clients subjectively remember and anticipate seclusion. *The first theme* points to emotional regulation as adaption of the client, created by suppression ensued by lack of talk described with traumatic pausing, might aid in understanding clients concealing emotional expression, to avoid seclusion in the involuntary inpatient setting. This theme is highlighted in (3.3.) "Motivational Consequences of Withholding Talk". Clients might not engage in open exchange, just visibly and silently reject the practice of seclusion out of motivational biased, quick decision (Webster, 1993, p.269) through before and after low and high affect pauses, to offset the recall of a traumatic imposition of a recent past withholding of conversation by psychiatric staff, announcing unclear direction, and unspecific route of participation. Failure of clients to practice this withdrawing of expression, and how it is experienced as a present mental state in recall, may result in a client vocally reacting and demanding talk, met by seclusion in a normative explanation of the labeling of unintelligibility and deviance.

The second theme is explored in the first empirical chapter (Chapter 3) where clients process own, and others seclusion in traumatic memory, how their own reacting to forced medicine and the demand for help not heard is transformed into agitation and disorientation, that in turn is generated into deviance onto mental health ascriptions that the clients reject. This theme is brought forward as early as (3.5.) "Enforcing Human Agency" part and reiterated in subsequent chapters. Clients then voice own beginning of socially learned awareness, and identification as social identity of the external, social forces creating the deterrent before hospitalization, and in the inpatient setting.

The client's opposition to the imposed isolation of others is supported by me to be credible, voluntary treatment decisions.

A third theme explores the experiences in the inpatient setting further, how clients reject the process the social construction of deviant labels, and why a client's actions may be explained away beforehand as psychiatric or behavioral deviance. These re-assertions are clinically constructed from imposed ascribed versions of departure from individual responsibility, and failures of self-agency and efficacy to withhold traumatic content. This phenomenon is brought forth in (3.10.) "Studying Clinically Applied Deviance Labels" chapters and evidenced in further exploration of the book. These individual ascriptions can include the structural and relational creation of non-participation, failure to adhere by the deterrent of seclusion, non-responsibility, non-consent, and involuntariness. Lack of personal agency also can contribute to the created incapability for the environment, to provide cues to the consequences of ones actions. Perfectly understandable emotional reactions under forced, unsupervised medicine are stigmatized as deviant, and mental health ascriptions are redefined as agitation and disorientation, without seeking external explanation to other sources of an account.

A fourth theme explores the phenomena of the experience of the individual as a departure point, from the revolving door cycle of agitation, disorientation into deviant claims from the outpatient in to the inpatient area. These configurations might be broken by a client by only speaking of illness as experienced as a group, as a "We" (Tuomela, 2007, p.12) rather than an individual. This beginning of awareness of dissemination to "I" in the situation and attention to "We" as a collective body is first experienced by clients to distracters and surfaced indicators to traumatic events highlighted in (4.4) "Primary and Secondary Attention to Traumatic Items". This socially learned awareness is solidified in the contribution found in the second empirical book and called (4.5.) "Traumatic Event Re-experienced as a We". Clients become aware of similar situations involving other clients around them. Predominately present in early and later stages of treatment of long-term clients, may be the concepts of "We" refuse a created non-consent of punitive care between mental health client and doctor, and mention of doctors and staff are made in the absence of a doctor or staff to, for example, further construct incapable individual achievement to abide by the deterrent of the threat of seclusion. There may be an attempt by the clinic to divide the "I" or self-concept from the "We" consciousness, to collective rejection of sources of the deviant claim, and consequent seclusion.

A fifth theme discovers in order to offset further seclusion as an inpatient, clients help researchers to understand the seclusion emotional suppression theory discovering how emotional regulation, and adapting a socially aware agents antecedent motivational preventive power to rest in bias of expectation of low treatment outcomes of inefficacy, can help clients prevent seclusion. This presentation is found in (3.9) "Seclusion as Deterrence" and alliterated in further chapters. The seclusion emotional suppression theory is displayed by individuals aware of themselves as groups, to avoid the threat of psychiatric en-

counters and dispatch pre-motivational self-suppression, before and after the utterance of traumatic items. The seclusion emotional suppression theory stems from compound motivational powers, to pre-dispose passive resolve as a precipitated measure, rather than seek out a potential psychiatric crisis.

A sixth theme explores and makes visible the beginning of verified, socially shared, client awareness of unaccommodating conditions binding agency and withholding efficacy, creating a primary function of the hospital to force declining, supervisory care under the secondary auspicious of serving humanity. This is found in the chapter (4.6) "Social Awareness" and (4.7) "Combined Social Awareness". This collective, ontological knowing of others learned experience helps to prepare the client to utilize concealed pre-motivational lowered affect composer, and the seclusion emotional suppression theory helped me to understand how clients protect themselves, against further coercive encounters. The sixth theme further acknowledges the difference between conventional and clients told subjectivities, reasons and justifications for seclusion in the hospital as an institutional norm. Clinical investigator inquiries frequently encounter reports of staff that ordain self-cognitive rule as the speaker of rules, which may be designed to create disorder of spoken needs constructed and however redefined and unmet, in practice. It is often underlying practice, and escapes research that professionals may be normatively visible to represent the needs of mental health clients, but in reality can misrepresent them to assist to manage, re-define, and modify the social needs and rights of mental health clients. This transformation might be brought to client awareness in the analysis of how they perceive professional explanations of the situation, of enduring frequent seclusion. It is important for me to quickly recognize in the analysis of the data, if in the shorter or long-term and if with growing in necessity, created suppression through seclusion might create the inability to extract declining material value, from the therapeutic social needs of mental health clients. Both empirical chapters (3.0- 3.11) and (4.1-4.10) explore these re-occurring themes to some depth.

These themes are explored with sociological conversation analysts such as Harvey Sacks (1972a, 1972b) making an invaluable contribution, to understanding the recall of withheld talk as emotional regulatory pausing in conversation analysis, by simply relying on common sense reasoning in analysis of the data. Studying the wisdom of Sacks helps me to take a look at what is understood as the "nuts and bolts" in memory of a plea for help that was not answered by staff, in the inpatient mental health setting. It is important in analyzing the data to pay attention to clients suspect of forceful treatment, each individual may only answer as a collective or as a "We", indicating the beginnings of social awareness of traumatic conditions to protect and prepare by pausing, and maintain social self-avoiding the description of seclusion as incidentally, "making an example" to others. This prevention from re-visiting harm might again resurface in a more precise account, of what is really happening to the client, evident in the analysis of the interviews.

In initial outpatient contact, or within the clinical constricted setting, mental health clients may speak of psychiatric staff making dialogue inaccessi-

ble, by what Sacks (1992a, p.372) calls establishing the disorderly. This contradiction of cognitive, structural rule and client behavior happens in the analysis of the data by identification or not, with subtle deviance ascription based on absence of receiving rules, and how an individual cannot abide by them to be orderly, only become labeled so-called abnormal, via reason to seclude. How this description of a created involuntary process is held in suppressed memory is important. This suggestion may enable enforced false subjective experiences of failed individual agency ascription constructed by the structural process, according to merit unfalsifiable, normal, seemingly objective open efficacy, in the so-called same social order. We will document in the client interviews, if establishing the disorderly to drive down lower modality of care, can become known to the client as a primary function of the institution, rationalized by the construction of deviance and unintelligibility by seclusion.

III ANTECEDENT MOTIVATIONAL SHUT DOWN OF MENTAL HEALTH CLIENTS

3.1 Introduction

In the following section, I will introduce the reader to the seclusion emotional suppression theory that came about in the analysis of the data. A client's emotional reactions to uncontrolled outcomes by virtue of an external, objective restriction such as failure to conceal expression, within clinically imposed silence to ward off the threat of seclusion, increase motivational drive of an individual at first (Wortman & Brehm, 1975, p.283). The individual then goes through a process that reduces the quality of explanations of external reasons statements (Williams, 1981, p.107; Audi, 2004, p.119) such as communicated knowledge of what level of pre-motivational effort of balancing low affect, can conspicuously merge into a dangerous, interactively non- reflexive pre-seclusion setting. Clients can hasten cognitive conclusion, counter and neutralize affect into equilibrium around the room in recall, and as a remembered present state to restore goodness of fit of the social environment. This can be an adaptive measure, in order to make a recalled assertion of the environments efficacy to responsiveness to agency by evolutionary pathways, that human agency cannot flee harsh conditions, or fight but which it can freeze, in pre-motivational emotionally stature low affect (Whaley, 2001, p.93) to quickly shutdown description of self in the setting, and avoid coercion. Disoriented symptoms experienced in recall, and as a present state can be viewed as negative low affect such as within psychosis. Positive symptoms are viewed as heightened affect such as agitation within mania. Expressions under the impact of low affect can be re-defined as disorientation, and high affect can be socially suited into agitation. These expressions have trouble in communicating something legitimately defined, like reluctant environments or become highly specific to bring to light, the importance of the central reason to seek combined help in the first place.

The learned helplessness model, in conjunction with the reaction model, suggests that active problem solving will be impaired, such as trauma expression after constant exposure to uncontrolled outcomes (Wortman & Brehm, 1975, p.307) such as forced measures. Loss of agency and capability to exert im-

pact upon the social environment with favorable results can come from being exposed to the threat of seclusion as a treatment outcome, the scarce setting of inefficacy around the room, and in its recall. Long-term avoidance such as deterrence questions the conditions under which the respondent is either expected to emotionally react or reject trauma items, due to recalling and in current placement of the trying social environment. Power of agency to affect change is recalled with low affect without detail of self. Efficacy is withheld by the constraints of the scarce setting specifics in recall. Details of the external environment come to light with trauma recall, alliterated with low affect pausing. Low agency power report reflects very little, if any irresponsibility on the part of the client for transgression leading to seclusion. Perception of no violation of structural enforced norms reflecting no self -wrongdoing for isolation is defended from a social standpoint, as the personal accountability of the seclusion description of events is infrequent. Descriptions of an unaccommodating environment as inefficacy are described with low affect, because dis-empowered agency is not the predominate reason that the particular setting was mastered. Capability to describe in recall own self in situation as agency and aspects of the setting is suppressed because of own helpless experience, and absence of detail of how own self avoided the deterrence, is seen in others visible seclusion. Inefficacy and agency are important questions because I seek to discover what effort can be dispatched by clients to avoid seclusions in this environment.

These recalled traumatic structural, spatial, interactive and socially environmental constrictions impact present instances of a client's agitation and disorientation, that might construct mental illness and deviant labels, issued a quick escort to the seclusion room. Deviant assertions might also be clinically created by the stigmatic labeling of visible emotional expression, incapability to participate, sanctioned failures to requests to talk, among other client's high arousal reactions, justification for seclusion. Trauma recall includes motivational exhaustion from agitated arousal from such clinical and social conditions. Clients develop self- determination to motivationally re-engage aspects of trauma, to remember the clinics denial to speak and requesting staff to talk again, and in the present inquirers guidance in direction of interviewed participation again. Assisted recall in repeating the telling of utterance of traumatic items includes higher and lower affect motivational performance. This awareness of seclusions terrifying remembrance precipitates terminating effort of the re-try of trauma recall, and exists pre-motivationally in low affect pausing, before the utterance of words associated with seclusion. In the re-try of told instances with traumatic objects, there is a preparation, a pre-attentive process (Christianson, 1992, p.301). This preventive pre-supposition exemplifies the theory of antecedent motivation (Mele, 2003, p.87) silent or vocal opposition to disengage interviewed exploration and allocation of items in settings of unyielding inefficacy. A long standing bias of dis-empowerment of congenial agency cancels explanation of failed outcomes, long before a re-try of utterance of traumatic items and redeploying effort, in anticipation of future placements of the inpatient setting.

3.2 Studying Clients Antecedent Bias in Motivational Conclusions

Antecedent motivation governs anticipatory drives before a quick, closing assessments of own perception of lack of agency, in clinical remembrance, situated within the harsh socially constructed setting. Pre-motivational state of minds have already decided, expectant pre- anticipation of engaging low affect in emerging into, and evaluating conditions of inefficacy again, in re-engaging conflicted settings. Antecedent motivation can forfeit the process of recall of requests to talk with staff in memory, and in present recall by clients through low affect motivation drives. Surfacing incapability to moderate composer can manifest increased explosions of high affect motivation, in the re-approach to talk and in present inquiry, because of the current effect of losing control of tempered affect to adjust to the setting, that demands structurally induced suppression endured by past seclusion. This re-approach to request talk, then incorporates careful monitoring of the cognitive labor in withholding certain expression, well before a situation explodes into agitation via seclusion. Clients refine safe engagement with the little to no choice setting with determinate clinical and social conditions, challenging human adaptive strengths in protecting oneself from adverse memory. Performance in self-monitoring low affect increases with physiological or mental arousal, but only up to a point. When levels of arousal, and its anticipation become too high such as in trauma recall, affect performance decreases. The degree of which a client can withhold agitated expression, increases and then decreases with higher levels of arousal (Wortman & Brehm, 1975, p.307).

At the point of exhaustion of non-negotiable termination, such as in recall of traumatic narratives telling of pre-motivationally avoiding a request for talk, institutionally deemed agitated via deviant, and when a person is forced to re-engage in the agitated task in memory is to initiate in the client, a long-term reoccurring upswing of opposing intensity of composed expression. Agitation requires low affect motivational auspicious, in order to contain hostile expression. Agitation can turn into rage, disorientation into disorganization until exhaustion, abrupt conclusion, and re-engagement places disuse and reuse in increasing performance in a high and low affect motivational cycle of concealing expression. The re-admittant long-term upswing in agitated or low motivational affect, may take on an increasingly conclusive erratic rationale, in an adaption of the irrational ecological inpatient setting. This learned adaption becomes more precise in performance accuracy, and comprehension of external reasons statements for concealing expression as a mutual intention (Tuomela, 2005, p.367) in order to avoid coercive encounters.

The seclusion emotional suppression theory exemplifies remembrance of past low affect concealment of expression, also has current pre-motivational pre-dispositions to maintain composer, sometimes noticeable in pausing before and after accounts of traumatic objects. A person recalls concealed emotional manner away from expression in time around mention of the seclusion room, and in its grip with noticeable pausing, and an immediate, already decided bias

rejecting seclusion use attributed to self-fault, rooted in pre-motivational low affect. This cool, covert detachment pre-anticipates the re-occurrence and re-engagement of low motivational affect inaction to expression, before initiating talk is employed, in little to no choice settings. These externalizing statements of inefficacy, of the inpatient surroundings may be accurate or less than accurate, due to increased exhaustion or agitation in assessing agent placement, in adverse clinical and social environments. The upswing in increased or decreased performance of low affect in recall of these environments, are motivated by agitation, disgust, contempt, unspeakable rage and taking offense. In the remembrance of clinical encounters, exhaustion in the upswing deteriorate or encourage low affect performance, the low motivational termination beforehand silently re-kindle, carefully prepare, and advance the re-engagement of expression of requests to talk by clients, in the settings mainly devoid of talk.

Manifest around long pauses, this re-engagement of utterance of traumatic expression formerly suppressed makes the downturn, and performance of emotional containment decreases in rehearsing recall. However, a person can depart or re-engage back into the beginning of the climb of the traumatic memory task, with more accurate performance of emotional composer and strengthened allocation to name specific conditions, not reflexive of efficacy. A person forfeits participation, into low motivational exhaustion through an antecedent motivation (Mele, 2003, p.89) rebound high peaks of exhaustion, and agitation in the recurrences of termination of requests to talk, in recall of lack of interaction around the seclusion room. Antecedent motivational theory was developed by philosopher Alfred Mele in 2003. Among his many contributions to social philosophy, the theory suggests that rationalizing antecedent motivational explanations of agential actions and cessation to expression for example, are also causal explanations. Agents are acting for a reason only if reasons can be causes for motivation already in place, before the agent reaches his or her cognitive conclusion. This recall of corollary of high arousal events such as seclusion and its agitation, dissonance of past low treatment outcome expectations attributed to external reasons statements to avoid coercion in recall, gives rise to antecedent motivational theory (Mele, 2003, p.89).

This theory developed by Mele (2003, p.89) is of incalculable value to clinical social work research, to understand low motivational affect for avoiding trauma explication, deemed deviant via reason to seclude. The theory explains reasons for lowering affect or motivational inhibition due to external reasons, assert that all motivation non-accidentally produced by practical reasoning, issues in a belief favoring a course of action to forfeit requests to talk. This quick cancellation of emotional expression from motivation-encompassing attitudes is already determined and present in the agent, before the client acquires the belief, and when communicating it in recall. Mele (2003, p.89) asserts that reasoning includes motivation which is already in place before the agent, or mental health client, reaches their cognitive conclusion. The seclusion emotional suppression theory reveals a client can develop conspicuous emotional composer as agency power in environments of inefficacy, as an already formulated, bi-

ased (Webster, 1993, p.270) pre-determined long standing pre-motivational state, to withdraw requests to talk. Clients become more tactful in balancing angry or disoriented expression, mediating the cognitive labor of withholding certain central, specific expressions of traumatic objects, and the telling of this in recall.

Mele (2003, p.89) suggests that in instrumental practical reasoning a desire to terminate trauma vocal expulsion quickly at any cost, arises out of tempered anger and exhaustion, as a preexisting motivational mental state. In evaluative practical reasoning, agents come to believe through an attribution of little to no choice low outcomes of own, socially learned, presented or confirmed testimony of poor treatment outcomes, a certain cause of action such as to inquire for talk again, or ceasing emotional expression is the best thing to do, or good enough to do. There is a motivational process to arrive of the low affect inexpression such as exhaustion in agitation, and pre-existing fatigue can serve the action of terminating effective perception of capable agency, and conclude self- evaluation of little to no practical navigation, through non-prolific environments. Mele (2003, p.89) says that this evaluation is derived from a preexisting own evaluation of exhaustive agency, within a low outcome external impracticality (Mele, 2003, p.89) of engaging beforehand, or any further. The desire to action of ceasing emotional expression due to belief of low outcome as inefficacy, and the desire to anticipate low treatment outcomes can come of motivation prior to reasoning, of best course of action. The desire to terminate participation of the agitated arousal tasks of seeking out responsive stimuli, because of belief in anticipated exhaustion, may motivate the best course of emotional containment of perception of little to no choice settings, and low treatment outcomes of inefficacy. This sets a pre-determined course of a driven environment to emotional cessation of talk, and the client cannot claim responsibility of own actions, in its little to no choice low outcomes as causal (Mele, 2003, p.99) due to the trying environment. The client then already arrives on the scene, formulating immediate or pre-motivation to terminate evaluation of self-report before engaging the setting of inefficacy, both in recall and as a pre-anticipation of praxis between agency, and of involuntary placements to come.

A person cannot credit self-rested in bias that agential power cannot avoid seclusion, withstanding own pre-motivational emotional cessation, due to an expected socially created, already established troublesome environment. Actions to forfeit interactive exchange in the setting and in afterward recollection have reasons that are causal to external scarcity that a person does not intend. This perception of lack of agency assumes non-deserving irresponsibility of sanctioned actions justifying seclusion, and repeated requests for help in the open area around the room, or constricted environment, are interpreted by the client as causal (Rogers & Pilgrim, 2003, p.21) and stressful. Refusal of restraint and subsequent seclusion institutionally interprets the eliciting of agitation and disorientation in opposition to coercion, and in reliving the event, in the interview. These vocal objections include taking offense at the clinic, for not acknowledging requests to talk, that are institutionally transformed into a deviant

seclusion assertion. This reemerging after disorganization of exhaustion, of mislabeling of requests for talk into deviant infraction towards seclusion door, forms the affect low level of performance in recalled high stimulus environments, and back towards the agitated high performance climb. This downswing of performance of trauma recall depends on an alertness that can voice externalizing statements, also become stronger re-engaging accuracy of description of the setting in the recall of agitation, within the traumatic memory task.

Heightened ability can re-surface accuracy of the re-telling of past placement in and around seclusion, and how its present and past recalled formally suppressed items is made central and manifest, in the little to no choice social environments in recall. However, at any time during the process of telling of past trauma suffered of seclusion experienced as a current mental state, a person can pre-motivationally (Mele, 2003, p.87) abort the process rested in already situated bias to cancel and avoid the clinics deviance assertion. The client later approaches trauma item again, with more precise and strengthened self-description as mentally ill. The description can give a discrepant, accurate report of no neglect of personal accountability, as clinical cause for a seclusion episode. The longer the pause between trauma laden words as deeds, memory of canceling expression brings current low affect in the re-telling. Self-report in the situation is terminated by suppression to focus on external details of the experience of seclusion due to stripped agency, interacting with obstacles in the setting of inefficacy. As this self -report diminishes, heightened ability to name specifics in the environment gains ground.

Less information of social settings due to a temporary suppression in a client's recall, can lead to improved performance (Gigerenzer & Todd, 1999, p.7) of balancing subdued emotions; there are situations where more arousal is better, and less information uptake makes assisted retelling more reliable. By overruling conscious control and behavioral flexibility, high levels of arousal of composer in a client's recall, triggers an old route or one that already resides in a pre-motivational disposition that practically secures certain behavioral outputs, such as flight, fight or freeze reactions (Hanoch & Vitouch, 2004, p.430). These self and structural suppression can be observed, in low motivational and cognitive affect pauses, in order to decrease exposure to high arousal events, when they are recalled. The low motivation states exist in the present, when recalling of past and expected future neutral settings, such as the area around the room, in order to avoid high arousal references of seclusion in the interview.

It is not only relevant how difficult a client's traumatic memory task is, and how performance of leveled affect in the placement is defined and measured, also relevant are the levels of exhaustion in performance or the retelling of the experience, and what consequences there are for solving or not solving it (Hanoch & Vitouch, 2004, p.445). An emotional arousal, like the danger of seclusion, that depends on regulation and suppression has an opposite effect (Hanoch & Vitouch, 2004, p.431) that draws on increased short and long-term rebound performance, in naming traumatic obstacles to treatment. These swings in motivational cessation of expression and its release can be due to yet

unaware strengths developed in the emotional regulative maintenance of trauma, especially if left unexpressed for long periods of time. There is an attributive process of reason that evaluates motivation in past, current, and future tasks in present and expected environments, and in the self-suppressed present motivational process of telling and recall. Behaviors that demand a high mobilization of motivational effort, in a client can encourage memory storage (Bradley, Greenwald, Petry & Lang, 1992, p.388). This includes a mobilization of termination of effort, and at least a brief description of motivational states that governed the determination in the retelling, and other cognitive conclusive information gathering. This can include termination of details in recalled past "cognitive waiting", and abrupt cancellation of "cognitive labor of listening", and dismissing alternative viewpoints.

The seclusion emotional suppression theory disseminates terminated cognitive effort corroborates the cancellation of participation, of bringing forward central traumatic events. These central events through memory generate antecedent motivation to low affect withdraw, due to the pressing maintenance of anger and exhaustion. The recall of high stimulus traumatic events, deploying low pre-motivational affect, reluctantly generates rational explanations of the social environment as un-responsive, and inefficacious to agency and choice constructing involuntary status. This rationality evaluates external reasons for voicing incompatibility with inefficacy and constructed incapability and establishes perception of lack of agency as common unrecognized ability. This perception of inefficacy summons termination of a common futile effort, and the impact of the disadvantageous social ecology such as the area around the room as being widespread, and common to like others in partial realization of social learning, in recall and its pre-motivational influence at present. An accurate survey of the setting of inefficacy around the room is important, because a client can arrive at a long-standing bias, that the institutional condition is not safely navigated by conforming self and others behavior. A perception of inefficacy is important, because the disparaging conditions may be a predominate influence in the creation of the seclusion event and failed treatment outcomes, not so much level of personal and demonstrated agency.

After studying the pausing phenomena in the remembrance of staff withholding talk, it is exemplified this cancellation of effort to search for talk in the inpatient setting as it was executed in memory, can affect present motivational systems in the re-telling. A person adapts low pre-motivational, and observable withdrawn affect that dismisses the order and carrying out of sequence of tasks in the situation and interrupt the present involvement of the task telling of trauma recall. In recalling a traumatic emotional experience, a human being emits the experience of past suppression as a present, current mental state especially of telling of objects within the structural, spatial or ethnographic site. When accurate descriptions of its low outcome design, such as the inpatient clinic become central, these have contributed to the construction of the emotion as an aggregate, or the inhibition of the emotion presently. The recall of the event sets into motion an emotional narrative, presenting a formerly sup-

pressed reemergence of peripheral description of self in the situation, to central trauma objects.

In conclusion, recall of traumatic sequence of events can rule the cognitive and motivational processes such as attention, memory, action monitoring, and measures of planning that can set into motion cool or hot executive functions in the brain, that involve the regulation of affect and indirect aggression. Pre- motivational moderation of emotional expression to emerge through a stranded setting is not exclusively ruled by a dualist physiological and philosophical state as Descartes claims (Haldane & Ross, 1989, p.1) but a socialized, emotional, interactive manifestation. A lowered affect guise can be emotional containment involving silence, remembering harsh environmental settings, that is proper (Solomon, 2004, p. 92) and understandable behavioral response, to the recall of dangerous coercive instances. A specific account of external reasons for conspicuous balance of manner due to anger and exhaustion, carefully monitors emotional regulation against agitated expression of trauma content of settings of inefficacy. This leveled affect maintains and demands pre-motivational discrepancy to avoid a deviance ascription socially fashioned to requests to talk. The careful balanced overlooking of composer observable in level affect is partially unaware to the client, as peripheral agential attention to visible selective expression of objects of inefficacy. A failure to mask agitation arrived at by both an in-availability of talk and forced medicine in the inpatient setting, can be structurally comprised as deviance therefore reason to seclude.

3.3 The Motivational Consequences of Withholding Talk

This study now presents six mental health clients, Hilkka, Sinikka, Johanna, Esko, Juha, and Maija, speaking their friendly concern, and recalled testimony of their experience with seclusion. Maija is presented exclusively in the final chapter as a key informant, in order to extract more precise qualitative illumination. All chosen clients were accepted to be of full capability, to exert a treatment decision and participate in research, to tell of their medical care. Rejection of seclusion as treatment, is an all-consuming bias (Webster, 1993, p.261) of little to no agency in shaping outcomes with long-term effects. Object relations recalled after a long period of time, heavily influence affect tone, quality and reaction time (Westen, 1991, p.439). Westen (1991, p.436) suggests that if representations of self and others are susceptible to defensive biases, and if mental health clients have conflicting feelings, then reaction time such as pausing and motivational refusal to pursue further, balanced by emotional regulation of anger, reflects conflict among highly schematized cognitive affective structures. Westen (1991, p.432) claims that object-relations theory and social representations and abstraction of memories of interaction with them, affects an adverse affective state.

In the data presented below, Sinikka quickly dis-empowers any relations of the staff, holding it to no consideration, in telling the mental health client

what to do, serve no expected positive outcome due to held back agency. Notice that Sinikka has a quick pre-motivational and cognitive suppression away from talk; the client has not been listened to but simply told what to do. In their way, the staff represents a social relational suppression mechanism that has not helped, and the recalled rejection of any positive outcome, is quickly reinforced with a "no way at all". This suggests a solid pre-motivational low affective disengagement that seclusion will never serve a positive outcome, frustrated and silent at the prospect of further explanation of limited agency, withholding cognitive laborious expenditure, as a present state. Sinikka's first reaction is to be no less than skeptical and reject the accessibility of talk therapies as a capable external agent of help that staff talking does not help as well. This is communicating a pre-motivational decision that talking to staff needs to be firmly rejected, as a future course of action toward treatment and escapes a viable means toward assisted agency, forging favorable outcomes. These are friendly, patient open-ended questions eliciting any perspective of self-reported human agency toward change, valued as a low outcome. The external impact on change toward betterment through fluid efficacy around the room is rejected, not seeking any further consideration. Recalled seclusion serves to pre-motivationally suppress human agency and increase rejecting external help, as the rejection finds limited quick ways out to not have to take time, with lengthy persuasive cognition. The idea that human agency can be aided by staff is obscured quickly, with a cognitive and pre-motivational biased suppression, surfacing no own wrongdoing in the process leading to seclusion.

100 Q: How have nursing staff supported your own will and
101 your decision-making in the treatment of your illness before
102 your first isolation or restraint, your OWN decision-making?
103 Sinikka: *In no way at all.*
104 Q: Do you, have you been listened to...
105 Sinikka: *No...*
106 Q: ...you been able to influence your own care...
107 Sinikka: *No they haven't listened to me but told me what to do.*

Sinikka is currently in low affect describing seclusion, and quickly extinguishes perception of held back human agency in a told subjective way (Line 103,105,107). At the time of seclusion, there is considerable suppression due to the limited interaction, and there is difficulty in the retelling descriptively the deprivation of praxis at length, as present mental states. In a cut short pre-motivational biased perception of little agency within inefficacy response, there is cautious sensibility in approaching projected unfavorable outcomes, that the mental health client's values rejecting staff support, are in terms of regulated emotions. The client dismisses any elaboration, reacts objectively in disgust, then rejects and refuses to look for agreement, through reinforcement. Through a pre-motivated determined value that is relayed as subjective in one sense, and objective in evaluating closed efficacy of environments shared by other clients, the mental health client speaks of psychiatric staff not providing a two-way dis-

cussion, just using orders with no combined participation; therefore, little or no agency to affect outcomes takes place.

Mental health clients draw on examples from hypothetical third parties, as they are drawn to recall reacting disgusted, from an objective perspective that demands it must persuade a dispassionate observer (Kunda, 1990, p.491). However, the current emotional impression and experience led to such a solid pre-decision that it does not seek to persuade using any elaborate alternative perspectives. Motives or goals affect reasoning, in that people are motivated to make self-serving attributions, that permit them to believe what they want to believe, not only because they want to believe it although some people have little to no choice. The social reality can present no decision, just the pre-motivational disposition of quick execution and termination of decision. Some draw self-serving conclusions, not because they want to, but because these conclusions only seemingly appear more plausible, given their common prior, present, or future beliefs and expectancy of low outcomes and limited self- reported reasons for such. Further, in this data lowered motivations and their external attributions are in place to withstand a hostile environment, and rejecting help is a conclusions necessary position, that expects not to consider alternative outcomes as a result of capable agency. The client does not seek listening or be told outside persuasion, and quickly closes the door to be open to elaborate persuasion or to persuade, of self-agency compelled by structural constriction around the room in recall.

Researchers believe that people rely on processes and representations to arrive at desired conclusions, but motivation plays a role in determining which of these will be used on a given occasion (Kunda, 1990, p.480). Motivation can be any wish, desire, or preference that concerns the outcome of a given reasoning task, and motives can be represented, as any expected outcome that shuts down perceptions of the power of individual agency to make change, and dismisses and rejects external agency toward change. Lowered motivation represents the inner-subjectivity of rejection of external enforcement of a self-reported low outcome, in treatment that has been stripped of participation of agency, and interactive efficacy. Motivation affects the process of reasoning, forming impressions, to determine one's own beliefs and attitudes; evaluating evidence and making decisions about the unyielding social environment, are all a part of bias about self -powerlessness and reflections of the social environment. Forming a pre-decision to reject reflexive self in future treatment becomes an executive course of action, and voice opposition to involuntary, non-participatory care. Frey (1986, p.59) and Swan (1983, p.39) studied regulated behavior, by determining which people or information one would like to observe. When the mental health client reasons to make no decision based as a conclusion, but rejects coercion and does not attribute self in details of the event, then a client is indeed subordinating their own motivated reasoning, to a self-pre-decided institutional directional closed pathway, advances inactivity as an adaption, and decides to avoid description in recall.

Distancing driven desires in speaking of trauma recall does not seek any other consideration to believe, or discuss lowered affect self-report in projected favorable outcomes. This inactive expression is a positive decision to not correspond to dis-advanced treatment. The suppression around trauma descriptors is a long-term mental state that becomes aware of the socially constructed reality around the room to be constricted of choice, although there is a contradiction that it is often visibly presented as an efficacious environment open to agency. This pre-motivational emotional regulatory, manifestation of leveled affect is temporarily lost in inattention of the social settings specifics, until partially retrieved after a hesitation time in suppression. The pre-motivational process can be highly receptive to accrediting the unyielding social environment of the institutional pathways, mostly closed to agency. This can be obstructed by low affect in sometimes silent flight not fight, as the lowered motivation seeks not to insist on talk, then voices frustrated cancellation of description of disuse of agency in vocalizing memory tasks, therefore refuses and concludes any acknowledging of clients' social value of being heard.

0001 Q1: What is the situation that led to your being put into seclusion?
0002 *Johanna: I've been in seclusion so many times that I can't remember the first*
0003 time very well.

In another interview time had been taken away by seclusion and the recall of it retains a stalled hesitancy (Line 0005) as a present state of loss of own empowerment, to take charge of own level of remembering of the passage of time to the management of trauma memory.

0004 Q1: How does it feel after seclusion?
0005 *Juha: (3:50) I lose my sense of time (…)*

Memory of seclusion is shut down in the recall of both clients above and the motivational system is suppressed (Line 0005) (3:50) temporarily inhibiting expression of the emotion. Uncontrollable outcomes, such as interrupted memory of emotional helplessness and explosion of reliving trauma such as a perceived self-innocence when forcibly secluded, contribute to an attention focus (Bodner & Mikulincer, 1998, p.1019). Emotional helplessness in leveled affect or reacting to an unresponsive environment, and attribution to its cause is stable or unstable, global or specific, internal, external or reactive (Abramson, Sligman, Teasdale, 1978, p.59). A lack of responses of the mental health client represent little or no relationship of agency to surroundings and acknowledgment of this, become disengaged (Pyszczynski & Greenberg, 1987, p.133). A quick utterance of "no" before and after a pause, have an effect on changing external outcomes, and become a strategy of agency. Emotional regulation is in check and extrinsic over a long period of time with little self-awareness, is employed as an opposite medium, and it takes emotional labor to simply use or disuse expression. Expression's dispose involves dis-involvement without further explanation of

perception of lack of agency, and increases proficiency at naming external obstacles, to advance congenial care.

The seclusion emotional suppression theory conveys constant exposure to uncontrolled outcomes, constructs a client non- response that motivates in a person, the preparation of antecedent low motivational resolved pre-decision to disengage, before engaging not to react to impoverished settings. The client then silently resists conventionally assumed social and individual powers of agency, and notions of efficacy in the social environment, such as a clear avenue to conform to conduct around the seclusion room. Clients develop the antecedent motivation with attempts to arise out of the suppression, of identifying terrifying and threatening aspects of the closed, structural and social environment to abruptly quit engagement. They develop a growing apparent, social standpoint, insider awareness of the hospital producing the no talk, low-stimulus setting, before high and low affect emotional reactions enforced by seclusion, the theory explains. The seclusion emotional suppression theory observes clients refusing and deconstructing the experience of a pre-determined structural attempt, to socially construct illness as deviant by labeled in-correctable conform to rule. Mental health clients refuse to engage in the process of endangerment, by temporarily withdrawing requests to talk, through exhaustion and emotionally regulated anger. This urgent refusal such as a reported "no" benefit to seclusion, does not require from the mental health client lengthy explanation, and is confined to quick qualitative definitions due to suppression of memory.

> 010 Q1: Has staff supported your own decision making in the treatment of
> 011 your illness before your seclusion and do they listen to you?
> 012 *Sinikka*: *Well not if you want to see a doctor.*

Memory of the collaborative helping interaction is quickly canceled and talk is withheld in the client presented above. The seclusion emotional suppression theory discovers that refusal to recant a disappointed search for talk, can become an antecedent motivation to avoid verbal interaction, current and future treatment options, as an ongoing emotionally harbored strength. Clients are motivated by retraction of interaction due to exhaustion or agitation to reset determination, due to frozen, focused, channeled, opposed, expressions of anger. Whether it is an intense immediate dismissal to move to quick termination and conclusion, self-negative inner focus, or intense attribution of negative external focus, the antecedent motivation long-term pre-disposition of disuse of expression, extinguishes expected institutional attempts to pre-determine, the agitated or disoriented emotional reacting of the client, re-defined as reason to seclude. This primary institutional functional process moves to construct the individual's requests to talk, by impeded structural pathways to create an uncontrollable emotional outcome. An example of these are silent helplessness or traumatic outbursts, rendered deviant or unintelligible, via reason to seclude such as a demand to see a doctor. The seclusion emotional suppression theory ascertains the partial awareness of antecedent motivational low affect to resist

compromise to composer, may come to surface in acknowledgment of attentive focus when auxiliary anger, rage or offense exist of the recall of seclusion. In expected upturn of re-engagement of remembrance of the clients expected re-deployment back into the setting of inefficacy, they angrily erupt beyond containment, and reverses into a pressing secondary emotion sadness endured by disorientation. Low affect then can serve to regulate these expressions in moderation, because of heightened affect temporary inability to contain and balance trauma. The client then unsuspectingly pre-motivates a steady, mediated emotional posture.

> 020 *Sinikka : I woke up in seclusion and started shouting that now I want out of here (…)*
> 021 Q: So that they do listen to you?
> 022 *Sinikka* : *Well it's not really the purpose when your there (…)*

Expression is suppressed and a misrepresentation of the prevailing problem is replaced with seclusion, presented by the client above, and the client is motivationally incapable by suppression of conveying the reason for the isolation in the first place. The client below is not presented with reasons for being placed into seclusion.

> 030 Q1: Are you told when your put into seclusion, you have to be there?
> 031 *Johanna*: *Not necessarily (…) at a time (..) that hey now I'm getting out but*
> 032 *ohh no I'm not after all (20:50). I do think that (12:15) people that have*
> 033 *massive phobias (…) can't even move and get out of bed (…)*
> 034 *what's frightening me and my heart is beating like crazy (…) that I'm scared at*
> 035 *night, I don't know if I'm allowed to (…)*
> 036 Q1: Let's change the subject if it's difficult to explain.
> 037 *Johanna*: *Yeah Ok*.

The reluctance to provide talk in memory's insecurity of seclusion, re-surfaces as lost time between trauma objects. The clients delayed release from seclusion is relived with pausing (Line 032) (20:50) (12:15) and the difficulty to express the frightening experience of seclusion is relieved by Interviewer 1 (Line 036) above. A suppression in memory is manifest in the beginning to express feelings of the telling of others, is temporarily presented rather than personally assess the adverse feelings, and taken up again with closer. The self relation "I" (Line 034) to a "We" identity transformed by a temporary pause (Line 132) (12:15) is relieved by the description of similar expression. The "I" identity moves to closer to a "We" with a pause (Line 032) (20:50) after description relating failed release from suppression's grip. The unwritten rule of cessation of expression around the seclusion room is unexplained to the client below.

> 040 Q: How is seclusion supposed to work?

041 *Juha* : *Yes, I don't know, I mean I think that if you're really creative (…) so that*
042 *you could improve and then calm down*
043 Q: Yeah
044 *Juha* : *But when you're locked up, after that (21:05).*
045 *The experience that what it's like is that you have no control over whether you*
046 *can open the door, can you step out into the street, like (…)*
047 Q: Let's move on, we will come back to this if you can think of (…)
048 *Juha*: *Yeah.*

Creativity and freedom of expression is suppressed in memory in the client above. The description of being in seclusion is cut short by a pause (Line 044) (21:05). Again, the relived trauma is relieved by the interviewer (Line 47). The unwritten code of no talking bringing one to seclusion is relayed and remedied by a plan to not talk, by the client below.

080 Q1: What do you, I mean if this is right in your opinion being in these
081 straps all alone, is it wrong?
082 *Johanna: (sighs) somehow I nowadays have this problem that like, I can talk*
083 *about these things*
084 *but I don't feel anything it's difficult to (…) any feelings (…) cold sweat, I've*
085 *lost my feeling altogether, I'm probably so numb I don't know, when behind*
086 *locked doors it's like (…) nothing to lose (…) or but you lose your freedom, but*
it doesn't like…
087 Q1: *numbs your emotions*
088 *Johanna*: *Somehow (53:26) emotions*
089 Q1: Ok let's move on how has seclusion helped you rehabilitate from your illness. Do
090 you
091 have any sense that seclusion has helped you?
092 *Johanna Yes it has, yeah, in the sense (54:03), you feel freer, you're not like dependent on*
093 *television (…) cigarettes (…) somehow it's like sort of you feel you're capable of*
094 *entertaining yourself sort of. I don't know then if I'm a hermit or something (54:20)*
095 *(sighs)*
096 Q1: Then what I in your opinion helps your recovery the most?
097 *Johanna*: *In such a contradictory situation the thing that first comes to mind is*
098 *psychotherapy…*
099 Q1: Yeah.

100 *Johanna*: (…) like I feel that, uhh, that ah, yes, like cause I know this psychology, the
101 (…) *like if a person like can mirror (…) (55:28) Q: …mm…*
102 A: *… I can draw the inference that (…) that I may have the feeling that (…)*
103 A: *Like I can't always form a clear picture of (…) I like to project that like, do I*
104 *mirror or, are you honest or how do I explain this, there's some problem here 105 that doesn't….*

The client tells that she is suppressed of talk due to memory of seclusion (Line 082-083) and positions the statement as a like other, to normalize the traumatic account (Line 086). The alternative to seclusion is presented quickly (Line 097) as a conclusions statement, already settled with the client, in an already assumed, attested agreement. Johanna is assisted into a long pause (Line 88) (53:26) to motivationally rest from the retelling of the traumatic instance. Equipped with this reassurance, Johanna pauses (Line 101) (55:28) telling of the visualized, absent combined help from a doctor. A self -description embodying emotional expression is suppressed in the client above, by a description of past seclusions and restraint. Stifled self-emotions (Line 088) (53:26) and more freely expressed combined feelings (Line 101) are accompanied by a suppressive long pause to rest from trauma of the cognitive labor, recalling the treatment words. An inability to express inner reflection comes to light, after succinctly describing the absence of psychotherapy. The reminiscence of mirror of self in absence of therapy brings a long pause (55:28) (Line 101) as it has been divided from the client. The successful identification with a deteriorated description of alienated self as a hermit (Line 094) is presented with a recovering pause (Line 094) (54:20) then changes focus to speak of the isolated, combined experience of sense of its commonality. A quick alternative to seclusion as talk is posed speaking of the situation as an un-penetrable, non- maneuverable setting (097 - 098).

Quick, hesitant, end of the continuum cognition, such as short rejection statements of seclusion loss of self- initiated alternatives, not including talking therapies preventive strategies, situates self to the setting. The pre-motivational cancellation of former harbored emotions, erupting into agitated talk brings to the surface, formally suppressed descriptive recall of harmful psychiatric measures, because of no fault of own in the process. This is part of a developmental stage process of an adult mental health client formulating bias (Webster, 1993, p.261) of self not causal to the description of disturbance. This bias of perception of agencies hindrance to effect change in the environment, other that low affect guise to emerge into the strained setting, refraining from costly lengthy description of exclusionary detail, cognates a healthy distance from treatment. This further develops social, not personal, values and meaning making of illness and treatment. Preexisting exhaustion though uncontrollable outcomes set pre-motivation, to not exhibit effort due to accurate allocation of inefficacious settings, are manifested in pauses around relayed traumatic objects, in narratives of inpatients hospital stays. These short quick utterances and items

around pauses are studied in limited sources of data, because of the hidden made visible nature of suppression, and include residual re-emergence of terrifying incidents, within traumatic narratives. Sinikka presents below, stating that there has been subordination in decision making to the doctors, the client has not made a self-decision in collaboration, but there is pre-decided reasoning of little to no human agency, in the ongoing situation of inefficacy. This rejection does not seek to persuade an impartial observer (Kunda, 1990, p.486) quickly abandons an effort to elaborate. The dismissal has put lower motivational drive into action by pre-decision, in future considerations of the futility of exertion of personal human agency, to be of any effect in treatment.

115 Q: The question here was that have nursing staff here
116 supported your own will (...)
117 Sinikka: *Well no not in my opinion.*
118 Q: (...) expressed your views (...)
119 Sinikka: *No I haven't, no…*

The wearied emotional labor to reject (Line 117,119) own agency powerless to the enforcement of coercive measures may be the only responsive avenue of change, in the absence of an interactive environment. The presentation of the no talk setting is recalled with suppression. The awareness not to engage, but dispatch observed affect expressions of motivational flight (Line 117,119), not fight is preceding before, during, and long after coercive methods are ever first tried. The structural process can be well under way, before the problem for the mental health client is created and resisted. The seclusion emotional suppression theory suggest abrupt conclusion can be accepted first by the motivational system, then described by a perception of evaluation of held back agencies, within a limited outcome social environment. The theory proposes, lower affect and withdrawal can be in place first, and govern a pre-motivational set when a mental health client is reluctant to state cognitive reasons, for why the reasoning is not open to re-consideration. The client finds through the process of social, clinical, or cultural self-awareness observation that exhaustion, and tempered anger governed the decision in recall. Affect or low motivation can be in place, even around associative figures or traumatic objects, emotionally regulating a mental health client as not yet fully conscious and sometimes recalled at the scene, so never looking at the item fully in question. In this study, current and recalled low affect noticeable in frequent pauses reflecting distance from communication, is discovered to be created by structural and spatial constriction. A client making decisions at the time and in recall, without enough or information overload of in-efficacious environments, will exhibit quick, already arrived at, biased conversational recall of limited agency, and of other mental health clients shared disparaging social environments. These biases are more so precise in balancing low affect expression of formerly suppressed agency power, in specifying demonstrative personal experience.

An interviewer's suggested course of action to request talk within a setting of talk's unavailability, cannot to any degree be justified as rational, even

against each other's deliberation, unless supported and already arrived at, client's antecedent motivation. The direction of attribution of cause, as external and socially learned knowledge of the clinic creating the problem without its alleviation, becomes central to helping the mental health client. It is not practical reasoning that sustains processes, but bias of "held back" agency and perception of fabricated failure to self- responsibility not causal to seclusion, is also due to antecedent motivation, the drive to disengage before engaging. The antecedent motivation already established lowered affect is long- held as a powerful emotional regulatory strength that sustain and withstand not being able to express constricted social conditions of trauma, such as the threat of seclusion and its suppressed remembrance. The seclusion emotional suppression theory, draws an example from Wortman and Brehm (1975, p.293) insisting an initial response to uncontrollable outcomes, such as becoming cast within seclusion or the closed reflexivity around the room, can result in an increased pre-motivational effort and performance of concealed emotional manner. However, as uncontrollability increases, and awareness and accurate externalizing statements govern attribution that agency and external conditions, such as closed structural considerations have limited alternatives, motivation decreases in containing anger, and learned helplessness and low affect increases in recall, and as a present state. Wortman and Brehm (1975, p.331) say then the most adaptive response may be to give up to no control. At that point, a complete rejection of any presumed positive outcomes to ask for talk due to one's external circumstances reduces dissonance, place "avoiding" with limited participating, further lowered motivation indicated by pausing, and reluctance to explain further, thus allowing the institution its directional goal. However, an awareness of limited agency, can become a preceding motivational awareness to increase effort of neutral affect. The ability to more precisely name external obstacles strangling agency within inefficacy becomes a stronger capability, and ability to determine optimal pathways through them, that can further equip personal attribution toward change.

A client's rejection, of the constricted social environment's conditions creating non-consensual coercive treatment is devalued and disqualified, as the only perceived personal human agency. An attempt by the mental health client to reduce qualitative lengthy reason statements to quick pre-dispositional summation is discovered in the data, when talking to a researcher, both in the interview and recall show a strong pre-motivational commitment against self-actions that are sanctioned in the process of seclusion. By carefully talking to a psychiatric professional, the mental health client employs pre-motivation in pausing around items of trauma, retracting from further elaboration that does not seek to explain or persuade, in recall of forced methods. In the face of recalling the low affect conducive expression dispatched in the past to avoid coercion and its rationalization for causal origin of problem, became insisting of agencies innocence when the interview process becomes rigorous, insisting taking responsibility of self. This testifies to fighting the recall against temporarily hidden suppression that creates regulation that dissuades description, and de-

ludes full immersion with offense of the deviant labels. The clients recall in the interview includes residual motivational states, while in seclusion and be governed by suppression.

The helper role, as described in recall creates present detachment that is remembered by the termination of the exhausting "labor of listening" quick cognition starting with conclusive biases of limited self- report. These quick self- cognition of limited agency are recalled emphasizing closed aspects of the constrained environment, by the shutting down of clients' motivational processes, noticeable in long pauses. These pre-motivational pre-dispositions of contempt abort information gathering, creating high or low affect states that sharpen externalizing statements for avoiding uneventful convergence, with inefficacious settings. Agents utilize defense processes, when retrieving adverse memories in the long-term and even in short-term memory, and difficulty in its present recall. The suppressed cognition detach the mental health client by way of suppressing personal human agency. Even though the client is able and willing, the suppression due to the enforcement of rigidity of relations between staff carrying out forced care, cancels motivation to exert agency presently, and the effort to explain this in recall.

120 Q: (…) are the reasons explained to you, why this
121 decision is made. What about seclusion, is there sort
122 of, is it discussed afterwards how
123 Johanna: No. (28:38)
123 Q: But do they generally explain the reasons if they say
124 something, like if you're put into seclusion do they explain
125 (…)
126 Johanna: (23:50)

Johanna extinguishes any discussion of considering alternative viewpoints by first a "no" then a long period of silence. Time marked as either (28:38) or (…) indicates silence. Silence in the psycho-dynamic world means that a person is, and has been suppressed by a past separation, for example. The silence is a foregone effort to explain, persuade, or even consider otherwise any hope of collaboration with a professional, because of treatment failures, not an individual problem of the mental health client. It can be recalling past seclusion, however it tells also of the present effects of suppression. The first no (Line 123) in the extract is not followed with a reasons statement, but silence (28:38) that is not open for collective discussion. In the second silence (23.50) (Line 126) Johanna refuses to consider own position from the perspective of the staff's view relayed by interviewer 1, and cancels motivational engagement, due to exhaustion and contempt. The silence tell of the distance and detachment from staff help, as this mental health client rejects any benefit of explaining why not to engage in any reasons, to decide to avoid the coercive situation in recall. This silent long term mental state devised by the withholding of talk and staff's incomplete explanations, tells of an all-consuming present mental state, perhaps

of avoiding coercion with limited effort in a pre–motivational low affect posture. There is quick abandonment in low motivation as the client does not listen to a re-formulation of the problem, and steadfast refusal to listen to a collaborative suggestion. The client is angry, and the suppression has ceased motivated effort to persuade or be persuaded.

Sinikka and Johanna have made in their open, friendly recall a motivational, already pre-decided, surfacing, formerly suppressed bias to withhold trauma expression as a precaution against becoming secluded, that will not often elicit any cognitive utterance other than a quick "no" (Line 123) and abandoned, frozen, paused, quick conclusion (Line 126). It is part of the pre-decision however unaware, because of repeated constricted perception of low or no agency in shaping outcomes, low affect has deduced refusal to consider any other roads, as well as the futility of talking, have diminished or completely evaporated any pre-consideration of efficacy of their own, in a seemingly deterministic preset social setting. They have perhaps long ago, envisioned an antecedent motivation that further renders their own reflexivity as it institutionally defined as inability, but that also pre-establishes a low external outcome impracticality attribution, as incapable of creating agential change in the social setting. This low affect comes without extensive exertion of reasons for emotional cessation, and is sometimes receptive to others visible demonstrative low affect, in avoiding coercion.

The incapability to effect change, not ability is displayed as low affect. However, it is also a pre-decided motivation to reject external inefficacy affording able agency to be reached, or talk about self-sufficiency enabling help. Clients are far beyond consideration of even talking about it, because they may abandon exhaustive cognitive statements of allocation of inefficacy, perception of helpless agency, forecast and reconnaissance of an external constricted social environment, and adapt motivational disengagement. Mental health and disabled clients suffer severe consequences when a clinician is unaware of accurately interpreting low or high affect, in emotional regulation of anger and frustration, as an adaption to placement in a constrictive and restrictive social environment, and communicating mistrust (Whaley, 2001, p. 93). No talk produce low affect, and an incapability to shape outcomes or low agency power, therefore the institutions' justification exists, to enact behavioral correction. Corrected initiative to participate creates high affect agitation that is emotionally regulated, to avoid angry expression. A question arises, if the constricted environment is exacerbating low affect, and in turn if that is driving to produce a low affect evaluation of the environment, of the little to no choice setting, or both.

An adaptive measure to overcome the negative memories of seclusion is to withdraw, and lower affect in motivation for a time. An environmental cue, such as a friendly question from an interviewer or therapist help mental health clients to engage in research inquiry, utilizing their motivational and cognitive skills to attribute causes for disturbance, as a result of seclusion. The interview process included mental health clients slowly distancing themselves, in the recall of traumatic items at first. Distancing trauma objects lowers motivational

reactions, while a presumed or predicted future threat raises them (Lazarus, 1993, p.7) both in recalling and expectations of future averse seclusion, depending on the individual mental health client's cognitive styles. As the mental health clients were sensitively made aware that they would be recalling negative mental states in their experience with seclusion, their motivational state at the start of the interview, was low manner. With enough friendly environmental cues inviting them to participate, they were able to access their memories and share their vast experiences. In appraising this situation of seclusion and around the room, the mental health clients often categorized it, as being forcibly placed in a situation of little to no choice, and limited alternatives. Their memories of these experiences were recalled using lowered motivational drive, to adapt themselves to these negative memories.

At first there is a reduction in their range of "cue utilization", and delay times become covert (Easterbrook, 1959, p.187) and mental health clients dismiss acknowledging the benefits of seclusion and later, talk therapies quickly with a "no", pausing, and no further explanation, in suppression of communicating memories of seclusion. That is an adaptive rational in the abstraction from memory, utilizing emotional regulation (Christianson, 1992, p.289). As emotional suppression degrades memory, memory is also a self-regulation process. It involves changing in self-monitoring and self-focus (Pyszczynski & Greenberg, 1987, p.125) which decreases attention resources, in encoding and remembering external events (Ellis & Ashbrook, 1988, p.35) such as conditions leading up to the clients emotional reacting, prior to seclusion. Motivational responses elicit self-focused cognitions that are exhausted and agitated, when an external agent such as the threat of seclusion limits personal attributive responsibility, to affect one's social environment for a better outcome. Negative expectancies (Neuberg, 1989, p.375) lead to a self-perceived loss of control, and to learned (Bodnner & Mikulincer, 1998, p.1012) and personal helplessness (Abramson, Sligman & Teasdale, 1978, p.60) that attributes external causes for perceived threatening stimuli, such as the danger of seclusion, and wrongful self-accreditation of personal and individual fault for it as bias. An internal causal attribution for limited agency in shaping a social environment for better outcome is made, when a person accepts personal or learned responsibility for failure (Briere & Vallerand, 1990, p.467) for poor treatment outcomes. The social institution has moved to re-define agitation and disorientation, and sanction created distance from care, and its consequent eruptive or helpless behavior created by the beforehand lack of attention.

050 *Juha : There are situations in general you have a feeling that they have very*
051 little contact that they use to make observations that nurses draw, those kind of
052 that (27:02) sometimes you want to
053 Q1: Have more care?
054 *Yeah.*

Distance from care (Line 050-051) seclusion substitution of therapy and a nurse's inability to draw accurate inferences about a client, is presented above. Suppression (27:02) is relieved (Line 52) by hesitant expression of the separation of combined care. The client's memory has been suppressed, fighting for reasons for the seclusion in the extract below.

> 060 Q1: Do you think that people are put into seclusion too easily?
> 061 Sinikka : *I can't remember now, there was this now, was it during this past*
> *062 week that(sighs) I was (49:16) nurses (…) I can't remember (…) seclusion (…) nurses…*
> 063 Q1: What about after this situation (seclusion)
> 064 *Sinikka : I can't remember did they put me in seclusion but I (…) This was the*
> 065 *time when I (…) urine (…) and vomit (51:45) (…) afterwards I (…) to the*
> 066 *nurse, and then she just asked, did you ask; I don't know, I can't remember (…)*
> *067 didn't even ask for water (52:01) nobody saw (…)*

Memory of seclusion's absence with nurses is blunted (Line 062) (49:16) by past seclusions in the extract of the last client. Notice the long pauses accompanying objects of treatment that have been taken away such as "nurses" in order to suppress the need for help. A description of the present suffering is distanced with a pause (Line 65) (51:45) and shifted quickly to take up an afterward account. Clients' eruptions of frustration and disgust (Line 065) that silences before persuading another (51:45) and inability to recall rules to contain traumatic memory of seclusion and fatigue expressions are due to powerlessness in agency role in care, as this testifies to the unyielding setting and powerless agency. The terrible account in the form of self- report helplessness, and external reasons for suffering and recovering from the trauma of the seclusion is rested after, with a long pause (Line 67) *(52:01)*. Reasons for this are ascribed to by the threat of seclusion, sanctioning conventional to failures of individual self-responsibility (Wendland, 2016, p.11) to wellness behavior and mis-established norms (Line 064-065) to abide withholding talk. Devoid direction forward, the weighted outcome in the setting expel capability to remember trauma, inability to contain traumatic frustration, and agencies compromise of an achievement, of attaining modifying behavior.

Open efficacy to exert choice, is often presented to be the only process occurring. A conflicted, non-deserving accusation of detour from self-sufficiency from refraining from asking for talk, toward neglect of reform construct involuntary status. The creation of failure to abide by compliance of norms conveyed in client subjectivity, act to seek external reasons of agencies motivational non-reflexivity, and exclusion between self and social environments, for treatment failure. This conventional attribution of placing more emphasis on the individual, impacts the high and low affect pre-motivational powers, not to further effort and cancel present or expected engagement, due to the re-occurrence of seclusion alluded to requests to talk in recall.

This is shown in the data, by asking clients the power of their own agency to do something to avoid or benefit from seclusion, where the clients perception of little to no agency impact, starts to formulate exclusively external, structural and relational reasons for coercive encounters. Uneventful convergence with coercion can point to little to no reciprocal relationship between agency and environment, and may present structurally created unexpressed emotional and motivational pathways, inconsistent with evolutionary expression that continues to wrongfully fail, the mental health client. The question is there any benefit to seclusion, asks the client to account for own level of agency in memory and future expectancy, in the outcome of the situation.

Seclusion contributes to an attempt to enforce personal responsibility for the self (Kruegel, Smith, 2017, p. 2). Enforced suppression encourages or discourages false acceptance of personal failure, not necessarily the fault or blame of the mental health clients, but imposed constructed internalization of irresponsibility to avoid coercion, on a vulnerable and oppressed population. This may result in awareness of direction of attention of causation toward external agents, from the intentional institutionally created severing of social interaction by staff that escalates expressed social needs unmet. This results in memories defense from social expression because of visible, enforced cognitive suppression, and refusal and rejection of seclusion, created by the threat of it. However, seclusion and suppression can result in a definition of social self that combines with others to reject dis-empowerment from personal, human agency and responsibility, due to obvious obstructions of external agents, such as constricted institutional pathways. Psychiatry, due to the absence of talk, can dictate redirection of a client's cognitive and motivational intensity and duration of affect flight or fight, from approaching or dissuading opportunity to talk.

The seclusion emotional suppression theory emulates an adaptive process in not being able to effect change in one's environment for a better outcome, is pre-motivated reasoning of emotional regulation of cool, calculated manner exploring the detailing of external structural forces, impacting self and others. This compromise to self-sufficiency (Senate & Cobb, 1972, p.1) can present institutionally created needs, and individual responsibility as incompatible or incapable of meeting self- need, due to obstructed pathways. Interaction in recall is not present, to make unavailable the addressing of the cause of one's helplessness, in frustration and withdraw. There is discovered to be a clients' motivational element beforehand, preceding withdraw from communication, its influence on current emotional expression, and dispatching low affect tone in re-engaging to ask again for interaction, in the constricted area. Here in this empirical research, this approach and re-approach requests to talk utilizes negative low affect that is part of the current cognitive and pre-motivational process, and distinguishes appraising, or discouraging a situation of distinct limited alternatives, in memory.

Mental health clients' have pre-decided that external reasons (Searle, 2004, p.214) of designed, uncontrollable treatment outcomes are enforced, and imposed upon them. Instead of making the social partner aware that incapabil-

ity, not ability is a created hindrance, the mental health client modulates affect, and motivationally resists a presumably low outcome social setting, with rejection of much choice of change. They express rejection to listen, and are so predecided that agency is held back that they are unwilling to voice self-opposition, in explaining imposed structural details. Formulating long-term active pre-decisions of humans to stop expressing self, and be re-explained redefinitions by staff of closed little to no choice environments includes exhaustion, uses quick preposition that sways the mind that does not listen, and cuts short to describe lengthy reasons, for the deprivation of strength.

Antecedent motivational variables of compromise to frustration are anger, disgust, agitation, and fear that set into motion the maintenance of low affect performance and self- suppression, in memory retrieval of traumatic events. Because a central operational affect, to require talk is formally suppressed and a peripheral monitor affect, its immediate unavailability is made manifest and visible, seemingly opposite affect can be employed in order to fuel the emotional labor, of regulatory composer and containment. Psyszcynski and Greenberg (1987, p.127) suggest that the conscious inhibition of emotional behavior degrades memory because of the complex self-regulatory, self-monitoring, and self-focus process it involves, which decrease attentions resources for encoding and remembering external events. Ellis & Ashbrook (1988, p.35) and Psyszczynski & Greenberg (1987, p.127) point out that suppression requires individuals reminding themselves to suppress, self-monitoring for signs of unwanted emotional impulses, and conducting self-evaluations of how well they are doing. This client's pre-decision to reject fault bound scripts of seclusion and unlikelihood of talk, is unwilling to express reasons. The mental health client is hesitantly incapable to attribute accurate attention to the friendly responding of a cue, such as a question from the interviewer.

The suppression from the seclusion makes it very difficult, to expend the cognitive effort to self-monitor and conduct self-evaluations of supportive reasons to the external event, other than to react to it or reject it. The emotional regulation limits the description of an external force, or seclusion that the mental health client tells of little human agency other than to terminate quickly, look for any way out of conversation, to be agreeable to just about anything, and avoid its description with a stronger determination, as a current mental state. This plan of action becomes to refuse help justified with a strong defiance, as strong as the universal emotional expression of disgust at appraising a limited social situation. The social condition it is discovered construct these reactions, labels them, then serves as justification for the ongoing cycle of seclusions. Disgust or agitated affect serve as justifications for the seclusions from the first to the tenth episode in 72.2% of cases (Kaltiala-Heino et al., 2003, p.145) where there is agitation, and the threatening of no violence to people, but to property.

128 Q: You said that they're not at all sympathetic…
129 Juha: *Yeah they don't support you at all, I think they*
130 don't support you at all.

131 Q: Do they listen to you if you want…
132 Juha: *No.*
133 Q:...want to...
134 Juha: *Well yeah for a while and then they close the door.*

Juha voices no confidence in staff (external agent) to assist with problems of being in the seclusion room, and surfaces by first attributing a pre-motivational "no" closed further cognition, then repeating no hope to collaborate absolutely and at all, twice (Line 130-132) then a final no (Line 132). This is discovered to be limited cognitive laborious description, by closing all considerations otherwise. Juha, through negative experience with seclusion and staff become agitatedly "disgusted", and rejects any suggestion that talk therapies would be beneficial, by joking. Disgust is an evolutionary universal emotion that quickly seeks to avoid adverse situations, and is discovered to develop powerful antecedent motivation to avoid any future social situations that has exhausted cognitive expenditure, thus setting into reverse, becomes an extremely powerful social motivation. Joking becomes a defense waged, before any other consideration of any other perspectives.

Juha jokes (Line 134) in order to expel the tension arising from the inability to self-suppress, and disguise the anger of becoming secluded, and indicates that because of coercion's fashioned deviance, the new label overrides anything else a client could ever say. An inability to regulate anger quickly, finds any way out through joking to reduce the cognitive labor, of withholding its expression. In the early stages, these self-focused cognition required for inhibition have negative consuming consequences, eating the energy that would otherwise be used to process the world, thus producing loss of memory of external events (Richards & Gross, 1999, p.1042) as frustrations and out of control temper tantrums, for example can occur (Kopp, 1989, p.351). The self-effort to suppress and guard against over insistent listening, may contribute to the loss of memory of the effort of suppression itself. Emotional suppression may be a part of cognition itself as a part of self-regulation (Wegner, 1994, p.44) and acts as mental load, and reverses, as suppression of pain for example, is less effective than abstraction or distraction. Incapable of costly cognitive effort of describing external events, the mental health client is discovered to resolve to reject help.

141 Q: Have you had situations where you've disagreed
142 with the doctor or the nurse about treatments.
143 Esko: *Well yes to some extent but then (5:02)*
144 Q: But have you been able to talk about these
145 disagreements.
146 Esko: *Yeah.*
147 Q: Yeah, that...
148 Esko: *Yeah, yeah.*
149 Q: ...that what they've wanted and thought.
150 Esko: *Yeah, yeah.*

Quickly allowing interviewer 1 and the recalled clinical directional goal, assumes devalued own individual viewpoint, to affect the mental health client's situated position. Above, another client Esko takes into consideration first the position of the interpreter, and then explores whether the self has been included in treatment, goes along with what is said, and allows interviewer 1 whatever they suggest. Then the client agrees that they are allowing the doctors what they suggest, embellishing their own decision making capability, and refusing to listen to interviewer 1's perspective, of open talk in the clinic. This mental health client has dismissed, any hope that the doctor would listen to them. The interviewer 1 then configures the doctor's re-directed goal as a collective "They" (Line 149).

Esko speaks of making treatment decisions with the doctor in recall, perhaps until coercion or absence of talk happens represented by a pause (5:02) (Line 143) or clinical neglect of collaboration. The mental health client collaborates (Lines, 143,146,148) then the interviewer makes an attempt to encourage a response (Line 149) that gets rejected by the mental health client, therefore canceling any attempt to persuade any further (Line 150). The mental health client immediately motivationally rejects that the provided talk treatment can be of any help as well, abandons cognitive overload, and allows for interviewer 1 to form a conclusion (Line 149). The mental health client simply acknowledges the seemingly only agency in their world of inefficacy, the practitioner, and bids the interviewer and the treatment team in recall, their directional course. At the point of rejection of one's own effective agency, viewpoint as an individual as an instrument of change, and with an overload of cognitive cost, a person will give up and take any way out, and become agreeable and permissive to another directional goal, here interviewer 1's, and the doctors in recall. Suppressed agitation and disgust, do not often seek elaboration description.

The seclusion emotional suppression theory ascertains antecedent motivation is displayed by the client as one disagrees, but then with enough "overload" the recall allowed the doctor to override their wishes, by canceling cognitive and motivational lengthy processes. The client departs from exhaustive cognitive expenditure, in avoiding trying to persuade by reasons statements as a long- term mental state, holding an already decided, diagonal line of direction. A clients' incomplete description of the desolate environment limits itself to a lowered report of self in the situation, and this is a dichotomy because a client is socially issued an exclusively fault bound ascription, as a sole suggestion of cause for seclusion. Esko agrees to anything, to simply not go forward with an effort to recall any disagreements (Line 143), as it terminates quickly all involvement, while staying physically present. The time (5:02) tells of pausing representing departure from care in the past in recalling, which simply is being suppressed in memory. A pause is standing in the way of telling of the situation in the present, as current suppression of not being able to disagree. As this forfeit of explanation is suppressed, it exists as an ongoing pre-decision of terminated effort to express any disagreement with care, in the past that had been

suppressed then. This tells not only that Esko has been excluded from decisions in treatment, but also in visits with doctors.

It is discovered that Esko has been coerced on many levels, and the client expresses that it does not matter what he says or what the doctor had said, in telling of it in the inpatient setting, as in the present inquiry is a so-called "waste of time", and might be "sick and tired", to speak about any disagreements. This grants the institution re-directed directional pathway, as this is itself disengagement. With no confidence that a social partner can read and interpret one's expressive needs, the mental health client devalues own individual perspectives, responsibility to express and resigns it to no choice. Esko takes any so-called way out and bargains a way out, of the situation unconditionally and abandoning preference, by agreeing with anything by not disagreeing with anything, as a way to flee and move to motivational pre-conclusion. The fourth time, the interviewer attempts to configure professional alignment, it may show enforcement (Line 149) withholding talk as this occurs frequently in naturally occurring talk.

Esko closed down present Interviewer 1's (Sanni) and the remembered psychiatric staff's suggested pathway to talk, in recalled assertions of personal irresponsibility, and instead allowed the direction of the inquirers assistance to evaluate agencies neglect of self-efficacy, the description of the problem. Schegloff (2000, p.205-206) says repair initiated by a person other than the speaker resolving the trouble source, is called next turn repair initiation that is as a locus of initiation. The up-take is what is described as taking the next turn, and its appearance proffers a candidate of understanding from the client for confirmation. The author says this is also common among nonnative speakers of English. Self-initiated repair of Interviewer 1 for example, involves the speaker of the trouble source that forms an organization of practices indicating action, in which the occurrence justifies itself and constitutes actions, in its own right. It tells that the Interviewer 1 trouble source is structural practices (Line 149) and there is an invitation made, repair made, and immediately accepted (Line 143,146,150) and it does not go forth to position repair, as the explanation telling of practice is shaped by the social construct.

The repair seeks the first opportunity to quickly confirm the explanation. It is first presented by interviewer 1 and the recall of the psychiatric professional's position of dissonance, to pick up realignment silent time or (…) (Line 149) and the question that needs repair in the first place, is a justification of carrying out seclusion; the silence (5:02) (Line 143) is made early in the interview in order to standardize, enforce, and normalize coercive practices. Schegloff (2000, p.212) says that repair initiations are positioned in next turn by seeking to transmit the nomenclatural, purgatives, and practice as categories carried out among a membership that seeks normativity. Schegloff (2000, p.212) maintains this serves adjacency, to mitigate deviance to conscript the occurrence as agitation or disorientation for example, assimilating it into a reaction or seclusion understood as normatively common, among mutual (client to client) and unequal social relations (staff to client).

Expected failed instances of collaboration with staff, and refusal of orientation to listen to future suggestions to positive outcome initiated by the interviewer, are displayed by clients to not solve the problem. This rejection is quickly adopted by the client as a confirmation that this is a structural problem, involving only psychiatric professional membership only, not as a solution, or even a description of the cause that would involve mental health clients. As the interviewer 1 enforces an infraction to individual responsibility for no collaboration with the doctor, and repair of the interviewer 1 in the extract above does not derive a specific occurrence of mental health client behavior, but instead a quick account of actions and deeds of professional problems consistent with the social structure, that enforce this distant relationship. Clients communicate this with suppression, and immediate cognitive termination in recall for lack of talk, might be remembered without much elaboration of self in the closed situation. The reference to Esko is secondary to the attention given to the interviewer. The repair is immediately enforced as delayed, distanced, and not extended but it is quickly affirmed by the client that the problem is structural, because the next turn is positioned, repaired (Schegloff, 1992, p.1295) then completed by the Interviewer 1, enforced as a failure to correct the clients neglect to talk (Line 144,145).

In conclusion, descriptions of the professional carrying out seclusion are not lengthy detailed accounts of their actions, before and during the sanction as it is told by clients, due to closing motivational and cognitive conclusion confined to unstated rules, and its transmission to Interviewer 1. Less quality description after carrying out seclusion is conveyed in recall, and takes no further time to describe it as an enforced self- identity upon the client (Line 144, 149) compelled by Interviewer 1 (Sanni). With very little quality description of the confirmation of the problem of seclusion as a structural policy, little description of practice places professionals' contribution as relational, in an indirect consequence to clients emotional reacting. This forces a client to abide into motion, from the constricted area to the restricted seclusion room. The clients' suppressive silent pause and motivational non-negotiation from short cognitive contempt starts at that point, as the seclusion bring a new unfounded hardship indirectly related, and non-proportional to events of clients emotional reacting. The reliance of Interviewer 1 is to complete a gap of silence that attempts and fails to find an immediate alliance, as this can resolve or exacerbate dissonance, of alleged lack of responsibility. A specific question to speak for oneself as a credible agent compels a lack of alignment with structurally created non-responsibility that ushers forth contempt of an otherwise able client, a consequent angry disengagement from emotional expression, refusal in listening, and pre-motivational refusal to credit self for seclusion.

3.4 Configuring Re-Defined Needs

This chapter seeks out the creation of involuntary status, where there is an attempt to strip able agency by exposing it to a closed setting, then make re-defined re-assertions about the incapable self in the setting as being the predominate decisive impact on why failures to outcomes occur. This chapter discovers client's recall of lack of participatory care suppresses the experience of voicing a structural external causal description (Hochschild, 1986, p. 44) of the lack of help, as a pre-motivational cancellation of agential elaboration and failures of irresponsibility to withhold speech, configured deviant. Descriptions of an agents actions by normative understanding are made in suppressed, quick, re-defined, afterward accounts, in recall under what structurally occurred or incurred. What is constructed by this is the incapability of the client to effect choice created by the little to no-choice environment, un-responsiveness to cues created by a non-participatory setting, and unanswered pleas for talk, that are re-defined, merit placing an individual into seclusion. Accounts of psychiatric staff by patients may not offer any detailed description, because of the enforced shut down of communication, only their own relevancy outside of participation that is later partially recalled, in motivational low affect and suppressed. The producing and interpreting of their own conduct is a result of being in the desolate interaction, but the interaction only speaks of the end-result, that of seclusion, as conclusive bias of clients reported actions of psychiatric staff because of client's exclusion, in the producing of the event leading to seclusion.

Mental health clients tell of professionals offering no description of the cause, so much that the mental health clients' actions do not even have to happen, only that they are constituted, re-defined, then interpreted, with no detailed description nor measure of quality of the action. The beforehand cause of the action is told that the reaction or seclusion took place, told with enforced motivational suppression indicated by traumatic pausing in the re-telling. The only relevancy is that it is a one-sided interaction, and it devalues own conduct, simply enforcing what ends with restraint and seclusion in suppressed recall, in end stages and false starts of the client explaining, accompanied with pausing. Enforcing seclusion does not depend on a description of others' conduct, and it does not involve client participation in the event in recall. It does not rely on client self-detailed description of actions or in-actions, only that the social structure enters into what Schegloff (1986, p.110) calls the production, and interpretation of determinate facets of conduct that are confirmed, reproduced, modulated, neutralized, and incrementally transformed into actual conduct, that can be quickly re-defined, and be different from the conduct that occurred.

The actual conduct that occurred or incurred, can be very different for mental health clients than what is transformed, re-defined, or modified by the psychiatric professional. These descriptions of clients emotional reacting to provocation of the need to exert agency, make a treatment decision and ask for talk, labeled as deviant by psychiatric staff systemic of conventional norms of normality, are produced, ascribed, reacted to, proceed and ended in seclusion.

This recall in self- description might be diminished, due to pre-motivational disengagement due to closed bias, of little to no agency in projected positive treatment outcomes. The emotional reacting to the no talk setting can be forcibly modified, into seclusion. The transformation is comparable to an arrest in which the only charge is resisting arrest, or being reacted to (Cicourel & Kitsuse, 1968, p.126) charged, processed, and held responsible for something other, than what actually occurred. Regardless of how many times a client is in the process of seclusion, there is no resisting, and telling of psychiatric professionals there is no detailed description of the implied conduct or charge, but only scant explanations of staff and confinement. The resistance may be configured as agitation and transformed into deviance. The only account of the client involved is that they are temporally unaware, of being constituted vaguely delinquent, within a constricted social environment even in the pre-seclusion area, entering into a process of alleged actions before seclusion. The seclusion is then rationalized by construed seriousness of conduct by a deviant ascription, and that if indeed mentally ill, is at best motiveless conduct. This process of devaluing and then hiding expression is what staff and structural influences are there to do, within the constricted social environment, with least talk and only in order to abide by the norms of the social structure.

Inter-subjectivity is a biased belief system of one's actions that seeks agreement in order to make normative, sometimes inconsistent with own or others' personal values and beliefs. These common actions either finds or fails collaboration with combined activity within one's own membership (Kieffer, 2001, p.91) as other clients, in carrying out structural institutional norms. The entire process of seclusion, suppression or any coercion happens enforcing no turn taking in conversation. The emotional reaction or requesting talk to these conditions as incurred client's action is all that is justified for seclusion, not just assumed unintelligible pleas for relief. Imposing motivational lack of self-responsibility to withhold emotive content, bring the clients pre-dispositional refute to recognize the relationship between professional helper roles and the helped roles. This social distance becomes insistent in its pre- motivation quick rejection to seek an alternative path, without patience to listen in recall, and exists as a present mental state. In the next data extract Johanna is telling about her distant relationship with her named nurse.

199 Q: How do you feel about this, your relationship with
200 your named nurse.
201 Johanna: *That hasn't worked really*
202 Q: For you that hasn't
203 Johanna: *Well I've asked but she's really a rather quiet*
204 *person, this the one who …*

Notice there is abrupt conclusion due to the suppressive effect of the lack of talk (Line 204). Asking for help is re-modified (Line 202) into the clinics management of needs (Foucault, 1973, p.143). Interviewer 1's (Sanni) helper role, recognized by the mental health client as the imposing of self-identities and stripping

of social identity by establishing agential fault (Line 202) in the data extract above, is also rejected silently in lowered motivation as a defense (Line 203) then developed recall as social awareness. Distancing social self to prepare for social expression, to cognitively express relief from trauma by the client in recall, depends on motivational rejecting the professional helper roles' redefinition of the problem, as lack of agency (Line 202). The suppression is temporarily motivationally concealed, to quickly dis- empower the traumatic realization of more possible untold former past, current, near, or far reaching seclusion, that brought to central focus the mental health client to speak. This accounts for the suppressed difficulty, in accounting for what actually happened. Clients are doing this recalling to a professional in the interview, telling about the past suppression of agencies efforts without result, this enforced sole identity was defended by even more social positioning, and maintaining of the socially learned awareness of the client's role on the inside, as not an individual departure from conduct. This social concern builds a validating foundation that might be more precise, in naming confided conditions of isolation in recall, to present reporting to interviewer 1 (Sanni) imposing the transgression of agential power as causal of seclusion, and the clients defend and protect self, by affiliation with social identity, from past and however future isolation.

Immediately, the clinics and Interviewer 1 (Sanni) configured self-identity met a defense of client's social identity, and assumed pre-motivational communication shut down of the reciprocity of the environment in the interview, at the prospect of describing limited self-agency, without much elaboration. It is a re- telling of a dis-advantageous environment with an accusation of failed agency. In telling of unanswered pleas for talk, the client shuts down description of the staff's enforcement of responsibility (Line 203) as well as a quick stop (Line 204) as the unsatisfied search for talk, is suppressed. In traumatic recall to the interviewers, social scientific inquiry demanding a self-identity answer, and stripping a social identity close same group client membership cohesion answer, mental health clients became stronger, even more socially self-aware. This enabled the client's motivational protection in preparing to defend social self as apart, and away from adherence with a professional helper. I became silently aware in the interviews, that this naturally occurring communicative interrupting, imposing client incapable agency, client rejecting perception of effective agency as a motivational precept, and limited suppressed sources of external information was happening between interviewer 1 and the mental health client. There was a tendency in conducting the interviews for Sanni to insist for an answer, interrupt, or offer conclusions which later, as it is perfectly natural to do so. While analyzing the transcribed data, turning the lens on the professional interviewer, became yet another focus of study for me. This redefinition of imposed agential fault contributed to the breaking of suppression and re-surfacing of content, at the time involved of the mental health clients simply waiting to voice opposition to seclusion, by coming forward to speak. The client transpired enforced self-identity (Line 202) shutting down, of institutional pre-conclusions insinuating self-blame for reasons leading up to the sanc-

tioned event, and abruptly canceled descriptions, due to pre- motivation disuse of stated maximum threshold of labored hearing, and harbored expression.

In the interviews, mental health clients are listened to recalling being motivationally dissuaded from talk by staff, reviving emotional regulation of pleas for help, reliving the trauma on the other side of the wall, separating them from the constrictive environment around the seclusion room. The suppressive effect may still be hidden emerging from visible agitation, and brought into expected relief from enforced motivational low affect, that can be complicated by illness symptomology and becoming subject to little or no talk. This resurfaces in reproducing client adamant, little to no-choice estimations of social environments inefficacy that is evident in the effect of the constricted coercive environment. The enforced and imposed stripping of social identity deals with Johanna's long-term effects of suppressive self-regulation of its description as well. Johanna breaks through interviewer 1's self-identity interruption (Line 202) after motivationally shutting down the first question, closed to reconsideration of an alternative viewpoint, and quickly closes down further explanation (Line 204) as motivational shut down transmitted by the recall of an inhibited description of a quiet nurse, who did not interact (Line 203-204). The alleged event, take down, seclusion, silence, waiting, recall, and the telling all endure suppression and emotional regulation, to distance the offence of the coercive practice that further solidifies bias of helpless agency, of expectant poor outcomes in pre-motivational affect conclusion. The low level of participation is then re-defined as lack of adherence. Incapability to master external constraints such as naming treatment objects in memory is re-defined into punitive care to recreate involuntary status.

In further developing the analysis of the last extract, another example of a natural occurring human suppressive device, as an unavailable attachment figure away from social self as expressive, describes a psychiatric staff member as a "rather quiet person" (Line 203,204). Line (201) starts from the pre-decided position that social expressiveness is not responded to, and that lowered motivation is acutely determined to adopt a distant relationship, as it is responded to and enforced by a health professional in recall. The psychiatric nurse is described being quiet, and visible inter-relations with other clients with an already agreed upon, collective demonstration of the phenomena of human withdraw of talk that elicits suppression, as the answer positions itself as social identity by defense of a collective demonstration (Line 203) of talks unavailability. On Line (202) there is a second attempt by the interviewer that asks for the person to respond as a responsible individual and suppress a social identity, allude to the client non- reform ability. On the last line (Line 204) sudden stopping indicates ignored need to be heard at the failed description of the nurse, due to motivational disengagement. Emotional reacting or learned helplessness is the only social reality as far as it is reacted to, regarded or responded to, and socially constructed because agitation, disorientation and any opposition to the use of forced consent may be re-defined unintelligible, and shut down indicated by the health professional in the first place, and transmitted to clients experienced

as suppression of recall. Notice the request for talk therapies is made, with no help provided as the client assumes happens to many people.

174 Q: Yeah. Do you feel that when you have these emotions
175 that it's better to deal with them by talking with
176 others than on your own...
177 *Esko: Well I do think that it's good to work them through*
178 by yourself, that if you start criticizing nurses very
179 much then (15:30) your own care.
180 Q: What do you mean by criticizing nurses?
181 *Esko: (15:36) sometimes you feel it's better to deal with*
182 these things yourself than...

Above, blocking a response by the nurse re-configuring needs make a client dangerously more talkative, insisting on an answer, or it can motivationally depart recall of the trauma interaction and this forfeit to request talk is expressed in memory, in this extract (Line 179) (15:30). An attempt to re-define the core problem as "own self" (Line 176) is dismissed rather, social identity is maintained, and a description of the problem as social and suppressed (Line 178-179) (15:30). Esko rebounds from the motivationally suppressed, then resurfaced fear (Line 179) of description of criticism (Line 181) as re-definition of needs according to nurses, toward some explanation of taking the path of least resistance, before a sudden start (Line 181) and stop of suppression (Line 182) of a description of the agential tactic of self-suppression. Agitated criticism is discovered to be an indirect institutional intention, and Esko decides to deploy a pre-motivational low affect auspicious (Line 181) (15:36) and refraining from this, in favor of dealing with the crisis alone. Interviewer 1 asks a direct open-ended question of personal perspective to be answered as self-identity, and is answered positioning the perspective as commonly shared as yourself (Line 178, 179, 182) rather than myself, immediately positioning a social-identity answer. An "I" identity is a fictitious "alone" consciousness instilled around the room and past seclusion, that is enforced by the institution, to derive a break with a person's social identity. Social identity is the learned empowerment breaking an enforced self-silence, ensued by the suppression due to past seclusion, rejecting and deconstructing the idea that they have been victimized as a sole, alone individual. Its deconstruction refers to self as conscious of others facing similar maltreatment, aware of the conditions facing all who reside in the in-placement setting.

Esko considers working with staff as an option for treatment, then quickly adapts pre-motivational abandonment of it in favor of "working on one's own", before fear of obstruction of care, represented by a pause (Line 179) (15:30). The (15:36) pause time before the acknowledgement of personal responsibility, tells of detachment from the nurse's help on (Line 181). Esko answers from a collective assumption of what you would do (Line 177,178). A pause (15:30) on (Line 179) distinguishes the jeopardy to own care as self, in contrast to an awareness of a social aspect of care, as essentially our own care. Your

"own" is assumed as a collective understanding seeks no alignment with a nurse, and separates responsibility transmitted, and re-defined as blame to an individual from the social aspect of self. By (Line 178) the social aspect of self is You. (Line 181) tells of a common effort to enact antecedent pre-motivational distance from nurses, and acknowledge self as a social self.

The pause (15:36) (Line 181) happens before a description of any interaction separating participation, and difficulty in stating own agency in the situation (Line 179-181) to describe simply working on one's own. This pause tells of suppression away from collaborating with a nurse, and a reluctance to persuade or criticize an impartial observer. Esko believes that personal expressiveness does not make nurses aware of what helps, and adopts a pre-motivational pre-decision position to disengage interaction and participation with a nurse, and tells in recall that criticizing like holding on to own definition of needs, is to no avail (Line 178). A pre-motivational property immediately concludes criticism of nurse's acts, to deal with matters alone rather than initiate talk, as an active long-term pre-decision of non-participation. Description of the nurse is cut short in suppression, because of the external incapability to facilitate agential power therefore; self -elaborate description is diminished.

Clients tell of psychiatric staff, that have enforced personal irresponsibility in a deviance assertion, re-conceptualized as blame of the individual, rarely adopted by the client rather recognizing externalizing for a compromised situation, and that interaction and participation with them, make worse one's own care. Enforcement of abandoned individuation, patients report there could have been collaboration, as told in recall. Structurally constructed and staff enforced instigation as an individual incapable of self-responsibility, the client is temporarily suppressed to reemerge identifying self as a social member prevalent of not receiving care. Esko describes inefficacy in the environment, and a learned (Line 181) social identity adopted to arrive at external reasons to display deluded emotion, and avoid seclusion by avoiding nurses (Line 181-182) out of mistrust of care. Ordinary people with any kind of trauma can draw social learning from others that have experienced same trauma, thus holding onto social identities absolving self of constructed individual lack of agency. Criticism of care is part of collaboration, and in the absence of this the self- description may be suppressed (15:30) (Line 179) and becoming aware to creation of individuation happens after a pause of (15:36) (Line 181) telling of the effect of suppression, away from participating care. (Line 181) (15:36) pause tells of a pre- motivational objection, and an already arrived at bias, to not ask a nurse for re-defined help subject to criticism. Esko first answers in emotional suppression, then follows an uncertain general non-specific description of abandonment of care, that had been suppressed telling of sometimes (Line 181) and put the prospective of future distant care non-specifically in regard to the past, present, or long-term after a traumatic pause. The time freeze (15:36) separates participatory care and talk from present ownership, to something that was formally needed and might be needed in the future and not accomplished, and may not be achieved if not for a preemptive and preeminent pre-motivational decision to not ask (Line

181,182) for a re-definition of needs, and be enforced to initiate self-sufficiency that cannot entirely be realized.

The pause resides to mark the recalled absence of talk with the nurse, and the action to core requests (Line 179) not achieved by criticism is followed by the pause, and the pause exists before the participatory action failed in recall, and the treatment had been denied (Line 181). A failure of individuation became the institutional functional result of a distant encounter, reportedly for the benefit of dissuading a social activity, among many clients. A social account diverges from acquiring second hand personal accounts, of the reacting that precipitates seclusion, and assume the action that preceded it, lack of talk and the enforcement of individual agency as irresponsible, despite exposer to the trying environment of inefficacy, and avoidant human social relations that can cause it, as common and widespread. Clients pre-suppose the termination self-report of agency power and become pre-motivationally reluctant, to provide a quick demonstration of persuasion of this to the interviewers.

It is integral to make researchers aware, that a pre-existing pre-reasoned prejudicial rejection of self-fault bias of poor outcomes in mental health treatment, and institutionally constructed non-adherence can be due, to past and expected treatment failure outcomes, when delivering services to vulnerable populations. People with mental health illnesses possess the extraordinary capability to strength to make decisions toward betterment that is cut short creating dis-empowerment to develop bias of no wrongdoing, before confronting poor treatment outcomes thus avoiding friction with professionals. Strengths of pre-motivational pausing in recall of trauma objects develop well before, during, and long after seclusion doors shut to challenge, withstand and even confront psychic pain. The diligent reader can be aware that the client's use of antecedent pre-motivational pausing power around items of self-report can be present beforehand, and through emotional regulation avert settings of social inefficacy, socially constructed as uncorrectable irresponsible agencies individualized processes, with the consequence of seclusion suppression serving to "contain" socially expressive needs re-defined and unmet. Recall of ascribed deviance to agitations indirect aggression to sought care not achieved, creates social connotations of hidden to visible long-term mental states (Barsky, 2002, p.483) as revisited by pauses (Briere, 1996, p.1) and includes a long-term reverse suppression before and after traumatic items, in comprised expression of high and low affect among the human species. Collaborative professionals can guard this attempt to hide institutionally constructed cause of disturbance, and clients insist public vocal social opposition of seclusion revolving door, when visible talk does not threaten the client or third parties.

In sum, it is important to bring philosophical and theoretical understanding to the findings of this theoretical chapter, that draw on assumptions based on the exploration of what clients have been telling us, about the social world in which we all live. These discussions and explanations help social researchers to understand pre-motivational drive and inactivity that permit human beings to accept little to no choice outcomes. Motivational systems shut

down, and negotiate the constant maintenance of low affect and self-suppression required to avoid seclusion. An evaluation of the weighted setting quickly dis-qualifies self-cause for treatment failures. Client then point to external attribution (Abramson, Seligman & Teasdale, 1978, p.53) both in experience, current and future outcomes in social conformational search (Croyle & Sande, 1988, p.485) for open talk therapy, and in emotional regulatory memory recall of restricted, and exclusive social environments. In succeeding chapters I explore the bare social conditions preceding the hospitalization, absence of voluntary therapeutic work and re-definition of needs my findings show, exist to increase punitive supervision, and establish the non-productive, rationalized by the expected amount of motiveless crimes of want, in society. The institutional indirect inpatient intentional function creating disorder of social relations, acts to re-define self-responsibility, and loss of agency as a pre-ordinance. This absolves the social environment unresponsive to self-efficacy, as a social disarrangement and immediate route to collapse mutual cooperation between worker and client and drive a more corrective practice of social control.

3.5 Enforcing Human Agency

This chapter investigates the enforcing of human agency, where clinicians are found by clients to point to disregard to self- sufficiency as fault, in order to present agential relevancy a greater determinate, than a seemingly neutral environment in shaping treatment outcomes. In this interview, Esko considers help from nurses an option of dealing with problems, then quickly extinguishes it with pre-motivational bias toward avoiding enforced interaction with a nurse, who emphasizes personal agency, a greater determinate in outcomes than inefficacy. The nurse enforcing agency is again to no collaborative avail, due to distancing talk imposed by the clinic. The nurse acts as a natural "human suppression" phenomenon, that avoiding the nurse is an effective personal agency, put into action by the client.

183 Q: Have you been able to tell them or these nurses, or has
184 that caused problems to them.
185 Esko: *No well I don't think there any point saying anything*
186 during the situation (...) ward nurse...
187 Q: What's the main reason that one doesn't necessarily want
188 to talk about one's emotions (ettei halua puhua tunteista:, in
189 the passive voice) with nurses.
190 Esko: *Well they just say that you should deal with your own*
191 matters (pitäis omat asiat hoitaa", almost "mind your own
192 business) don't start meddling into other people's affairs (...)
193 Q: What, what if, is it easier to talk with nursing staff if
194 they feel that the problem doesn't have to do with somebody
195 else, but with oneself...

196 Esko: *Well yes, in personal discussions...*
197 Q: But not otherwise.
198 Esko: *No.*

An enforcement of dis-enabled agency enforced by the nurse is presented succinctly (Line 190). An assumption of diversion from personal responsibility, the problem to be corrected is made by interviewer 1 (Sanni) (Line 193,194,195). Interviewer 1 (Line 183) starts with the assumption of individual agency as able (Line 187) continues to enforce client agency as capable to exert what one wants (Line 195) and concludes the inquiry by enforcing self again of problems, emphasizing agency capable, to speak to nurses (Line 193) as easy. It is discovered that avoidant deterrent mechanisms around the room produce the pre-motivational retreat. There is a client antecedent motivation to avoid help (Line 185,186). Notice the pause time indicating separation and detachment from the nurse, before the imposition of the nurse's intervention (…) (Line 186). Esko (Lines 185,186) starts with the devaluation of speaking or talk therapies with nurses. (Line 187) The question is posed to an individual perspective, but a social account of discussions is preferred to a personal, as a personal discussion is not helpful (Line 196,198) with nurses and Interviewer 1 can only guess otherwise (Line 197) or that nurses do not help with problems, and the mental health clients define them as socially inexpressive. A social account takes into consideration learned helplessness of other mental health clients. In the end, Esko says that the nurses can help with personal affairs, but not other affairs, not social affairs. Up to this point, Esko had been answering assuming shared agreement among mental health clients as a long-standing bias that expression is not socially received with understanding, and only motivationally reluctantly answers as an individual. Esko discounts social interaction with nurses, and only tells of the lowered motivational pre-decision in saying there is no point (Line 185) quickly answers nurses do not serve a social perspective of self, just do disservice to personal, as these are not personal problems, rather problems with staff. An incomplete description of the inefficacy is cut short due to pre-motivational exhaustion, and is at a loss to describe own closed agency, in the limited situation.

If treatment is to be collaborative, the self-enforcement of failed individual responsibility may be creating unrealized agency. This makes public and visible the process of suppression and seclusion, and it serves the created problem, which is not personal or autonomously agential, where there is no ownership of the personal problem. The nurse's irresponsiveness is no use, to a personal problem. A prior low affect motivational survey of the setting may be all that is needed to render perception of lack of agency, in advancing the setting (Line 185). Low affect is an adaptive way to avoid coercive encounters (Whaley, 2001, p.93) by balancing angry, affect explication that might arise in a stronger ability to harness restraint from communicating trauma objects. Transformation of non-corrective conduct as deviant, and to construct and enforce responsibility to assumed efficacy in an impenetrable environment, is substituted by presenting problems of treatment, rather than vital therapeutic issues about illness

to the client. This distracts from any tangible problems with living of a person in the first place as unexpressed trauma, and the enforced suppression does not serve self-containment as emotional regulation. This complicates areas that the client needs to address causing further duress by not being able to communicate trauma, adding to further problems or overload, then terminating agitated cognitive expenditure. There is an early point of departure of motivation immediately (Line 185) that indicates that the problem may be social as one with collaboration, rather than personal (Line 196,198). A traumatic, suppressive pause (Line 186) is between saying something and the nurse, and relates separateness, and absence of talk.

Emphasis on self-identity is institutionally enacted to not seek social identity, as self-fault is more readily clinically constructed, as an individual infraction. This presents an attempt to isolate as an individual problem toward an individual solution, and failure to make a social problem toward a common solution; an intervention to enforce an individual agencies dis-empowerment and create emotional suppression of the initial prevailing problem. This is discovered to exhaust motivational operation, cancels the seeking of widespread, visible positive outcomes. The mental health client made a potential description of a staff person but not elaborately, as descriptive talk does not capture isolation, as this is imposed silence. The question in Finnish (Interpreter 1) asks to be answered as an individual (Lines 187-189) and (Lines 193-195) the answer (mental health client) is as a social member. It happens in recall of psychiatric staff enforcing a misrepresenting departure from social identity that suggests, "Mind your own business" (Line 190,191,192). That tells of what staff say to mental health clients, that (one) or anyone, should deal with (one's) own issues. This devalues social relationships among mental health clients, and between staff away from help to the health professionals, enforcing silent isolation even within the open constricted environment, to maintain privacy of trauma content.

Interviewer 1 (Line 195) asks Esko to answer from a personal position. Esko (Line 196) answers that personal discussions with staff are enforced emphasizing agency, which do not help with other matters and problems when dealing with staff (Line 197) as inefficacy (Line 198). Esko quickly agrees with this definition of no help dealing with other matters (Line 198) and insists that problems may not be personal. Identifying a departure from agencies individual efficiency, is an application of a deviation from normal conduct, as a label of an infraction. Regardless of inefficacy in many cases, it may be part of the processes of the revolving door to assume the client as an incapable individual, to contrive deviance. Esko positions the problem to be other than self-fault, as one's own account (Line 190,191) of trouble, is instead enforced upon his derailment of agencies individual responsibility. Esko points out that trouble is not with other clients (Line 194,195) but with staff (Line 191,192).

The preceding inquiry positions individual agency at fault, for Esko not being capable to talk to nurses (Line 185) not expressing emotions (Line 187,188) and enforces agencies individual fault or problem (Line 194). Esko reports no fault to agency in present inquiry, and of past look of not interacting

with nursing staff. The social construction of abnormality is a perceived conventional function, constituting the individual as the "individual to be corrected" (Foucault, 1974, p.101) as subtle deviance to responsible capable agency. The socially constructed individual "verges on undesirability with no evidence, that the person is able to respond to correction or not, and the usual techniques and procedures and attempts at training, have failed to correct the individual, and appear to require correction" (Foucault, 1974, p.57). Based on appearance before any exchange of words, psychiatric staff quickly judges a client's agencies deviation, as normative standards of infractions to behavior. This forces the client to stifle agencies effectiveness, and to comply to accept a regiment of rules without the capability, not the ability to follow them, as seclusion sanctions are the consequence. The client is then forced to accept undeserving responsibility, for the seeming detour from conventional individualist responsibility, and personal participation. It is a point of transformation from a widespread social problem of constrained inefficacy, into failures of individualist responsibility. The judgment is not based on actions, but reacting to little to no help is re-confirmed in the re-creation of the seclusion reacting, as formal or informal sanctions. Foucault (1974, p.19) suggest expert opinion, tries to show how the individual already resembles the crime (deviance) as individual fault, for example before they have committed it. These taken for granted, assumptions about mental health clients exist before asking to account for, what really happened to them. These punitive aspects of deviance do not have to be mentioned, require no lengthy explanation, and are ordinarily understood as labels, fixed and predominant in the mind about people around prevailing ideas of mental health.

Client participation and requests to talk are discouraged, and a punitive label enacted to it. Social construction and labeling theory requires an apparatus of correction to be in place to "correct" the "individual" (Foucault, 1974, p.58) along the vague conventional labeling of the expected amount of the unproductive. Even beforehand, the institution is pre-designed to attribute individual responsibility to no fault illness, and predesignating a decline of productivity among broad sections of the populations and depends on unequal social relations, between staff and configured within peers. Construction of neglect and sparse interaction makes broad assertions of individual and groups of mental health clients, and assigns ascription of lack of personal responsibility, as a form of already established deviant labeling in order to create involuntary status. Ordinary normative conversation, quickly assigns a disparaging place where the created unproductive ends up, or foretells of what will happen to people like that, for example in the inpatient area, possibly devaluing any other designation than what is conscripted by dominant, constructed pre-established pathways. It is important to understand how the mental health client situates self in context with traumatic objects within the inpatient setting, among which are professionals. By describing professionals as not generally being approachable, client's voice incompatibility of psychiatric staff in recall, of developing normative based assumptions of an evasive master status of psychiatric staff,

and secondary posed to help. Recalls of staff indicate they attempt to impose the assimilation of new auxiliary mental health roles, upon ordinary requests for talk as non-corrective upon the client, imposing self-responsibility to not ask for talk and any departure, from this as primary deviance upon mental health clients.

> 199 Q: Very well. We're now talking about care staff that do you, generally do they
> 200 listen to you if you have something on your mind…?
> 201 *Johanna*: *Well they're in a hurry, they're in a terrible hurry because (yawns)*
> *202 because (…) staff's at a minimum (…) is that one has two nurses, in the daytime*
> 203 *there's a bit more, there are 24 beds on this ward…*
> 204 Q: In the evening if you want attention? Is there (…)
> *205 Johanna: Well generally they hold you down (pidetaan kiinni) that (…) named*
> *206 nurse and the doctor, named nurse meeting named nurse and doctor.*
> 207 Q: Do you mean like is that the time when (…)
> *208 Johanna: Well yeah it erm, (12:56) you may go and talk to them (…) if you're*
> *209 and they are not concentrating on anything and then start shouting around (…) 210 give you an injection or (13:13) injected medicines (…)*

Constructed reliance imposed to one's self agency, is created by the inefficacy of staff at a minimum, too busy to talk thus forcing Johanna to speak quickly in a hurry keeping expression of needs short, overreliance on agency to bring about what is supposed to be a collaborative model of care. Agitation is constructed by the unavailability of nurses, where talk is repeatedly sought (Line 201-208) finally met by forced medicine (Line 209). The neglect of talk elicits provoked shouting (Line 209) is met by involuntary forced injections. The client approaches staff with a need (Line 208) that is repudiated, then transformed as an instance by shouting for combined talk that is neglected by staff (Line 209) as the expression is transformed into an agitated instance, that is met by forced medicine (Line 210).

> 211 Q: Would you want that they'd listen to you even more when they make these
> 212 decisions about treatment, or are you happy that with what the nurses and
> 213 doctors are doing (…) that you're being listened to.
> *214 Sinikka : (14:02) Well generally they're all the time glancing at the clock or*
> *215 glancing at the calendar or glancing (…) of course they're busy (…) the*
> *216 authorities they've downsized this that these facilities.*
> 217 Q: …mm…

When trying to talk to staff, the requests for participation are assigned unintelligible by "glancing at the clock or calendar" (Line 214-215). Forced measures are quickly rationalized by a shortage of acceptable care (Line 216) that little further explanation is quickly dismissed and shutdown. Staff is found by Sinikka to enforce the self as the primary force shaping a favorable outcome, categorized being too busy or ignoring (Line, 214, 215) the request turned into a demand for social needs. The emphasis of agencies divergence from personal responsibility to withhold talk, and absence of participatory help serves the client an insistence to demand needs, and this request is deemed unintelligible that can exacerbate the petition into agitation, that is labeled deviant. The creation of unmet need, failed trial at participation and provoking inaccessibility to talk creating a reaction, is then transformed into irresponsibility. Sacks (1992b, p.44) indicate that in memory for example, there is a failure of orientation by co-participants or between patients and staff, to work jointly with each other. A transition point existing as a pause, acts to represent sought care not achieved, and failed attempt to participate, being stripped of the capability, residing in place after the absence in recall, and before an imposed intervention to prepare for the utterance of trauma.

These interviews with the clients suggest this forced institutional process, does not illicit the mental health client's own understanding and agreement of the new roles imposed. Self-identity and responsibility to help oneself, with assumed self-efficacy in environments are encouraged by staff to be socially expressed, among mental health clients within the constricted setting. The failure (of efficacy) of opportunity to exert choice, therefore in many cases is rendered incapable, while unrealized agency can be constructed as visibly at fault, due to objective social inefficacy. This is made primary known to a client where it is not deserved, because of their created failure of exertion of effort, and at the very least this new awareness can be totally unsettled, with any mental health client. Sacks (1992b, p.44) suggests that a person in the middle of a socially constructed ordered arrangement, is not concerned with a product of the constituted setting, as reaction or helplessness to expressed need is transformed into seclusion as continual implicated transformation, consequence, product and its reproduction.

The client accounts for this with a representation of time in isolation, acting as a suppressive force that may be presently, and at a future time become released with a greater low affect or agitated positioned emergent expression, because of the inability to counter-pressure regulatory emotional containment. The expression of human need, in recall whether met or not met, increases and acquire an untold heightened, or lowered precision in pre-motivational affect expression due to passed isolation. The emphasis of identifying causes for seclusion by the client, rests predominately with external forces, and is discovered less so, with failures of exerting agency. As intensified expression is affected by time of isolation, perhaps the longer the pause, the more distant the recall may be of separateness from treatment, in degree of severity of agitated need, as

pleas of help can be configured deviant, in length of human interactions absence.

Self-identity stripped of component to change, creates unresolved suppression discovered as opposite low affect, whichever allows the person to fit into the context of the environment of the constricted setting. Coercive measures are more imposed on involuntary, than voluntary mental health clients; the latter receiving more talk therapies (Rogers and Pilgrim, 2005, p.213). In addition, there is lack of confidential talk, administering of involuntary medication, and a denial of multi-disciplined services among both groups. Structural constraints such as desolate interaction around the seclusion room, inhibiting capability creates non-participation that constructs involuntary status, even though the clients can be willing, able and ready to pursue change. As psychiatry does not have to provide basic support for people to enable free reign of ability, it can do so if forced by self and social advocacy. It is possible that clients when involuntarily hospitalized did not possess the capability to enact a decision, refuse and express consent; however the data suggests the institution may create the inability to exercise a decision, voice consent and issue an assisted refusal by the manufacturing of involuntary status, as this theoretical chapter briefly explains. The clients were hospitalized and issued involuntary status at the time they signed consent to participate, as well as responded promptly to an advertisement by following routine directions (See Appendixes A and B).

By obtaining an educated informed consent in an involuntary placement setting, there is a contradiction of socially constructed and human evolved processes of non-consent, without the clinics acknowledgement of client's refusals, indecision, exercise of realized agency, and attainment to comply with unindicated rules. Indecision and incapacity can result because of the forced setting and situational conditions of the compulsory inpatient commitment create it, thus creating the seclusion. One client refused for her interview to be used, and this decision making agency power ability in the compulsory area was immediately recognized by me, but it is possible that a constricted area in the hospital creating the need to refuse, would not slowly or quickly serve credibility to a refusal based on the surrounding incapability, to issue adherence to consent. The process of seclusion may attempt to do what psychiatry really cannot, or impose criminalization covertly in the creation of agitation and disorientation by the lack of talk, resulting from an angry awareness of created lack of agency in a fixed, manipulated, weighted setting. However, this dangerous process also relies on separating the mental health client from being aware of wellness behavior, and imposes a concocted deviant label that can be resisted, along with partial subjective acceptance of any other real ill label. Clients reject this institutional stripping of social identity, by maintaining visible account of social self demonstratively, without much description of limited agential empowerment, due to termination of hesitant motivational anger or helpless overload, and closed bias of how "anybody" would be affected by inefficacy. Clinical social work can equip a level of self-suppression in clients, struggling not to react to own symptomology and awareness of structural suppression contrib-

uting to hindrance to agency in treatment decision. Emotional regulation is required to help clients stay out of the hospital, as an antecedent pre-motivational drive to avoid coercion, based on a created a non-consensual setting. The client below is unable to achieve talk therapies to ward off the danger of seclusion.

218 Q: In what way does therapy help?
219 Esko : *(…) things that it helps you to understand yourself…*
220 Q: (15:35)
221 Esko : *Yeah*
222 Q: That it's not easy to get, or how do you feel about this?
223 Esko : *No, no you don't get it very easily.*

Above, Esko is cast into a self-agential entity forced to seek recovery, while the prospect of combined help with a nurse is seen as seldom provided. The absence of care is quickly explained and shutdown, by an unavailability of resources (Line 223). In another interview a talk setting is infrequently met, that endanger Hilkka to coercion below.

224 Q: When you said that you had to work through these things alone, and
225 do this alone (18:27) or is the atmosphere here in the hospital like that…
226 Hilkka A: *It's a bit too rarely that we have these meetings*
227 Q: Too rarely…
228 Q: (*18:45)*
229 Q2: ... Her treatment should include bringing her into a community.
230 Q: So do you feel that your treatment of your illness would require more people
231 Q: around you. Do you hope that there would be more…
232 Hilkka: *Yes a little bit, there could be more…*

In the above extract, the prospect of an "alone" condition has brought out a temporary shyness where the clients, suggests help with a nurse might be a more effective combined path. The multiple suggestions from the interviewers struggles to find the former isolated individual, whom help had been denied talk making her a seemingly sole agency power in treatment. The absence of meetings with people is recalled in silence (18:45) (Line 228).

The social structure enforces distant professional human social relations to construct failures of agencies individuation, rather than agency grasping social awareness. As Parker (1997, p.184) explains, limitations of psychiatry or psychology may discourage group identity, particularly when entire populations are affected by disease and dire resources, and have returned to the individual as a focus of study in research, suppressing social identity. European social psychology has been brought back to embrace individual psychology, as the foundation in research of group behavior, even more so today. The explanation Parker (1997, p.184) gives for the shift in emphasis toward individual pro-

cesses, away from group therapy processes, took place over more than the last 40 years due to increasing interest in the individual as a locus of action, rather than the collective. The researcher acts to explain individuation of group phenomena, by describing the image of the individual emerging within group studies, by primarily the cognitive models of attitude formation and social behavior, which reduce much of the explanation of human behavior down to the individual, and failures of agency. This makes it easier to ascribe and formally or informally reinforce deviance to mental health symptomology, and assign either hidden or visible individual trauma that everyday individual humans encounter with everyday living, and this effort to hide so-called social trauma is considered normative. These individual explanations of tragedy rule out the social accounts of trauma. Individual assumptions of inefficacy itself bring to surface external allocation, of cause of disturbance.

At last, Parker (1997, p.186) explains the departure from group identity as setting up a crisis, for method in the disciplines surrounding mental health. There are many debates over individual and social identity, including postmodern psychology that says psychological phenomena are socially constructed, and act to justify the turning point from groups to individualist identity. This has given rise to questioning the view of individual identity and agency having an impact on the social reality and, more so constituted by language, particularly with quick definitions afforded to the individual with labels lacking quality, such as those of deviance and mental health labels. Knowledge of self, and sense of individual identity, and groups as networks of account and experiences of identification, are culturally bound and historically located (Parker, 1997, p.188). Cognitive properties or common dialogue of collective behavior, can be separate from local conventions, and make an account of group psychology systematically by reducing explanation to the individual, and their actions to the interpersonal level (Billing, 1976, p.250). A social account of external cause of disturbance, can fortify a sound externalizing reasons statement of the closed social reflexivity, between self and staff underway in the setting, creating another account of a problem that had occurred or incurred. The individually ascribed label of subtle deviance fabricating demand for help, and failed assistance inspires offense, and the mental health client may become aware of the structural attempt, to construct the problem of constricted agency in the first place.

3.6 Inefficacy of the Environment Creating Lack of Agency

In this chapter, I briefly detail inefficacy, where agency is not provided with means to manipulate outcomes favorable to treatment, because of inopportunity of the uneventful setting, which pervades the prevailing impact of whether a person achieves what they desire. Each perceptual agency versus accrediting inefficacy, to favorable versus unfavorable treatment outcomes, opposing belief construct generates competing interests, that justify normative explanations of

self-blame for treatment failure, suggesting open agency in the setting allowing proposed success, in treatment outcomes. These justifications for inclusion or exclusion from better treatment are sometimes firmly embedded, and charged with power differentials, in the language of labeling mental illness and deviance, that implies departure from personal, moral, social and failures of responsibility (Potter & Wetherell, 1998, p.138) to abide by plausible conduct, characteristic of the like population. Ability versus capability labels charged with rationalizations of lack of individual productivity toward betterment, often equips the other of an intentional action with its own terms of normativity, justified by an overemphasis of individuation, that the failure of betterment is explained by the proclamation, that essentially most individual treatment failures are attributed to lack of able agency, in the like population. This sweeping characterization (Sacks, 1992, p.588) of an individual at fault is held by psychiatry and lay people alike (Rapley, McCarthy & McHoul, 2003, p.427). This public rhetoric relies on cognitive structures to the foundation, of an individual at fault (Breakwell, 1993, p.2) rather than the impact of inefficacy. Rationalizations of merit and deviation from a productive ethic often can be reduced, to explanations of privilege or disadvantage. Most any person's demonstration of able agency compels a person to cite external, structural, and social environmental advantages or limitations.

Clients present two inconsistent cognitive, visible not acknowledged of communicative needs as an assumption of inclusions agency often demonstrated by capable others, lack of clarity in direction of participation and second, a hidden assumption of an accommodating environment of a caring explanatory setting. These account for incapable non-adaption to the setting, where there is dissonance searching out these contradictions among others, and own experience. Hidden realities constructed in the inpatient setting to what was not expected of a person's visible status, credits psychiatric professionals' visible presentation of bias of clients failed ability. This assumes clients inability to reform in proposed capable environments creating an unsuccessful client that does not seek explanation among rationale motivational scripts. Dominant individualist social ideologies presented to mental health clients it is discovered, unravels visibly un-falsifiable social efficacy, in almost any social environment as normative. Open agency is sometimes justified by construing others, only by the absence of relevant conditions (Coulter, 1973, p.155). This absence of explanation such as the defining of exclusion from failing to act independently, and failing to take responsibility for ones' own resources for example, is sometimes cognitively construed as an individual's failure to conform. This conscription is held commonplace, regardless of ability or capability to exert agency. More so, structural exclusion determines poor and successful outcomes, as a person apprehends pre-awareness of this, and reject the only presented visible successful outcome as un-falsifiable, thus avoiding a poor outcome. Professionals situate self in ideas about the social reality, where an unchallenged assessment of social efficacy is presented visibly, as a plausible, common sense version of someone else as the ideal person, misrepresenting this to mental health clients. Clients'

needs must supersede the best interest of the so-called ideal person, and the dominant understanding is visibly cast as the ideal person successful, in almost any social environment, as congruent with common-sense knowledge.

Coulter (1973, p.160) further contemplates the attempt is to visibly present only successful actor relevancy as presented subjective experiences, that attempt to situate open agency. Assumed open agency makes general, and warrants claim of background expectations of purely surface phenomena of advantageous objective social conditions accommodating able agency. Dominate beliefs insist that social efficacy is always true, and its exception unintelligible and deviant. Comparing exclusive attributes of socially constructed irregularity to demonstrations of inefficacy, inability, and proposed in-ordinary conversational contexts to simple requests to talk, is dismissed quickly by the label of unintelligibility. Implausibility assigned mental health's request to confide with staff substitutes self-initiated social expression, for professional re-definitions, of a deviant diversion from norm. These deviant connotations cite language pervaded with counterfeit deficient labels, attested to communicate mental health concerns as normative, conventional, every day, common, taken for granted assumptions about the social world. These beliefs absolving the social and structural environmental impact on outcomes are reinforced and centered in failure to abide by an individualist achievement dominate ideology in disenabled personal ability, to withhold emotional expression around the seclusion room.

According to deviance scholars (Holstein, Gubrium, 2008, p. 355) through assigning unintelligibility to requests to talk, an individual's assumptions of the conceptions of self in context with their outer world, there exists no wrong doing, only labels. The exclusive environment socially designs a process, in order to formally create a violation of conduct, that if it did not exist, there would be no existence of a violation of conduct. Maija tells of the mental health professions that in some way serve to create labels socialized of poverty of capability in environments of inefficacy, and depend on the subjection of oppressed peoples, in order to suppress, re-create needs and their solutions. As a result, unexpressed trauma surfaces into externalizing statements, of an evasive clinical design, the predominate contribution for low outcomes in treatment.

435 Maija: This is I think the theme for me that whenever I talked to one
436 of the staff I felt they weren't really listening, they weren't
437 really paying attention, they weren't really taking my (33:01)
438 seriously. And what I did a couple of times was, after being (…)
439 four or five days (33:12) get something appointed as my caretaker.

In this data extract, inefficacy steals agencies ability to communicate self-report of "I" in the situation creating ongoing "needs" as a lost word. Maija is unable to find the word to describe her concerns of inefficacy when trying to report own powerlessness to staff, as the pause substitutes the un-indicated real reason for approaching staff. Maija's recalled attempts to participate in treatment are ignored, represented by the pause (33:01) (Line 437). There is a suppressive

hesitation before utterance of the "I" agent, as "my" identity (Line 437) that exists interfering at the direct point, of conversational contact with staff. The feeling of wanting to communicate, is suppressed with frozen time (33:01) (Line 437) after recalled description of staff, that does not take seriously socially expressed "needs" to be heard, because the staff were not listening (Line 436). The pause is a difficulty in presenting personal inclusion in treatment, and a suppressed item yet to be attended to therapeutically, as a present state. An attempt to describe being ignored for a few days (Line 436,437,438) in the hospital is accompanied after with a pause (…) substituting the disappointed motivational effort of an unsuccessful search for talk, recalling unanswered pleas to help of waiting after "my" (33:01) "needs" unmet, culminating in the disconnecting of needs (Foucault, 1973, p. 24) as an element of inefficacy.

A limited account of self, apart from needs is made to rest before a pause, due to depersonalization as loss of self-identity, because the self had been hurt emotionally, and needs time to recover. Frozen time (33:12) (Line 439) after waiting expressed in recall, is the present mental state of not being able to express over a period of five days, then finally being applied a scarce resource, or help from a provider, structurally reduce collaborative descriptions of needs, and force the mental health client by way of suppression, to wait to adopt the professional re-description of unmet needs. The pause resides before a recalled description of approaching staff with needs, waiting to get someone appointed caretaker (Line 439) (33:12) potentially to re-define them. The suggested implied missing word, my "needs" is lost in peripheral inattention, and is unable to verbally surface through the suppressive pause (Line 437, 438). This can account for the low level of amnesia (Loewenstein, 1991, p.189), (DSM-IV- TR, 2003, p.464) among other criteria, is long pauses around items of trauma describing both the lowered agential self- report and the setting of inefficacy.

The help Maija finally receives is described as something (Line 439) rather than someone; as depersonalization and estrangement from human relations. Notice the attempted division of the material from the social expression of need, as the social expression is withdrawn, and this is held separate from the material dispensation, by the institution. The pause (Line 437) of (33:01) after indicating self needs can be a suppressive effect of not being listened to and unresolved waiting in recall (Line 439) that acts in motivation to flee, to avoid not again expressing self, and this request for help had been rejected. The pause (Line 439) (33:12) is a suppression due to structural and relational isolation not met with somebody, but to take up something (Line 439) as an objectification as what would be substantially materially created unmet social need, represented by a silent debenture value of how much more, would have been accomplished by the symbolic missing relationship distended in recall. This is important because in order to reduce material resources, there is an attempt to re-define its social manifestation of talk, as a need. The pause indicates the partial understanding of the material (something) stripped of the social value (somebody) of the appointment (Line 439) estranged from current articulation, and professional mutual emotional recognition. The pause (33:12) represents the re-

experiencing of the wait of not being heard, and re-visiting the emotional labor to suppress past expression, for four to five days. The pause (Line 439) resides before the sought help in an environment of inefficacy, was attained by professional collaboration, as a partial social identity.

440 Maija: Erm, I think even from the beginning when I first came to the
441 doctors (…) at the health care center (…) there was a doctor and
442 there was a nurse, I think there were three people in addition to
443 my (husband) and myself, but they did this interview to find out in
444 what kind of state I was, and I found that situation very
445 manipulative to begin with, and I felt that, my experience was
446 that it was like kind of a game, that nobody's really sincere in
447 this situation and they're trying to fool me and trick me (10:24)
448 and that I can't like (…) and honest connection to anybody in the
449 room.

In this extract, a frozen separation exists after the words "doctor" and "health care center" as it is introduced from their perspective, and outside one's own perspective (Line 441). The pauses (Line 441) replace ownership of treatment objects, to be of any help. Again, the pause resides before the recall of approaching staff, and a separation with an honest connection with staff (Line 447,448). There is partial awareness of the self, situated in the social construction of the desolate interactional deceit, known to Maija as a trick (Line 447) and the clinics un- acknowledgment of her little or no choice emotional reactions, is represented as a pause (10:24) in this deception and estrangement of inefficacy, from real versus configured re-definitions of the initial problem. The agential self-report of "I" or "me" in the situation, stated six times before becoming lost in suppression (Line 447) after presenting the attentive action of the "trick", as central to creating the problem. The low motivational pause of mistrust, describes their (Line 447- 448) or predominately psychiatry's perspective, enforcing coercion. This speaks of a healthy suspicion, and growing awareness that the social construct in the setting is created, to set up the problem and the solution as cause and re-directed consequence, seen here as among human relations that are "tricking", not being sincere in the situation. It is a heightened affect performance statement, of the awareness of clinical creating of the external forces of inefficacy, absence of agencies influence, of the socially constructed social structure that attempts to "manipulate" (Line 445) and "a game" (Line 446) and "fool and trick me" (Line 447) producing Maija's reacting. Then the pause time follows after the expression of me as the "I" identity (Line 447) (10:24) as an insecure after-effect of suppression, that distances a coercive connection with staff after the request to talk, this is suggested to have been created by the clinic, as a way to recover from the trauma of the structure constituting itself, of false attribution to displace trouble source on the client, and client's awareness of external reasons for suspiciousness of being "tricked", in little to no choice situations of inefficacy.

The readiness to come forward and speak of trauma specific memory re-enactment, encouraging the pause time, are a manifestation of an enforced suppression by way of recall of isolation, and it is counteracted with a recall of social connections. This counteraction is leveled against the enforced suppression, in the telling and the self-suppression of speaking of the trauma treatment. The re-telling proposes effort to self-suppress the anger of the treatment, and at the same time tell of enforced suppression, creates tension as pause time before and after, articulated with long-term absence of talk. The seclusion emotional suppression theory proposes this pause and hesitation by way of low affect pre-motivation, may speak of immediate and future long-term withdrawal, termination from communication, and social commitment to evaluating and emotionally expressing little to no choice outcomes, in externalizing statements of the setting. The pauses barely escape surface attention creating contraction in trauma items, when the low hidden affect employed in the setting is remembered, there is a pause representing the suppression, and it's sometimes disproportional rebound into partial awareness, are long lived. The seclusion emotional suppression theory promotes the pauses, indicate the clients own future non-negotiation with inadequate care then move to conclude, with the non-participation of the clinic, through disuse, and disgust as a universally recognized emotional expression that is intuitively adapted by other clients. The social self is distanced and deterred from fear of assignment of the eccentric to confrontations, and from avoidant inaction of emotional communication and termination of future coercive care, by structural and pre-motivational self-suppression, over a long period of time.

490 Q2: Right. Do you think at that point you would have known, do you think
491 Q2: you were able to know the consequences of your actions?
492 Maija: *I'm sure I would have (21:48) like first of all (…) at the*
493 doctors' office, I would have wanted the doctor to tell me, okay
494 now this what (21:57) I'm responsible for diagnosing you, and what
495 I hear is this this this and that, and like this is the conclusion
496 I draw from this. And your situation is this and you need this and
497 that. And now no such information was passed on to me, in that
498 form that I would sort of have received the message that this is
499 the doctor's ordination now. So when they started walking me off
500 to the ward, I felt that this is some sort of trick, that, it's
501 like being tricked.

In this extract, Maija is hesitant in time (21:48) before telling of socially constructed non- participation in treatment, but it has been suppressed when the client was trying to recall self -exploration in an abstracted imaginary past tense position (Line 492). The word "want" is lost in suppression (21:48) (Line 492) until successfully stated (Line 493) as an unsuccessful approach to manipulate the environment for outcome of desire, due to inefficacy. The pause before "I" (21:48) (Line 492) can suggest self-identity, in an unlikely searching to unite

with a doctor, first discouragingly, hesitating before reenacting the trauma, of not receiving care. The pause (21:57) (Line 494) is before indicating the absence of the knowledge of diagnosis, and before a conclusion is drawn. "I" is an attempt to take back the trauma object (Line 492-500) as an item of treatment, and this evasiveness of care is indirectly imposed by the doctor and nurses, a part of a functional intention in order to create clients non-abidance to rules. A willing, able and capable Maija is forced, to undertake specific details of the creation of a constructed involuntary status, and the client relives the experience of the creation of the non- reformed, of untold appropriate behavior in the desolate setting, that could have been the sole determinate in no information given, leading up to the seclusion. The care that was not received by the doctor is suppressed in memory (Line 494) (21:57).

A question exists, if the inability to know the consequences of ones actions arises from the clinic constructed inefficacy, or originates with configured lack of capability to exert agency. The client focuses on the impact of the environment, and its influence on the un-likelihood of a positive treatment outcome. Maija takes hypothetical re-enactment initiation to enact participation (Line 492) but cannot, because of constructed non-participation and non-conformable rules, as this lack of congenial help is represented by a pause (21:48) severing and separating "I", as self from care. The description of self-agency is intentionally distanced, by pauses from professional direction, partially because agencies power is suppressed, to unleash influence of the inefficacy in the setting. In visualizing what the doctor would say, if one was available, Maija pauses in a representation, of the distant relationship. Maija recalls that she was incapable, to be responsible for the consequences of his or her emotional (reactions), and identifies these clinical conditioned responses to be a trick (Line 500,501) she was not brought into participation, withheld information to abide by (Line 497) a clinical intention (Line 498,499) to seclude (Line 499,500). There is a mental representative pause (Line 494) (21:57) hypothetically hearing or visualizing collaborating with a doctor, as this does not happen as confirmed by no information given (Line 497) even as Maija would be willing to receive, in a hypothetical projection the help (Line 498) in the past tense. As the request is approached, the first pause is before the description of help not attained, and after the weak "I" identity (Line 492). The second pause (Line 494) (21:57) is what Maija would have wanted, but had been reproached or turned away, and a description of "I" self-identity comes after the pause, working up the encouragement to utter.

The same second frozen time (21:57) in recall (Line 494) after a refusal being denied exists before traumatic reenactment of a hypothetical collaboration, as a failure of communicating an interchange, between the client and doctor. The pause exists before the action or expected action of personal responsibility, or what the client would have wanted to hear (Line 494) in the already established social setting, and has been imposed with coercion, and separated the client from self-reliance. The refusal re-surfaces, as what the evasive doctor would have told Maija, but did not (Line 493). This is posed in objectified form

away from a proposed positive, constructive interaction with the doctor, delegating responsibility to her (Line 494) in a failed process of individuation, away from participation. Maija wants to be heard and feels she is not. The pause follows after telling of "I" personal experience of wanting to talk, and after its need has been shared with a doctor, there is a pause before the need suggesting the client did ask the doctor, and encountered the refusal of the clinic, to provide adequate care. It is possible that the clinic secluded the client for no action, for no real reason, as the client reports possessing the ability to be mutually aware of the consequences of their actions, but not the consequences of the clinics seclusion reactions. Maija speaks of the wanting, requesting mutual congenial participation, being refused by the clinic and walked off the constricted area toward seclusion (Line 499-500) recalled knowledgeable of the social construction of non-consent, and non-adherent conduct as deviance underway. The deviance application is communicated like being tricked (Line 500-501) as an assertion of its commonality, and functional features of inefficacy "holding back" able agency.

In restricted outcomes, expressed need produces no exchange of information given, where Maija's agency cannot be in possession as aware of the consequence of not her expression actions, rather reactions. Leaving a structural and social relational course, there is no prospect of naming of all known outcomes, predominately due to agencies effort. This exclusive poor outcome does not guarantee that the client will not find other alternatives, as long as that knowledge is not shared with other clients or explored in assisted recall, especially if the alternative relies on independent agencies evaluation of chances, toward success in outcomes. The phrase "tricked", is mentioned numerous times throughout the interview, to describe relations with professionals. Awareness of this demonstrated, indirect clinical design of deception may be a quick way to begin to socially understand, and describe the created process. It is the beginning of forging a new course of recovery, away from the "I" identity, beyond psychiatry, and toward a mental health group identity.

In visualizing self -report in the foregone help impacted by the system of inefficacy, Maija's detached pauses in her recall is inconsistent with what Fonagy (1997, p.183) reports of autonomous individuals that value attachment relationships, regard these as formative. More so, insecure individuals have trouble recalling, and integrating memories of experience with their assessment of the meaning of that experience, and dismissing attachment as denying and devaluing relationships. Fonagy indicates in recall of these relationship detachments and dissociated affect, a person may assume a glazed expression in pausing absorbed in expressing intense experiences as Maija was, without being able to report a mental event such as a thought, image, or memory that can relate self-observed behavior to concurrent events that are estranged, from ongoing dialogue with the professional in recall, and telling of it with the investigator (ibid. p.184). Fonagy says re-enacting information from the environment when recalled accompanied with pauses, whether incoming, stored, or outgoing is not integrated and is temporarily unavailable (p.189) as a defense with

the presence of depersonalization. The clinical investigator can be quick to identify any traumatic mental representatives of separateness, the mental health client makes of themselves in self-perception, and of others in recall. In order to restore relations with others to acknowledge a normative conclusion of the trauma, the best standardizing statement the client can make, is of the social awareness of clinical deceit among other mental health clients, because of the inability to credit self with wrongdoing. Clinical researchers can suggest practitioners take action to recognize ability among involuntary patients, affirming a client's account characteristic of a deceptive clinical setting, consistent with the social reality, and this may help a preoccupation with trauma laden content in remembering trauma objects within inefficacy.

Clinical investigators and practitioners can help mental health clients, with preoccupations with relationships in treatment that are highly conflicted, polarized, and contradictory, in speaking of trauma object relations. When asking mental health clients to define inefficacy, it is important to focus on transference that the seclusion may serve, intended to mobilize, re-define, and contain the contradictory self and object representations that clients project into a mental state, inhibiting interpersonal relations. These recalled representative detachment states through scarce talk, make known processes that become aware of self-reporting of social dimensions to scant interaction, through assessment of staff's relationships that create noncooperation and the disorderly among the mental health clients and resultant coercion, then a clients constructed refusal to substandard care. Maija's told perception of off limits professionals, reveals power differentiation in the re- definition of behavior, among mental health clients who express need, and those who charges social provisions for those unable to express decision, and the professions rely on very narrow quick definitions to re-profile, and implement needs and solutions.

Maija tells of professionals that serve to limit solutions for those who it dictates in need, and mental health clients learn to assess their own needs in an evaluation of inefficacy, and develop a combined agreement of a solution. Maija tells of a view of the clients about professionals that are sometimes unable to understand they serve a collective population, by labels charged with differential power attributed an individual. These enforced self-connotations emphasize building resiliency overcoming obstacles, as an individual, discrediting a social account. Maija's testimony presents professionals that cannot frequently abandon their perspective from own advantaged position that relies on privileged dominant ideological dictum. These idioms come equipped with meager definitions of clients created un-reformable conduct constructed by inefficacy, within our told personal subjectivities of the social reality. It takes effort and care to see the world from the perspective of the mental health client. Professionals do not present the position of reasons that justify the actions of those we serve, as oppressed populations with strengths of the adaption of low affect non-participation, to better ascertain a collaborative solution that serves groups of clients that act to counter objective, widespread social disadvantage. For example, better help informing the mental health client to exercise aided right to re-

fuse (Bently & Walsh, 2001, p.181); (Alexander, 2003, p.110) coercion. Clients original purpose of visit insist abandoning denial of talk therapy models, forward the effort at participation by psycho-social education, and make a socially combined rational choice about actions, within irrational little to no choice social ecologies. A strategy becomes avoiding becoming compelled to emotional reacting, to clinical provocation within inefficacy.

An inconsistent search for talk may be assumed as a mutual good, activating a monitor process in executive functions search that confronts dissonance, when ruling talk will not be found in inefficacy, in recall. A search for talk may be turned away, re-defined as implausible therefore a deviant description as a sanction is employed. One of the aims of the health worker and mental health client relationship is to arrive at an agreed assumption, of what is considered good, such as enactment and attainment of decision, and this definition of the social reality is most often collectively held, and assumed to be shared by many people, sometimes between mental health clients and health professionals. This is sought to be understood to be arrived at by an individual's rational decisions to achieve, within a context of constrictive social conditions, such as within the inefficacy. However, unlikely positive treatment outcome due to social inefficacy is secondary or even ignored, and the emphasis is on the mental health client's personal agency, to enact decision. This belief is important, because many times people living in trauma and poverty possess subjectivities of efficacy, merit (Marger, 1999, p.207) self-responsibility to avoid clinical friction, of achievement in search of wellness behavior for example, widely held by conventional (MacLeod, 1987, p.75) standards of attainment. Its deconstruction and re-evaluation of learned awareness of external reasons for disuse of agency, in which clients test levels of efficacy within exploration of memory, is a part of a long standing pre- motivational process of low affect abstention to avoid confrontation, and suppress traumatic words in unaccommodating settings. As much as open social efficacy is assumed normative, opposition to this and insistence of social inefficacy is labeled unintelligible.

The failure to accept clinic created individual irresponsibility results in an informal or formal sanction upon a client, such as seclusion. It can be said that there are social powers such as a perception of social inefficacy, and agential likelihood to encounter poor outcomes alive in the person, and in the level of objective awareness of clinics, practicing indirect evasive deceit by discouraging talk therapy models. These little to no choice outcomes, are not due to a lack of ability and capacity to participate as an at fault identity (Soyland, 1994, p.113) but testify a level of the consciousness of pre- reasoning, before engaging agencies effort at risk, of the objective spatial design constriction of inefficacy. Rational evaluations of enacting low affect in a particular social environment, such as avoiding a coercive psychiatric encounter, the avoidance of public utterance of traumatic words, in high-risk conditions that might end in seclusion, deter a re-admittance to the hospital, or death from restraint. These exist as the beginnings of external reasons statements (Williams, 1981, p.107) for withholding unrealized agency and demonstrating personal, and collective ability obstruct-

ed by inefficacy around the room. Structural pre-determined failed outcomes affect broad layers of human beings as social exclusion, configured no consent, and indecision to affect the social environment, and uncertainty of incapability to conform oneself, to avoid seclusion.

Häyry (1991) makes the assertion that a person is explicitly rational if they, and only they, as an individual are autarchic (or free, not limited only or in any way affected by external reasons or conditions) of the social environment that is objectively and subjectively responsive to personal agency. The person is rational if their beliefs form a coherent whole; that their preferences form a coherent whole, and the individual's decisions and choices are consistent, with these beliefs and preferences. The person can also give a clear account of how they reach particular decisions and choices, by collecting evidence and basing their conclusions on it (Häyry, 1991, p.121). The strained environment in any contemporary society may exclude many people before engaging agencies risk, who testify of inefficacy of the recognition of consents and refusals, such as if, modified behavior can be recognized for avoiding seclusion. Efficacy can be commonly held to a demonstration of personal ability and capability, and agency has more to do with adhering to normative individualist conventions around self-responsibility, achievement, seemingly open to all in an "equal playing field" and its failure already settled, highly regarded as an individual deficiency. These are perceptions communicated of scarcity affecting advantage and success, and marginalization and failures in social settings, and constraints in any social environment challenge our subjective experience, because the human species may create long-term erratic emotive rationales to withstand them. Failure or success to avoid concurrence with seclusion around the room may be ruled overwhelmingly, by client's predicated interaction with inefficacy or efficacy, and over depend on the clinics constructed non-consensual involuntary status. A failed outcome might be avoided by clients shared pre-evaluation of limited self- report, in contributing to treatment outcomes of exertion of human agency, in disparaging environments.

Summing up, human beings like mental health clients joining combined reasons for withholding expression, can look at the impoverished social world as they evaluate their own actions to terminate emotional exploration, and develop ideas about the structural reality creating emotional reacting. Lowered affect can assist quickly explaining these ideas in terms of reasons to others, many of which can become combined experiences, socially learned pre-evaluations of the agent-external worlds. The pre-motivation to avoid emotional expression as a pre- caution to seclusion, can be ruled exclusively by the trying social environment. Davidson (1980, p.4) says that rationalizations are explanations, and the reasons rationalize the action, or that rationalization is a species of casual explanation, and that the most bizarre action for instance would be so called 'crazy', but would, however happen for a reason. Under trauma regulation within little to no-choice poverty conditions, it is understandable to realize own and others' lack of agency of choice, or the desperate choices made, can be overwhelmingly, exclusively due to a scarce setting. There

are many explanations and reasons for emotional inhibition, this research points to examine clients in situations that are considered as having non-normative, and externalizing relentless social environmental reasons for avoidant actions that affect many people. These conditions perpetuate bizarre reasons for actions, given the circumstances that governed the action, are widely considered absurd. This rationalizes a seemingly bizarre advanced pre-motivated action, as disuse of expression.

Finally, the seclusion emotional suppression theory explains the agent or mental health client disengages expression, in the situation of poverty of choice with increasing strengths of discriminating danger. The client then develops reasons for not acting out in agitation, beforehand in pre-determining containing expression, and in the long-term canceling of engagement of naming trauma objects due to exhaustion and anger. This emotional "held back" demeanor is regulated in rational or irrational expectation of agential memory performance increments and decrements in low affective "keeping a low profile", naming details of disadvantageous environments. Poverty of maneuverability in an unstable environment is the overwhelmingly factor that a bizarre action, such as withholding trauma explication occurred. Balanced manner enables a person to withstand little to no other choice, employing extraordinary long-term, and a sudden type of benifitial irrational strength. It is important for researchers to actively pick up a clients need to speak, in situations where they cannot utter trauma, utilizing a long- term silent emotional regulatory composer strength, where self-confidentiality is integral to protecting the client.

3.7 Emotional Regulation to Avoid Coercion

This chapter ventures successful application of a deviant in place of mental health labels, is encouraged to produce visible emotive behavior and its troublesome regulation that is partially reacted to by professionals as deviant upon mental health conduct, because it can be undeserving. Constructed and conceived failed agency resonate with pausing, does not rest easy with the client, assuming undeserving personal responsibility for not withholding emotional expression. Clients temporarily suppress perception of cause of disturbance as external inefficacy, and the clinical surroundings description is also signaled by emotional regulation, sometimes noticeable by pauses. A constricted setting gives rise to a realization of constructed stripped agency, an incapability to benefit from the product of ones effort toward betterment, and this contributes to low affect in how to perceive ones helplessness in the situation. This knowledge of limited self-agency, and created inefficacy constricting others around them, is partially obscured by suppression due to the totality of agitation, frustration and exhaustion. This surfaced agitated emotive display then becomes a self-fulfilling prophecy, constructing a viable cause for seclusion. Although hidden, stifled ability to exert change in the environment is emotionally suppressed,

withstanding the in-efficacious environment gives way to a visible, unregulated emotional demonstration of its closed reflexivity.

162 Q2: Ask him or her, when she does have, when she does get angry,
163 she does get frustrated, is it, is she able to ... when
164 she sees people going to seclusion, does that teach her to
165 (...) talk about things when she gets angry, or does she
166 just deal with the anger in her own way.
167 Q: Like, have you had any feelings of anger, like how do you
168 in your own opinion handle your own feelings of anger...
169 Esko: *Yeah, well I don't really very much, because (...)*
170 purpose for being here? There's not much point getting
171 *emotional...*
172 Q: How in your opinion do you deal with these emotions?
173 Esko: *Perhaps quietly on my own, like when I'm asleep*.

Esko's motivational system and cognitive script is suppressed and quickly closed, when he says there is "no point in getting emotional". This does not lead to consideration away from the antecedent pre-decision to disengage description of trauma, as a sudden stop (Line 171) in suppression, after the word "emotional". This planned avoidance displays a self-described emotionally regulated regress, from the staff's enforcing a human suppressive antagonist, representing separation from the recognition of social expression. The process is visible and partially public, although Esko is reduced to a self-identity (Line 173). Expressing emotive trauma (Line 170,171) to staff is again found to be unbeneficial.

The pre-motivated conclusions statement comes from an assumed shared perspective, with other mental health clients (Line 170-171). Esko extinguishes the "point" of considering seclusion from a social perspective. Esko insists that an already bound ascribed label of anger, by being in the hospital setting, is of no value and the purpose (Line 170) and nihilistic enragement serves own self no purpose. Avoidance of strong emotion or rage, when brought to a social visible level is of no value to self or presence in the hospital. Any personal value of dealing with anger is to suppress it, on one's own as counter attitudinal leveled off affect, as a pre-motivational strategy. A counter struggle to express frustration of the "point" of being in the hospital is deserted quickly, imploring sleep as a route of pre-motivational termination of explanation. Suppression as a mental representative of seclusion, enforces personal responsibility of there is not much point (Line 170) assumingly among a widespread population of getting emotional (Line 171) then asked by interviewer 1, to draw a conclusion from own perspective (Line 167, 172).

Deployment of emotional regulation of expression, suggests that talk is a created need that is unmet. Esko answers interviewer 1's direct question if the problem is of own self-suppression, to see if there will be an opposite effect, if the client has emotions that don't get a chance to be expressed, then the created suppression effect comes into place. However, seeing visible expression brings an inability to contain emotional expression. Esko answers that the problem is

derived by professionals enforcing reasons and purpose, for current goals in treatment. Esko conveys little elaboration of explanation as it is shut down immediately (Line 170) and emotional expression is shut down as well (Line 171). A solution is suggested by the mental health client to avoid, be away from the professional's re-definition of illness and treatment on my own (Line 173) quietly, as there is no point in getting emotional (Line 171) or exhausted, lying down on one's own (Line 173) or suppressed because of the awareness, that partners will not read the mental health client's social expression, from social constructions assertion of deviance of non-participation, upon a mental health label.

The client has dismissed and rejected any benefits of preventive talk, however places own reported subjective experience above a professional's, carrying more weight in identifying a loss of integration, into constricted environments. This is the reason for short elaboration of the pre-motivational decision, as agencies failure invokes a reacting that is construed in order to be avoided (Line 170-171) and this impacts the motivational system, to quickly conclude. The mental health client points to perception of his own agency in the situation, where there is little to no alternative in outcomes in their environment, by indicating the benefit from an assumption of shared agreement from another person's perspective, by saying "you have to be on your own". There is an attempt to salvage a social aspect of experience as "You", of what is considered individual reasons for isolation. The mental health client adds that if this third person or another person from a social self-position does not benefit, he quickly acknowledges its use, by referring to seclusion as an opposite of a want or a need. It is important to understand that this process is applied to people, because they are communicating a vital unmet want or need to express, then are forced into a place such as the area around the room where there is no communication. People are driven to a sole alternative, such as lying down by one's self asleep in a room, in order to endure its suppression and effect on the motivational systems. An alternative is found by Esko to regulate emotions by resigning to a structural suggestion to lye quietly, rather than express as a pre-motivational issue brought to attention, by an exhaustive focus. Resigning allocation of disturbance bring off course or heighten visibility, and clarity of emotional expression and its regulation, in naming tried and tested external reasons for crediting inefficacy of the setting around the room, for misplacement in the hospital in its recall.

Esko enacts a strong pre-motivational disuse of expression as a tactic around the seclusion room, to avoid the configuration of deviance to conduct, via reason to seclude. Expressive therapies, as Alexander (1939, p.39) had written as far back as the late thirties, continues to encourage conscious awareness of subjective experience, of inhibited emotional responses within the therapeutic relationship. Others have said that emotional regulation serves a developmental purpose (Kopp, 1989, p.345). The argument insists that healthy adults must often inhibit to certain degrees, their angry emotion-expressive behavior (Tomkins, 1984, p.169). The argument also points to the destructive effects of unregulated emotional responding, such as reverse motivated expressive anger,

of different clinical disorders. The failure of emotional inhibition can be problematic (Gross & Levenson, 1993, p.970). In the late 1920's Cannon (1927, p.122) argued that the inhibition of expressive behavior leads to increases in other aspects of emotional response. Gross and Levenson (1993, p.975) point to reaction, disorientation, among ongoing pre-decisions to avoid description as a result of inhibition. Findings from one study (Gross & Levenson, 1997, p.102) suggest that suppression had no effect on self-reports of being disgusted, after studying the effects of consciously inhibiting emotional expressive behaviors, elicited by subjects after watching a disgusting film. Emotional suppression of expression, as a result of lack of talk impairs the efficiency of motivational and cognitive functioning, blocks adaptive action and limits social partners to accurately look and respond appropriately, to needs and plans.

Suppression allows people to modulate expressive behavior, for example by verbalizing anger rather than acting it out, thus avoiding friction in social encounters utilizing suppression impaired memory, when inhibiting emotion-expression behaviors. There is literature that says suppression enhances or impairs memory and delay times in performance (Christenson, 1992, p.186; Neiss, 1998, p.335). Excessive arousal causes performance decrements defined through relations with both antecedent input, and consequent output variables (Berlyne, 1967, p.12) which is similar to the inverted U (Yerkes, Dodson, 1908, p. 1) of affect performance, after a peak. Exhaustion motivates the person to disengage, a pressing levied affect "holding- back" of the seclusion emotional suppression theory of affective performance pre-decisive bias of low level of agency, in a setting of inefficacy. Pre- existing exhaustion operates an upright level of pre-motivational lowered effort to modulate affect, in low outcome settings of counteracting formally out of reach, balanced emotional affect in rebound expressions that were formally suppressed, but that are now more powerfully asserted in mediating cognitive expenditure in identifying aspects of closed settings.

There are motivational consequences for shutting down client's combined expression, through self and structural suppression. There has been a reverse in the progression of talk therapies, and a dis- advancement of mental health clients' voluntary rights to higher tier care, by bringing the process of socially creating each mental health client living with the illness as an "individual" case, thus furthering declining progress of the population's cohesion with each other, to involuntary management by the professional apparatus. The act of disregarding a mental health client's request for talk therapy, the clinics disregard to recognize informed, assisted, renewed, refusals, and other services on demand as a common socially learned identity, may rely on increased coercive methods such as unsupervised pharmaceutical biochemical procedures that rely on "singling out" behavioral correction. Creating the unreformable, it is discovered depends on quick explanation of disadvantaged placement in society serves its totality, of what is reacted to (Kitsuse, 1962, p. 247) such as drug induced agitation, without grounds or legitimate warrant (Rains, 1975, p. 10) as well as sanctioning a request to talk. The process is not concerned with reforming future individual conduct alone, rather with the destruction of social di-

mensions to common entitlement to resources one client at a time, rather than fail to extinguish the collective expression of social power, that demands human needs. A clinical refusal for a self-identity to acquire human needs might quickly become indistinguishable, from an individual failing of attainment. Therefore, a combined voluntary process is terminated and a punitive, individual involuntary oppressive one is constructed, that increases the incidence of incarceration into hospitals among the mentally ill. Further, a corrective track submits this client to further high risk health concerns, withholding preventive measures including talk therapies monitoring medicine, creating visible agitation through under- supervised medicine, that increase the death rate, due to restraint toward seclusion or fatal shooting in the community. Sinikka below conveys that she was placed on medicine in the community that made her feel worse eliciting seclusion. Seclusion served as protection from receiving more medicine.

> 1040 Q: Okay. But can you describe in more detail the first time you were drugged with (…)
> 1041 Sinikka: *Well I was drugged before I came here..*
> 1042 Q: Yeah.
> 1043 *...the reason I was brought here was that I'd been drugged and then erm…*
> *1044 they just kept giving me more drugs and then I felt worse and worse all the time.*
> 1045 Q: (…)
> 1046 *…and then they put me into isolation.*
> 1047 Q: So you (…) days in isolation.
> 1048 *(…) or a week.*

Sinikka speaks of pre- seclusion forced medicine induced symptomology as a rationalization for isolation. In order to define the "deviant individual" to be corrected, and further designate the person as non-reformable, is to make visible a construction of a so-called ill or "worse" (Line 1044) that is non-compliant to a re-definition of individual needs. A side effect of medicines alone, for example either of sedation or lack of medicine monitoring, recoiling to agitated heightened affect can contribute to what Foucault (1974, p.58) defines as the "everyday obviousness that renders the mental health client as immediately recognizable and beyond conformity", unresponsive to responsibility or comprehension of rules. This makes a quick assertion simply by clinically creating the created high or low affect as sedation or agitation, thus requiring further "corrective, oppressive" intervention by a psychiatrist or nurse, who further constructs the problem, even before the "solution" is imposed. Both reside already in place in normative biased conventional deviant labels, of those who cannot be corrected, so-called reformed or conformed, before engaging in talk among one or more clients. The created absence of talk and unrecognized participatory agency resurfaces, as visible frustration of the constructed inefficacy later recalled with mounting counter pressure, leveling emotional regulation as a precaution measure. The agitations helpless or affect state is discovered to lay

the foundation, for quick generalized labels of inability to individual sufficiency that do not attest for quality, upon a group of people. The socially developed, structurally shaped agitated deviant labels quickly dismiss elaborate articulation of their quality, and these connotations usually reside in a pre-motivational, unshakable bias to avoid becoming labeled, "at fault" for seclusion.

The lack of basic support becomes a real risk, and puts a mental health client in severe danger of being taken advantage of, and misunderstood as behaviorally deviant of a motiveless crime, such as accumulated through agitation, or lack of decision making, due to disorientation, but not often statistically forensically deviant. Moreover, due to a lack of basic talk support in the constricted area, clients have to fight off low disorientation or high affect agitation due to failure to contain anger. The process of overriding or forcing consent after medicine had been applied, after the motiveless crime had already incurred, might rely on the unjustly blaming of the individual, and failure of a later involuntary consent. A social identity and winning the awareness of others' consciousness, is insisted to be present in these clients, even when answering as an individual limited of agency, by enforced inefficacy and vocalizing trauma recall of isolation, when aware of others nearby being secluded, and when potentially facing more seclusion. Supervised medicine for Sinikka presented below serves as a way to more freely communicate and relax the regulation of the motivational system to speak accurately of feelings, until its lack of supervision contributes to agitation and indirect aggression.

1049 Sinikka A: *The chief physician…*
1050 Q: Yeah…
1051 *He gave me this red stuff and that I already started feeling better, I started*
1052 *to feeling a bit like, the reason why I was here, the drug…*
1053 Q:mm..
1054 *that it no longer affected me as (…) as before, and then I started sort of*
1055 getting more and more relaxed. And then when they no longer gave it to me,
1056 then I started fighting.
1057 Q: (…)
1058 *That's why they put me in isolation in the first place because they (…)*
1059 *fighting (…) and then what the person that annoyed me was never there (…)*
1060 Q: (…) annoyed…
1061 *She was never there?*
1062 (…) *then they would give me stuff to make me angry the next day or*
1063 *something.*

Sinikka indicates the non-consensual pre-medicine mis-supervision made her irritable, angry and determined her to become pitted against, and endangering another client (Line 1059). The seclusion emotional suppression theory warns mental health clients avoid medicine induced rage, by way of pre-motivational

low affect, through emotional regulation in perception of little to no choice, in exerting agency. In addition, clients formulate a pre-determined effort through inexpression and not reacting, not speaking of trauma items when confidential talk is not provided, and in doing so becoming protected. Fighting off medicine induced withdraw concocted for reason to seclude, clients can also formulate what Coulter (1979, p.40) says an avoidance of the structural and relational explicit intention, to further stay out of the way of danger. This happens by way of a mental health client's presupposing (p.41) and pre-deciding a mental predicate that constantly formulates reasons for not acting beforehand. This pre-decision determines, not so much knowledge about what might happen as these are no choices and not plans, instead develop steadfast insistence resolved in silence, as long-term neutralizing affect strengths that develop the mind. This commitment continually relearns the process of an ongoing pre-motivational stance to avoid, and to carry it out over long periods of time, under uncertain unyielding terrain.

As the difficulty in executing out simple composer is mastered two to three fold, and with continual heightening ability to counter and contain anger, they become pre-motivational mental states, enduring, persistent, long-term stances and pre-decisions among the general mental health population. The ongoing concealed expression is overwhelmingly pre-motivated, drawing strength every second of every day, re-learning the ever-present pre-decision to emotional disuse with extraordinary determination. Indenturing pre-motivational lowered affect overturns the causal explanation that pervades formal functional emotional reaction, as it becomes normatively known. The data suggest, clients draw on social retraction of interaction, as real agency power and this may reflect common assertions about ability, self-responsibility, and conduct, that are critically challenged by making those who hold conventional dictum aware, of constriction to actions in little to no choice environments of inefficacy, such as around the seclusion room.

135 Sinikka: *You have to be*
136 on your own.
137 Q: Can you think of any benefits? Are there any benefits,
138 any benefits of being in isolation?
139 Sinikka: *Well if you want to be in isolation then it has benefits*
140 *but no I (...) then it's just detrimental...*

If an individual cannot communicate what they need or want (Line 139) and gets secluded, they cease to demonstrate as self-regulated by the pause (Line 140). Rather they make social reference as a person as any other, and begin to pre-motivationally attribute no other human agency, in enacting participation in social needs becoming met. The seclusion creates self-suppression in the persons' perception of agency and fluidity of environments and in turn, the emotional suppression theory attains communal knowledge on this powerless position, through low affect suppresses trauma content, in so doing avoids seclusion. The position that there is commonplace collective agreement, from anoth-

er person's held back perspective is an assumption, of a social widespread lack of individual agency. Due to constructed inefficacy as causal (Rogers & Pilgrim 2005, p.21) the client above points to the constructed lack of participation as a group impression around the seclusion room, socially designed as an involuntary area. To be alone and incapable to follow rules not recognized, and expressed will to be alone not acknowledged, Sinikka states seclusion is detrimental to many (Line 140) and its impact social.

Participation is eliminated, and a coercive practice is initiated (Line 139). Sinikka may have to be alone (Line 136) making herself unresponsive to cues, social stimuli, or incapability to participate, if not for missed instructions that are formulated to be broken, in turn labeled as an infraction. Being alone is a motivational pre-decision to regulate and suppress interaction, on the part of the client. I observed the client joking (Line 139) that breaks the low pre- motivational "ice", by alleviating tensions of a little to no choice social situation, giving way to ironic affective acceptance of low agency power (Line 140). One's own offsets an institutional attempt of loaded social interaction, with professionals. Sinikka refers to 'you' on (Lines 135,139) and the 'its' (Line 140) when referring to seclusion as it would be socially to anybody, almost speaks from the imposed self-identity, by saying I, but then visibly self-corrects the imbalance of emotional regulatory containment, to socially speak in the interest of humanity, helping fellow mental health clients. A regulatory pause follows an attempt to answer as I or self, but becomes suppressed, as a failure to enforce self-identity (Line 137,138) by the interviewer. A quick, firm no (Line 140) indicates long-term pre-motivational bias stopping elaboration of absence of agency, could indicate past separation form care and against self-initiating participation as voluntary. She predicates agency power, if it were realized in inefficacy, could lead to seclusion being "beneficial".

Sinikka has structurally created social needs that are not answered, but sanctioned by seclusion, distanced from what a client wants (Line 139) to attend to social needs. Notice again the way the mental health client is questioned three times (Line 137,138) to respond as an individual. There is a conflict with identity of I (Line 140) followed by a pause, and identity as you (Line 139) or us as a "We" identity. It's (Line 140) indicates social identity, as understood by another client. There exists potential for the seclusion room to be a consensual place of help however it is constructed as a punitive place, of treatment resistance. Sinikka states of ample abilities of clients to participate in a treatment decision, not for them to be made on their behalf, as there needs to be no written consent in Finland to hospitalize. Along with creating the disorderly and incorrectable, the setting constructs the non-consensual by establishing non-compliance, generated by the rationalization of the involuntary context itself. Creating the non-consensual, may enact the incapability of exerting action on a treatment decision, overriding able refusal. The client's statuses were involuntary, and had been secluded more frequently, however all possessed the ability to consent to research at the time, and all recalled their ability to past and present consent or not, to participate in treatment at the time of the interviews. The

client's permission was achieved by us, whether or not the consent or refusal to treatment, was recognized by the institution. See (Appendix B) for consent form to participate in research.

Disregarding the idea of seclusion as an avenue of agency, along with the inability to communicate with a "human" suppression is discovered, because of the failure of staff to include them in interaction, to only impose individual scripts. This results in awareness that other social partners cannot read one's expressiveness, resulting in frustration and disorientation. This intensifies either motivational insistent reacting, or learned helplessness to quickly retreat and resign, dissuading assigned, re-defined labels of agitation or disorientation, leading to a seclusion episode. However, the seclusion emotional suppression theory says these mental health clients are pre-motivated to avoid, both these institutional functional strategies, through a reasoned bias of no perceived fault for threat of isolation. They are not unintentional imperfect information processing strategies, or cognitive errors (Erdelyi, 1974, p.20) but set low outcome expectancies that demand low pre-motivational defense that consolidates selective, dramatic rehearsal in short and long-term memory. In pre-motivational low affect, the client may never ever again begin to recognize real structured, behavioral or psycho-social correction, or with high affect, become increasingly pre-motivated to insistence to talk, and perhaps less so with social adherence, to created un-reformed "ability". With shared awareness of high probability of negative occurrence of no fault of own in the procession to seclusion, they are displayed in low affect or agitatedly communicated in recall, as pre-existing bias of externalizing statements based on information, experience, personal, and assumed expectation of treatment failure outcomes. With stripped agency, details of the relentless social environment readily move to partial consciousness affirmed in others awareness.

These firmly held objections to coercion are reinforced, by observing other clients, as in the case of deterrence, avoiding and positioning self away from asking for help as communicated in recall, spatial distance represented by pausing. A professional is highly visible, but not assessable to mental health clients, as commonly they point to differing reasons to discount the professional's proposed belief in self-efficacy and agency (Perrig & Crob, 2009, p. 16) toward help. Clients begin to discredit efficacy in the open area around the room, frequented by visible pausing in recall. This is important for us to understand little to no choice settings as inefficacy, because within the said subjectivities of the professional social world, there may be more weight in the outcome of the situation, than efficacy. The social environment and opportunity of choice affords agency, and accommodates us into a position of advantage, whether or not it is directed to abide by open efficacy for the client, around the room. Description of inefficacy and its laborious impact on the motivational systems, draws a social account by clients, resonate with pausing. This is important to consider, because whether or not one can reform, or conform behavior to avoid seclusion, and whether the constructed context already stakes the claim of something out of the ordinary, reason for suspicion, via reason to seclude,

might be contended. The mental health client's received subjectivities assume shared perspective of constrictive and restrictive personal agency, tells of conditions and environments that exclude power of individuals. The set situation requires clients utilize emotional regulation of the description of the social situation, and compelled own perception of limited agency often indicated by pausing, in the first place. It may be normatively assumed there is efficacy in the open area around the seclusion room, that one or presuming groups can be in possession of capability, to affect an outcome in the situation of efficacy. An insinuation of labeled fault for lack of agency, in dis-advantageous settings is discovered to provoke an offense in the client, bringing forth a limited emotionally regulated pausing, residing among a laborious description of objects in the external environment.

At last, with this pre-decision to emotionally avoid and pre-motivationally shut down present and future attempts to exert interactive agency, the dissonance is less, and the conflict is resolved as incompatible. The predisposition is to decisively, continually and silently recline, yet remain physically present. The emotionally conflicting beliefs are that, outcome potential of seclusion does not reflect personal human agency reforming itself, but an imposition of institutional reactions that the mental health client becomes aware of, through a social process, that begins with an assumption of self as socially inexpressive. The client visibly expresses the attempt to "hang onto" joined selves identity, with combined externalizing statements of inefficacy that may release suppression. These emotionally regulated externalizing statements point to a lack of constructed obstructed human agency due to inefficacy, and the enforcement of institutional sanctions around the room. The visible demonstration of this is closed to exertion of agency, due to inefficacy that fights to shake off the imposed self-identity of isolation, unrealized participation, and enforced structural and self-suppression of self- restricted talk. Suppression and emotional regulation decrease the more that a client develops social identity, and common externalizes reason statements for demonstrating common inefficacy, apart from failed individuation. However, suppression of expression is a present and long- standing pre-motivational strategy, in order to avoid provocation and being aroused to anger, from a structural environment that creates, and scripts clinically label bound categories to high affect outbursts, or low affective disorientation. These affect states and their explicit explication, agitation and disorientation can be created by mis-supervision of medicine, and outbursts provoke forced injections. The social control of eruptive emotions can be highly visible, in order to dis-empower vocal public social identity concerns that can more, concretely identify structural obstructions to self-change. The awareness to social identity then assumes low affect auspicious, in order to hide emotive behavior, in a long-term pre-motivational stance, where to not do so, would likely end up in seclusion.

3.8 Preceding and Long Held Antecedent Motivational Awareness

This chapter further explores the seclusion emotional suppression theory described at the beginning of chapter (3.1) stipulating beforehand preventive cessation of expression of emotion may resurface, as a silent long-term pre-motivational adaptive rationale to regulate behavior, thus avoiding its fraudulent correction based on unintelligibility, resulting in a deviance ascription. The mental health client presented below, answers the interviewer decisively, assuring their experience of wanting talk, as a long-term desperate unsuccessful pre-motivated search (Croyle & Sande, 1988, p. 473) for a positive treatment outcome is commonplace. They have been kept from talk for long periods of time, assuming these conditions impact many clients. This contradicts a tested low outcome and brings forth the search of potential alternatives yet to be tried. The mental health client says that a social conversation, talking things through, as social expression would be more helpful than seclusion. The cautious client pre-motivates a hopeful search in the future to re-engage the approach to demand talk, to avoid seclusion and later arrive at talk. The seclusion emotional suppression theory promises, insight to long-term regulation of evolved motivational processes, might exist to offset socially pre-destined, already situated, institutional pathways to avoid a confrontation or learned helplessness, in naming trauma objects with psychiatry and nursing. The seclusion emotional suppression theory demonstrates that a client estimates efficacy, in both the in and out- patient areas more accurately, that impacts the motivated affect system in the setting to at a later time, approach psychiatry again with the prospect of talk to "drive a higher bargain", for higher tier collaboration. Agitation is modulated toward sensibility regulation, stipulating an opposing affect, fueling the balance of motivational fortitude in cool, executive functions future search, for talk with professionals.

Agency and incompatible social efficacy does not interact, with misrepresentations as institutionally socially constructed, non-corrective, and non-abidance, based on a long- term pre-motivational awareness, of negative emotional regulative consequences. Evolution has equipped the human species with adaptive affect pre-motivational mechanisms, such as relational dependence defense employed to adapt to separation distress, its emotional regulation. Suppressed is the formally expressed need clients express to re-establish agreement and alignment in professional projected future expectation of inefficacy, such as anticipating low treatment outcomes for self and others. The seclusion emotional suppression theory proposes that when clients' sense, that an environment is non-reflexive of agency, they adapt emotional regulation, such as withholding agitated expression of trauma objects, as an antecedent property to navigate around it. Since the seemingly opposite suppressive emotion is displayed, the theory postulates these stifled expressions, resurface as a more precise emotional expression of re-engagement to approach psychiatry at a later time. This re-approach embodies a concise pre-motivational route to participation learned by interaction with other clients, such as with a long-term plan to

include a helpful mediator, like a clinical social worker in the session for example.

The mental health client below considers that participation from the staff, in talk therapies helps avoidance of an averse seclusion, hypothetically perhaps in a future time, suggesting that staff have not helped with his treatment. Time points to the hope that not now, but sometime in the future the careful re-approach is currently out of reach, objectified and distant, disproportionate to actually receiving it, the mental health clients would not be presented with a treatment alternative that would be better than seclusion. The waiting for help relies on an uncertain, untold time, employing emotional regulation for an unstated duration of time, before given the opportunity to talk, if this chance comes at all.

150 Q: Yeah. What in your opinion would be a better alternative
151 to seclusion or ...
152 Esko: *Well perhaps like conversation would be more helpful.*
153 Q: Yeah. What in your opinion helps your recovery the most.
154 Esko: *Perhaps the opportunity to talk things through. And time*
155 is another thing.

There is a level of caution (Line 154-155) in attempting to conceal "cognitive waiting" of expectations of long-term length of time, to simply speak to someone. Esko is aware of little to no choice than to be talked to by staff, enforcing and imposing re-definitions of treatment solutions as talk and its opportunity, all the time recognizing it is often unavailable, and offering little effectual course toward helping the situation. These social expressions show to foster long-term mistrust of a professional alliance, and a pre-decision to resign no personal agency in a constrictive environment used as an adaptive solution. A quick demonstration is made (Line 152,154) collectively, that agency is socially attainable by all, provided clients' initiation to talk is recognized as collectively voluntary. The question is asked what would help as an alternative to seclusion (Line 150,151), and the answer is presented distanced in a future and conditional tense (Line 152, 154, 155) that long-term expectations detached from present ownership and opportunity, from recovery to illness are considered from a social perspective when asked of an individual. To be kept from talk (Line 152) of trauma and time (Line 154) suggests distance from professional help, and that to initiate talk recognized by staff is not evidenced as a basis to voluntary status, rather the imposition of no talk is regarded as involuntary. Time (Line 154) is presented after talk therapies to be helpful, suggesting time would be helpful after the need of receiving talk therapies, was re-formulated and recognized. This is an abstraction of distance from help that is requested, rather before help that is imposed, and re-defined an opportunity. Time also indicates distance to pre-formulate an antecedent avoidant strategy, in the face of expecting more future coercive instances, and less chance to talk. Social identity is institutionally broken, in order to re-establish a corrective relationship with a professional.

Interviewer 1 is asking twice, to enforce discouragement of a social insight, so the mental health client might assert more strongly, the self-identity of an "individual" need but unsuccessfully, and the client asks for a future "social" need to talk more (Line 154). Time is also expressed as a need to heal, and run counter to time to talk that had yet been failed to be taken away, as this time to heal is requested in the untold future, and how it will benefit is yet to be known, and asserted quickly. Conversation and its benefits are still held back by skepticism, until reasserted again (Line 152,154). An individual approach spoken with self-regulation of suppression of talk is said as perhaps (Line 152,154) twice, as this emerges from a regulation of uncertainty. A repeat of talk (Line 152,154) to bring the prospect of conversation in recall out of the suppression of multiple seclusion, and out of containment of the long-term effect, is also holding cessation of expression.

The non-substantial support for the alternative of talk is hypothetical, and might have never been tested to any effect, and there is little commitment to reinforce that suggestive idea. The client states the need to talk twice (Line 152, 154) perhaps to reinforce the urgency of its need. The future prospective opportunity of time, to talk things through is not presented with confidence, as it does not seek collaboration, but closes quickly. The mental health client poses the suggestion as a possibility, because they have not been presented for the opportunity to talk by the staff. Future time (Line 154) may also suggest many more unknown times to talk things through, in an objectified worth alienated and derivative from present ownership. This is important because with the threat of seclusion, future time can be taken away from the client. The mental health client answers questions of their own treatment, assuming to speak of many clients. The suggestion to talk has strengthened a collective impression. Although the need is unmet, there is a careful pre-motivated willingness to reapproach talk, with increasing confidence and participate in treatment that the constricted setting, may have not allowed.

The readiness to search for talk, as it is reiterated is suggested by a survey of the non-receptacle setting, as unsatisfied and its denial present preestablished events, as already decided. Socially situated positions are recalled affecting the "I" account, of a mental health client population. Retrieval effect or forgetting words in recall through prompts as cues, results in delay or distancing words to cope with stress (Lazarus, 1993, p.9) as in the presented data, or institutionally construed away from social-involvement into a self-involvement, to relieve two inconsistent cognitive irrelevancies (Ditto & Lopez, 1992, p.1130). These inconsistencies are that the situation calls for active social talk, participation and decision, but the compulsory placement considers talk and interactive partnership irrelevant to constructed forced individual involuntary status, and critical to insinuate a deviant claim. This understanding credits adaptation to initially withdraw, and holding rejection of these treatments becomes ongoing and direction oriented, including a pre-antecedent motivation to avoid coercion. Clients hold talk therapies will benefit self as a substitution for seclusions, with skepticism. The contradiction of illness requiring help, that in turn is insti-

tutionally designed deviant, rejects the process of labeling from a client's view, of what is a responsible patient. This contrary labeling process takes away the definition of what it is to participate, perception of being ill- well from the individual, and how it is commonly regarded as a member of this sub-population. Labels enforce individual responsibility for seclusion and re-enforce this as personal obligation through an ascription of pressure, that the client is so-called deviant because of secluded history. The deviant label compels personal rather than social problems that induce commitment, and how this perception rests with the person and is reinforced by others.

Clients demonstrate lowered pre-motivational pausing limits cognition, and narrowed alternatives in one's own cognitive script, due to an obscured directional course can also lower motivational drive, and then lead to a rejection of any external agent, capable of providing relief. Detail oriented cognitive processing in this data, attributes cause of harm to threatening stimuli, and requires coping strategies to reduce cognitive expenditure, such as reducing personal experience, as commonly shared. Awareness of external considerations of constriction of agency, adapts lowered motivational affect to withstand the negative stimuli of the mostly closed setting, which results in little or no confidence in external causes providing relief. Talking to clients told of the 'skeptical' approach (Ditto & Lopez, 1992, p.1130) to overcome a treatment obstacle may require more information, to reach a preference inconsistent conclusion. With increased restriction of alternatives, and less expectancy in the search for positive outcomes, a person may develop a pre- conclusion bias, that the obstacle will unlikely be overcome or safely navigated, and limit description of disadvantageous outcome.

Pre-motivated bias, to avoid a corrected labeled claim, disqualifies expressional drive when overload of the totality of the explanation of inefficacy, overrides any other consideration of capable agency. Mental health clients in this data are able, capable and willing to participate, interact, make decisions and present the opportunity to talk things through and initiate participation, however mutually choose treatment options hesitantly, as a future tense unlikelihood. Complete abandoning of information processing to these clients occurs when seclusion doors shut, and when talk therapies are denied and participation yields no fruit; then the mental health client whether aware of this or not, pre-decides long-term motivational awareness that expression will never be acknowledged, and so will never again ask for talk therapies thus coming to cognitive closure (Webster, 1993, p.262). This formulated bias attributing 'no agency' for expected low outcomes when environmental obstruction is apparent, appears in recall to be further enforced by psychiatric staff, by seclusion and its suppression. Clients revealed being held in seclusion's grasp and withholds talk in self-suppression to avoid it does not readily communicate inefficacy to interviewers, suspect to hold conventional ideas about open efficacy, in trying environments.

How a client in this research regards a situational external constraint, such as institutionalized created dis-favorable outcomes, is made manifest by

emotionally self-regulating motivational efforts to be more accurate through self-critical information processing, as much as a mental health client feels accountable for their judgments (Tetlock & Kim, 1987, p.706). The little to no choice setting is more accurately described, when the deviant sanction and judgment of this is subjectively undeserving, rectified by checking out the assertion from an objective social source, such as another patient, in the case of observed deterrence for example. The client can be unaware of the full weight of the traumatic content around the reoccurring pausing in the recall, because of the deterrent creating long-term suppression and temporarily cancels the expressed detail of self, regulated the attentive emotion of "I", and moved toward realization of others socially shared experience with seclusion as "We". In a little to no choice setting, this assumes how mental health clients believe that it is "cognitively feasible" to have pre-motivated bias of closed interaction as case for seclusion, this bias is arrived at to begin with by reducing detailed information of self, and processes it as a population with lowered affect performance of detailed information, of the constricted setting. However, pre-motivation governs the attribution process in memory retrieval, and most present in attention focus, is the undeserving external accreditation upon the individual for poor outcome expectancy. This unfavorable projected outcome may increase undue personal responsibility to increase accuracy, in identifying external structural causes for seclusion.

These assertions collide with mental health client's partial sense of the social reality of efficacy, presuming the accommodation of advantage in treatment, and agency that gains attainment in treatment through merit, and the delicate balance between the two impacting each other, affecting outcomes. The way that client's resolve this, is to withdraw level of effort of projected agency, avoid and regulate expressing routes of human agency, and predominately become aware of formulating externalizing bias of the constrictive social environments, trying to impose a deviant, illness or both labels, on almost any social expression of need. The seclusion emotional suppression theory explores the client's covert "assuming a low profile", can intercept the clinics construed failed attempts to label wrongful, the clients initiation of participation by means of devaluing capable agency, and approach psychiatry again after silent time, when performance of concealment serves more accurate protection from coercion, and guarantees client's leverage, in negotiating talk treatment.

In this extract, the client demonstrates the ability to make a long- term treatment decision to withdraw participation in talk, make choices in an involuntary setting, and conceals avenue of agency in accurate estimations of disfavorable clinical conditions.

156 Q: Do you even have any such experiences that would have
157 helped in any way?
158 Juha: *(…) I've learned to avoid…*
159 Q:…mm…
160 Juha: *Do you understand.*
161 Q: Yes, you want to avoid it as far as possible.

The data presented above, presents how interviewer 1 reads and interprets the mental health client's pre-motivational position, to end explanation abruptly, due to emotional exhaustion of holding back anger. By answering as you (Line 161) interviewer 1 relieves the mental health client's pre-motivational desire, to not explain further (Line 160) and a more immediate conclusion with a period, avoiding costly "cognitive expenditure" that does not seek to persuade, but to partially eliminate angered explication, due to lowered pre-motivation to recall, existing as a present state of canceling detailed effort. The mental health client acknowledges little agency other than to avoid seclusion in the future, and seeks to create a reinforcing conclusion, not by explaining reasons by elaboration, but only if the pre-motivational resolve of avoiding is understood quickly by Interviewer 1. Juha asks do you understand (Line 160) to avoid further explication. Notice the period that concludes, it's not a question that immediately closes the conversation. The antecedent motivational termination of information gathering and "labored listening" is not open to further elaboration, as the predecision is a strong spoken subjective adverse experience of the constricted setting, closing further communication, and seeks not to succumb to persuasion. The last word of asking of the question, on the part of professionals or interviewer 1, is silenced and diminished, by making sure us professionals understand, pre-motivational shut down is only to be acknowledged, by repeating the final words that have been received as understood.

The seclusion emotional suppression theory draws an example from a perspective that senses the same socially learned (Line 158) approach and avoidance that leads humans toward, and away as fight or flight from desirable and threatening stimuli or situations, also provides present and recalled motivation advancing and fleeing away from undesirable, or threatening objects and beliefs. This long-term silent approach of clients work through evolved processes in memories, socially mentored recollection of expectation of obstacles, to withhold expression to fit into situations, where lack of talk is likely to accelerate into agitation. How emotions are displayed with regard to inauthentic affect, such as with the presented client's forced to fit the situation, require "social acting" (Steinberg & Figart, 1999, p.12) over long periods of time sometimes attaining how to pre-motivationally regulate, release and suppress emotion. These considerations of subjective feelings and perceived social expectations of how to express can be influenced by structural re-socialization, and the understanding of how others encourage emotional reactions, governed by norms surrounding anticipated punishment, consequent behavior and ways to adapt to avoid it. Strict ambiguous clinical norms enforced by the structural setting can be associated in context with the person having a certain status, where the client's behavior as the non-correctable, is inferred (Brandom, 2000, p. 91) as involuntarily deviant. Inauthenticity relies on social acting to neutralize and balance the emotional labor to not behave, according to a particular stimulus in a situation. The negative effects of social acting, in order to avoid consequences of sanctions to violations of conduct might be motivational fatigue, burnout and ingenuity of expression (Steinberg & Figart, 1999, p.12). An adaptive strength to

avoid seclusion can be to motivationally disguise emotions, and try to subdue expressions arising from illness, for example. Social actors experience greater satisfaction when their expressions match their inner feelings (Loseke & Kusenbach, 2008, p.522) and consequently find ways to integrate subjective and social expectations, managing and reflecting on the processing of the emotions of others.

An analysis of reported subjective bias does not require the sole predominance of the idea of a bodily or motivational system impact of emotion, reportedly because bodies are socialized to experience and express emotion (Leavitt, 1996, p. 514). Above, Juha is capable of mastering weaknesses of emotional expulsion, and developing avoidance (Line 158) strengths of emotional regulation. In the process of acquiring and relearning advantageous accommodation, he closes down agitated blocked expressive pathway but compensates by creating conspicuous, conducive pre-motivational strengths, currently unknown to themselves and the clinician. This lowered posture overrides and negotiates a "silent pathway", through the distant relationship, carefully balancing angry expression, and re-evaluates self, accommodating the setting, perhaps with a more learned socially assisted developed idea of the setting, and at a later time to approach the prospect of talk therapies.

Negative stimuli, such as the experience of the unavailability of talk around the seclusion room, requires an immediate behavioral response to either avoid, or accelerate mobilization of motivation, that narrows the focus of attention in cognition. This new motivation brings central allocation of attentive resources, to endure the cognitive labor of maintaining composer, due to regulation of exhaustive and angry expression. The data indicates that the goal to be accurate can lead to bias, in seeking dis-advanced information overload, and negatively biased impressions, even with negative expectancy about the target or topic (Neuberg, 1989, p.380). Clients cancel out talking of adverse memory of seclusion, by its suppression and re-formulate new pre-motivational routes, in attaining talk in the future. The mental health clients create bias to avoid the coercion, and neglect specifics about details of a shared negative social experience of seclusion as experienced by many, to challenge stereotypes having been "made an example". Clients develop positive reasons for social identity as ill or well behaviors, while individual negative reasons for seclusion, are temporarily buried in suppression. Impression formation of a possible future negative situation, utilizes vigilance as a motivation between awareness of trauma and suppression for example, as a mechanism that remembers negative information better (Pratto & John, 1991, p.389) and potentially activates a demonstration, of its widespread social impact.

Pre-judgments of inaccurate and accurate outcome attribution generate both adaptive and so-called maladaptive ways of regulating emotions, in the process of rejecting and deconstructing ascribed labels and mis-representative collaboration, within a socially constructive reactive setting. It is discovered clients are motivated to perceive, categorize, remember, and make inferences that lead toward desired conclusions and outcomes, and inhibit those that in-

crease the likelihood of undesired ones. People take no other way out, not only to maximize positive and minimize negative affect, but to maximize goodness of fit to position their perception of own binded agency and like others, in the unyielding structurally dis-advanced design. Individuals consciously know that moral rules, such as the informed consequences of their low affect sadness or its expressed opposite, rage for example, can result in seclusion, but have no emotional investment in them (Westen, 1991, p.437). It is also possible that sadness re-emerges from suppression into a growing intensity of depression, into disorientation, if left without talk, via reason to seclude. The seclusion emotional suppression theory proposes the awareness that a social partner does not interpret social interaction, like these sadness indicators, may create a predetermined motivation that is ongoing, that withdraw and pre- compose emotions of anger, in recall of seclusion.

The seclusion emotional suppression theory explains that any attempt to act outside of what is expected, incurred by the conditions, determines that a mental health client abides by their not reacting and socially learning helplessness. This learned helplessness emerges from suppression of anger that incorporates dull, negative opposite affects. These strengths such as wisdom to disengage or strategically fear, allows a person to accommodate the recall of their isolation in a future lowered posture, in expected coercive encounters. These fear and quickly dispersed countered agitated strengths are simply overlooked by staff, which then becomes incapable of secluding a client who avoids, and whom does not take issue with mental health or deviant ascriptions, as redefinitions of problems of living. Mental health clients further have tensions of increasing alienation that can be relieved, by what they perceive as punishment that leads to forgiveness and reconciliation (Lykken, 1995, p.40) among attachment figures, such as staff, that have previously symbolized fear, detachment or lack of social interaction. Societies and cultures vary in the degree to which they reinforce or oppose fears, as evolution "prepares" the human species to learned associations, and humans are born with few "hardwired" fears, but are prepared to acquire certain fears easily (Haidt & Joseph, 2004 p.58) such as the precipitation of abhorring coercive measures, and avoid becoming clinically "branded" as a bad patient. Fears accommodating adaptive goodness of fit within social environments such as through avoidance of a deviant ascription to a mental health concern are discovered to be attained, in social learning over a long period of time.

The talk with clients indicates the psychiatric professions try to separate participation and talk from the client, and fail to initiate persuasion including partnership of treatment. Clients socially learn from others that their expression will likely never be acknowledged, and avoid expression of trauma and therefore create strengths, in avoiding hospitalization. When people draw emotional biased conclusions, it can emotionally influence judgment and decision making (Gross, 2002, p.383) for a long period of time. Psychodynamically, this defense process is where mental health clients, including therapists, twist their agential beliefs, to fit what they would like to believe about the exclusive social reality.

An accurate assessment of efficacy as it affects others, in the social environment requires a client, to shape their worldview of inefficacy, returning to the at -risk community, and this can be at odds with the professional. The collaboration of the therapeutic alliance weaken when clients challenge what they hear from professionals, in withdrawing motivation to listen to re-definitions of trauma explanation, more so internalized socially learned from watching other patients, or develop rationalizations to explain away discrepant information about details leading up to the seclusion. Clients develop their own biased subjective world view of no wrongdoing, of closed reflexivity in agency versus inefficacy, within a context of reactive social environments. This might help therapeutically to personally, as well as socially assess their own strengths and capabilities of agency, to influence the social environment, by approach and avoidance of trauma objects in recall.

At last in this chapter, lowered pre-motivational drives limited cognition of recalling the negative stimuli of the threat of seclusion. Mental health clients quickly diminished cognitive dissonance to avoid and dismiss any consideration of the benefit of psychiatric seclusion that was so pre-decided, to not seek to explain detailed reasons, even when mental health clients were asked to do so. Lowered expectations of positive treatment outcomes exists in an on-going pre-decided motivation to reduce dissonance, and hold a socially learned, solid, hardened bias rejecting non-available talk therapies as a result. Institutional suppression can create emotional regulation, an evolutionary mechanism for the low affect adaption "built into" the human species that may lead to a temporary inability to recall certain events, before and after structural hindrances. Antecedent motivation anticipating avoiding and comply with deterrence, and regulation of emotion to deter becoming provoked into its expression, visibly among other clients are raised.

3.9 Studying Clinically Applied Deviance Labels

Featured in the chapter is the setting into context the client's emotional regulatory process, intercepting the conscription of deviance and aversion (Gambrill, 1997, p. 403) to seclusion, by the rationalization of sanction to visible agitation and disorientation. Clients lower expressions drive and avoid stigmatic (Crocker & Major, 1989, p. 608) labeling to requests to talk and initiating consensual participation. The subjective recalled experience of emotionally voicing offense to insinuations of client non-responsibility, for not abiding by self -efficiency norms, is experienced in suppressed recall to an unjustified episode of isolation. This results in high arousal agitated and low disoriented pre- motivational affect states, created by the impoverished structure. Psychiatric symptomology is labeled agitated or disoriented by narrowing criteria. In turn, these quick assertions of deviance become rationalizations for seclusion. These descriptions about the constricted setting around the seclusion room, lack quality at the time

of enduring trauma their present description is short, quick, and often biased about lack of agency within unaccommodating environments.

In the disadvantaged low outcome reality, a client's judgment of the conditions often looks to either discrepancies in convergent individual agency power or situational circumstances, in order to assign self-perception of fault for seclusion. Smith (1978, p.16) says that clients' labeled mental illness recognized as subtle deviant behavior is constructed, by way of another person offering no other reasonable conclusion, but that the development has occurred or incurred. Social constructionism offers a valuable explanation, suggesting the constrictive social conditions accommodating seclusion for agitated or disoriented motivational affect for instance, create the expectant and recalled inability to mask expression resulting in low treatment outcome, by lack of social interaction in the first place. The lack of interaction is then recalled with lowered motivational drive. The seclusion emotional suppression theory points to uncontrollable outcomes such as the threat of seclusion, elicit a need to resist expression of the trauma of seclusion, and suppress illness related compounded problems by a pre-motivational dispensation of bias, in order to avoid a deviance sanction alleged to negative behaviors i.e. cause for seclusion. In this way, other persons or perhaps staff members' accounted practices of assigning deviance to insisted demands to talk, become ascribed in a context, then assumed by the client as commonly held, and shared as a public identity in order to normalize the experience. This shared account discounts assumed fault of the individual for expression of social needs. The surroundings set the context for a formal application of a mental health label that was not there before, with the client below.

Juha: Before I was in the hospital I was not considered to be ill.

The client above speaks of the social construction of an individual understanding of illness, rather the institutions re-defined conceptualization. Specific contributions to social constructionism looks at what kind of structural situations and events that can provoke emotional feelings associated with behaviors (Loseke & Kusenbach, 2008, p.512) and how they are subjectively, then socially shaped and expressed publically. Human subjects can be readily manipulated into mental states such as anger (Schachter & Singer, 1962, p.396) due to spatial and social environmental variables alone. How emotions and their expression are suited for the situation have internal states, perceived communicated influence, and social pressure of how they are received by others (Lutz &White, 1986, p. 405). Expectations of how emotions including anger, are outwardly motivationally displayed, are also influenced within contexts, including locations and period of time endured in the setting.

Social constructionism suggests that persons and groups interacting with a social structure create an understanding, and develop meaning to mental representations of actions. These roles and concepts begin to integrate into reciprocal identities, in conversations interchanging symbolic interaction with the social environment. These new roles become institutionalized by the structure,

where meaning becomes balanced of a subjective and objective reality (Berger & Luckman, 1966, p.147). Ontological relativity, states ideas of the social world depend on a world view, and common sense meanings among human beings (Crotty, 1998, p.43). The existing social reality forms a part of ideological interest, in continuity of knowledge and situational truth, and these exist both as socially constructed and perceptual (Turner, 1998, p.559). Social conditions might be a predominate impact, of shaping persons experiences and pre-motivational biases. Views of the social reality can be socially constructed, and there is a difference between the social construction of the institution creating social reality, and labels shared as perceptions critically challenged and deconstructed among human beings.

Deconstructionism might refer to a re-examination and de-affiliation of how closely a perceived label rests, with one's own self-image and re-enforced by a presumption of how it is commonly understood, if it can be rejected to one's own self-reflection. Guba & Lincoln (1990, p.148) indicate that ontological relativist and epistemological subjectivist and hermeneutic methodology, emerges from the persons experience, and can be analyzed along the combined socially constructed and evolutionary emotional evolved nature of reality, among human beings. Social construction of a person influenced by the impact of external features of unequal social relations, and degenerated environmental conditions is taken into account, when moving toward common consensus with other people that exist apart from correspondence with an objective reality. I am aware that there may be a process of achieving knowledge about reality that is different from the constructed reality. The institutional design has the upper hand of constructing normativity, if for example, a person who has not committed a crime is prosecuted and found guilty of it; they are for all time guilty of a crime in the construction of deviance. However, there is a process of outwardly and inter subjectively accepting or rejecting assumed blame for an unexpected seclusion. There may be ontological meaning and deconstructive understanding of the new role that carries symbolic interaction of formal integration in compliance or not, with regimented social connotations of the constructed label that carries a non-deserving status. This subjective consideration of the wrongful new deviant role is not regarded as the constructed social reality in conjunction with connotations of the label mental illness, whether it had been communicated publicly or privately by the client, how this had been received, and understood with the aid of the therapeutic alliance.

The same is true of informal and formally labeling conduct as psychiatric or psychological, even when it is perceived as normative, and whether this appraisal is known and rejected by the client. Shadish (1995, p. 67) writes that an attempt to construct psychological, behavioral, and deviant labeled aspects to behavior can be different from what is perceived by human beings. This gives rise to deconstruction to throw off the prevailing social reality, generated to serve the hospitals interest to reproduce stereotypes of the powerless (Denzin, 1991, p.153). Practicing abduction in interpreting the data helps me to see the connection of what clients are saying, paying attention to their temporary ina-

bility to recite traumatic words describing the non-reflexivity, between the agential ability and sociological environmental incapability in shaping treatment outcomes. Consistent with my phenomenological approach in identifying client's ways of processing knowledge about the social reality throughout the interview, I was led back to questions about the social structure as a constitutive force shaping clients emotional reacting that helped, evaluating social and environmental conditions. In close examination of clients utterance of objects associated with treatment alliterated with traumatic pausing, sociological phenomena exist just below the surface of primary attention and awareness. In phenomenological research, Denzin (1978a, p.166) reports that naturalistic behaviorism attempts a wedding of the covert, private features of the social act with its public observable counterparts. The central words of treatment come with conspicuous pausing, and the effort is to examine how the words are carefully approached as abduction, working back and forth between words, deeds and definition as recalled words and their pauses, are the actions of self and other people under differing social conditions. Denzin (1978a, p.167) reports that humans have social selves that act to reflect their unfolding motivational and cognitive definitions of the situation, and this becomes a joint act as I as a sociological observer, attempt to understand and point out, for example, how mental hospitals create mental illness. The pausing phenomena featured by the client's interviews can be created by spatial design in remembrance of seclusion, and its temporary inability to recall becomes central to understanding trauma recall, and this serves an excellent way to organize and manage what clients are telling me.

The accusation of deviance for alleging client neglect of personal responsibility toward abiding by norms of containment of anger, and failure to recall norms in compliance to motivationally "mask" trauma is explained exclusively by the label, in an afterwards self and institutional assessment description, of being subjected to seclusion. This quick account of assigning lack of treatment attainment accredited to self-fault is already arrived at before the coercive event, during and expectant of this socially constructed processes. This self account held falsely accountable for the coercion is explained without elaborate detail by the client, after the seclusion episode due to suppression. Agitation and disorientation are re-defined, produced and transformed into deviance by lack of interaction, drug inducement and a conscription of devoid self-responsibility (Marger, 1992, p. 2) to refrain from talk among other rationalizations. No rationalization communicated to a client needs to exist or be justified, however in order to carry out the process of seclusion. Becker (1963, p.81) says the master status is that the person is constructed in their social environment as ill, or behaviorally deviant, and this produces a seclusion reaction as an institutional labeling process. Auxiliary status (Becker, 1963, p.81) is anything else the identity of the mental health client, in their subjective or objective worlds contends they are, that must not override the master status. A successful application of a deviant label, depends on the person being stripped of their former social identity that sometimes exists as a mental health client, disregarding any-

thing else they would be or say and accepting a master deviant status, as a predominate perception of self. The label might override a client's normative explanation of cause for seclusion. A seclusion attempts to enforce the master status of unresponsiveness to correction, whether the mental health client can quickly or slowly become aware of this manifest or latent process constructing deviance, enforced by the psychiatric hospital. This application of a label as deviance or mental health overrides any other considerations both to whom apply the label, such as psychiatric professionals, and presumably to whom the label is applied. How this process is accepted and rejected, openly in reacting out of offence to devoid help that is met by seclusion, and recalled by clients is either a master or auxiliary function of the hospital. How the primary or secondary deviance Lemert (1951, p. 76) is ascribed to the client is applied or failed, and how clients adapt and reject new roles is important to this research.

> 163 Q: If you can think of any situations that you've observed, what thoughts
> 164 you've had…
> 165 Esko: *Well I think it's down to the nursing staff to decide, that sometimes they*
> *166 take them away (into seclusion) too easily (…) for instance is somebody shouts*
> *167 in the corridor and for that reason is placed into seclusion…*

Rather than receive human interactive contact, the client recalls someone else taken to the seclusion room as a master function of the hospital "too easily" (Line 166) as this process is made centrally known to the client as a primary consequence for emotional expression. There are clients levels of central and peripheral awareness of master and auxiliary (Hughes, 1945, p.353) institutional, causal functions of the hospital setting of primarily assigning deviant labels in the secondary rationalization of relinquishing resources, and how they are made aware to the client, to become rejected and avoided. A researcher can understand punishment from the standpoint of the mental health client's experience, with seclusion and from the effects of such, by understanding the process and development of the construction of deviance, and how it creates itself again. Pollner (1978) writes that labeling theory of deviance is a practice of social construction that relies on a person to "orient to, display, detect, make observable and thereby accomplish an act stating as deviation, as it is only so, in that it is responded to as such" (p.280). Clients, armed with a prodigious calculation of voicing of inhospitable conditions, comes demonstratively with emerging social self-identity (Tajfel, 1981, p.255) statements, opposed to dissuading the labeling of deviance to requests for need for talk therapy.

The seclusion emotional suppression theory reveals the description of combined devoid settings come exhaustion, expulsion of anger and reset predetermination to re-engage or disuse involvement of expression, of hostile emotions in recall. The theory contends, the pre-determined motivation can exemplify emotional regulatory labor to maintain expressional composer, as a long-

standing, present pre-motivational mental state of contempt and offence in uttering trauma objects, such as a perceived unjust cause for a seclusion episode, for example. A client can be aware of this beforehand, in a process of deconstructing enforced failures of self-responsibilities (Wendland, 2016, p.12) to withhold emotive expression, and hang on to central mental health social identities other than peripheral deviant assessments. Clients reset pre-motivational emotional regulatory leveled affect strengths, self-assessment in expected future confrontations, avoidance, and precise allocation of the setting in further coercive encounters. The theory further holds this balanced affect can be before, during, and long after and anticipating seclusion, antecedent motivational determination is set in the constricted placement, however temporarily partially unaware to the client. Furthermore, clients become increasingly aware of a motivational pre-decision of cessation of angered and sadness expressions, to the implicit and explicit attempts to label deviance through seclusion, as well as present mental state at time of recall.

At the same time the social environment is mostly non-responsive to agency, adaption to the setting restricts this retold capacity, it acts to terminate rational interaction in the re-telling. The cognition of clients point to unavailability to respondent staff, and mainly devalue access to talk, as they are constructed to quickly shut down and withdraw personal motivation in recall, thus forced to rely on distortions in personal attachments, to the hospital's redefined solutions of unmet needs. The short suppressed re-explaining of these experiences of seclusion, distance from talk therapies, and descriptions of inefficacy are accompanied by pausing in short utterances, accompanied by traumatic objects, relived as a present state.

> 168 Q: Right, as you haven't had these experiences of seclusion, what do you think
> 169 the reason for this, have you tried to avoid them in advance, like you've
> 170 thought that I don't want to get in this kind of situation, or what do you think is
> 171 the reason that you haven't had these….
> 172 Esko: *Well I try to behave in such a way that I don't disturb people like…*
> 173 Q: Right, so it's just through your behavior,
> *174 Yeah.*

Above the re-definition of adverse behavior into deterrence of reason to seclude of client's needs, are discovered to be bargained at material value, by extracting professional declining material to social value of talk therapies. Availability of talk is transformed and created as a commodity to drive up or down, construct or collapse a future therapeutic relationship, and pre-determine to track a punitive, corrective treatment regimen, by the active avoidance of what is understood as bad behavior (Line 172, 174). It is commonly known that clinics may have to effectively turn away clients in order to abide by fewer resources, and the process may depend on punitive ascription made in and around the room,

in accordance with the ongoing social construction of deviance. The partial understanding of client's opposition to forced methods, and effort to avoid "stepping out of line", by not communicating a cry for help to stay away from a deviance assertion, may rely on understanding quick conclusions. Abandoned cognition may also become a factor about multiple seclusion made of clients and told of staff, grounded in situated bias of helps unavailability, reason of danger of seclusion. The accreditation of the danger in the environment, points to an official version of seclusion, used on anyone who violates rule, emphasizing the social account. Other individual considerations contributing to the seclusion may not be discussed with clients, as told of staff. This quick normative generalization bias as Turner, Hogg, Oakes, Reicher & Wecherell (1987, p.44) say serves as a functioning of a self-concept, that serves an interaction between the characteristic of the perceiver and the situation, and termination of description of the so-called others. Quick deterioration of interaction of the individual client, by the sweeping generalizations of false, deviant, and mental health ascriptions as indicated by them of staff, may not rest with the subjectivities of the client, as the perceiver and contrast with a shared account. Quick cognitive or absent assessments of the client's actions leading up to seclusion, may rely on overshadowing other human social aspirations of the client, and lack of clarity about how to reform conduct, other than from a consequence of staff correction.

Both the deviant and mental health labels may be in exchange for another, the two depending on a no choice bid of the least human value, forcefully determined to the least cost of the constructed unproductive to society. This testifies what (Rapley, McCarthy, & McCoul, 2003, p. 428) call the "creation of mechanistic and depersonalized identities" as self and others that do not explain the social or similar legal situation, but rather a pre-determined action constructed by the institution. The client is forced into compulsory treatment to deny a conscripted deviant claim, in exchange for a socially designed self-negligent mental health label, and can be formally or informally coerced into accepting both, or one for another. Alleged deviance overrules any other consideration in a perceived mental health role, in order to enforce a seemingly deviant, involuntary status as an "invisible attribute" that enforces compliance.

The conscripted failure of reforming the mental health conduct label, may then serve in the casting of unintelligibility of the clients vocal opposition, to reduction of preventive material and communicative supportive resources, so that a client needs to stay out of the hospital or jail, resulting in a cycle of social construction of criminalization, re-admittance and de- institutionalization. Afterwards, the constitutive self or deterioration of the social identity of client's accountability, finds that it is not always successful, but rather a failure of the lack of detailed explanation (Schegloff, 2006, p.2) of lack of self-sufficiency of this beginning process of seclusion, and this affects clients. The client does not own the reacting of talking prior to the sanction, due to inconsistencies in first arriving at hidden mental health applied visible secondary deviance, and in turn its recalled description is generated by lowered motivational affect, among clients. This social account of no wrongdoing may be the weighted variable in

order to avoid, elaborating about being non-deservingly cast, as the actors or co-participators, in the middle of the partially irreconcilable social situation, assigning primary deviance to a mental health status. A self-perception is one's own account of told subjectivity, and an individual account is made objectively and demonstratively to others, in visible view.

In regard to the question of defeating enforced, constituted deviations from individuation and regaining social identities, Scheff (1968, p.7) insists that individual responsibility is at least partly a product of the social structure, that relative responsibility is assessed, include a process of negotiation or not, and this process can in part be constructed as relational. Scheff (1968, p.8) states specific conditions susceptible to agreeing or not to the definition of the problem, may exist as being compelled or pressured to a joint influence function, using the psychiatric professional as in a wrongful legal process. There is a difference between public or official reality and private reality (p.7) especially if a client is coerced into accepting either explicit or implicit deviant, or mental health labels. Each label or both may be applied, disregarding the initial client's choice to participate within a constricted capability to consent, overriding both the refusal of the hospital and client, to the betterment of voluntary care.

Coercion and the imposition of involuntary status, in accordance with non-negotiated institutional rule takes place through seclusion, when a client is clinically indirectly manipulated by inefficacy, to not be in full capacity to make a treatment decision. The creation of involuntary status exist, to consistently enforce and lower a standard of preventive medical and therapeutic care, and little to no way to bid toward a mental health status, thus making ambiguous the process of awarding higher care, to those still carrying a non-deviant status. The absence of preventive talk therapies and over-medicine may have contributed to an aggregate at the scene of a crisis leading up to hospitalization. Scheff (1968, p.7) says that these institutional processes are similar, that they appear to represent the negotiation of reality, although the legal bargaining process appears to be more open, and accepted than the diagnostic process. The client is forced into a deviance process, as a result of agitated motiveless crime, for example to bargain mental health status as a result of lack of preventive care, and the client may be forced to abide by a construct creating non-adherence and subtle deviant ascription, therefore repeated seclusion. Avoidance of visible agitation to allure seclusion forms the discovery, of part of the seclusion emotional suppression theory aiding the analysis of the interviews.

Within the idea of negotiating diagnosis, and social scientific explanations of deviance, Scheff (1968, p.8) further stipulates psychiatric professionals may reject, the mental health clients attribution of external circumstances. If the effort to design deviance is successful, the client is in danger of potentially a concocted hidden label, and may have to endure long periods of the inability to express its injustice. Client's adaption as the seclusion emotional suppression theory suggests might re-surface as exemplary strengths, such as the ability to contain frustration, cessation of anger in the face of a hostile situation, and later a re-emergence with heightened affect ability, to name specific trauma objects.

Clients can then with rejuvenated affect, relate traumatic details of extra-psychiatry (Szasz, 2009, p.13) and extra-legality (Foucault 1989, p.79) such as being held to a medicine regimen without talk, and careful supervision before assisted consent is mutually achieved, after which seclusion, a motiveless crime against another client took place, and voice any dissonance with other social institutions brought about by these lone variables, agitated/disoriented effect.

A constricted setting is created for the assurance for mental health clients to beg, for the simple hope of ascribed assignment of human needs met, as an incapable individual through the process of isolation. No consent is potentially actively sought out by staff in the re-definition of needs, in order to bring the client into non-participatory treatment, in the involuntary setting. Mental health clients recall this canceling of a congenial collaborative process of obtaining consent in the inpatient mental health setting, consistent with Sacks (1992a, p.199) helps to discover tearing down with at least, to establish reduction of resources quickly, due to the growing ascribed non-deserving label of the helped role. For example, as mental health clients become assigned as the not helped, they become increasingly aware of this and repel it in recall, as part of a process of failing and objecting to create an alleged deviant, in order to start or continue care from the lowest level. Psychiatric staff conventionally characterized as a visibly accessible relationship in the closed setting, are described to be in -assessable, involved in a procedure of enforcing the withholding talk of the client's requests of social expression, configured as unintelligible, via reason to seclude. Visible expression overrides motivational and emotional regulation that could be inhibited, to display client's interaction with professionals, as the only presented allowed processes occurring. This is not the case, however because the client is undergoing a process of balancing both motivational and emotional impressions, in the rare occasion to talk with a responsive professional.

In the process of seclusion, mental health clients recall professionals that are not visible in the present, but where help had not been provided rather substandard care already provided, had contributed to the current and however future projected situation expectancy. In the process of assigning unintelligibility to requests to talk, it is told of psychiatric professionals are discovered to attempt to enforce as a sordid look or faint utterance of being disturbed by a question for information from a client, and does not follow with continuers re-defined implausible. This may be officially re-defined later by any social institution, as cause to motivationally withhold human expressive need, and refusing a client determining own needs in accordance with others, when scarcity is created, or arises. Scheff (1968, p.14-15) says that independently of the so-called facts, there are assumptions about contextual responsibility that are imposed by authority to coerce, however the process relies on the ability for a professional to manipulate, only that the professional re-defines what the client wants, or in this research a socially responsive environment.

> 175 Q: Does that affect you when that people, patents are being taken into seclusion,

176 or that nurses shout at them, does that have an effect on your not wanting to
177 talk,talk about your own thoughts and feelings to others?
178 Esko: *Yeah. But then it makes you scared (…) not allowed to talk about your*
179 *own matters very much (…) that this is something you're not allowed to talk*
180 *about anymore.*

In the above extract, the client is aware of a cue in the environment of nurses shouting (Line 176) to provoke a demand to talk that is transformed into reason to seclude, and to not talk in order to avoid this. The institution develops what is like a legal bargaining or an aggregate cue, such as reacting to the lack of talk imposed, in the environment that the psychiatric professional can label, because of the formal seclusion. Institutional constructs beforehand creates provoked client participation, then can call this a label of deviance as something that a mental health client has to abide by, which can be likened to a hidden or visible conditional release, like the forcing of acceptance of a plea bargain. Clients are then forced to submit to a higher level of punishment, accept informal or formal mandatory treatment for example. The mental health clients in this research avoids it, as this in itself is trauma, and an individual becomes incapable of looking at it for long by hanging on to closed, already decided social aspects of the problem. The problem is regarded as shared, learned agreement with other clients that the problem is external, and constitutive realities are derived, from disparaging social constructs upon the individual. Moreover, the client develops social awareness before, during, or long after this process, and becomes aware of it sometimes, able to consider the impact of external influence on problems that are not usually considered, and comes to understand it as enforced, as part of the trauma treatment. Mental health and deviance labels are socially and clinically created, because the client is never really outside of their ecological setting no matter how barren, rather acting in context with it.

Exploring the research question, tell of little interaction and description between individuals, rather of what the direct and indirect interplay between reacting to relational impediments, and their institutions seclusion reactions of participants including what professionals can achieve quickly and normatively, that require no other interaction what make up the social order. A formal edifice label that is associated with categories, with lesser criteria to establish something out of the ordinary in talk, clients ascribed by the inappropriate emotional expression of threat of seclusion around the room, depends on less measure of explanation, such as deviance as opposed to psychosocial quality. Rogers and Pilgrim (2005, p.134) say there is a struggle of psychiatric professionals to establish and maintain a deviant role of the mental health client, that may have to succeed in applying a label to an individual. Rogers and Pilgrim (2005, p.134) speak of a loss of agency, once the individual is labeled ill, and this obscures the roles and responsibilities of all parties involved, and includes removal by psychiatric professionals of a person's identity, or social expressive identity. Rogers

and Pilgrim (et al.2005, p.134) say it involves stripping the person of usual sense of self, as the label requires the removal of individuality then, the label seeks to explain away entire groups of people.

At last, Ingleby (1981, p.32) indicates psychiatric professionals rely on subjective interpretations with either more or less criteria that is unstated in the culture itself, that can be even quicker to script a deviant label, that justifies the restriction of scarce resources. The reduction of resources or creating and devaluing a market of stocks of knowledge (Peräkylä, & Vehviläinen, 2003,p.727) of treatment terms, are carried out occurring exclusively in the structure, or executed by the psychiatric professional conducting and supervising such, by withholding rules and explanations of the external manipulated setting, and mental health diseases to clients. Taking back treatment terms includes what Ingleby (1981, p.44) says that rationality and the nature of social activity can only be what people say they are, as they conscript each other's individual needs and demands as either met or not met, re-defined, or moderated by society, by social institutions that are supposed to provide for them or not. Ingleby (1981, p.44) goes on to say these institutions do not represent some common good, but are concealed behind the notion of economic progress. Finally, Szasz (2003, p.141) has stipulated indirect communication, permits the expression of needs and simulating denial or disavowal, much of which is avoidance of the physician, assigning to a client. The assignment of an individual at fault phenomena, created by the inability to conform to unspecified rule, may be simply psychiatric staff not talking to clients that is in turn, reflected in a clients' frustration, kindling an agitated expressions drive culminating into a motiveless event met by seclusion, later re-configured as subtle deviance.

3.10 Seclusion as Deterrence

This chapter warns an effort to conceal trauma expression can explode, if not mediated by the operational overseeing of the motivational system. A perceived deterrent to talk in recall is indicated by pause time, in a strong emphasis of what was employed such as the threat of seclusion to avert the client, from asking to talk. The recall may be blurred, because of the terrifying nature of the frightening away effect; also the avoided action such as a request to talk is partially obscured by suppression. Created clinic constriction inhibits knowledge of consequences of one's actions, as these can become ambiguous to conforming behavior to a reminder of past seclusion, underscoring the deterrent effect of potential future confinements.

Esko has never been secluded, but have in recall of seeing others who have, and this acts as a deterrent of suppression to "avoid seclusion", and twice repeating the word "seclusion" (pause time) out of fear of the utterance of the word.

205 Q2: This is really difficult, how do you feel that, is it

206 possible to show your feelings of anger, or does it easily
207 lead to a mental health client, or if a mental health client is angry, does it easily
208 lead to their being secluded, or are there any other ways,
209 or is it possible safely to demonstrate your emotions, that
210 you're not always placed in seclusion.
211 Esko: *Well pretty well, I do feel that, but that Finnish people*
212 we're rather sensitive and we don't talk so much, so people
213 who have talked more than would be necessary, then they've
214 into seclusion, (...) started crying and therefore was put
215 been put into seclusion (24:40) I just heard.
216 Q: In your opinion, do they put people into seclusion too
217 easily.
218 Esko: *Well yes sometimes when, but perhaps they've thought it*
219 through so that when somebody started in the canteen to
220 (...) the desire to maintain order (...)

There is a suppressive pause after the word "seclusion" (Line 214) (…) and again (Line 215) (24:40). Esko tells of assumed, socially learned, shared agreement that there is a pre-decision among people who have "already thought it through", as an antecedent motivational (Lines 218,219) weighing of the cost, benefit of expression. Esko acknowledges the premise as social construction of the institutional pathways, to control one's emotions, and a social process of becoming pre-aware with enough emotional regulation, so they would not have to be secluded. Esko has also dismissed seclusion for ones' self, but has accepted it from an assumed shared agreement perspective, that practically "anyone" prospectively, would have little or no agency in shaping a course, other than by avoiding naming objects, in this constrictive hospital environment. Esko concludes by saying that avoiding seclusion is just presumed by other people, in the third person perspective, to be pre-decided and thought out beforehand, to maintain order. The question is asked of an individual, and tells of responded pre-established ways to avoid the constitutive process, and approach from a cultural standpoint with pre-motivation, to conceal expression (Line 212). The mental health client is not necessarily asked to answer as one, member of a population (Lines 207-210) but answers as a collective, and he speaks of gaining another's experience as socially learned. Esko indicates that people can be placed into seclusion, for talking (Line 213). It is taken for granted and assumed as commonplace that they (Line 218) or "We" fellow clients think about avoiding the situation beforehand i.e. it is assumed that professionals and institutional construct, have already determined collectively to seclude, as an exclusive outcome as necessary (Line 213). The question is posed to an individual and understood by Esko as deterrence to talk and aversion, that is pre-established, that can enter the realm of in-patient client entrapment, if the client expresses emotion. The deterrent employed by staff may influence someone that had already thought it through, to not socially express agitation (Line 219) as a pre-

established self-suppression. It may induce cognitive labor to reverse expression of vital emotions, for danger of seclusion.

A deterrent effect happens when Esko speaks of another client put into seclusion for crying (214) and a suppression of Esko's crying, as well follows a regulative pause (24:40) time of emotional standstill. It is pre-decided in memory recall, been described by a visual and vocal institutional display of another client crying, to avoid crying being suppressed by the threat of seclusion. Suppression of time (24:40) (Line 215) happens to recuperate, after an utterance of the word seclusion. The word heard (Line 215) separating the self-identity positions itself as socially received (Line 215). The interesting thing is social control is visible, and then it can be common punishment but more cruel and unusual, because it happens in order to openly terrify, in view of other mental health clients. The self-suppression becomes learned watching other clients and exist as a self-deterrent. The same isolation to keep and suppress what is confidential, then rely on an openness of motiveless events leading to the constructed deviance of mental health clients, in the community that can endanger the privacy of the client, in the case where there has been a visible imposition of deviance, competing to override a mental health diagnosis, and subjectively held, as it is enforced by others. Clients can hold a hidden, private, secondary, auxiliary attribute of mental health identity, to guard against stigma, helped by the application of the seclusion emotional suppression theory, ceasing to expel traumatic content, deemed deviant. In contrast, the primary deviance assertion can reside in subjectivities as unjustified, and its unrestricted public communication might endanger the integrity of the clinic, by someone whom the deviance asserted label may not be visible, therefore ensues more credibility to the testimony of maltreatment.

It is also told, the reacting by the other client is superseded by the pre-motivated regulative effort to not start (Line 219) something as a visible agitated incident; it is told in recall distanced apart from a distinct example of what was being suppressed, and this acts as suppression to the teller. There is an example of pre-motivated suppression of action, posed as an example of another person avoiding seclusion (Line 218,219). The description in memory is detached in emotional regulation, however the client (Esko) repeatedly describes the other patient starting to express emotion then the recall is disturbed, by self-suppression in pauses (Line 220). There is a pre-arranged effort on behalf of the staff to abide by conduct that is unquestioned, and the client does not expound on the description of what the other person started to do, create disorder in the canteen. The descriptive process is stopped abruptly, and further suppressed by two pauses (Line 220) in the telling of another being secluded, acts as a suppression avoiding the telling extensively, of the visible trauma item of the other client, before it is re-defined as agitation.

Client's behavior outside the realm of normative bounds is reacted to with seclusion, as a separation between individual and group identity, self-agency and correction discouraging group tested, successful route of passage through inefficacy. For instance, the client starts to tell of a human expression

that is suppressed by the structural attempt at social control, and is suppressed after the telling of the word "seclusion", as it refers to another client. This attempted process re-creates itself over again, as when the client expresses, they are not able to finish expressing, then the fear of seclusion around the room, is made to suppress ever starting to express again, telling of self-control enforced at the first sign of expression. Esko in recall, tells that talk is not allowed to continue (Line 213), and the suppression of another specific recalled client is relayed (Line 213,214) talking too much, then starting to cry and therefore placed into seclusion. It is interesting that the pause (Line 214) describes another client's social awareness of the dangers of expressing emotion, and Esko is receptacle to the social learning afforded the other client. (Line 215) Esko visibly started crying at this point in the interview, but self-regulated and stopped oneself, during the frozen time (24:40) Esko recalled hearing of another client, put into seclusion for crying (Line 214,215) or talking (Line 212).

The suppression effect of the room affects many people by simply being around it, in its traumatic remembrance, and as a current state. The visible social control of one individual, is enforced upon them in the common or constricted area, and may legitimize the suppression of other client's expression, to be made hidden. Social control of crowds or groups of people from freely speaking, or even agitated socially expressing discontent or contempt in a court, for example, can be visible for a small time, then made hidden. Emotions may surface in another form that is unsuitable for the context, in order to alleviate primary attention to trauma content. The client below describes the feelings created by the contribution of the conditions of being in, and around the room.

01 Q: What kind of benefits or drawbacks during isolation or being restrained …
02 erm benefits (…) Yes, what kind of benefits or drawbacks do you think are
03 related to isolation or restraint…
04 Sinikka: *You feel more anxiety and (kieroutumista-vieroutumista?* (Transcribers
05 note– possibly a misconstrued word combining vieroutua ja vieraantua? A mix
06 of withdraw and alienation in one word).
07 Q: It just adds to that?
08 *Yeah.*
09 Q: Tell me about your experiences when you were put into isolation or
010 restrained for the first time in the hospital. Describe.
011 Sinikka : *Aggressive*
012 *I was aggressive the following days and weeks.*
013 Q: (…) remember can you describe
014 *I was fighting all the time with the nurses.*

A consequence of seclusion fails to subdue, and deter the fighting and emotional expression of Sinikka. Agitation and indirect aggression is the result of seclusion rather than a diversion effect, and opposite expectation of the failure of warding off the behavior, as this control measure does not suppress the feeling. The agitation lasts weeks (Line 012) longer than the seclusion. The client was secluded again, other than a first time (Line 10) for agitated, fighting behavior (Line 014) contributing to the seclusion itself. As well as visible agitation and indirect aggression displayed by the client above, Cicourel & Kitsuse (1963, p.135) defined people treated as "strange", "abnormal", and "delinquent", as deviance. The authors have long held that labeling theory, fashioned to promote social control of deviance, to the attributes of a mental health client construed to a social setting, make the client aware that they hold these characteristics, in conjunction with others like them, and create deviant behaviors such as agitation. The seclusion emotional suppression theory stipulates, the failure to produce the new deviant problem staged in exchange for demand for recognition of social expression, may draw on covert pre-motivational powers that are capable of conditioning composer. This self becomes central casting off the peripheral positioned constructed characteristic with a new social-identity so defined (Cicourel & Kitsuse, 1968, p.126) to one's individual identity that rejects the process quickly, in order to avoid re-living the naming of the trauma item. This individual ascription is rejected and deconstructed collectively, avoiding the deterrent by withholding expression.

Mental health clients' cognitive utterances that voice contempt, are reflective the growing ability to control inner motivating states, and are produced by an outward vocal assessment, of a low outcome social condition. In turn, cognitive refusal may be produced by a constricted area, in memories and visible demonstrations of enduring the restrictive social setting. There is a pre-motivational communicative aspect of emotional functioning. The suppression of trauma in recall, surfaces in motivational attempts to distance then an inability to place in perspective, the telling of the event. In other social settings the emotion is not expressed, but avoided and buried. One cultural Finnish way to adapt to frustrations, mourning, sadness and overload of intensive, on-going demands of communication is withdrawal and silence; an acceptable way to express emotional frustration with implicit rules of managing communication. Privacy is consistent with the Finnish culture's vocal expression of isolation and processing pain, self-repressing and hiding it, as health workers commonly tell mental health clients, they must bear their pain alone. Public language comes equipped with ascriptions of the self-suppressed individual, and seclusion in psychiatric facilities may be an institutionally and socially designate way to produce, by way of suppression a re-direction of displays of anger, frustration and disorientation. The untold function of research practitioners may be to discourage involvement with constructed lack of participation, in order to create non-abidance and lack of adherence with psychiatry and nursing. However, the correction may be interpreted as a deviant sanction, and produce resentment designed to be unresolved, among the client population.

These regulated sadness emotions are a result of the mental health client left without social support, like a therapist or other client on site to express and process emotion through psycho-social intervention or therapy. Shweder (1985, p.192) expresses the idea that unexpressed emotions are functionally connected, and this is to suggest that sadness, for example will not go away until acted out. If the emotions cannot be acted out in one way, they will be acted out in another or a less dangerous way, or transformed into something else. The problem is just as plausible to imagine the opposite, that anger, if unexpressed slowly, dissipates and ultimately disappears, or that low affect will not emerge as anger, and high performance regulation of communication. Shewder (1985, p.193) says, misplaced blame externalizing defenses such as projection may be disapproved in some cultures, but not in others. Managing or silencing expressions of inefficacy can be the untold function of the helping professions, as power differentials constitute privilege in skills, to correct so-called cognitive errors, and manage individual expression of intense pain, and conceal it from public view. Denying psychological social interaction with staff and doctors, transform what was once socially expressed need, scarcely material. However, the seclusion emotional suppression theory warns, that anger among anyone intensifies if left isolated or unexpressed, as this can create a dangerous cycle of inability to contain it and re-direct its consequence in a more concrete approach to level composer, as well as heightened ability, in its emotional regulatory maintenance. The individual complying with deterrence around the room is discovered to be a socially peered public control device, to keep mannerism low, to avoid seclusion, although its awareness can be undetected due to suppression of its confided remembrance.

Within inter-disciplinary or multi-disciplinary approaches to mental health, one's own biased understanding of what constitutes abnormal or contrary behavior via reason to seclude, outside convention of descriptive cognitive identity of self and others may be a category bound activity. It presumes behavior consistent with others like them, are compelled to dominate scripts of normality. Mental health client's internalization of the seclusion deterrent, created by the organization of the harsh socially interactive and constructed setting manifests itself, in culturally adaptive strategies, such as a healthy paranoia (Whaley, 2001, p.93). Equally, the extroverted action that follow a so-called disordered cognitive or motivational low or high affect thought and its communication, tells of the success or failure of avoiding seclusion, even visibly among other clients. This objection to substandard treatment is commonly re-created as resistance and non-adherence, and brings sudden closer to a solid description of the social reality of expressed trauma, and poverty in movement of being able to affect choice in outcomes.

The unavailability of preventive social support, and neglect of bio-psycho-social interventions in the mental health client's world that allow for health and recovery, offset exasperation and deterioration of the illness. Desperation and hard times contribute to the client's effort building even stronger self-efficiency strengths, such as retention of emotion. A mental health client's

communication of meaning of illness and treatment is more than social construction of their world, it is their combined, social collective grounded experience that allows researchers to draw inferences about the structurally designed incapability, strangling the ability of the small population to exercise individual human agency. Inadequate social supports create phenomena by a desolate design, constructed within the hospital setting produces provoked behavior. Collins (2007) makes an excellent example, structurally, of how hospitals are socially constructed in order to conceal emotive expression (presentation at Helsinki University). With low levels of participatory conversation based on news of confidential tests, positive diagnoses of cancer are made to people individually in a public place, to conceal the cost of a lengthy private confidential conversation, and its consultation. Rather, after receiving the news the client is led by themselves, quietly to a silent room in the cancer ward to process the expression of grief privately, as it is structurally and relationally suppressed, rather than be afforded costly talk therapies by the hospital, at a critical time in their life. Collins (2007) asserts that the client first receives news about the diagnosis of cancer in a visible, semi-public place, to suppress immediately, any social expression of the person.

Structural descriptions of mental health clients allowed for consideration of aspects of communication, that are not readily identified (Zuengler, Ford & Fassnacht, 1998, p.3). The feeling and atmosphere of a setting, the priorities or underlying inability to suppress preoccupations of mental health clients in recall, enabled the identification of distinct behaviors that were recurrent, and to be routinely related to similar practices (Stivers, 2002, p.1112) associations between the communication practice, and the overall organization of the constricted setting. Suppressing expression of trauma spatially and communicably, recalling phases in the interaction or suppression, are directly related to the social setting in the first place.

221 Q2: So maybe we can finish with are there any more
222 questions. (...)
223 Esko: *Being in your own room that's one alternative to*
224 seclusion.

When known there is no talk, no mutual participation in the face of an enforced end of conversation (Line 221) being alone or in own room, is favored by Esko away from the constrictive area, and no alternatives by way of little to no choice, are made in the uncertain future tense. Antecedent motivational predecisions are those that evaluate conspicuous composer, in accurate estimations of the inefficacy of the setting, confronting like others beforehand in this data extract. A client's impoverishment of agency, due to the accurate realization of inefficacy in the setting around the room is ascertained, without any more exploration in pre-motivational conclusion to avoid coercion. Esko dismisses seclusion from an individual perspective, in favor of bias to avoid behaviors redefined as deviant, disseminating "being on your own", as a client's common perspective brings back the question from a self-perspective, to the level of so-

cial identity (Line 223). Social identity is visibly learned that many clients can be alone and lower affect, as an alternative to being brought into a betrayal of collaboration, leading to seclusion. Esko rejects use of seclusion and acknowledges own won agency that is visible, but assumes widespread, social inefficacy in the open constricted area.

Esko elucidates the seclusion emotional suppression theory, by communicating little to no choice but be away from professionals, devising withdrawal and pre-determined detachment from expressing emotion to staff, that is already made up in their mind, closed to further expression. In openly expressing emotion, Esko makes a conclusion and expecting no other future choice, long before any seclusion arises. Without explaining options, Esko is assuring there would be many more than one alternative (Line 223) but closes the prospective list down hesitantly, due to low affective pre-motivational exhaustive closer. In speaking about the institutional suppression or seclusion, Esko is not separating themselves from other clients, and maintains a social perception of account, and more so initiates active distance from expression to professionals, created by refusal by the hospital, to provide an alternative to seclusion (Line 223). This creates stated, relived emotional suppression in the interview away from the seclusion room at an untold pre-decided time, employing the pre-motivation to avoid, as an ongoing strength transpiring any uncertain time.

The seclusion emotional suppression theory points to a client's traumatic avoidance mediated by operationalizing suppressed motivation, has already determined to stay away from uncomfortable items, although might be a clients expressed developing process of carrying out this pre-determination of future route of action, to avoid coercion. The suppression of the lack of communication has failed to institutionally construct Esko to individuation, because in stating the pre-motivational decision to stay away from seclusion, avoiding being brought into non-correctable, non-participatory exchange, he formulates a position for social self and other clients, to disengage from emotional expression. The inaction of interaction and communicative exchange of staying in one's room, cancels engagement with the clinics indirect, created non- participation. When asked to make a conclusion (Line 221,222) Esko brings forth one sure fire, confident, avoidant low affective motivational emotional regulatory alternative, an antecedent preparation to adaption to created helplessness, confidently coming up with a fortifying, definite, future canceling of a search for alternatives, when asked to be short. Esko demonstrates real long-term participatory decision making in treatment, to avoid coercive measures enacting in-expression to trauma content, and physically avoid situations where seclusion might be likely. Esko favors to withdraw his consensual participation influenced by deterrence, and it is realized that the construct entails no interaction.

181 Q2: Ask her if she believes that is there any encouragement to be well here,
182 or it is just punishment that if you act badly you will be secluded.

183 Q: So is there anything here that encourages you to behave well, so is there
184 about seclusion, do they say behave properly or you'll be put into seclusion.
185 Esko *Well nobody's said that to me.*
186 Q: No, yeah.
190 *But what I've seen about other people who've been there (30:55)*

The client has been persuaded by a collective impression that does not need to qualify the deterrent knowledge by reasons statements. He is succinct and silent (Line 190) (30:55) at the prospect of further persuading the interviewer of this public deterrent. Above, it is commonly regarded as seen (Line 190) as being responsible and abiding by a deterrent (Line 181,183) to expect no seclusion, and what is understood to be consequence to "acting badly" is seen likely to lead to seclusion. The lowered self -report (Line 185-187) and other client's specifics rests in pausing (Line 190) (30:55) from the motivational effect of the deterrent to avoid description of other client's visible adherence to avoid seclusion. The client then focuses on the details of the culture of behavior around the seclusion room, forcing clientele to assume a "correct conduct" unspecified (Line 185). This seclusion exchange for behavior is unstated of ambiguous rules, not warned of clients, but brandished by the visible threat of being led to isolation.

Temporary inhibition of emotion in still affect while not requesting talk, serves a positive consequence by avoiding a deviant sanction. Emotional regulation and suppression of negative behaviors have negative consequences as well. Inhibition decreases details of self-reported experiences of some emotions, such as pain, pride, and amusement, and people inhibit negative emotions at a greater negative cognitive cost, than inhibiting positive emotions; Gross & Levenson (1993, p.102) found that those who inhibit ongoing emotionally expressive behavior, show greater signs of psychological activation, such as decreased self-reports, than people who do not engage in emotional inhibition. Inhibition due to the deterrence of emotionally expressive behavior of negative emotions, such as sadness is unlikely to make a mental health client feel better, interferes with successful adjustment, and it blocks cognitive processing and performance. A client's inhibition of emotion of self, draws quick incorrect dispassionate inferences about social situations, that are less accurate due to exhaustive mental load, willingly employ cognitive countering self-suppressing emotions, withholding expression, that lose dimensions of quality about the seclusion deterrent, that retracts interaction.

In closing, a client in these moderated pre-motivational affect states, point to a combined social identity experience demonstratively, in order to more succinctly make externalizing statements about inefficacy and lures in the environment that provoke and disuade talk. Conventionally, it is normative to be presented with examples that suggest efficacy, without much more explanation, simply assumed to be true, and its exception reliant on even less quality details of avoided consequence of talking in the environment of inefficacy. It is

also conventionally assumed that an ascription of deviance is constructed to failure to abide by norms in a setting of efficacy, and the ideal success transpired inefficacy to favorable outcomes. Clients activate unannounced composer for an untold amount of time, among the uncertainty of in efficacious environments to come. In this research, mental health clients repeatedly described themselves and others, as socially affected by public deterrence around the seclusion room, in the face of being held isolated. Volunteering to speak out, when asked an open-ended question about self in recall, exhibited quick, closed, present state, and future attributions of social expression, are avoided. This suggests an opposite motivational power such as retraction is created, such as a pre- advancing antecedent motivation to meet a difficult environment with a retreat formulating deterrence, by being in one's own room, self-suppressing to avoid the conscription of deviance as Esko points out. Finally, the fear succinctly expressed by these clients is to avoid speaking out of needs, in order to deter and suppress the request re-configured as agitated or disoriented, and ascribed deviant via reason to seclude.

3.11 The Social Construction of Deviance and Mental Health Labels

This chapter relies on the understanding of deviance and abnormality considered a social construct, because they are defined according to what a particular society defines as normal. Outside versions of dominate values are often set aside from the norm. Social construction of poverty can be considered a determinate, because society constructs a certain amount of crimes of want. Stigma is an example of a social construct, because biologically a person may have an illness, but it is the social component that fashions it as abnormal. Social constructionist approach to deviance suggests what is outside the norm in one context, may not be considered outside the norm in another. Over-medicating, lack of communicating trauma totality, and quick defined mental health or deviant explanations overriding any other consideration of context, carry dire consequences for a mental health client, and consistent for this population is for them to suffer unexpressed trauma due to this. The combination of conventionally biased rhetoric, of mis- education of illness and recovery as over- biological, pharmaceutical might make clients susceptible to fall victim, to simply speak out of these social needs in agitation that can be re-defined by seclusion, as social construction of departure from conduct transformed into motiveless crime.

Labeling theory defined by Becker (1963) can be applied to motiveless crime (and) deviance that is institutionally conscripted, by incapability to follow direction, agitated insistence to talk, and un-correctable initiatives to participation. Deviance is constructed as objective labels and subjective realities, where it is a "product of processes which involves responses of other people to the so-called behavior, which can be in response to infraction of rules, and deviance relies on the interaction between the persons who supposedly commit and act, and those who respond to it" (p.14). Becker says a deviant as a client told sub-

jective view of the label may be unjustified, as they condemn those who condemn them, and the normative model of social processes that makes up the conception of deviation in mental health clients is made up of "inconsistencies to the deviant as this self-constituting capacity of labeling are overridden by the constant, fixed objectivity of the deviant label, and conformity or departure from normative standards" (p.20). The socially constructed deviant labels assigned adjacent to illness, by way of seclusion may not succeed in application with some people, for example that have predominately biological, behavioral labeled explanations of mental health. This contributes to emotional rejecting or reacting to inconsistencies of the formal constituting of a deviant label, by subjectively and visibly deconstructing its application to the constant fixed objectivity as what incurs, and is ascribed and re-defined in the constrictive, restrictive social environment. The application is an objective experience, because the deviance is visible and social, in its employment of control. The process of social construction of deviance may assist the question, of understanding what the institutional motive for coercive practices, such as seclusion is. The most common pre-seclusion behaviors of disorientation, agitation and threatening staff only become deviant, with the response or reaction of others or staff, that result in seclusion.

> 015 Sinikka: …*try out these new drugs how they work (…) fuck these drugs they*
> *016 should'nt be let out, I can't remember its name now this drugs name (…) it was 017 like quite similar to similar to (…) I mean you had no control yourself over*
> 018 *what (…) the next situation?*
> 019 Q: (…) like the aggressive state (…)
> 020 *Well the bullying…*
> 021 Q: The bullying?
> 022 *Yeah.*
> 023 Q: Did you experience bullying from…
> 024 *Yeah.*
> 025 Q: … on the nurse's part.
> 026 *Nurses yeah.*

Sinikka experiences pre-seclusion medicine induced agitation (Breggin, 2013, p. 81) and a nurse as an antagonist to provoke the rationalization to isolate. The question from the interviewer is not leading (021-025) but encouraging, through the risky telling of staff provoking a reaction from the client. The label of deviance has a quality that lies in the interaction (Becker, 1963, p.80) between persons who so-called commit an act and those who respond to it, like psychiatric staff or other people, and reinforced by other mental health clients, by seclusion. This label, with its own quality, has a consequence for expected future social participation and self-image of the person (Becker, 1963, p.80). In this research, seclusion as deviations are show by clients to be repetitive and have high visibility, as there is a severe societal reaction which a process of identifica-

tion, that is incorporated as part of the self-perception as an isolated individual takes place, and as Lemert (1951, p.9) insists, the re-organization based upon the new roles, and other roles occurs. This is discovered in my research to reject the new imposed role maintained by social identity, to guard against the implication of wrongdoing. Clients undergo a social activity of deploying an implicit cover manner, to conduct oneself with pre-motivational cool, detached emotional regulation, to avoid coercive interaction with professionals, of what might be viewed as negative behaviors via reason to seclude. Professionals are forced to mis-represent one ascription for the other and correct behavior as implausible, to primarily quickly contrive a deviant label, to be so-called incapability of reform to non- specific route through institutional passage ways, to lay the basis to rule out the secondary delinquent claim. The lack of talk, quickly and normatively justified by ascribing discourse of patients as implausible and eccentric, even on an outpatient basis makes a client vulnerable to visible vocal agitation or disorientation, angry or helpless to criminalization and death, by extra-legal (Gøtzsche, 2013, p. 2) first respondents. Patients are not made aware that they can receive outpatient support as prevention that monitors medicine and expressions talk, and be at risk to side effects that can effect decision making, as well as not be made knowledgeable by way of educated informed consent their ability to refuse lack of talk, and unsupervised medicine, before these neglected issues result in a forced hospitalization. This forced process itself is traumatizing, and it carries assumptions at the public level, about what is commonly understood as mental health and deviance.

The interviews with the clients, revealed there is a failure of an application of deviance by stigma, of defining socially expressive needs, are discovered to occur in the form of labeling, around seclusion, and exists in most public places. First, there is an understandable request for the recognition of socially expressive need, reacted to and ascribed as agitation or disorientation in insistence to talk, at the scene of the barren environment setting, its need fashioned as unintelligible, and opposition to this is created around the seclusion, failure of deterred emotive expression through pre-determined avoidance, and compromise to leveled affect is re-defined in clinical concern to isolate, reaching the restrictive setting; second, this leads to social penalties or seclusion; third, there is further primary labeling of deviation by doctors or psychiatric staff; fourth, there are stronger penalties by psychiatric staff; and fifth, there is further labeling of primary deviation (Lemert,1951, p.77). This forces a mental health auxiliary status with understandable hostility and resentment of clients, focusing upon those doing the penalizing.

The process continues: sixth, a crisis is reached in tolerance level expressed in formal action by the psychiatric staff stigmatizing the one who is labeled the deviant; seventh, the strengthening of the deviant as a reaction to the stigmatizing and penalties, also that the mental health client starts to act as a deviant, that they become aware that any behaviors are only reacted and regarded deviant as such; and eight, the ultimate acceptance or rejection of the deviant's social status and efforts at adjustment on the basis of the associated

role (Lemert,1951, p.77) irresponsible to contain emotional content, as a mental health role. Clients in the interview data, reject the temporarily inattentive deviant auxiliary applied to overrule the ill role, as subject to disagreement from a social identity perspective. In addition, in order to ward off a deviance assertion, the mental health client can learn low affect pre-motivational helplessness, and to not react as a directive within the context of the constricted social environment. The agitated disoriented reacting had been met before with seclusion, is visibly displayed and identified by staff with the sanction and subsequent labeling of deviance, and a mental health ascription as either auxiliary or primary, according to the understandability of the client, and others around them. The mental health ascription as primary, more so fits than is falsely and unjustifiably labeled deviant, through this process of seclusion. Remember, throughout the process the institution provides the least afforded care to a person based on alleged conduct, and the forcing of a deviant label can be of primary interest to the institution.

In the public expression of trauma, the health client setting over or under medicine, inactivity to interaction or a social antagonist may lead to a seclusion restraint measure before, during, and after or ongoing multiple times between the A or constricted environment, and B or the seclusion room. If not fatal, within a matter of minutes these agitated incidents, can lead to isolation. Because of a lack of talk, resources in outpatient health client care and involuntary over and under medication, mental health clients have been subject to poverty conditions, where they are susceptible and have been taken advantage of either through no fault of their own; their conduct had been misunderstood as deviant preceding a crisis. These agitated, and less often indirect aggressive motiveless constructed crimes have resulted in seclusion, and further give the potential of psychiatric care the upper-hand in insisting on mandatory in or outpatient mental health client care, forced medicine, or unjustifiable jail or prison sentences, particularly with compulsory medication, restraint, and forced therapy, overriding voluntary consent, and refusals. This results in the criminalization of the mentally ill, risk of death, and failure of voluntary participation.

026 Q: (…) Remember (…) can you describe (seclusion)
027 Sinikka : *I was fighting all the time with the nurses.*
028 Q:… with nurses..
029 *Right.*
030 in the bin..
031 *Not in the beginning because they could'nt.*
032 Q: Aha.
033 *Then when they then started to put me on drugs in the middle of the night*
034 when I was sleeping.
035 Q: Then…
036 *Then they locked me up.*

Sinikka is subject to medicine induced low affect disorganization (Line 033) then isolated. Social construction of deviance and mental health labeling, by

poor treatment outcomes are not due to a client's agency, but social environmental constraints. Structure and agency refer to the capacity of individuals to act independently of structural constriction, and to make their own free choices, which seem to limit or influence the opportunities that individuals have. It is discovered among mental health clients, an overemphasis on agency stifled by inefficacy. Assumed lack of ability, within an open or constricted setting is normatively assigned a deviance infraction. Behaviorally, the setting as in any public life normatively grounded in presumptions about efficacy, leads to a set of response tendencies designed to coordinate adaptive action a defense, through avoidance of professionals views of open environments; social self and its demonstration of able, not capable agency cannot be separated from other mental health clients by psychiatric professionals, that enforce individual fault ascriptions, even though each mental health client was alone at the time, in a room with two interviewers. The seclusion emotional suppression theory explores a pre-motivational decision, to avoid seclusion to not emotionally react is so costly to cognitive and motivational effort, that it is not expressed with measurable quality, but in regard to social self, that does not require much conscious effort for its comparison to self.

Hilkka in the next data extract, discredits the description of deviant labels quality, as this attempt to isolate and suppress the client is restricted, with an insistence of social self-engaging inefficacy, and abandons accuracy in statements, when exploring agential alternatives to seclusion. The alternatives have been suppressed; hypothesizing about them interferes with adjustment of motivational and cognitive reflections, about self.

225 Hilkka: I'd say it more like captures you, subordinates you, it
226 makes you like, afterwards it's like, you don't dare, you
227 really don't, really dare do what you're thinking of or what
228 you'd like to do... I don't know, it's hard for me to think
229 of anything this quickly that…
230 Hilkka: If I am in a manic stage then what I'd really like is
231 the opportunity to talk and talk things and, but it's
232 possible that I'm not my usual self then and that
233 afterwards you might feel embarrassed, I don't know.

Suppressed items are immediately taken back and questioned, then persuaded as a population as (you) in a general sense, under no uncertain terms. Hilkka realizes there had been emotional cost as motivational expenditure and again takes the opportunity to talk (Line 231) back, by saying "I would be embarrassed" (Line 233) and avoids a deviant assertion to mental health symptomology that becomes delinquent through the request to talk (Line 231) through suppression. Hilkka, still under the effects long term of the suppression, finds it difficult to express with quality and quantity aspects of seclusion. Hilkka on about every other line, communicates that there is a motivational cost for accurate self-assessments, and allocation of open or closed efficacy, and in communicating the effort of self-suppressing, by taking the " I" statement back at

least eight times, Hilkka becomes more comfortable speaking from a shared, collective agreement of demonstrative able combined awareness of conditions. This fights against the failure of the seclusion to take away human expression, and fails to label the experience around the room and seclusion itself isolative, retaining its social manifestation, in recall and in the present. This extract clearly reveals a failure to contrive a deviant ascription by suppression, and emotional regulation of talk as an already decided pre-motivational state. Hilkka predicates a future search for talk as an "opportunity" then motivationally retracts the need, by questioning "but" (Line 231).

In the present tense Hilkka moves quickly (Line 229) to avoid exposure to the attentive emotion, in this hypothetical future tense motivational processing is inhibited, and brought back to unstable assertions. Hilkka describes inhibition by avoidance of first expressing the experience, then the emotional effort of self-suppression, and there is an opposing force of taking it back, due to the exhaustion, of both self-suppression of the utterance of trauma objects, and the suppression of the recall of the seclusion. There is a decreased and cut short self-report, separated by commas in the first sentence. The inability to describe what (you'd like to do) shows that it (is hard to think of anything quickly) which is an inhibited capability of cognitive reasons, which is the negative cost in emotional regulation of (being) captured, and subordinated in seclusion and its description in recall. After the seclusion, there is an effect of self-suppressing Lines (227,228) telling of not only what one would not dare do what you are thinking, but also what you would like to do. This suppressive pressure to inactivity (Lines 227,228) tells of the knowledge of the construct, establishing no participatory means to agency.

This presents seclusion as having far reaching consequences, making a mental health client incapable of carrying out executive function of personal duties, prevents first thinking and formulating a plan about carrying out a duty, and the suppression prevents a client to carry out, what they would like to do because of being captured (Line 225) and subordinated. Hilkka immediately positions themselves affected by seclusions as a population, assuming shared agreement (Line 226) or you. This is an attempt of self-protection of group identity. As social needs to talk are expressed, the suppression of self takes it back for example you don't dare (Line 226). Don't and dare is said again, before action as a pre-motivational inaction on (Line 226, 227) and its lack of confidence in the restated word is stuttering in its execution. Long-term suppressions outside of the seclusion room surface in self-regulation of emotion in "I don't know", "it's hard", "anything like this quickly" (Lines 228-229), that (unfinished) sentence no quality (Line 229) not usual self (Line 232) feel embarrassed (Line 223) I don't know, as multiple self-regulations of suppression and the after effects of little, or no talk. The avoidance of feeling embarrassed (Line 233) is a warded off attempt to assign deviance to the prospect of talk, avoided by an antecedent motivation to disuse of expression, before the potential to become labeled incurs. The clinical imposed non- corrective self-fault of embarrassment as accounted for after being denied talk, suggests a phenomenological recollec-

tion (Smith, & Thomasson, 2005, p. 94) of the self-knowledge of the clinic, conscripting deviance, to a mental health concern.

There has been an attempt, and a failure for the clinic to position a primary deviance label, by way of a secondary self-perception of mental health, no account of wrong, as "I am not my usual self". (Line 232) points to a hidden label false accountability of danger of sanction, where the process of meaning to Hilkka may start to feel embarrassed, because it is not a result of their own wrongdoing. It affects them so they do not dare communicate, as this is an imposition of a shutdown of manic talk, labeling a mental health concern as deviant to Hilkka's talk (Line 230). The communication shut down the client receives, is found in the client summation of description, of seclusion by suppression. There is a beforehand antecedent motivation fear to not talk with a quick cancellation, using but (Line 231) as a reconsideration for fear afterwards (Line 233) that is a strong indicator of the presence of emotional regulation. Hilkka also identifies the attempt to fight the so-called deviant reacting, with a pre-motivational low affect posture, as a balance of emotional suppression not to speak, that Hilkka would not dare (Line 226,231) talk, for fear of embarrassment (Line 233).

Talk is understood as a subtle deviant sanction describing seclusion (Line 225,226) avoiding capitulating to a subordinate role, and as consequence forfeiting consideration, pre-determining not doing (Line 227,228) and pre-motivation to not express emotion. This deterrent is in favor of the seemingly more visible mental health label, (Line 230) manic auxiliary label, rather than feel embarrassed (Line 233) as not usual self (Line 232). Another role unlike usual self (Line 232) is accepted as a preferred mental health ascription, and the suppressive sanction imposing embarrassment, to avoid a conscripted deviant label and seclusion. Hilkka fights through the repeated suppressions with amazing strengths of resurfaced articulation, comes forward to talk and pre-establishes a long-term treatment decision, to re-approach talk (Line 231) and expected pre-motivated emotional regulation, until the chance is acquired (Line 231) or possibly avoided (Line 233).

Hilkka's failure to conceal expression, is configured a deviant sanction according to the understandability of the client, and how it is reinforced by others. Lack of talk may provoke agitation and incur disorientation, alert those who react to it making it deviant, but also to Hilkka, who then cannot act outside the confines of the primary deviance label. Hilkka begins to dismiss any secondary roles they serve, such as avoidance that is not reacted to as deviant, only as much as it has not been responded to, as deviant. The client then is at grave risk, becoming primarily deviant as Lemert (1951, p.9) states satisfies role conception for the client, and it must be re-enforced by the reaction of others, here as feeling embarrassed. Wanting to speak to someone after the seclusion (Line 231,133) by repeated seclusion, or then acting openly and visibly deviant, as the client is not reacted to, in any other role conception. Then demanding a receptive treatment environment becomes collectively deviant, and is not only reacted to but, joined and defended by other clients. This more intensifies the

surfacing of self-suppression of anger, for example as clients' mental health secondary behaviors serve to explain an enforcement of the master or primary label of deviance of the institution, reinforced by others, in separation from social connectedness. Then requesting services or refusing, become openly deviant among many, that results in a self-fulfilling prophecy, where the suppressed need resurfaces in demand of talk therapies (Line 231) is met by seclusion.

Lemert (1951, p.75) makes a distinction between primary and secondary deviation. Primary deviance arises, or is created by the institution out of socially recognizable identifications of departure from conventional conduct, the failure to hide expression and defined as undesirable, however immediate or long-term. This has only marginal implications for the status, and psychic structure of the client, as this can justify hospitalization, diagnosis, and coercive measures such as seclusion. Lemert (1951, p. 76) says, that secondary deviation refers to a special class of socially defined responses, according to how primary deviance is ascribed by a social institution to a client, as it is understood subjectively by the client. These labels of deviance are understood by those by whom they have been applied, serving to socially construct cyclical problems that create societal reacting and talks seclusion sanction, such as opposition to their application. A client reacting or not, such as in deterrence to an ascribed sanction of their so-called deviance, might involve their reacting to the formal assignment of asking for talk, deemed unintelligible. Punishment and social control (Lemert, 1951, p.76) is then applied as seclusion, fashioned by the social institution onto a client. It affects the way the so-called deviant or mental health client views the sanction as separate from self -sufficiency, how other clients see them and their perception of others' experiences, and these reluctant self-identities, are institutionally bound. These institutionally contrived self-identities are experienced as undue punishment, might alter the psychic structure affecting self-regarding attitudes, how a person's community treats them, and how this false conception of a client affects their social identity.

Aside from criminal forensic adjacency to a mental health role, or real, confided, objective, full ownership of related responsibility of a processed crime, there is a difference between what Lemert (1951, p.75) calls effective causes of primary, and secondary deviance as antecedents, and deviance as being situational. These react symbolically and are enforced as primary and visible in the integration of other roles, such as when mental health identity is disrupted as the so-called (me) or concept of self in the context, as this is only a subjective aspect of the societal reaction (p.76). An individual perception of self of mental health secondary deviance does not identify, with the false claim of primary wrongdoing, when a client merely is reacting to poverty of maneuverability, and its trauma within a social and clinical context, by talking. Lemert (1951) hypothesizes that psychological reactions are more acceptable for example, in conversations in defense of self-perceived innocence, such as opposition against any new imposed role, and clients refute a deviance label to a mental health attribute, such as the request to talk. When a client encounters overt and covert problems, created by the emotional reaction of the intensities situations,

warding off its primary implication it can become secondary, and objective evidence is found, in heightened mental health visibility such as disclosing a diagnosis (Line 230). This is discovered why clients hold on so unceasingly to a social, not individual aspect of self-affected by visible seclusion, not having a positive impact on anybody, and imploring its widespread use. A client then objects to individual wrongdoing, fighting off secondary deviance and begins to draw accurate accounts of the social context, under which a reacting took place. For example, intensifying demand to talk in treatment, where the context of constricted isolation around the room had provoked a reacting, or simply the raising of a voice to explain that reacting is understandable within the context, which brought about the seclusion as a formal reaction, and secondary misplacement as a mental health concern.

After demonstrating social account of the conditions, in the context where the reacting takes place, a client may still not integrate an institutionally created implicit or explicit deviant or mental health label self-identity, consistent with demanding talk. For example, the vocal objection of not receiving help is not often explained to have taken place, because of major mental health diseases. A created failed non-corrected mental health disorder may be offered and accepted or not as a label secondary, to the reduction of resources in defense of the attempt to configure deviance, in order to assign under-serving individual blame as a sanction, and to make the client aware of the institutions primary function, to create the corrective supervision, of non-deserving care. The person despite revealing their mental health involuntary status is considered secondary, to the institution still, to the ascription of lack of self-reliance, and little self-responsibility to withhold talk, as a primary deviant attestment. Failure in refraining from talking of trauma, for fear of ostracization of a mental health disorder (Line 230) in the extract above, make primary the deviance label, enacted to it.

The result of constructed suppression, and its consequent release of harbored emotion, can justify the seclusion itself. Isolation and events leading up to it cannot be studied residing outside of the social context, and the consequent temporal relations to those who carried it out. There is an immediate rejection of a deviant for mentally ill identity as it is imposed, sometimes according to no other precondition as the deviant or ill context itself. Coulter (1973, p.37) insists that relying on these mechanistic processes of creating beforehand the conditions of human want, and attempting to take away material value by a set and already established social situation, provides grounds and a warrant, for creating extra -legality, by any or no justification for attempting to label types of conduct, but not a determinate for the mental health client. Seclusion may compel an institutional determinate in the beforehand created setting, within the area around the room, and in the client, an antecedent motivation preceding, and further after, diverting the coercion that a mental health client endures, incurring to co-participate. This ultimatum to over-reacting or not responding to aggregate cues, incorporates highly visible violations of re-defined rights, abilities, and capacities involving only the sanction to an occurrence of a motiveless

event, incurred due to manipulated conditions. The event can be substantially traumatic, especially if the client cannot speak of the event for fear of ostracization, however a client might effectively withhold emotive speech, and does not react to the told trait dimensions of deviant labels that can be hidden, secondary to every day human characteristics. Seclusion may be sometimes only conjuring up, already firmly established notions of normative conventions assertions of non-correction rooted in stigma, images of deviance merely suggested by the association with the word.

Ignoring and isolating when the client says no, to seclusion for the first time in the psychiatric setting, and likewise in the outpatient health client setting, compels an ascription of a deviant non-correctable, that one person or professional or even civilian, is committing an act of institutional deviance, against another. A client indicates refusal against consents for specific reasons, and the problem with psychiatry is socially and clinically, most doctors do not check a client's claims (Maher, 1992, p.261) of the social reality, and over time, the deviant ascription of the coercion created by the very social condition upon the client, does not change. The words of the clients interviewed are to be taken very seriously and believed, as the profession of psychiatry cannot often disprove a client's claims. The profession often does not take into consideration actually what happened to the client, but rather recognizes the development of the clients' coping strategies to withstand conflict in the social environment, without an accurate accreditation of inefficacy. External reasons for hindrances to agency develop into opposition to maltreatment that can come privately, or as a more desperate approach, communicated publicly. An erratic environment is accommodated by an eccentric preventive strategy to regard the ecology as beyond comprehension, residing in a mental health subjective understanding of inefficacy by the patient, central to the failure of the application of secondary deviance, and a widespread use of seclusion critical to a social account, vital to its discredit.

It is implicated in the data, there is visible concern for clients to refuse to listen, ask or beg for interaction that is modified by professional re-definitions of assigned labels, and re-assertions of their behavior. However, there are also functions of subduing formally valued intellectual capabilities that enable the re-surfacing, of careful articulation of social expression. The important phenomena are that clients become aware of this. Primarily, people expect the hospital to be a place where humanity reigns constantly, in what Sacks mentions as a nice and visible (Sacks, 1992a, p.200) relationship. However, the distant social relations and structure are primarily designed, to hide emotive expression or create its visible explosions, and mental health clients can notice this cycle, by acknowledging a social experience to avoid coercion, the interviews indicated. Because of suppressing one role in order to compel another, mental health clients in this data expect to encounter humanitarian primary roles of the hospital, but really encounter the temporary auxiliary placement of constructing deviance, of hidden roles of the institution. These hidden institution roles are substantiated by presumed, opposite of what is to be expected of professionals, be-

fore the secondary nature of the primary role comes into partial awareness. Professionals and social institutions expect to achieve primary corrective dictates, to reduce material resources for care for clients, and auxiliary claims come to attain formal socially learned, acknowledgment of mental health status. Labels divide lower and higher tiers of care, but not necessarily human needs met, like social expression, long- term prevention and legal advocacy, when the deviance label overrides the mental health imposed role in the outpatient setting, for example.

In closing, there is visible and hidden expressed trauma, guarded by the therapeutic alliance. The social expression comes in different forms: often it is publicly, even privately, traumatic; other times it is so extensive that one cannot socially express it; yet at other times one can do no more than wait to find some way to express it, or there is immeasurable loss if a person or persons cannot express it, either privately or publicly. What is usually expected in suppression of social expression in its explanation as normative, are solid externalizing statements that enable the ability to speak, of the subjective unjustified experience of seclusion constituting deviance to a mental health claim, and allow a deepening social awareness of the construct creating the problem in the first place for many. This subjective awareness resides in explanations of no wrongdoing, to account for the infliction of seclusion, stratifying the widening gap between deserving and non-deserving poor, that accounts for the poverty and trauma in the first place and resultant coercion, divide and destroy ridged mobility between the two, creating one big layer of punitive care.

3.12 Discussion and Conclusion

This chapter is dedicated to exploring mental health clients' meaning making, and understanding of the construction of deviance assertions, as well as their level of social consciousness (Rosenberg, 2004, p.1) of each other's agential aptitudes. This first discussion unveils the construction of deviance by lack of talk and involuntary medicine as produced agitation. The second discussion unravels the social construction of deviance labels as unintelligibility. Awareness of "sameness" of effectiveness of lowered affect situates to non-reflexive inefficacy, at specific developmental stages of the inpatient process, before, during, and after seclusion episodes. This level of awareness is indicated, along a narrative sequential time order in current suppressed state, the coming of attentiveness of formally submerged descriptors of hospital stay, is accompanied by pausing in recall. Clients pre-motivate and precipitate pre-decision of future affective inactivity, and discretionary move toward naming trauma objects. It is important to understand how a psychiatric hospital presents the lowest level of care first, due to justification of deviance as constructed non-participation upon the client. A mental health client becomes primarily aware of vital social needs materially demanded, however re-defined and not met. It is vital to explore how clients prevent seclusion, by preparing their own pre-motivated non-participatory re-

fute, and silently dispel the imposed deceptive symbolic interaction by refusing to ask for talk, as this request is often labeled unintelligible and deviant. It is imperative to uncover the institutional reasons for creating non-permission to talk, by configuring deviance labels to mental health assignments and invoking unintelligibly. One way to achieve this is to fashion client needs, re-evaluated by the primary function of the inpatient setting in order to be reduced, denied, reluctantly provided, or potentially made ineligible. It is vital to validate how clients hold on to social identity, and a common account of seclusion, in order to fight off and reject the imposition of the primary label of deviance (Rapley, 2003, et. al) in a semi-visible place. I seek to discover, and briefly explain the institutional function of designing involuntary status, structurally applied to the created lack of adherence among able, willing and participatory seeking clients.

The primary manifest goal of society and the institution is discovered insinuating claim of deviance, by introducing medicine induced agitation and shortage of interactive care, then forcing compliance as admission of auxiliary mental health status, as reasons for poverty of free reign of ability. Unfavorable outcomes point to essential fault attributed the individual, for failure to comply with un-indicated norms of withholding speech. It is revealed that the setting can exasperate illness symptoms such as low affect and create deviant nonconformity to institutional norms. The primary function is discovered to deny or forestall the awarding of benefits, and to drive a lower modality of treatment, based on less cost and higher concentration of corrective care set into motion by the resultant exposer of poverty, unexpressed trauma, and danger to motiveless crime. Clients do not arrive on the scene, with a primary awareness of mental health or deviance, as it is forced by institutions' claim of a seemingly mental health auxiliary claim to unintelligibility, to requests to talk first, then a deviant ascription primarily as seclusion. It is grounds enough to know, that there is a punitive social institution in place that is well rooted in conventional explanation, in order to generate a pre-motivational, socially mentored pathway well beforehand to avoid it. A mental health client can enact a deterrent to stigma, avoiding a course around it, and simply make a preventive resolve to stay away from coercion. A social identity develops into a world view, that challenges normative assumptions of an ill deviant, fixed in the mind in dominate ordinary convention.

The primary socially constructed function of the hospital and many social institutions is to create these ascriptions, as allied to the doctors that rule out the deviant label, for the mental health label. This corrective design then becomes a primary role in order to enforce leverage upon an imposed corrective definition of illness and wellness behavior, as a punitive relationship in a dangerous attempt of inpatient and substantially, outpatient criminalization. These limited resources designated to an outpatient client, might endanger them to agitated or disoriented incidences of motiveless crime, misunderstood by the system of stigma. These labels are applied first, to an individual then objective, broad general descriptions of the mental health and disabled population that

formulates deviant laden ideas in conventional bias, justifying the criminalization of the mentally ill. The awareness of the social construction (Searle, 1995, p.175) of a deviant on a subjective level coerce a client, to effectively empower the seemingly auxiliary trait, such as becoming a good mental health patient. However, the mental health clients become aware of the manifest status of doctors, as the enforcers of applying this indirect pressure in their told subjectivities, and this brings awareness of the falsehood of primary function, emulating humanity of the professions. Among people who hold dominant versions of the social reality, the agitated disoriented motiveless event such as reacting to no talk for long periods of time is understood and labeled, however informally as an aspect of illness. It becomes harder to demonstrate aspects of illness that are not counter to what is expected, and normatively explicitly understood, as deviant behaviors of individuals.

When lack of psycho-social therapeutic support overrules a motivational and behavioral system, clients must not be judged for their desperate conduct in the fixed setting that exists in order to socially shape, the non-correctable. There is a failure to enforce the perception of fluid, transient agency to comply with a counterfeit symbolic interaction alleging client sought personal responsibility not met, to clinic re-defined deviant departure to norms, re-assigned a mental health ascription. If the so-called non-reformable mental health ascription of client fault is described to be causal (Searle 1995, p.127) to inpatient placement, is subjectively wrongfully accepted as primary to interpersonal identity, the conscription carries an exchange whereby the client must submit an unrealized level of agency as an individual, and dissolve a collective identity that challenges the ascriptions integrity. The primary label is applied to the client, hidden from public view as a deviant "invisible attribute", while a client retains an implicit mental health label, thus the coercive process may be said to be unnecessary.

Clinical methods of inquiry in retrieving this data, allowed for the observance of cognitive standstill of pre-motivated bias in exhaustion. The cancellation and re-emergence of social expression of sadness, and anger of coercive methods due to suppression, are indicated by trauma content, pausing, sudden stopping, and stuttering. This motivational affect also shut down elaboration of anger of future prospective alternatives to seclusion, to precipitous conclusion. The mental health clients in this chapter have been exhausted by intense emotional labor, to recall a former low probable positive outcome attribution (Webster, 1993, 261) attributed to no fault of own to restricted alternatives to treatment. Clients have adapted a pre-motivational stance with lowered affordable performance accuracy, in naming settings of inefficacy and social experiences of helplessness, as a suppressed mental state. These states are noticeable in long pauses of cognitive expression, around items of intense trauma. A relief of the tension of surfacing trauma items can be humor, that is precise and "to the point", in descriptions of inefficacy. Mental health clients are constantly in the process of pre-motivationally pre-evaluating accurate externalizing of the traumatic elements of inefficacy, that their own personal agency (Bandura, 1982,

p. 122) cannot often effect change under constrictive conditions, such as in the inpatient hospital setting, ill- equipped for talk support and prevention. Mental health clients are presented the socially expressive unmet need to talk, and later this becomes bargaining leverage.

Client's emotional reacting is propagated by a lack of connection, when help is needed. This unmet need and its reacting is recalled as causal of devoid of talk, and indicated as a present pause. Authors such as Christianson (1992, p.297) state that rather than show an impaired memory performance, in states of a high level of emotional arousal, like in recall of a seclusion episode, studies show that people retain detailed information from highly aroused emotional states quite well. Easterbrook (1959, p.191) also makes an impression saying that a restriction of the utilization of the range of cues, during high stress recall, like that endured by comprised leveled pre-motivational affect for example, reduces relevant information, and processing of external events. This condensed held in check, affect moderate focus is exceptionally receptacle, to explanations of perception of low agency power, such as source of trouble as externally institutionally causal. As a client's high stress arises, the ability to exert agency diminishes and external reasons to subject self to low motivational powers are first deficient, then highly accurate to naming specific traumatic items and external events of inefficacy absolving limited self-report. Recalling cognitive waiting, of when talk will be allowed is discovered to be temporarily buried, in suppression.

The clients check out validity of self-secondary deviance, with others visible primary deviance. This client's cognitive activity, that attributes perception of low power of agency to affect outcomes produced, is a social account of an expectation that 'one's own', is the only meaningful way to treatment. This is based on a complete rejection of labeled fault for seclusion as an isolated self, and embraces awareness as a social identity. This rejection of self-identity involves open visible recommendations to reject this self-perception, in conjunction with other clients, as in the case of deterrence, to avoid talking with staff. Client's doubtfulness of seclusion use, is based on unwanted overload and limited information processing, creating pre-motivational closure by a rejection of hospitals' methods. Clients present avoiding the lure of talk therapies, held to suspicion, and must be the only personal or learned agency, capable of change. Mental health clients express self as social, altruistic, concerned and go out of their way to help other clients in these clinical interviews, in recall of confined placement. Beforehand learned accreditation of the environment may discount personal experience, and mental health clients succeed, in making both own experience and memory (Wittengstein, 2006, p. 93) of learned information socially shared, to benefit other clients. The social identity is maintained to reject the implication of the primary status, deviance by seclusion by structural and sparse interaction, concoction of self- fault and suppressed, terminating limited self and social description of actions, leading to the sanctioned event. Forced medicine it is told by clients can precipitate agitation and disorientation thus a subsequent restraint and seclusion.

Frequent pauses in the client's interviews, is an indicator that lowered affect and pre-motivation is already present in approaching items of trauma in recall, suppressed descriptions of avoidance of coercion, and in future attribution of cause of seclusion. The pauses suggest absent participatory work, where the client's input had been suppressed, existing as a present mental state, in order to resist the enforcement, of a clinics one-way directive. Doctors and nurses dictating re-directional course of emotional expression, ordain the constructed conversational and motivational expulsion or containment consequences that is structurally pre- determined, and already established. Clients are not capable due to environmental limitations to address agency to withhold emotive content, as institutional and even cultural norms convey, and are helpless demonstrating others held back in inefficacy, raising objection by way of allowing the institutional its functional goal, of assigning deviance to mental health symptomology. Clients in these findings, more accurately develop awareness of external reasons (Searle, 2004, p. 214) of the clinic imposing new non-abiding norms, upon deviant roles alluded to requests to talk, according to the perception of the client. Client non-deserving fault, as causal is an already arrived at, well positioned, conventional explanation for being held in the context, of remembering being held in, and around seclusion.

Theoretical Considerations

The clients demonstrate that almost any conditional situation, social environment, anyone's detailed description of participants responding with agitation, to preceding social conditions creating human need, is all that may provoke a response issued an informal sanction. Acting on a conditioned state of mind, include emotions connected with structural determinate cues producing reacting behavior, in one spatial location of the constricted setting, having already been in another highly conflicted spatial area. These quality details are buried in suppression, brought to central attention self-protected by adapting a social identity, and brought to retrieval accompanied by pauses. The seclusion and its recall, is not a repeated recollection of other than what had been carried out, under temporary suppressed auspicious, due to demanding talk and participatory agency reprimanded multiple times, where the need can be created and deliberately ignored, to produce the seclusion reaction. As psychiatry indirectly implicated in the data, may not purposefully carry out active criminalization, according to Searle (1995, p.37) creating a new institutional fact is a process that is collectively, functionally intentional. An imposition of the status as an ill-deviant can be a function of coercive treatment, existing to designate an individual as unproductive to treatment, and non-participatory. This status function becomes a matter of general policy, acquires a normative status, it becomes a constitutive rule, and creates the possibility of oppression, that could not exist without the rule. These social constructions do not just happen clinically, they are created publicly, socially, and culturally, and they are not hidden or visible for very long. Any patient who fits normative descriptions of the departure from accepted norms, are quickly cast aside, by labeling open talk unintelligible

by ordinary conversation, and are made aware of how marginalization is created by way of the sanctioning of violation, in simple conventional talk every day.

Clients disclose experience of the created low outcome, and this intentional, institutional directional course is in place long before, during, and after the mental health client is in so-called need of correction. The institution has a place in conventional talk to intercept, a seemingly abnormal individual, and their social proclamations. The possibility of such forms of oppression is characteristic, of institutional facts. Searle (1995, p.49) points out the relation between rule and convention, that is understood to be normative practice. Aside from knowledge of time toward release from castration type environments, objects such as a seclusion room can function as a medium of restriction, to communicative exchange around it. The seclusion room is visibly and widely known, among mental health clients to be rationalized as a system of avoidance, reward of externalities, such as a requested provision, punishment and narrowing criteria. It is not just a matter of convention but of rule, of what objects perform this function, as psychiatry determines it is a matter of public policy, and is quickly understood as normative.

The data revealed the restraint seclusion reaction, and reproduced action due to the in-efficacious setting, does not have to occur, due to a rational explanation of a consequence, to emotional composer. The only institutional action needed to incur for this phenomenon to happen, is the reaction of seclusion restraint, and it would not exist, if not for the structure producing the reacting through provocation. Not providing for clients' human needs, and failure to recognize consensual participatory agency, shapes involuntary status. These are widely held as beliefs by many people speaking as anyone, can make a social group identity statement, and be aware of the failure of these imposed roles. Socially shared mutual knowledge of social self-identity warding off the deviant label, is an intentional (Tuomela, 2005, p. 348) constructed social strategy of clients. Conventional beliefs, construct a label of non-opportunity to choice that assigns more or less agency, and closed context to an individual affected by inefficacy, and to categories of people. Corrected past efforts at participation, absence of talk therapy combined being at the scene of poverty, and the reacting to these conditions endanger this small proportion of the population in the outpatient setting, for example. Oppressive medicine without talk support, that comes quite commonly with a mental health diagnosis, such as with the clients in this study, without consent, coupled with structural scarcity, can further produce indecision. Unsupervised medicine contributes to the failure to build decision making capacity further creates uneasy emotional settlements, such as incapability to disguise agitation and disorientation based on human desperation. Indentured agitation and disorientation in the inpatient area are created, by a lack of talk therapies around the seclusion room, before obtaining a deformed consent (Padgett, 1998, p. 36) or renewed, refusal regardless of involuntary status. Offense at constructed non-compliance of participation, to precipitate expression of aggravation can be in the inpatient setting or in a public sce-

ne, for example when typical restraint security measures are there, to physically smother a client's rage, and the client is at grave risk of being assaulted or killed. These are negligent claims, and legal liability must fall on actions of multi-disciplines, gathered around social institutions serving mental health. However, they are characterized by extra-psychiatry and extra-legality, as individual issues of personal moral responsibility, that are governed by an over-emphasis of individual, reform based, behavioral, and biological explanations of mental health.

Retaining traumatic content over time increases the reliability of description in memory (Jobe, Tourangeau & Smith, 1993, p. 567). The data suggests these social expressions exert themselves, and over a long period of time in another way, as both a social strength and pre-motivation to low affect becomes unleashed to prepare for, and endure harsh environments. Naming trauma objects are especially strong in composer if they have previously been suppressed, over a long period of time. The seclusion emotional suppression theory promotes mental health clients become aware, that socially expressed want and needs held collectively vocal, and communicated in a combined sense that are discovered to be re-defined as non-conformity and deviant, by the institution. Clients become reluctant to individually ask for help, or respond to cues, rendering a person non-participatory for fear of ostracization based in normative bias, for example. Then the institutions might not be able to rely on, quickly redefining an individual's unsatisfied want, based on anything else, outside the realm of what the social setting conscripts, as another label, that anyone would not often readily consider any other lengthy explanation.

Finally, a clinic mis- representing client conduct, and assumed appropriate communication casting the mis-directed label, present clients with not much choice, but to correspond with emotional concealment. The seclusion emotional suppression theory demonstrates, antecedent motivation employing emotional cessation is shaped and held in check, by increasing and decreasing performance levels of the supervision and careful mediation, between pre-motivational high and low affect expectantly. Clients in the data, tell of staff carrying out a quick, false application of the labeling of unintelligibility and deviance, rationalizing this by constructed neglect of norms. This seclusion sanction justifies the institution to override status, right, consent, refusals, ability to participate, however the deviance assertion may be created, therefore the coercion is unfounded, creating visible client opposition and further agitation, toward seclusion revolving door.

IV "FROZEN IN TIME" THE EFFECT OF EMOTIONAL SUPPRESSION OF MENTAL HEALTH CLIENTS

4.1 Introduction

This chapter attempts to explore why clients' emotional suppression in reliving events of seclusion, is presently manifested in pauses accompanying trauma content as an adaption, employing low affect and withdrawal. However, suppression ultimately produces counter-effects such as the regulation of agitation and disorientation, into balanced concise social expression of these trauma items. The experience of seclusion due to agitation or disorientation increase "frozen" (Kunda, 1990, p.482) lapses as pause time before, and after trauma objects in recall, communicating perception of little to no human agency in resolving crises in a constricted, social environment. I will analyze emotional suppression and re-surfaced traumatic content, as it is manifested in the client interview, as frozen lapses and long pauses. Frozen time is a hesitant constant levying between the motivational and operating system, and the search for bringing items of trauma to surface and monitoring these processes. The search for thoughts inconsistent with the achievement of control, decreases their conscious accessibility during suppression. People take longer time to name items of trauma, because of the suppression in word association responses, suggesting the pauses are the inability to speak of trauma inflicted on the individual, by past scarce sociological-environmental surroundings.

Control lapses (Wegner, 1992, p.40-42), with self-control in relaying trauma, exhibit exposed and submerged decreased accessibility of words, due to the exhaustion of leveled affect shoring back anger. In addition, decreased stimulus, and mental overload in an isolated environment, over a long period of time result in upsetting the balance. With this compromise to control, ironic effects begin to be expressed. A result of seclusion and the unavailability to express emotion over a long period of time, the pause in recall of the experience is a way that people move from seeking or avoiding (Wegner, 1992, p.49) and un-

consciously take time in recovery from words, articulating actions associated with recalling traumatic content, toward the suppression and realization of trauma expression. The human species acts to adapt to recalling adverse memories, and seeks to resolve self to recall a "connection", where pause time serves as a resolution, in recalling a trying social environment, that is mainly unresponsive to exerting human agency. If a human being finds their experience is not received with understanding, they severe the attachment, detach communication and withdraw. After inspection of the data, I will formulate how seclusion creates temporary suppression and is disclosed to create an inevitable emotional reacting and helplessness, resulting in failure to emotionally masked ascription of agitation, and disorientation rationalizing seclusion, in a revolving door that reproduces itself.

Maija's interview is used in this chapter as an example, because her experience stands aside at the forefront, that she goes to great length to describe the process of purposefully, temporally forgetting and forecasting painful events, indicated by long pauses or frozen time. This deliberate inhibition is characteristic of suppression suffered by the seclusion process for a long time after the event. Her effort to describe the process is an excellent example that reflects insider knowledge, with special insights of trauma recall, that she may have not been aware at the time, that might help professionals assist clients avoid coercion, navigating through the inpatient setting.

Maija disclosed knowledge of primary diagnosis, bi-polar disorder with mania, but did not self-report any knowledge of trauma or post-traumatic stress disorder or PTSD, before or after recall, of the seclusion episode. Maija had not received stable consistent talk therapies in conjunction with medicine monitoring as an outpatient, and this had contributed to the early beforehand hospitalization. Maija showed up to an interview after already released from the hospital after a few days, to a room arranged by a doctor and I, directly outside the locked gate. Familiarity of the DSM- TR- IV pointed the direction to rule out any other general medical condition that might have contributed to the phenomena. Showing up back to the place of trauma is already courageous, and part of strengths confronting the saturation with the terrible account, then after the interview the client left the hospital. It may be that Maija suffered a long-term trauma as a result of the seclusion. However, it may also be possible that the facility secluded Maija already with the condition.

4.2 Studying Frozen Lapses

A client can deduce the memory of navigating an unaccommodating route of passage, through a constricted social environment enforcing disempowered lack of agency, to be aided by lowered conspicuous composer. A heightened affect dispose loses self-details and sharpens ability to name external reasons for withholding talk to avoid coercion. A solution to avoid coercive treatment initiated by limited social environmental conditions, is social awareness of the

problem as it is already socially constructed as inefficacy. This pre- disposition develops a learned low affect agential preventive process to adapt. The seclusion emotional suppression theory asserts a pre-motivational way out of the problem is provided by the impoverished spatial, structural and sparse interactions conditions alone, that invoke in a person neutral affect in the telling. Emotional containment can subdue, or solidify bias of limited agential self –report in inefficacy and make one, more and less aware of harsh surroundings in memory. The client deduces an individual agencies and social empowerments long-term emotional regulatory strength, to withhold emotional expression that transpires deprived social, clinical, cultural conditions, and protect oneself in memory. Social environmental forces have more of an immediate impact on the person, and the constricted situation induce negative, unwanted emotional reacting to no talk, for example by the client such as disorientation, assigned an uninteligible ascription by seclusion.

Abramson, Sligman, and Teasdale (1978, p. 52) proposed that helplessness and reaction are likely to occur after an inability to produce a highly desired outcome, or prevent a highly averse outcome such as a seclusion episode. This can result in frozen lapses, and attributing external circumstances with disorientation, when a mental health client is describing the helpless situation, or memories associated with it. An inability to avoid a highly adverse treatment outcome requires the mental health client, to create an attribution, for their loss of control. Disorientation and agitation, loss of emotional composer, control or deterioration of capability to take care of oneself, arise out of disparaging conditions alone, and can impact the motivational affect systems. Affect is governed by the primary motivational system that acts in response to structurally constrictive forces of suppression and self-monitoring. This level of demeanor includes affective agitation, contempt, disgust, rage and the inability to respond to a cue that emotionally reacts to, and specifically identifies closed inefficacy of an environment, mainly devoid of interactive praxis. It is induced in recall, due to the suppression of time pressure, stuttering, sudden stopping or fear freezing (Freund, Kruglanski & Shpitzajzen, 1985, p.480) and pauses before, after, and during objects of trauma and can be reversed (p.487). The traumatic narrative can be chronological however the emotive process can be unceasingly charged with the most recent event, looking backwards, thus pausing before and after trauma descriptors occurs (Loftus & Fava, 1985, p. 280).

In communicative recall, a motivational process is reflected in the placement of the pauses around trauma descriptors. These pauses utilize an opposite protective process that manages the anticipation before approaching, and after leaving the emotional narrative of traumatic objects. They are released in the telling of the experience of being held, under long-term structural and self-suppression. Lapses with detachment, attachment or freezing pauses before and after described objects of trauma, indicate cognitive labor disqualifying motivational affect of labored listening to persuasion of ascertaining when talk will be allowed, and unresolved leveled affect under frozen withdrawal (Cassidy & Mohr, 2001, p.284) or sometimes misdirected (ibid. p.278) pauses, hesitating and

recovering from objects of trauma. Misdirection of attentive and peripheral placement of trauma objects indicates a suppressed un- availability of access of memories, due to the trauma of seclusion, due to disorientation and helpless cancellation of agitated expression. There are instances of visible suppression, and temporarily hidden trauma objects. A represents the constricted area around the room, and B represents the restricted area in seclusion, and a mental health client attributes a situation of limited alternatives, as having little to no positive outcomes. In response to this, they withdraw into negative affect and emotional regulation of psychic pain, and their present directional course toward an unlikely search for talk, is somewhat confused for a short time, as they rehearse A to B or back from B to A as detailed in recall.

The seclusion emotional suppression theory explains a person, when exposed to harsh social environments can develop confrontational, deterrent and avoidance strategies, and they suppress or express mediated motivational drives, in regard to trauma in recall. Trauma expression of inefficacy resides at the level of however central attention, and suppression of self in situation made peripheral, and vice versa according to the active naming of trauma objects in a clinical surrounding. From a clinical, social, or behaviorist perspective, a person begins to emit behaviors of a lower rate, as a strategic way to start to develop an adaptive motivational, pre- conditional strength. This pre- accommodation arises out of desperate surroundings, when an emotional confidant is in scarcity, and lack of appropriate designate skills to negotiate lack of social interaction are facing them now, expected in future, or recalling memories in the past and in the present telling of such.

It is important to provide a brief overview of how suppression, due to a recall of events leading up to seclusion, might act as temperate mediation in recalling traumatic instances in peripheral and central monitoring systems, in low and high motivational affective attention to core traumatic objects. Rejection of harmful psychiatric measures may be part of a de- constructive developmental stage process of an adult mental health client, and might bring to central surface formally suppressed external trauma objects into pronounced, intensified social expression, or long lived stifled hesitation in recall. Often the opposing affect is required to situate to the setting as expected. A staff's sanctioned request from a patient to talk produces heightened affect protesting, that is one way that involuntary status is socially constructed, in the area around the room. The protesting illicit agitation via seclusion, and it can be said that understandable emotional responses to the social environment scarce of interaction, aroused hostility. Structurally conditioned reactions are already established and manipulated by the institution, in order to create a setting for the person to explode (Marshall, 1972, p.790). These phenomena incur intentionally within a limited social context, because the very emotional expression that is intended to be suppressed, bring about a diametrically different affect reacting by the client, due to the design of the inpatient area, and the low level social stimulus in the settings. This is relevant because we seek to explore how structurally closed, and interactively retracted the pre-seclusion setting has contributed to creating

the social conditions, that invoke emotional reacting of a client, thus serve as a cause and cast a deviant unintelligible claim to the clients protesting, justification for the seclusion, if this is recalled in memory. An assessment of perception of agency is important, because the motivationally estimated, closed interactive structure can be contributing to clients' emotional reactions. These reactions are then configured implausible therefore deviant, by the application of sanction through seclusion.

The client needs time to recover and prepare, in pause time from the trauma in revisiting the past experience of agitation and disorientation. These re-defined client labels are transformed into a deviant account, by a quick rationalization of lack of personal agency for failure to refrain from talk, obstructed level of participation constricted by the setting of inefficacy, by initiating talk for example. In the inpatient setting either in the constricted areas, the effort to suppress emotions results in agitation and disorientation that utilizes lowered affect, or heightened confrontation, as the effort to self-suppress loses ground. Clients draw socially learned externalizing statements resonating with pausing, reflecting the detachment and alienation with the helping professions for example, and specifies recalled description, of the desolate ethnographic forces in the setting. The mental health client is unable to withstand the recall of the event, and inability to continue to persistently avoid the recall of the stimuli of deterrent to seclusion, and "explodes" (Marshall, 1972, p.790) unable to uphold the distance or estrangement from help, in an outburst of anger or startled response DSM-IV-TR (2003, p.463) as an indication of post-traumatic stress disorder. Fonagy (1997, p.192) points out that a therapeutic goal of helping people who experience trauma is to articulate, examine, and make sense of a mental health client's attachments and associations, with traumatic objects. A client can identify, then turn away from posed problems with treatment to focus on primary reason for visit.

In the middle of the interview, pause time serves to focus on the target social inefficacy statement, and then finds consolation and comforting alliances in social self-identified awareness experience, with little to no-choice settings. See chapter (3.9.) for a brief definition of social identity. Herman (1992, p.381) states that avoidance in communication seeks to resolve by alterations in time as disorientation, as it is related to lapses in monitoring and reasoning. The seclusion emotional suppression theory explains heightened performance of monitoring affect, due to impassable structural constraints, brings realization of social identity identifying hazardous conditions, by the memory of other clients experience with seclusion. This becomes a joint action that is undertaken in order to normalize and bring learned conditioning passive leveled affect, in describing the common account. The theory brings light to the importance of the pausing preparation and resolve, enabling low or high affect pre-motivation, to communicably pause to first counter to close, the descriptions of highly traumatic objects of environments of inefficacy in recall, and withstand its emotionally laborious retold consequences, as a present state.

Inhibition can create an intensifying leveled pressing affect as the self-repression of the suppression, demands a persistent balancing expenditure, of temporary submerged trauma objects. The suppression must hold a medium, by unceasing counter-pressure where there is withdrawal, when communicating the trauma, and avoidance in communication. Two forces that act out of repulsion, that operate from the direction of the unconscious to conscious in communication in recall, are the need for social expression and participation in treatment, and when the request is abandoned, after being denied. These two motivational powers, ascertain perception of the little to no choice setting, that is denied or re-defined social need of interaction by professionals. This formulates and enforces isolation constricted around the room, or restrictively in recall of being in, taken to the seclusion, after approaching staff with the request to talk, and when the seclusion reaction denied the request to talk in recall. In the absence of confidential talk, its description is suppressed and the seclusion institutional primary reaction to this request of social expression, is characterized as unintelligible, and is temporarily labeled as a part of the illness itself. Recalling trauma in a clinical interview exasperates general exhaustion, in pre-motivation that constitutes abandoned cognition that accredit, and expects a poor treatment outcome.

There becomes an effort to hesitate in time pauses, before and after the utterance of the word representing, and associated with the traumatic treatment, distancing self-regulatory suppression of the memory of the client, and its intermediary balanced vocal articulation reliving the event, in expressed recall in the interview. Dissociation (DSM-IV-TR, 2003, p.520) in combination with post-traumatic stress disorder relies on self-report for diagnosis, of the frequency of individuals' normative, or so-called pathological dissociative experiences. Zucker (2006, p.27) provides normative clinical data relevant to complex adaptions to trauma by what Luxemburg, Spinozzola, and Van der Kolk (2001, p.396) call emotional regulation, as affect dysregulation. It is observed clinically how therapists address areas of alteration in consciousness, as dissociation that is due to lowered self- report, and imposed suppression of utterance of trauma objects. In this chapter, I will explore qualitative disturbances in self-perception, by exploring extracts of traumatic experiences in depth and their subtle articulation, and integration into a coherent narrative, that proximate what Bowlby (1973, p.140) calls object relations to social relationships, as a client attempts to express them, with regard to attachment and detachment, to social self.

Zucker (2006, p.27) states that mental health clients can be living with post-traumatic stress disorder (PTSD) and dissociative experiences or de- personalization. This finds partial resolve in the mental health client hanging on to social identity, and dispelling institutionally enforced self and individual perception of account. Ross, Ellison & Anderson (1995, p.230) say that mental health clients with dissociative disorder, do not differ significantly from ordinary people regarding absorption-imaginative involvement, activities of dissociated states, low levels of amnesia, de-personalization and de-realization manifestations. Dissociative mental health clients seldom differ from normal indi-

viduals, in their degree of dissociative experiences. The disorder, then, might represent an extension, crystallization of normal psychological structure and function, and occur every day to ordinary people. Whether dissociative disorder is an extension of normal phenomena (Ross, 1995, p.233) or is so-called pathological behavior requires an estimation of whether the communicated trauma, is similar in dissociative disorder, and the general population. This is important, because the clients do undergo a traumatic experience on the way to seclusion however the client must also face becoming discharged into the same outpatient social conditions, in the future. An estimation of inefficacy by a combined valid account, in social and clinical settings is necessary, in order to evaluate effective motivational affect adaptions, to intercede agency versus inefficacy impact, on likely positive or negative treatment outcomes in future outpatient living, for example. Success in complying with the deterrent relies on the strength to regulate composer, in leveled affect states.

Self-perception of a mental health client displaying descriptions of past transient self in communicative de-realization, around retelling of interaction within constricted environments, uses everyday conversation to name deeds, own, others and institutional actions. It features detached proximity to representations of attachments to relationships with persons and objects, even remotely associated with trauma. In this study, social awareness is a value that the first client conveys as recalled in another client, as they both become aware of the failed attempt to isolate, separate, diminish and enforce self-identities to re-defined appropriate aspects, of socially expressive needs. Social awareness is an implicit, primary preservation defense, helping clients to process trauma, the memory of other clients however separated. Clients become centrally aware of inefficacy around the seclusion room, abandoning perception of secondary dis - empowered agency power creating the unmet need to confide in staff, and by a client identifying structural external impressions, around the other client in recall. A memory of heightened self-awareness is represented by a long detached pause, until reunited with the memory of social-awareness, where the accompanying pause is marked with less time, to resolve the silent trauma. This memory is enough for a client to draw accurate socially learned accommodations strengths of awareness of external impact affecting other persons, and conclude seclusion trauma as a common experience, dissolving the structural enforcement of failure of individual attainment (Marger, 1999, p.2) to self -care as causal.

As social expression is of value to a client, areas of functioning for a diagnosis of a dissociative experience disorder of extreme stress, are regulation of affect and impulses, attention, inattention or consciousness, self-perception relations with others systems of meaning, which are all linked to trauma. These disturbing recollections, include what Herman (1992, p.383) describes as disturbances in time sense or alterations, destroy a person's sense of self within relation to others, autonomy as well as dissociation of structures of self, internalized images of others, and deteriorate values and ideals, that give a sense of common coherence and purpose. The client breaks through these psychic barri-

ers, and goes through a process of identifying features of a "We" (Tuomela, 2005, p. 327) identity, becomes conscious of the common normativity of collectively withstood conditions, the invaluable awareness of "They" actions, and explicit primary institutional functional processes, of assigning unintelligibility, and deviance to requests to talk.

Herman (1992, p.381) further states, that combined presence of post-traumatic stress disorder, is defined by re-experiencing and re-living the traumatic event, seeking to avoid thoughts and feelings and conversations about the event, avoidance of people, places and activity associated with the event. Other indicators of PTSD are difficulty recalling aspects of or totality of the event, diminishing interest in formally pleasurable activities, feelings of detachment, and sense of timelessness, as recall is generated in memory in this study to be telling of socially expressive worth. Treatment of dissociative experience according to Luxemburg, Spinazzola, Hidalgo, and Hunt (2001, p.396) includes providing a rationale for affect dysregulation, processing and grieving of traumatic memories into a coherent narrative, that impact the mental health client's self-perception of social relations with others, re-connection with peers sometimes in recall, and either acknowledging, or long-term altering of systems of meaning. If the trauma occurs in the context with an institution of care givers it is important for the researcher to provide affirmation that the mental conditions are not an element of psychopathology, but normative and rationale adaptions to hostile social environments, such as the constricted and restricted setting understandably.

Herman (1992, p.378) at last confides, trauma associated with dissociative disorder and PSTD post-traumatic stress disorder, can be present in normative public settings. Breslau, Davis, Andreski, and Peterson (1991, p.217) identified many people with complex trauma living in public, a pre-seclusion or outpatient hospital setting. The DSM-VI-TR (2003, p.521) states that this disorder involves a reversible memory impairment, in which memories of a personal experience cannot be retrieved in a verbal form. If the items of trauma recollection cannot be temporarily retrieved, they cannot be wholly retained in consciousness (see chapter 3.5) and in this chapter, regress in pauses before and after words of trauma. Pause time around traumatic objects presented reverse into reemergence with trauma specifies, because they have been suppressed and take time to arise in consciousness, and present recall. Pauses around objects of trauma are reversed, because it draws traumatic emotional labor forcing a pause to prepare to utter the word, and other times it may take a pause time to emotionally recover, or move past the word to quickly, avoid reliving the event from the recalled experience, expressed around the word associated with trauma. There is also disorientation in the operating and monitoring systems that reverse order of sequence of tasks, in the carrying out of re-telling, and doing executive functional duties in memory due to past, or current exposure to trauma. In the retelling of trauma, there is a revisiting, or re-experiencing of objects in the carrying out of action of telling, that can affect the order of events.

In trauma narratives, client's tempered affect passions look back (Loftus & Fava, 1985, p. 280) in recall onto the terrible object, and in memory confuse the approaching and leaving the search for talk. This un- successful search in recall is indicated by reversible pausing, and in such cases focus on a central terrible object or experience leaving the sequence of events. The long pauses serve as an anchor point (Toulangeau, 2000, p. 29) to recuperate and prepare from the terrible account. Duration pauses are a long-term suppressive effect of the recall of not simply seclusion, but the inability to socially express traumatic objects entailed over the entire inpatient setting. They can exist a long period afterwards, as a current pre-motivational mental state. The client has already established a pre- determined motivational inactive route, to terminate recollection of the traumatic event, in any untold future time. The DSM-VI-TR (2003, p.521) states that a retrospective gap in memory, to utter the totality of the word associated with trauma is demonstrated, which there is a low level of amnesia, that may be minutes and as the client presents in the data, just under a minute. The DSM-VI-TR (2003) says this disturbance does not occur exclusively during the course of PTSD or post-traumatic stress disorder, as these combined symptoms have caused distress, and impairment with this mental health client in social functioning and other areas, such as family, and interaction with other social institutions.

The seclusion emotional suppression theory examines this tactful cessation of expression, in mediating opposite ironic (Wegner, 1994, p. 34) pre-motivational affect drive. These low affect gaps can be seen reversing around pausing, interrupt and act as representations in conflict to the self-report as an "I" identity, emotionally hurt, by the traumatic experience of seclusion. The theory states these formally suppressed, submerged, peripheral items of trauma treatment are wrestling with auxiliary to central attentive focus. They can be seen chasing and following paused utterance accompanied by recalled enforced and requested help, attaining healing resolution in the middle of the interview upon acquisition of social awareness, of externalizing structural and interactions constraints. Clients then move to more accurately articulate trauma objects, after the high stress content, pre-motivationally settles in low affect. After the longest recorded pause, the client confidently and socially assured as a combined identity, reports traumatic incidents with high affect calculated description, utilized mediation of balanced affect levy.

In my research, the seclusion emotional suppression theory discovers operationalized, balanced, medium, low and high affect motivational states in cool, conducive concealment recalling trauma objects, and a temporary avoidance of the emerging trauma word. Inhibition of seclusion remembrance pressures an introspective threshold of holding back trauma, indicating clients initiate pre-motivated silent pause time when presently agitated or disoriented, due to long- term suppression ensued by coercion. The client first displays a temporary inability to retrieve a specific word, associated with treatment in verbal form. However, when approaching in the middle, and end of the interview, the client exhibits long pause time emotionally regulating, preparing and recoiling

from the difference between disassociated suppressed personal "I" versus "We" identity. The client then vocally visibly makes the assertion of the social "We" (Tuomela, 2005, p. 327) traumatic experiences, relayed by the treatment word. The seclusion emotional suppression theory disseminates when central recall emerges out of an "I" identity, and heightened affect naming trauma objects arise out of suppression, clients realize through recalled socially learned protective memory of a fellow patient as a "We". Clients often undergo a "We" identity alone, in remembrance of time within isolated places. Combined clients experience becomes social awareness in a person struggling with the same setting of inefficacy, in recall of a previous time, exhibited an inhibited affect that is visibly displayed in other clients, subduing trauma expression within confined placement, around the room in order to avoid seclusion. The client then normalizes the socially learned account as aware and objective to common experience, then advanced heightened affect pace in leveled affect in order to arise, and confront in recall normative central externalizing statements of trauma, with an increased sense of agency. A client might identify not self-defined memory as isolated, but the traumatic objective external impact of the social environment as socially mentored, in recall. This normalizing perception of binding agency is a socially acquired accreditation of the environment of central perceptual inefficacy, position of peripheral helpless self in the situation. This brings central attention to an empowered self, and peripheral focus to details of inefficacy in order to emerge out of the trauma. Social awareness develops a sence of level of inefficacy, subjective limitations of agency and strengthens a personal careful procedure toward engaging it. Combined social awareness solidifies the sensitivity to inefficacy, and makes own and others diminished capability of agency, an objective learned aquirement of how a collective strategy manuvers it .

The mediating heightened or lowered affect then adapted by the client, is not self-defining, but socially defining of disconnections with talk shared by many. The widespread description of seclusion, made in agitated high affect does not take time to explore, but extinguishes quickly back to suppressive pause time in low motivation, due to the uncertain unavailability to talk therapies in the near future after the research interview. The clients frequently ask for combined expression with a professional, but the institutional function dictates that the staff's refuse, as the process may favor a visible, reactive compromise of suppression. Clients then describe awareness of the clinics failed attempts, to ascribe primary deviance and designate involuntary status, as delicate client neglect of self-responsibility to dissuade asking for talk, as non-abiding aspects to first the non-corrected self. A non -deserving identity is maintained for the lack of untold knowledge to abide by sanctioned clinical norms because of structural creating of the disorderly, and the construction of unintelligibility by the psychiatric professions cognitive rule in conventional dialouge. The exclusive cognitive corrective labeling of compromise to emotional composer, then intends to institutionally derive a break with social identity with other clients, in order to employ seclusion as social control. This fashions a punitive compliance with loose commitment with staff, enforcing lower

tier care among an individual client, because the process is visible. These allegations of departures from individual self-sufficiency of self -care may be institutionally construed, by the re-definition of wellness behavior, saturated with presumptions of lack of personal responsibility (Wendland, 2006, p.12) of agencies attainment to withhold trauma content, deemed implausible via reason to seclude. This fault-bound conventionally applied, incapability toward betterment by the hospital process is rejected by the client, after understandably reacting emotionally to the constrictive social structure, met with seclusion.

Finally, between so called deserving and non-deserving poor (Katz, 1989, p.9) it is assumed that in an individualist dominate assumption of the version of the social reality, that among the affluent patients, they will not be subject to dis-advanced care. Another conventional assumption is that the affluent culture is less aware, of the subordinate culture's misplacement in the social order, and oppressed cultures assume that the former, is less aware of common mistreatment. It is also a prevalent idea, among oppressed peoples that among the affluent culture, better off layers receive better care. Maija presented as the key informant in this chapter is featured exclusively in the context of affluence, because she possesses attributes of this "better off" social layer of the poor, such as had received somewhat interrupted, infrequent and an unstable regiment of private outpatient talk therapy, prior to hospitalization. She is undergoing a constructed institutional functional process of clinically, and socially assigning downward mobility toward stratified non-deserving care, thus the presentation of little to no talk therapies in the hospital, was more so traumatizing.

4.3 Detachment in Recall Before and After the Trauma Object

This chapter will demonstrate how Maija displays detached, frozen withdrawal in low pre- motivational drive, before and after describing trauma due to maltreatment, signifying a flight, freeze and fight approach, and reproach to identifying treatment objects suffered during her hospital stay. It will also explore the social identity awareness discovered and maintained by Maija, in the face of institutional imposition of an isolated self, through seclusion. Silence in "frozen lapses" in time where (…) indicates missing words or words that fall under suspicion of being "irrelevant just "mumbling", stuttering, and abrupt conclusion assumed as relevant. Time markings, such as (5:30) indicate pauses or missing words. These pauses suggest the phenomena of suppression is repeatedly consistent throughout all the interviews, and happens in many places, particularly when referring to memories consistent with objects of trauma, in and around isolation and dissociative, distant social relations with the staff. Reflecting the mental health client's self-described limited alternatives and constructed lack of participation in treatment, the frozen lapses precede and proceeded words used in treatment dialogue such as "admission" to the hospital, "diagnosis", "consent", "refuse", or "symptomatology", or "medication", or "getting better", "pain", and even the word "trauma", "confined", and "secluded". Sup-

pression reflects separation from consensual participation, from these "words" as deeds that represent treatment, are presented after some succinct explanation. Because of the distressing nature of these attachment figures or objects, this mental health client avoids the words, associated with the distress (Westen, 1991, p.434).

Stress and fear that accompany such an event result in a poorer ability to perceive an event, and poorer recall later on (Christianson, 1992, p.293). The author elucidates the effort to retrieve memories associated with trauma, shows impairment in verbal information in word stem completion and fragment completion. Only the initial remembering of negative emotional experiences under traumatic pressure, reflects a limited accessibility, to balance and counterbalance submersion of trauma objects. This temporary incapability is low tempered, unavailability to motivational expression, due to the labor of self-regulation. Self-suppressing aids remembering helpless descriptions of inefficacy and stripped agency, despite the long-term opposite eruptive counter-effects, of suppression to communicate objects of trauma, and the delicate concealment between the two. There is a counter self-suppressed attempt to avoid traumatic descriptions, that is inhibited in pausing before and after the word object in identifying seclusion, and unrelated consequences of client own actions. Suppression is present, with an accurate description of low agency power within the constricted setting, and inefficacy gains heightened performance of distinctive details, emerging from suppression. The seclusion institutional reaction of a client is subjectively held, and related to be non-deserving that does not attribute the event to internalizing blame, therefore must rely on an extremely accurate externalization of cause, as it is socially deduced by the structure. This externalization serves for a better, more specific kind of memory retrieval, in naming specific details of the self within social conditions. Further, consideration of situational demands when the person is recalling is important (Christianson, 1992, p.294) because the trauma tells of deeds, and respective words that are temporarily lost in pauses of suppression, not because the person does not have the capacity to articulate them. The objects and actions in the recall are saturated for some time in trauma rumination, until retrieved. The mental health client reported no distress during the entire interview, and was glad to relate their experience.

In remembering a violent suppressed memory such as seclusion, restraint take down or a shared desolate social condition that includes self-description, detailed information in recall of the critical objects of inefficacy and peripheral items of agency, are problematic. These external objects are communicated with a central source of the terrible, with suppressed surrounding peripheral informational descriptions of items, represented by words and the difficult trauma recalled. In this study, remembrance of coercive treatment methods, draw on pausing pre-motivational exhaustion, because attention to these items causes unconscious attention to distracters, that need to respond to the clients' rehearsal or cues, before being brought into consciously remembering the critical item, that is recalled, experienced, and told as a present state. Because it is pre-

sented before or after the subjects in recall of the events, the detailed information of coercive events describing seclusion, preceding or succeeding the emotion-eliciting event resulted in pause time, is expressed before and after the critical emotion eliciting event, and is remembered very well (Christianson, 1992, p.290). Detached pause time before telling of an item of trauma, can communicate gathering strength followed by advancement toward a trauma object, then speaking in recall of a request for help. Pause time after can communicate becoming reproached, after the word associated with the trauma had been advanced, communicated, and denied as in deterred from help.

Pause time can be used to process a problem with little to no solution presented to the client in the stripped setting, or communication of it, within an inefficacious situation with limited alternatives, and frozen time offers a resolution severing a "connection", of requesting and receiving help. Maija pauses (2:18) (Line 400) after an utterance of a peripheral "I" identity, effected by fear of recall of a forceful admission (Line 401) as central that gathers strength to advance the trauma item, of becoming introduced to the involuntary placement. There is a hesitation (Line 400) (2:18) in the first sentence of data in this chapter of empirical research, before finally saying "admitted" (Line 401). Gender has been coded in order to avoid stereotypes.

400 Maija: Well when I was first, when it became clear to me (2:18)
401 admitted, I wanted to refuse medication.

Separating the acknowledgement of self- participation (Rapp, 1992, p. 56) and mutual collaboration from the admission is a pause (2:18) (Line 400). Maija hesitates in frozen time in silence (2:18) before communicating their forcible involuntary "admission" (Line 401) indicating dissonance between stated subjective awareness of the undergoing process of hospitalization, as an undeserved application of deviance in refusing care (Line 401). The admittance process of the little to no choice immersion, into the constricted social reality, constructs non-participatory incapability for all parties. The client was not brought into alignment but wanted to refuse (Line 401) that was not acknowledged. It is a provoked response of an able Maija, cast in an incapable construct of non-adherence, when consent and able decision are called for, to become achieved. The utterance of unwanted medication brings an abrupt stopping, to elaboration. The little to no choice environment impacts the low motivational system, because Maija was not in possession of the product of his or her effort to avoid hospitalization, in clinical constructed lack of reflexivity around the room.

The word "admission" is suppressed and separated, because there is a recalled attempt to pre-motivationally avoid, and deter the admission process as a created disagreement to construct non-consent. Words of treatment in recall are affected by traumatic suppression in pauses, partially because the long-term effects of the isolation bring current lack of assurance, in the utterance of the word. The treatment is imposed on a clinically constituted, un- abiding non-autonomous solace and interactions separated self-identity, in order to eliminate participatory social identity. There is an insecure lack of confidence in ut-

terance of the self, me, or "I" (Line 400,401) that later finds stability as a social "We" identity, with other clients.

Self- regulation of emotion in affect drive, and the long-term effect of structural suppression in motivational systems are careful in the expression of these mental states, through pause time. Utterance of pauses before and after trauma treatment objects in recall, had unsuccessfully sought the helper relationship's assistance, such as the assumption of unrestricted talk turned away. Pausing represents the same avoided coercive form of treatment that is imposed, such as seclusion for no ordered code of conduct, in a failure of deterrence. A re-definition of the request to talk is then created and transformed into an institutional rationalization for seclusion, of Maija's treatment sought of what psychiatry has taken away or denied, such as requested talk. The capability, not the ability to express decision is taken away from the client, such as the ability to express choice in an involuntary context (Line 401) to collaborate, and adhere to a re-conceptualizing of treatment. The client attempts through suppression to re-establish re-orientation with the two objects of treatment, requesting talk and restriction to talk, treatment one of the deserving poor, then not of the non-deserving poor, because of an implication of deviance attributed to the clinics construction of involuntary status to the patients incapability, regardless of the clients abilities.

Maija tells of the order of events with long pauses, preceding and following treatment objects such as "doctor", "pain", "medication", "consent", and "refuse", in recall, and pause time may tell of the trauma associated presently, with treatment objects. At first in the interview, there was a reduction in their range of "cue utilization" and delay times became covert (Easterbrook, 1959, p.186). Maija adopts silence and withdraw, communicating memories of seclusion, in response to friendly questions from the interviewer. That is an adaptive rational in the abstraction from memory, utilizing emotional regulation (Christianson, 1992, p.295). An adaptive way to overcome the negative memories of seclusion, is to withdraw and lower affect in motivation for a time, until an environmental cue such as a question from a research interviewer or therapist, can help mental health clients to engage in friendly talk therapy. Clients then resurface their limited temporary in-assessable cognitive skills to attribute causes for disturbance, as a result of rebound of suppression due to seclusion. In appraising this situation around the seclusion room, the mental health client categorized it, being forcibly placed in a situation of limited alternatives. Their memories of this experience were recalled, using lowered motivational drive, to adapt themselves to these negative memories. Maija's use of terms of treatment are enforced and they do not rely on cooperation of the client, so there is a temporary estrangement around the trauma objects, indicated with pause time in recall.

Agency versus environment impact on treatment outcomes behind ideological assumptions of what constitutes the social order, and the manner in which structure is arranged, is critical to the awareness that an institution misrepresents open efficacy in the social environment, to clients mainly constricted

to in-opportunity of choice. This is done to moderate agential conduct eluding as the predominate impact, on good or bad outcomes. This justification serves to divide service provision as a primary function creating two-tier assistance, by adopting punitive measures that cannot often be re-fashioned, or revised to make an exception to the deviance ascription as irresponsibility, and non-correctability to contain expression. The institution socially constructs the rationalization for this by insinuating non– deserving self-fault of responsibility (Brandom, 2000, p.73) and failure of self-reliance of the client, and attribute deviant allegations to mental health symptomology. The data suggests this is an intentional structural order of social arrangements is primarily to refuse care, or ward off the request for quality care to so-called non-deserving mental health clients. This primary institutional function of labeling deviance is a temporarily unaware auxiliary function of the hospital, reluctantly providing less adequate care to a so-called deserving client rationalized by artifice unintelligible allegations to requests to talk, and able participation justifying deviant labels. A subjective awareness surfaces among clients of this primary institutional function, arising out from an auxiliary claim reluctant to provide resources, such as an absence of a participatory reciprocal relationship, comes into awareness and attention. This awareness of the hospitals primary function impacts on self-development, along a primary and secondary acceptance and rejection to balance full exposer to the constitutive reality, and generates mistrust and avoidance of description of traumatic events interrupted with pauses.

The seclusion emotional suppression theory proposes low affective mistrust is outright opposition to maltreatment, by both deserving and non-deserving clients, as this institutional primary function brings to attention subjective awareness in the client. This awareness invokes a client's offense and anger that needs to be subsided, in order to integrate into the strained setting. Social mistrust is distrust of major social arrangements, and fear of oppression. Clinical mistrust is distrust of coercion (Whaley, 2001, p.93) and requires low affect disuse of expression of traumatic content, in order to avoid and in pre-anticipation in description of an avoidant, neglectful clinician in recall, based on past treatment failures. Self-suppression of motivation as not exclusively bodily, but socialized mental states and emotional regulation of loaded affect, of being offended by seclusion is an adaption, and it may be counterproductive if it is enforced deviant, as a result of social control. The sanction fosters long-term clinical mistrust, not just as an aspect of illness but social mistrust, as a sensible reasonable external reason (Tuomela, 2012, p. 402) statement of level of awareness of inefficacy and "held back" agency. The adapted action is to lower affect in order to avoid psychiatric coercion, by withholding trauma explication in leveled mannered affect, both in its recall and current, attribution of future placement.

402 Maija: I had gone to my doctors because I had sleeping-problems, which
403 is something that I always have to take seriously because (…)
404 I was diagnosed with manic depression.

The trauma object of becoming "admitted" or introduced to the hospital is advanced, as the same momentum is gathered to utter the trauma item "diagnosed", and "I" indicates more ownership with the labeled identity of illness, as the two are not separated by the pause below. However, the combined help with the doctor (Line 402, 403) is separated by a pause (Line 403) indicating distance from clinical care and an enforced "I" self-identity (Line 404). In the following extract, Maija hesitates in a frozen lapse before the word "diagnosed" is communicated, from the client's self-perspective of having a diagnosis as a trauma item, separating self-treatment from combined clinic collaboration. The pause is before the expression of self, indicating insecurity before the utterance of "I" (Line 402, 403, 404) mentioned four times. The pause (Line 403) resides to mark the place in recall, readies self to receive the traumatic utterance of the name of the diagnosis (Line 404) by placing a pause, before it is named.

Maija is not capable to sense the benefit of effort to shape a better outcome, not due to having a no fault illness (Line 404) ability, said with no further dialogue, and a sudden conclusion due to its traumatic nature, but the design of structural constraints such as the repeated unavailability of help, after repeated requests (Line 403). No specific combined stable interaction had been named by indicating "had" gone (Line 402) "always" not acknowledged in a combined "We" sense (Line 403) with the doctor. The diagnosis is one that is held as an unstable "I" identity, held apart from the doctor and had to face alone (Line 403,404). Diverted sleep itself can create the incapability to manipulate obstacles, toward a better treatment outcome, regardless of the clients willing, able persistence to ask for help. Constructed inefficacy contribute to pre-motivational low affect, and insure no confrontational agitation toward people, but for externalizing reasons stated, conceptualizing an internal manifestation of helplessness, in a structural constriction to agency. Along with the re-definition of formal rights to approach help, the structure is dependent on shaping and constructing a social sphere, under which the transformation of agitation, disorientation and failure to self-sufficiency into sanction takes place and opposition to this, when the client is made aware of the label. A client goes through a human process, where they at later stages withdraw speaking, undergo deconstruction of re- devised prevailing ideas of treatment, and embrace own and social understandings of paths toward betterment. The attribution of little to no choice in the social environment, contributes to low affect and pauses, and the effort at regulation of expression of trauma objects and their attentive focus, are aided by their placement before and after these items. The interview revealed that capability to recognize one's right to consent or refuse to participation, happens in no way within the psychiatric setting, and is reflective of the separation from ownership of what becomes trauma treatment objects, by pauses.

Implausibility assigned to almost any client's action, by simply residing in the placement, is well established long before client's places each other's in this context that separates client experience, from comparison from each other, as a social entity. This reaching out partially explains the insecurity of the utterance

of an "I" identity, separate from treatment objects. This happens to long-term clients and like others, as the detachment from social self toward an "I" identity may be more so enforced, and does not need to be developed in conversation between clients, doctors or psychiatric professionals in recall. The concept of "sleeping" (Line 402) itself had to be re-formulated, to reflect the needs of non-collaborative help.

The agitated or helpless situation recreates itself, and it depends on a pre-initial cause, and deviant sanction in order to create real non-adherence, in another context. Furthermore, the context is held separate from the client, in order to formulate an assertion about the client, so the closed structure may be the predominate factor, in shaping the emotional reacting. A credible or incredibility characteristic of the formal emotional reaction, is seldom made about the seclusion sanction, because the central self-experience of the erratic emerging peripheral details of the social environment, might strip coherent description of these events. The justification of simply residing in the setting is enough, to label the mental health client's emotional expression, as this rationalization merits a warrant to ride over a pre-established right, capacity, or ability to restrain, right to refuse, and seclude. Institutional conventional norms, aligned with a client's already established pre-motivational bias, of what kind of behavior avoids seclusion use, as well as its presumed justification to the client, explains the seclusion away as necessary, for the suggested client fault attributed circumstances. Seclusion non-specific justification is quickly described, due to pre-motivational termination of cognitive exhaustion, and accepted as normative. Deviance and mental health labels fashioned to requests to talk are asserted, hidden, visible, created, re-created, suppressed, and isolated and a departure from individual responsibility to withhold speech can be assigned an unaided mental health problem, such as the desire to refuse medicine, unexplained lack of sleep, and unawareness of institutional rules. Right to compatible adherence to define social needs is more misrepresented, by enforced compulsory collaboration to clients in the social institution of psychiatry, either hidden by confidentiality, or regarded as commonplace among mental health clients.

> *405 Maija: I don't remember very much. I remember them telling (…) that*
> *406 there's a bathroom.*

An able Maija recalls staff giving directions in telling, and the suppression or pause precedes recalling the specific closed, one directional interaction with staff of what was heard, after a suppression separating "I don't remember" (Line 405) and what traumatic item was unclear of being mutually told, received and remembered, in a construct of incapability. A second utterance of "I" (Line 405) brings reinforcement of confidence, to a lack of self- assurance to the traumatic nature of denial of collaboration, as lost combined help with a professional. The pause is after the recall of staff dictating last words, indicating the suppression may effect remembering professionals least amount of talk, and the suppressive pause is in between distancing wanting to hear, and participate and the recall of psychiatric staff telling something. Maija may not be capable to

follow direction, because the talk is not socially interactive, but is rather imposed therefore less able, to receive and remember dictated information and elicit it in recall later on, due to suppression and objectification of combined care of the traumatic item, from collaborative talk of the item, its separation indicated by a pause (Line 405). The pause is after or abandoned, dividing trauma recall from collaboration with psychiatric staff. The involuntary context is one that a person is placed in order to label them incapable however, the context iteself is a place where the setting is unresponsive thus creating agencies inability of compulsary status as well.

Within this context of consecrating institutional rule governing normative conversation, psychiatry and staff delivers short explanations about so-called abnormality, grounded as commonplace, conventional assumptions transpiring time and place rationalizing seclusion. These common understandings are due to already established and voiced subjective bias about mental health and deviance, before a client says anything. The professional relationship means an action that serves to locate who it is, that will talk to a mental health client about a topic, so that if a client raises a topic, an object or perhaps a stock of knowledge of illness or responsibility, it appears to be owned by somebody (Sacks 1992b, p.92) other than the client, for example. The coercion serves to regulate talk of treatment, and doctors or staff to re-define it by virtue of the enforcement, a lack of capability among clients to make decisions, due to created beforehand dismal conditions. The emphasis on self-responsibility for unknown way to navigate the setting formally dissuades a client's assertive ascription of inefficacy, assigned to evaluations of the external environment, reasons for poor outcomes. This is important because the client's actions leading to the seclusion are re-defined in order to rationalize the sanction.

A long period of no talk is a traumatic event, which can suppress some directional description, and make other kinds of memory retrieval difficult, and especially specific in regard to details and direction of coercive objects. Especially difficult is when the client is recalling words associated with the approach to talk, or sent away and denied participation with psychiatric staff. Descriptions of own emotional reacting, or withholding expression to settings scarce of talk, are more accurate in words within recall of coercion carried out upon the person, and avoided after coercion was not able to be carried out upon a person. Among the spoken recall, pause marking the time among the words in the narrative, describes how the seclusion is brandished with suppression as a central report of inefficacy, and also marks the diversion of the deterred emotional reacting of the "I" peripheral lowered detailed self- report, such as an avoided institutional sanction to created non-participation, in-decisiveness. In a question to report self-agency, the client reports inefficacy the prevailing factor in the poor outcome of the situation. In studies reporting seeing and retrieval of memories of a weapon, in a film for instance, the direction of the weapon gets the attentive resources of the central focus, and limited resources are left over to encode surrounding information (Ellis & Ashbrook, 1988, p.35). Pause time suggests a substitution in recall, where there was self-need for talk and consen-

sual participation, and fear deploys time to flee and fight reemergence of formally suppressed peripheral information, make the details of the setting central, in traumatic recall. Pause time after an imposed traumatic treatment object, often demands separation of how seclusion is enacted by professionals, and time to motivationally flight from it as central items of inefficacy. When the pause time rests before the description of traumatized experience, there is often is an attempt to motivationally seek out talk unsuccessfully as peripheral of disoriented agency. There is a revisiting of the word beforehand in recall, overseeing and balancing affect, around its traumatic utterance.

The mental health client first attempts to focus, on the displacement of direction of buried objects of suppression, temporarily unknown to the mental health client in dissociative reason, sometimes outside of the therapeutic interviewers' rationale. This helps to prepare a defense by strengthening the powers of re-surfacing reception to the listener. The critical objects of inefficacy is recalled by itself, then directs the client from peripheral lowered self- report in the situation, to central traumatic objects into an attentive direction, in a short span of time, out of a level of trauma in and out of dissociative objects in the client's social world, into culturally familiar narrative interviewing. Maija is preparing peripheral agential to central inefficacy items of suppression, symbolizing seclusion experiences that prepare to release trauma. The mediation of trauma expression of both submerged and re-emerged, and spoken with self- suppression can become more powerful, as a result of lengthy seclusion or time around the room. In recollection, they presently acquire the opposite of formally suppressed abilities as growing intermediary strengths, to assume a covert low affect, avoid saturation with traumatic words, when remembrance of structural hostility arises, that reside beyond everyday reason.

In the next selection of data, the client is recalling how much she participated in treatment.

407 Maija: I wasn't protesting very violently, more verbally against (…)
408 what I wanted, why are you doing this
409 Q2: And did you know that seclusion would have been a possible
410 consequence for your…
411 Maija: I would, I guess if you'd asked me this a year ago when I wasn't
412 sick, I would have said yes, I realize that's the consequence, but
413 during this experience I wasn't (…) clear about that at all

There are frozen lapses that precede before words of participation in conversation, such as "what I wanted" (Line 408) being "clear about that" or needs, that reflect distance in the creation of lack of collaboration with staff. Maija insistently demands verbal interaction (Line 407) and its recalled refusal happens before staff involvement, because the client is deterred from participating, and requested mutual cooperation (Line 407). Absence of collaboration is represented by a beforehand pause, has been taken away from interaction, as they did not understand and it might have been unclear, how to congenially participate. Consent to participate had been taken away by staff, that did not explain, and

only dictated direction. The conditions create the inability to know the consequences of ones reactions (Line 413) to untold actions (Line 412). Pause time indicates the separation of treatment and participation, and resides before describing in recall a request made, by approaching staff (Line 407,408).

Maija repeats the institutionally imposed self- identity "I" eight times, indicating she does not rest in assurance of the enforced isolated role, of being held separate from capability. The client indicates capacity and ability to enact choice, as the closed setting has restricted its execution. The pause happens before the brief description of asking for participation, and absence of an explanation (Line 408) in order to detach and regulate emotional release of verbal requesting (Line 407) and help sought, wanted, not achieved. Verbally, not violently (Line 407) requesting an explanation, elicits withdraw of the hospital from talk therapies, that contributes to more requesting for talk. As indicated on (Line 413) there is a division between self, as "I wasn't" and "clear" with a pause (…) indicating the distress of the mental health client is suppressed of being stripped of the hospital reaching them, constructing the clients away from consensual participation, toward being told, and not made aware of the consequences of requesting talk in recall, by the psychiatric staff. The pause happens before the distress and separation action of the hospital directed at the mental health client, the detachment of human interaction, the absence of mutual understanding, awareness of the needs of the client, and the lack of clarity to the client of the hospital's primary function, of conscripting deviance to requests for help.

> *414 Maija: I don't think that the situation calls for hospitalization*.
> 415 Q2: Right (…) you agreed to come along with (him or her) and (…) voluntarily…
> *416 Maija: Yeah, up to up to the point where like, I wasn't (11:28)*
> *417 consent to go to sleep…*

In the last extract, frozen time in seconds resides before the word "consent" as a hesitation (Line 416) before recalling any ownership of this trauma treatment object, between Maija and staff. Maija had been stripped of her capability to consent, but not her ability. The pause (Line 416) (11:28) separates the recall of failed joined collaboration in consent represented as a pause, before the enforced consent outside of mutual agreement, created in the social situation. Maija's status was involuntary, and her capacity was re-defined incapable to participate, within the constraints of the setting on a voluntary basis. The data indicates structural incapability conciliate involuntary status, regardless of a client's ability to participate. The incapability to voluntarily act due to restriction, serve the hospital to construct status. Maija is consensual in recall up to the point (Line 416) (11:28) where participation is interrupted, by socially constructed incapability. Maija is applied a deviant label, as it was institutionally issued already pre-deciding no consent to sleep, as a wrongdoing.

The self-identification or "I" before the pause (Line 416) (11:28) and before the traumatic treatment item of "consent", suggest there is a temporary conflict

in low affect, competing with attentive focus of the impenetrable social environment, and inattention with level of combined agency. This dissonance finds resolve in identifying a temporary "We" identity, along with staff that attributes non-adherent causes for hardship, as central. Maija shows abrupt conclusion, suggesting the long-term effects of suppression on the retraction of the description of the event (Line 417). The pause separates an "I", and combined collaborative consent (Line 417).

After recalling escalating the insistence to an access to talk therapies, Maija in the next extract is frozen in time (21:00) that exists as a lengthy current self-rehabilitation, of the event in memory.

418 Q2: Did in any way, did the nurses or staff tell you, or where you
419 even capable of understanding that here was a consequence for your
420 protesting.
421 *Maija: No. I felt that they were, first of all they were two, (21:00)*
persons one quite big and strong, and they'd take me under my arms,
like one on the one side and the other, and they'd say, okay come
422 *let's go now.*

The pause (Line 421) exist before the traumatic contact with staff taking Maija to seclusion, indicating a pause of trauma in separation from direct consequence of the clients' actions, regardless of seclusion reacting. The traumatic content is displaced in inattention, until brought forward after a suppressive pause, and reveals existing at the direct point of recalled coercion. The structure and relations construct the inability to know the consequence of ones actions, and misrepresent this as the consequence of the reacting to no talk (Line 419,420, 421) or protesting (Line 420). Above, a pause (21:00) residing after the initial description (Line 421) is emotional regulation in the communication of fear, recall of time to low affect still flight, telling of compulsory physical force of the two staff.

The seclusion has no direct or indirect consequence to Maija's actions, irrespective of whether the client was advancing or fleeing, without regard of the clients' responsibility for actions. Because no action on Maija's part was resultant in the seclusion, it is a formal application of deviance, a form of undeserved punishment as Maija is not aware of how to modify conduct oneself, and it appears that no formal institutional rule had been broken. Suppression had been representative as an averted time, in the seclusion room as a diversion to punishment, now is saturated with inhibition in telling of the trauma, because Maija has difficulty in describing the staff's actions that move from peripheral, to central attention. The seclusion reaction came unknowingly, possibly surprisingly from behind, and without due cause. The central trauma object, two big persons (Line 421) is urgently presented first, then the secondary peripheral traumatic item, the stripped agency in the forced take down to seclusion (Line 422) surfaces through the temporary ir-retrievable, in-attentive suppressive pause (Line 421) (21:00) and is presented more significant. Maija is unaware of the consequence of her actions (Line 421) not because of ability, but incapability afforded

the in-efficacious setting, and can offer no explanation for why there was a reaction for any misconduct, and she received no warning to not ask for talk support, in the area around the room.

In the following data extract, Maija is frozen after a description of her feelings of being sick over a long period of time. The low affect pause indicating an alone "I" self- identity is in response to the inefficacy, of the little to no choice social environment of little to no help (Line 423) over the years, that has impacted the motivational system.

423 Maija: Not the first time I was sick, but two years later I was sick
424 again and then I was diagnosed (…) that wasn't so bad but enough to
425 give me the diagnosis.

The pause of low affect following the object of treatment or personal "diagnosis", suggests time of flight from its utterance. The client then goes on to indicate the estranged relationship communicated it as "not being so bad" (Line 424) of partial shared ownership with other clients (or) psychiatry living with the diagnosis. This indicates a pre-motivational hesitation and disengagement, before alignment of illness predicated as a "We" identity, temporarily including psychiatry. The pause time follows and offers resolution from the imposition of treatment, and separates self, from same group social identification with the illness. The pause allows resting after the utterance of the traumatic word associated with treatment, and recuperating and self-soothing assurance, that it was not so bad in recall. The "diagnosis" word is repeated in (Line 425) in order to afterward revisit the traumatic item, to build strength after its first utterance (Line 424). The first utterance of "diagnosis" is stated with an "I" identity (Line 424) and the second utterance is imposed by a distant relationship (Line 425) with a doctor. The two are separated by a pause suggesting an institutional transference point, from an "I" identity, into a loose professional connection.

Maija's spouse had participated in the decision of the doctor to hospitalize. Maija describes the conditions dictated upon her confinement in the hospital, when she was at home with her spouse. Maija indicates that she did not receive adequate talk or supervision of medicine while in the community contributing to hospitalization, only the combined care of the spouse (Line 426,427).

426 Maija: We had an agreement with my (spouse) that I would stay at
427 home, I won't go out, I go for walks, in the vicinity, but I won't
428 go to town, I won't use any money, I had given (him or her) all my credit
429 cards because I know what the symptomatology is, dangerous once I
430 get the symptoms, and I had contacted my psychiatrist to get
431 advice on how much I should increase my medication, and but, when
432 my (husband -wife) was, from his perspective (she) was following my situation
433 for a few days with an increased amount of medication and (...)
434 for (him or her) I was getting better (…)

This extract presents a situation of money or credit (Line 428,429) that is entrenched with responsibility, and any departure from this an ascription of dangerousness as a label of deviance, although consistent with this study not absolute deviance, rather an infraction to self-sufficiency. The data confides it is conceivable that this danger to self and others, had incurred solely due to non-monitored medicine or unattended symptomology. It is a functional failed attempt to more make deviant the endangered monetary ties with spouse, derail connection with spouse then re-define the relationship in lower quality care, and re-instate it with corrective, supervisory psychiatric collaboration. The frozen lapse occurs after the communication of the description of someone else's experience, of her being on "medication" (Line 432,433). A frozen lapse (…) also occurs after Maija describes the experience of "getting better" with medication, from someone else perspective (Line 434). A failed attempt of the self and family member monitoring medicine, accounts as depersonalization, because there is a failed attempt for the successful treatment to be a shared effort within a family. Additionally, there is hesitation to describe own view, rather more confidence in a shared account of getting better (Line 428,432,434).

The spouse's perspective as understood by Maija is a determinate toward becoming hospitalized, that makes less personal involvement with treatment as the pause time (Line 433) (…) indicates separation from personal involvement, and emphasizes the spouse's involvement more important before hospitalization, where the doctors involvement was reduced as less important (Line 430,431). The pause (Line 433-434) is made recuperating after the utterance of the words of the spouse. These are included as self in place of getting better, separating social identity determined between the self, spouse, and hospital, as an explanation to what led up to a forced hospitalization. Less quality description of getting better, is made of the description between self and psychiatrist, and placed more in between self and spouse, even though there was an unsuccessful attempt to contact the doctor (Line 430,431).

The client does not yet identify with same, close mental health client group cohesion, the social identity to help with illness, is mistaken as one of familiar with the spouse, and re-aligned with the doctor, as unsatisfied. The idea is that the close family must not be held in consideration in placement in the hospital, as the reason for placing Maija in psychiatric care, can be considered in the same light of hysteria, where the husband might have a motive to place the partner or spouse involuntarily in the hospital, and he had an influence on the decision to hospitalize. The husband had been present at the evaluation, before the forceful hospitalization. The entire sequence has to do with illness from another's perspective (Line 426 to 430 and 432 to 434) because of the weakness of the "I" identity capturing possession of illness and recovery items. These are indirect ways a psychiatrist might endanger a mental health client's own, or family financial situation, by way of neglect of carefully mutually supervised medication and lack of talk, as an outpatient (Line 431) and a spouse substitutes for a medicine monitor (Line 432).

In conclusion, the cycle acts as re-hospitalization because of the resultant lack of decision making, due to possible mania or disorientation, endangers financial harm to self and others for example, and may be an indirect institutional function to award a lower level of care. Aside from the present suggestion, Maija had been directed to the doctor because of a vulnerability to debt (Line 428,429) as informal deviance, and was held accountable for it by a former suggestion made by both the spouse and doctor, well before the hospitalization. Maija begins to substantiate an able willingness to abide by rules, and refusal to accredit personal irresponsibility, as a pre-dominate cause for problems with living. Note the beforehand antecedent preventive measure to reduce risk of debt (Line 428,429,430) and determined effort to avoid places of spending (Line 427,428) as a pre-motivational self-regulatory deterrent.

4.4 Primary and Secondary Attention to Traumatic Items

In this chapter, Maija throughout the interview struggles to find primary social attachments, and fails to bond with psychiatry, family, staff, and begins to formulate awareness of secondary self and primary social proximity, to other clients. Imposing a deficient individual identity and non-social labels of deviance, upon mental illness client's constricted incapability, to participate in formal treatment, individual socially expressive needs are avoided, and primary social self emerges to take place to seek common validation, with this experience. Agitation and disorientation is discovered to be due to the social environments exposure to trauma, lack of collaborative care as poverty dictates, withstanding the resultant direct exposure is experienced as a central object of trauma. This central trauma item comes forward equipped with a social aspect to protect the self "I" identity, against unjust blame for current predicament attributed to self-fault for hospitalization and seclusion. The social aspect came forth in recall and made the experience present and immediately creates resolve, which is why Maija presented an uncertain social aspect of the family, bearing the burden of disease, rather than a tight affiliation with psychiatry.

An initial "reason for visit" claim that served as a before attention item becomes replaced, suddenly with a central trauma item as "problems with treatment" by seclusion. Around isolation, Maija is waiting for weeks, simply to complain about treatment. This is an important stage of development among mental health clients, to cast off self-identity of family and psychiatric ties in the client's ecology, and strengthen social groups both in the setting, and in public. It is more likely that a mental health client would be able to reach for traumatic memory with a social identity, among other clients that share the same experiences, and meanings in the same context such as around the room. The interview suggests professionals do not successfully ascribe a primary deviant label, to a secondary mental health population. It is told of professionals that they first make the claim, that the mental health client as an individual has no social identity, by configuring social needs as un-rightfully individually requested and

denied, due to a rationalization that depends on asserting presumptions of deserving or non- deserving poor, one client at a time. Treatment needs and their denial are also justified and aimed at a social population, by using sweeping deviant generalizations, embedded in normative failures and violations of individualist achievement assumptions in dominate precept, such as reckless spending of the client, for example then apply the same criteria of judgment an individual failing, to a client population. However, in normative talk, the deviant inference such as this may be first applied to an entire sub-population justified in conventional bias, then characteristic of an assumed irresponsible individual client.

A frozen lapse follows after the word she "needed" (Line 452) formally lost in amnesia (Chapter 3.5) after Maija trying to describe what she was asking for or "needed", separate from what is needed re-defined from the perspective of professionals, alienated need taken away from expressed need, producing no ordered way to recall trauma. The pause resides before a recall of approaching staff or asking (Line 452) for met needs.

450 Maija: (…) in the evening because to me the whole situation was
451 like, okay they're putting me through this test, and they're, I
452 was like, uhm, what I would have needed (….) asked what I would
453 have needed throughout the process.

A test (Line 451) or further "trick", is for the clinic to see if Maia emotionally reacts or begs, for what she needs (Line 452). Maija's definition of what she would have needed is partially suppressed (Line 452) by an "uhm". The accurate description of inefficacy of what the situation depends that Maija would need, is not allowed to be formed because of the suppression, as it starts to process out of the inhibited state, by repeating the word needed as a stutter. Needed is said twice because it recalls an unsatisfied human social expressed need, an unmet suppressed need (Line 452,453) that is denied by psychiatric staff. Staff represent fear, and is identified by stuttering "they're" twice (Line 451). The first time unmet "needed" is said it is followed by an inattentive pause (Line 452) to indicate that it is unmet. It is repeated (Line 453) to usher in its central attention, to a core traumatic issue of "need". Through emotional suppression, the need is transformed into an unmet need, into the scarcely material need, through the constructed failure of combined partnership. The need may be the reason for placement, although it is re-defined as a mental health deviant aspect and as it has been unmet, Maija is specific about unmet need that is ignored, and no satisfaction to sought help met and more asking generated, that results in seclusion and the creation of failures of collaboration, with the hospital treatment. The externalizing statement starts a process of knowing the obstacle as a "They" or "Their" is said twice (Line 451). In (Line 452) the inferred missing word is "They" represented by a pause (…) and disappears after re-emergence back into suppression. The entire sequence points out the disappointment in a search for talk that had a poor outcome, and the regulation ensued in order to sustain the emotional medium in the meantime. The afterward

memory depended on a present suppressed recollection and a former actual suppression of needs, due to structural restriction.

Maija shows consistent long-term suppression in naming trauma objects, suggesting that the balance and counter-balance of central and peripheral awareness may be just within reach of comprehension. This next extract marks Maija's re-unification of visible suppression of emotional psychic pain, and hidden made visible temporarily unavailable traumatic utterances, of releasing the impact of need unmet. It also points out Maija's course toward identifying externalizing reasons, for hardship in treatment. By suppression, the description of traumatic objects are separated in the extract below, by a long pause (Line 488, 489) indicating a potential need to express, held outside the confines of the unattainable therapeutic relationship. In the following, the attempt to describe "pain" is followed by inhibition and suppression or pause (Line 488) and Maija attempts to describe "somebody" to trust, but these words are separated and the needs suppressed away from the solution or somebody (Line 489) by a frozen time lapse (39:46) (Line 489). The pause suppresses and separates personal, from clinician shared experience. Maija is expressing need, and then states the need to trust. A pause afterwards separates the recognition of need met by someone who can help. Recalling any collaboration with staff with social expression, is unresolved at the point where there is no trust, then long distance (Line 489) (39:46) and somebody referring to a lack of a former helper role. Maija shows an exemplary effort to pre-motivationally subdue, and regulate expression, potentially of own psychiatric symptoms for fear of a coercive encounter.

> *488 Maija: That when my greatest pain (…) going to express it, I need to*
> *489 trust (39:46) somebody who can help me.*

From here on, in the presentation of Maija self-report becomes suppressed as peripheral trauma, and inefficacy becomes central emerging out of suppression to accurately identify distance with treatment items, saturated with pausing. The access to talk is taken away, and it is represented by a suppressive void (39:46) that resides as an unanswered plea for talk in peripheral inattention, until attained as a central representative of the time away from talk endured, a pause then an expression of someone to speak to, is indicated seldom acquired in recall. The word trust is motivationally abandoned (Line 489) in inhibition, as this vital therapeutic requirement is lost in suppression, hopefully to be attended to at a later time. The client sees self as a peripheral, then a social account with a distant somebody, becomes suddenly central. The temporary peripheral inattention or "somebody" becomes more important, when coupled with its vital central counterpart, trust in expressing to them. There is fear in the hesitant utterance of the recall of not finding somebody (Line 489) (39:46) to trust, as a long-term mental state of suppression.

Pause time is used in order to rest in recall from a present frozen mental state, after coercive treatment objects had been approached, and not attained. This accounts for distancing the absence of trust in recall. The pause (39:46)

(Line 489) significantly separates the social bonding of trust with somebody to express to in recall, and the failure of social self to find combined identification with the helper role. There is also a pause after understanding the problem from an "I" perspective, if it is expected or not one will have a chance to see a doctor. This suggests that there is an out of reach, manifestation to somebody, estranged from the communicated subjective experience of balancing counteraction of attention of trust, to delayed inattention of former unresolved recalling of absent, and lost received discussion, of psychic pain with a professional.

Central detail of somebody can be more meaningful, for arriving at peripheral recall of trusting and confiding trauma, in helping Maija to develop strengths to wait to express pain, under the emotional suppression theory. Central items of inefficacy are found emerging out of suppression, and the peripheral lowered self-report gets lost temporarily with a pause (39:46). In telling of emotional pain, a client is saturated with hidden suppressed or visible unsuppressed trauma, that the client compensates for any weakness by resolved pressure and delayed counter- pressure, building strengths that attempt to reunite her with "somebody", to talk to. Maija is unaware of this strengthened rebound from pain into strengths, until the utterance of the word "somebody" after the pause (Line 489). The retrieval of the image of "somebody" is blocked, and might ordinarily be available, as the forgetting is partially not retained. The connected whole concept of combined "trust" and "somebody" is lost for a long time in verbal form, indicating a low level of amnesia (Loewenstein, 1991, p.189), (Schacter & Kihlstrom, 1989, p. 209), and (Spiegel, Frischholz & Spira, 1993, p.747) that could be suffered as a result of the seclusion or lack of talk therapies. The former word "needs" was lost in suppression in entire verbal form in chapter (3.5) and here it resides exactly next to the lost connection between "trust", and its expression to "somebody" (Line 489). Somebody as "They" realization emerges out of a long suppressive void to conquer fear, and become central to a description of inefficacy.

The seclusion emotional suppression theory teaches non-trustful distance of human beings, whether clinical or cultural, can be considered a mechanism by which individuals protect the self against negative affect states. These protective efforts manage affect, for example psychic pain, offense, anxiety, anger, agitation, guilt, depression, and their loss of trust of expression, associated with imposing institutional sanctioned infraction to treatment failures. This can be structurally ascribed by attributing failure of responsibility and loss of attainment, constricted for lack of clarity to client of the external social order, and relational disarangements. However, a counter- effect against the individuation process results in attributing fault to the social institution, because of not providing talk itself, as external statements monitored by self-regulatory and suppressive states, because coercion had been replaced, of the absence of better quality care. Situations leading to increased self-consciousness regarding personal accountability, under the assumption of social efficacy, involving interactions between individuals of unequal social status such as psychiatric staff,

where there is risk of harm to the disadvantaged person psychologically, physically, and socially, endanger paranoid responses (Whaley, 2002, p.557).

Bonder and Mikulincer (1998, p.1019) found that greater self-focused attention after personal failure, resulted in depressive like responses, while other focused attention under the same circumstances, produced paranoid like responses. The seclusion emotional suppression theory ventures pauses indicating distance from non- expression to professionals in recall, serves as a pre-motivational self-protected, adaption that evolution has prepared within the human species, in order to withstand a trying environment, and its description of naming trauma objects. They are a built in recall distancing defense, equipping human beings to adapt to present harmful conditions in the inpatient hospital setting, as well as to seek out external reasons statements for avoiding cause of disturbance in areas of outpatient inefficacy, before hospitalization leads to inpatient social environments. The seclusion emotional suppression theory suggests the pausing phenomena in the data, may be a cautious way to approach and recover, from the lack of trust to utter trauma objects in areas of inefficacy, balancing self-peripheral and external central temporary inattention of formally submerged items in emotionally regulated recall.

This data confides what Neighbours, Trierweiler, Ford & Muroff (2004, p.249) contend that low self-disclosure, and suppressive low affect are emotional regulative responses, that can protect the mental health client from harmful coercive treatments, such as seclusion and non-confided emotions that are suppressed in recall. Enforced involuntary inpatient commitment by a clinician they do not trust, clients adapt a healthy paranoia, in naming trauma objects that is often characterized by low affect, is an avoidant strategy to suppress rage and frustration. In this mental state, it is contemplated that clinicians are unable to read expressiveness, thus avoiding seclusion, as a result of disruptive or disoriented affect. However, it also sets the conditions for a mental health client to emotionally react to restriction of freedom and to in-efficacious obstacles resulting in seclusion. The level to which mental health clients incorporate low affect or negative emotions, in order to deliberately so-called "forget" painful events, and later telling of them in recall, in order to adapt to hostile conditions also deserves attention. A mental health client suffers severe consequences, when a clinician is unaware of accurately interpreting the low affect emotional regulation, as a recalled adaption to poverty and mistrust as an anticipated state refraining from telling, of the temporarily inability to communicate it, due to the totality of the trauma.

The process of suppression inhibits cognitive functioning as well as inhibited emotional responses (Gross & Levenson, 1993, p.982) and create counterpoising attempts to inhibit expression. Habitually overriding these responses compromise an individual's ability, to manage the challenges of hiding feelings successfully (Gross & Levenson, 1997, p.102) and emotional reacting behaviors then constitute a quick "out there" ascription, then seclusion. The seclusion emotional suppression theory observes the low affect agency power seeks self and structural suppression in pause time, to cancel effort to describe an unre-

sponsive social environment, before a traumatic object of treatment. The theory also discovers a low affect motivation pause time, searches temporarily unsuccessfully for effort of cessation in the exertion of communication of trauma in high agitated affect, and agency to do so before and after an object of treatment. The theory emanates, this pause time can reverse around traumatic words of treatment, in low intensity of maintenance of composer, when the client is communicating in agitated high motivational affect, enacting silence in disgust, and looking back after the traumatic item is identified. Low affect is incorporated in pause time before a traumatic item is indicated, in order to work up encouragement then heal, after speaking of structurally prolonged created causes of psychic pain, and its temporary inability of expression in recall.

Unsatisfied, an unsuccessful searching for social expressiveness relies on an unattainable unequal staff relationship, to institutionally enforce the unstable "I" identity. Misrepresentations of mental health clients' definitions of needs, by structural scarcity of interaction, creating human needs, pre-establishing their absence by suppressing them, and re-profiling them, is attempted by distance from the helper role. The descriptions of helpers is suppressed in recall of psychiatric professionals, a categorization of what Sacks (1992a, p.199) calls strangers, understood as a "they", and in the past tense in recall of what they were doing in action, enforcing closed communication, among impassable organizational structures. A concept of "They" develops after "We" is solidified as a partial explanation of what structural obstruction produced the problem, and pre-determine a re-definition of deviant wrongdoing, by a professional's solution of need, divergent from a social understanding of need. By way of initial lack of professional care, this process makes each within their own client membership a stranger, each attempting to establish loose self-identity of personal need, by little commitment to social identity to material need, according to a closer common mental health group, primary social ecology.

This pre-established, placated, self-identity disconnection are the result of clinically created phenomena to present insufficient agential treatment solutions. These re-directed structurally induced behaviors of Maija provided little or no social relationship with psychiatry in order to build the isolation into a need, to enforce and accede to the hospitals growing inadequate care. This transforms mental health provision, into increase needs for labeled deviant patients that might prove more costly, and time consuming to other social institutions. However, the deviance assertion quickly attests the "materially dispensable" for an in-correctable relationship, with clinical functionaries. This socially constructed "I" individual ascription of irresponsibility, serves to enforce blame. It is likely that anyone under these structural and infrequent social conditions, or even in the street would react, requesting talk or retreat to reformulate the situation, and set self to avoid the process of meriting a seclusion. This seemingly staged situation relies on correction and informal admonishment by psychiatric professional posed toward correcting client conduct, to first issue an implicit derelict warrant. Under these untold terms the mental health client is

dragged to seclusion, privately or in plain view, to discourage other clients from developing a social mental health identity, rather than escaping a deviant assertion to the "I" concept of self. In the process of trauma realization, the "I" self -awareness becomes suddenly peripheral, and external surveys of the setting, central.

In conclusion, the misrepresentation of social need, by situating an "I" self as solitary in the relationship with vulnerable populations, situate master status of psychiatry, as humane. This understanding of the institution may present temporarily unaware, auxiliary functions becoming central of applying breaches of conduct, as deviant status to individuals. This master status of the institution is presented to mental health clients and society as normative; it is transformed into a temporary auxiliary function to divide social needs, from limited resources. If this re-configured primary function is questioned it can summon an "up front" subjective awareness in a client, that slowly brings to surface a distrust of both functions. An effective way to ascribe self-responsibility to illness and deviant assertions is to fabricate the departure of collaboration, from psychiatry's definition of social needs. Sacks (1972a, p.156) says human beings, such as mental health clients, have administered terms to define staff actions, sometimes with little or no control over the deployment of the terms. There resides no agreement as the dominant group imposes characteristics of the group, that are not shared by the primary same group member (p.156) or mental health clients such as a deviant dimension, to secondary self "I" identity. The unavailability of help produces labeling of deviant terms; it is then re-defined as lack of a client responsibility, to permit its misrepresentation. This equates no consent with noncooperation, meriting coercion. In the preliminary stages of rejection of secondary individual labels, client's struggle with an imposed concept of "They" (staff) as the external source that satisfies assigning blame of structural constriction, to a definition of a deceptive trouble source as external reasons statements to avoid a primary "We" (client to client) in order to escape a deviant assertion labeled to an "I" (staff to client). In succeeding chapters, the client then subsequently develops a level of social consciousness, accurately assesses the setting of inefficacy and confirms these objective conditions, facing a collective body of people.

4.5 Traumatic Event "Re-experienced" as a "We"

In this chapter, Maija recalls motivation to release suppression, in the form of expression of need, as an assumed common account of "We" joined effort that is denied by psychiatric staff. Collaboration is constructed to be failed as a "We" between staff and client, and an involuntary status socially constructed as an "I". It also explores the clinics one way directive of abandoned talk, as a provocation to illicit a response, and how clients develop a "We" intention to adopt a pre-motivated, no response pre-requisite of self-monitoring of constant checking of emotional inhibition, and suppressive motivational after-affect, to avoid

seclusion. The suppression exist as a result of past seclusion and a present motivational state, that adapts emotional regulation to trauma expression, and accredits self-identity as a "We" social process, consistent with a mental health group identity as an "Us" to describe the long-term effects of seclusion. Clients demonstratively check out combined affirmation of the deviance assertion, to cast doubt on the explicit labeling of secondary deviance. The joint action as emotional cessation to "keep a low profile" in regard to expression, can be broadly understood as the "We" concept, as a single participant and mutually known. This is communicated silently by direct or indirect observation by signaling, that is picked up by the other mental health clients as intuitive (Tuomela, 2005, p.335) to non-participate as an agential strategy in not emotional reacting to an aggregate within an unresponsive social environment. The emotional containment is not necessarily expressed verbally, and is socially ascertained in assisted memory. This recalled visible observation is seen explicitly, and through pre-motivation held implicitly, as disposed for each mental health client participant. Joint intentions to inhibited expression are visibly expressible to a single agent, in acceptance and agreement that the agent does not emotionally react, together in conjunction with others. These inactive expressions contain practical reasoning, in cooperation with other clients, with motivation in a trying social environment as mutual ontological knowledge, as gradual awareness of the mental health group leading others (Tuomela, 2005, p.347) into awareness and evaluation of "un-charted" hazardous social conditions. In an erratic ecology, low outcomes in a seemingly neutral, open environment relies on a desperate rationality, seek mutually achieved success with composer, as emotional detachment, in avoiding reacting to potential danger such as seclusion.

In the next extract, a suppressed pause after a weak indication of an "I" identity enduring illness, and out of reach communication of this to nurses, is evident (Line 456) suggesting an absence of help. "Let out" as suppressed, represents the absence of leaving in recall (Line 457) as an "I" identity, without much self-commitment. Maija is taken out of the realm of agency in the constricted area, and stripped of her ability to participate, in order to win release. Own and others agency (You and We) as a mental health group identity can be let out in the open area, or emancipation from involuntary care is understood as staged (Line 455) a social construction of incapability, not necessarily based on ability.

454 Maija: I felt that they were nurses, and they were just there to
455 observe me and that they had just staged the whole situation, or
456 find out how sick I was (…) and that because I knew on the open
457 ward I knew that you could be let out (…).

There is an effort to recall concealing expression for fear of being observed as "sick with a pause (Line 455-456). The presentation of a "We" or "You" category (Line 457) as well as "They" (Line 455) stated in English and common to all cultures, or common "You" in Finnish, is a defense of mental health social identity, against imposing an individual category out of distant, unapproachable

observation to illness, as a treatment bound activity. This self-image is not yet not connected with same membership activity (client to client) (Line 457) or other membership (client to staff) (Line 454) activity, and as Sacks (1972a, p.569) says, they are just assumed to be known. These preceding, already established assumptions about other membership activity, are common for the mental health client homogeny category, and when or where broad inferences are enforced by professionals, that regard the mental health client as individually irresponsible, in order to construct fault toward justification for seclusion to create deviance. These self-identity ascriptions are made, to inhibit social awareness, by pointing to psychiatric professionals to arrive at informal, forced collaboration across membership lines (staff to client). Clients develop a central concept of "We" in recall of other patients, in order to be restored from isolation and to formulate pre-ordinate ideas, to avoid seclusion and hospitalization. This adaption to avoid coercion in its preliminary form, exists as a pre–motivational objectionable bias of no individual wrongdoing, that arises out of suppression in visible solidarity, as well as an intuitive survey of the open area with other clients as a "You" as a "We", that can join other patients on the ward (Line 457) and avoid the staged situation (Line 455).

Mental health clients under in-efficacious conditions observe other clients under the same conditions, referring to the same conduct and awareness as a "We" or "You" (Line 457) and this involves more than one person, under which broad conventional assumptions, about a mental health client population are quickly drawn. In my study, Maija becomes aware of social identity by way of identification, which is communicated in recall of same, or similar experience in awareness of other clients, and this further strengthens the pre-motivational dispose to avoiding a coercive relationship, and in that way "We" even separately, could work toward being let out of the hospital (Line 457) by concealing expression to get to the open ward. Further solidified, is a client distant definition across membership lines, about staff that identifies externalizing statements of the constitutive process, and clients become aware breaking through ordinary bias, and partiality to see through own subjectivities of the social reality, and speak of the failures of the profession or "Them" (Line 454-455) to be brought into a working relationship.

This refusal of the hospital, to provide talk and a consensual relationship is made subjectively known to Maija, not apart from the external reasons for expressions composer. Maija starts to see the external environment as not efficacious and permissible to agency, as this becomes awareness of a collective objective "We" exclusion. Maija is open to explore a pre-motivational consideration, to question whether the presented seemingly open area around the room is free of constriction and reflexive to all, that exerts agency. This deconstruction of the notion of open agency is a part of the subjective view, not necessarily a part of experience, but instead awareness that begins to be called into question by the client of the social construction underway, fixed or weighted to produce a non- reflexive problem as staged (Line 455) tricked, although more so understood coming into familiarity of falsity of self-credit for placement, by visualiz-

ing the non-reciprocal relationship with staff, as in the data excerpt above. This is because the client must see themselves apart from "They" (Line 454) organization and arrangement in orientation with the hospital staffs and in the last extract Maija deconstructs affiliation with staff, and formulates rejection of self-collaboration (client to staff) looking to similar peer group starting to build social identity with fellow patients, as a common "You" (Line 457) or "We" (client to client). Problems with treatment are understood as common client's problems, and solutions apart from self-isolation, within other systems among peers, and undergo detachment from psychiatric collaboration. Clients throw off an unstable "We" (client to staff) in order to see the staff and impeded structural created reacting in the setting, affecting many people as a "They", in order to be sure of the structural and no relational exchanges deception, as normative.

In the beforehand data extract, a frozen lapse follows Maija just observed by staff contributing to "how sick I was", then a pause (Line 456) to staff and a frozen lapse follows not a personal perspective, but how Maija has the perception of how the hospital sees him or her as sick. A perception of "They" stated twice on (Line 454) fails to indicate a mutual determination between self and nurses, of what is observed rather from the position of someone other than " I" self, rather, "We". The one self or "I" statement, makes an externalizing statement about "They" (Line 454) in the beginning, and at the end of the paragraph it comes from the position of "You", or really socially "We" (Line 457). Reference to a staged situation (Line 455) speaks of partial understanding of the social construction of deviance underway, under the guise of observation of being sick (Line 456) in the closed area, in order to confine away from the open ward where there is a source of open, fluid efficacy where you can be let out. There is an attempt to conceal expression as a "We", in order to become mobile to the open area where there is sometimes silent observation (Line 455). There is a pre-motivational plan of action to lower composer, in order to arrive at the voluntary open ward (Line 456-457).

There is presumption that "You" (Line 457) could be let out on an open ward, where self-perception as "I" is regarded as a learned, shared social self among mental health clients as a group, not as a "We" among self and professionals. "They" is presented again three times (Line 454, 455) and indicates a traumatic recall of distant relational interaction of staff, configured within the structure. In the process of achieving a "We" identity (Tuomela, 2005, p.329) stipulates that a joint action, or combined intention need not be carried out, however intend to see the action, still motion and emotional inhibition carried out. The awareness of "We" indicates that each participant in the carrying out of the careful pre-motivational composer, observed by others in low affect, must believe it can be carried out with success. This becomes an aim intention as "We", can be let out of the hospital, for example. The participants alone can combine the "We" intention, as part of the joint intention and it must have an ontological belief, separately that the intentions can be carried out, over possible inactive or active courses, and routes as a pre-supposition, in a final summarizing motivation (Tuomela, 2005, p. 330) to be let out of the hospital. As it be-

comes a social activity, the initiative does not have to affect the individual motivational systems, however with social awareness, a person develops a pre-motivational aim of lowering emotional expression, as a long-standing collective intention to avoid coercion, and provide goodness of fit, within harsh settings.

In the following extract, Maija is presented with a failed opportunity to exert the opposite of in-excitability, and seek assistance that is denied, in a botched attempt to display the withholding of expression until a later time, explains the seclusion emotional suppression theory.

458 Maija: (she's) in there now everybody always knew who was in there now,
459 who was doing all the screaming and protesting. So there was a lot
460 of banging all the time (…) I actually asked the staff one time
461 that is there a room where I could go together with one of you to
462 get some release for my anger.
463 they said no.

The audio screaming creates a public suppression, where Maija is forced to confide in a staff member privately (Line 461) asking to speak to one person. The attempt to voluntarily participate is failed and corrected (Line 463). When the client is describing hearing the screams of a person in seclusion, the freeze follows a recall of the other mental health clients' perspective, or "Everybody" heard (…) (Line 460). "We" and "in there" referring to the placement in seclusion, is repeated as temporally suppressed. Hearing the other person secluded, suppresses own need to release expression (Line 462). When the client says the word "time", the freeze happens after the attempted failure of an accurate perceptual description of time, unable to account for the duration of another client's suffering, due to the suppression of retelling of public screaming (Line 460). The pause also resides before an unstable "I" personal perspective, in recall of talking to staff (Line 460). There is a demonstration of a memory of a client, then identification as common. The visibility the seclusion deteriorates confidentiality.

"Everybody" (Line 458) always knew refers to "We" shared an account, as one of "Us". The request for talk is made to hide and inhibit expression from public view, assumed as "We" do, as a patient social identity. A recall of long periods of another client banging, is suppressed in the memory, and retelling by the pause (Line 460). The pause is located very near an identification of "I", not the social self, asking for participation in treatment (Line 460), but asking apart from social relational consensual collaboration, with the helping professions into the seclusion room to release alone, expressions emotional tensions as a "We", in conjunction with staff that is built to fail. There is a compromise to suppression in the constricted environment of the other client suffering, and the request is to be taken out of it with staff (Line 461) in order to process, and express anger away from the suppressed setting enforced by staff. The seclusion room and constricted setting is not defined as a voluntary place to express negative emotion, and the setting creates the intensity among all the mental health

clients and the need to express it, but does not allow for its voluntary emotional expression. Maija presents a willingness to collaborate, but is denied (Line 463) to cooperate with staff and the "We" is not recognized as a combined action with staff. The "We" in combination with social identity with clients is made aware (Line 458) of the conditions, by everybody knowing of the anguish of seclusion and avoiding it by in-authenticity of expression, as an agreed upon duty (Von Wright, 1963, p.240). This is an altruistic concern among clients where there is a known negative "cognitive cost" by the known pre-motivational disposition of withholding talk.

An element of deterrence where there is supposed to be confidentiality in expression of trauma, is an important question here, as Maija requests collaborative (Line 461) private communication and is denied. This punishment is heard among all the clients, and is visible. Asking to avoid becoming ensnared by sanction is created, among someone who does not deserve punishment, rather wants to avoid expressing emotion, indicating the consequences of such may be formally suppressed, among many. The potential for seclusion to be used as a voluntary therapeutic device is denied, and transformed into an involuntary punitive mechanism. The construction of an apparatus of correction or "They", to treat without consent enables the structure to make a non-rightful deviant claim, such as issuing a no (Line 463) to collaboration, as an informal infraction.

This previous extract (Line 458 to 463) leads me to understand that the inpatient setting, is a place where voluntary requests of social expression is discouraged, as a means of therapy, but grounds for coercion, to claim non-compliance and involuntary status by not abiding by the code of silence, and the area around the room serves to suppress expression of anguish. Maija requesting the professionals, if there is someplace to express relief from anger, may be asking for private expression and may be exploring protection from public expression, and resultant seclusion. The "We" identity is misplaced, and mistaken as one of collaboration and denial of expression with staff, enforces the sole "I" identity. The data suggests that "They" cannot wholly confine an "I" nor once the client adopts an identity as a "We". The effect of suppression of expression is built up, contained in the motivational system, not allowing for its release for long periods of time. However, it also suggests that Maija is recognizing and avoiding a developing external knowledge of a deterrence situation that enforces suppression, around the seclusion area.

Social learning, from the so-called mistakes of the other client is found to embrace withholding expression, as a strategy. This is a pre-established condition to promote an antecedent pre-motivational disposition to disuse of talk, to avoid the deterrent. With denial of collaboration with a professional, and request for voluntary participation denied by the hospital staff, Maija withstands the demotion of social identity, and is enforced by imposition an isolated self-identity, where the tension and fear is publicly created, that is denied private talk. An attempt is made, by both open constricted and enclosed restricted settings, to set a person apart from the impact of their surroundings which is resid-

ing before, during, or after, that can issue claims to conduct, that can be independent of social environment considerations within the context, between the doctor and mental health client. "No" grounds to voice refusal to consent, is a functional foundation for seclusion, well before the context of the evaluation are set by the doctor. This quickly pre-arrives as a pre-decided institutional directional path, not in the first place, or even the last place, but as a "We" evaluation of a preceding social environment, setting the stage before hospitalization, where a mental health client must retain the ability to refuse, and consent to treatment.

Maija demonstrates that it is possible to show decreased talk, in describing a traumatic event of someone else, by cessation of expression indicated by a pause (Line 460) separating a short abandoned description of others expression, then turning to own limited motivational foreclosed description, of both constricted settings. A distraction away from description of another's pain and compassion for another for example, can result in over-saturation of visible, audible, public trauma that socially suppresses, and cancels expression of many peoples, and makes expression so common, it deadens its affect. The psychological defense (Terr, 1994, p.1) of suppression, allowed the speaking out about another's expression of emotional pain, hearing someone else protesting. The client presents this as a snapshot momentary "reality check" memory, punctuating a long course of dissociative experience (Allen, 1995, p.87). The client communicated in a monotone voice, no surprise in the clinics creation of involuntary status explicitly ascertained as a "We", constructed "I" self-enforcement activity, and "We" enforcement of emotional inactivity around the room, and denial of participatory care. The client was in present exhaustive, conclusive low affect, in recalling this incapability to voice expression. It became a decisive point of considering no expression to be heard, therefore only report the void between psychiatric staff and her-self, in recall.

A result of becoming indifferent to the public expression of pain, Maija can simply not be deterred or provoked, but it can create a neutral affect to an open public display of trauma. This serves to dull the person's attentive awareness, of other clients' traumatic impact of inefficacy. This fear can contribute to widespread active cessation to expression, constituting a pre–motivational disposition for "We" to avoid actions misrepresented as infractions to conduct, the seclusion emotional suppression theory contends. This contributes to taking away visible expression of an individual or groups beforehand, for fear of coercive reprisal. Any action to reach out, affect inaction to retract interaction, or develop a social identity based on concern, might be suppressed more effectively by visibly terrifying people as a "We" experience beforehand, by way of a pre-condition. Also implicated by the data, is making longer the intensity of preceding disciplinary conditions that leads to stages, "all the time" (Line 460) under which it will be carried out, and that invokes more time in public, visible punishment as the panopticon (Foucault, 1977, p.195). This collective experienced terror is made more clinically beneficial to suppression of the inpatient public, in the hidden, threatening unexpressed anguish that is made visual,

then restrained and isolated. This increases suppression of the public, make primary the deviance application, rather its wrongful inferential non-corrected false disobedience, held widely by other clients seeing the violent consequence, and indifference to agitated or disoriented expression of it, therefore ensures increased past, present and future deterrence. This is an indirect clinical attempt, to place an individual terror non-receptacle to a "We" status of identity, in a kind of enforced "I" identity of an "every man or woman for themselves" code of non-specific conduct. The false attribution of primary deviance is held to suspicion objectively, by other clients (everybody) as Maia indicated (Line 458).

Maija's lowered expression, ensures the absence of knowing of the collective social power, placing the representatives of the public in more possession of their rights by intensifying the duration of time, and visibility of suppression by the objective fear of seclusion. However, the seclusion emotional suppression theory disseminates suppression is something that is often not made visual, but is instead partially hidden, which refuses to openly discuss initial problems that are met with staff shut down of talking. The shutdown of talk of traumatic instances come to cognitive closure that is transmitted to clients first by staff then among other clients for fear of a seclusion (Line 458) the theory stipulates. The ultimatum to talk, seclusion compels the populations to distance vital problems with living, and engage in complaints with a social institution in creating opposite actions of a kind of denial, acting as a diversion to important issues that have not been addressed concerning primary reason for seeking help. In this study, seeing and hearing another client being secluded, lowering affect acts as avoidance to the configuration of deviance, the verdict of involuntary placement, and speaking of seen and unseen deterrent influence on a client, invokes self and social control.

To ask for therapeutic help and be constantly turned away, can invoke the pre-incorporation of low motivational affect. Confined to a self-identity, Maija is in danger of an increase in the level of low affect surveying in-efficacious settings, over or underestimating the level of danger of coercion. Oppressed cultures may be suspicious of other clinician's culture or class (Whaley, 2001, p.556) care separate from a "We" collaboration with psychiatry, and this may be manifest in clinical distrust. Cultural paranoia, for example is manifested as low self-discloser, and mistrust of usually different culture (or social class) clinicians, as the mental health client does not display emotion, observed among clinicians as motivational low affect (Whaley, 2001, p.556). A clinician's illusion is the belief that low affect often asserted as mental health characteristics, through a course of psychopathology in chronic mental health clients, are universal features of mental illness, although it may be a healthy response to the practice of deceit in psychiatric encounters, and a "We" socially acquired adaptive rationale to constricted, little to no choice social environments.

The communicated mistrust is a level of awareness of membership of disadvantaged placement, in society. Oppressed mental health clients, for example, can exhibit paranoid-like behaviors during therapeutic encounters among

professionals, of the privileged culture. Whaley (2001, p.556) illuminates low self-disclosure, which has been interpreted traditionally as an element of psychopathology, during the course of diagnosis and treatment, may be entirely due to adaptive paranoia. The adaptive paranoia is a response to very real impoverished clinical and social conditions, and induces the trauma of pre-motivationally re-experiencing the events, objects and emotions even remotely associated with concealment and release. Fear can contribute to the re-occurrence of words, frozen lapses, stuttering and pauses, and be associated with the former inability to express the trauma of unmet need in recall. When low level of agency power exists to affect the situation, there is a hesitant limited account of the self in the situation in recall rather it slowly accredits inefficacy of the setting to the helpless and agitated remembrance, and as a current state affected by the surroundings.

Due to a clinician's lack of awareness and inability to read social expressiveness, mental health clients are made aware by other clients in the inpatient setting, of different social norms of cultural and clinical paranoia, which is a normative, healthy, and adaptive response to oppression (Whaley, 2001, p.556). The social institution can attribute affluence to better and worse treatment as a construct of the institution, according to contemporary society's determinate process, of designating an expected certain level of poverty. The helping professions construct social control, utilizing structural suppression of expression, and sanctioning facets of conduct, to less affluent social layers of poor. Clients then seek "We" cohesion (client to client) with their own descriptive dimensional status within their group, in order to seek validation of a common experience of inefficacy, demonstrate unrealized common able agency, and diminish influence of motivational suppression. In Whaley's study (2002) in measuring dimensions of paranoia as a healthy adaption to poverty, mental health clients' attitudes were specifically derived from pathological expression. Social mistrust of an oppressive clinician onto clients coming from affluence, can be due to what a client views as affluence. Privilege can also receive disadvantaged care, and be distrustful to whom administers it.

Affluence as a social construct, receives preferential treatment that is normatively carried out of the treating professional, of same culture or social class dimensions, to whoever represents privilege and ascending mobility, thus creating less cohesion and more distrust among those from other social layers, who receive lower tier help. There is a misunderstanding as to who "We" are, as consciousness part of the deserving care, therefore more so entitled to care, when not receiving it, becoming more so emotionally reactive, and demonstratively affected by trauma. Whaley (2002, p.573) states that pathological mistrust, beyond social mistrust among mental health clients, was more so due to the number of times secluded or restrained. Clients calculate around a dangerous coercive practice, silently expressing mistrust in low affect evident in lapses and pauses, interrupting trauma specific content, unable to express for long periods of time around the seclusion room.

My study observes clients socially mentoring a "We" intention, forfeits the combined talk participation of the agent and help, and develops a concept of "They" within a social setting, where there are different structural discordant interaction, that provoke clients and place them in coercion's way. The seclusion emotional suppression theory conveys clients initiate intentional harbored tension, as neutral emotional fortitude; however, this is due to a structural effect of suppression of visible knowledge of the room, and uncertain consequence that invokes a pre-motivational balancing mediation, of affect expression. If a client is inactive, it could be that on the inside they are simply quiet because they are fighting own illness, that is no stranger to management of health-related negative symptoms, by self-suppression. Knowing fully well the consequences of emotionally reacting, taking a silent path is what professionals observe as affect helpless; mental health clients as a "We" intention (Tuomela, 2007, p.12) are socially pre-aware to enact low affect, of the multiple structural causes of emotional reacting of scarce expressiveness, and have no scheduled routine response to clinic created cues, in created non- participation.

Involuntary status can be mis-represented as perception of lack of agency in an environment of inefficacy, and refusal of a re-definition of a structural inability to carry out institutional norms. The seclusion emotional suppression theory concerns itself to help researchers inform practitioners, to aid clients avoid agitated confrontation, that can be rashly re-defined as extra-psychiatric or extra-legal (Szasz, 2009, p. 2) and carry out the antecedent motivation and pre-determination to stay away from the hospital before a potential crisis, as the everyday disturbance subsides. This is understood among clients as an action of a "We" entity, along with the social value of helping clients is an attribute other clients possess, that is humanitarian and priceless, that a client may not denote a value from another. Helping another as collective social action is guided by a shared "We" goal (Tuomela, 2007, p.13) to dispatch low affect. These silent social connections become long-term collective strengths, where professionals encourage on an individual basis, rather these recalls of "We" cohesive socialization can be the most predominant factor toward recovery from mental health, and physical disability among same groups.

Finally, mental health clients adapt non-emotional reacting long after placement, and release from the hospital. The seclusion emotional suppression theory asserts that the low motivation carries out helpless, nonviolent, stubborn, emotional inhibition over long periods of time, over highly constrictive environments and own illness symptomology. Developing own, and socially acquired realizations and ideas of illness, rather than a counterfeit staff combined re-definition, Maija presented the ability to withstand trauma expression of coercive objects (Line 463) and develop ideas about recovery such as asking for talk voluntarily (Line 460). The seclusion emotional suppression theory attests to relying on concealed affect performance of adapting, advancing, and avoiding trauma content in expected low outcomes within "We" shared environments; humans develop mastery over the expected effect of provocation of structural causes, to construct emotional reacting to non-maneuverability, with-

in confined social conditions. The theory assures after lifelong exposure to low outcomes, after enduring long periods of being unable to express traumatic content, clients learn to not be ruled by instincts, and can no longer hide frustration and disguise social expression of trauma objects; A "We" mentored prevention learns withdraw and appeasement in the face of provocation, and does not react to highly traumatic and unfavorable outcomes, and learn to not engage and interact to begin with, as a constant pre-motivational preventive power. Mental health clients socially learn aware of each other to not emotionally react, convinced expression may be re-fashioned in a context of implausibility, therefore elicited a deviant ascription. Clients learn of each other to be collectively aware of constructed needs designed to not be met, to set the pre-seclusion reacting in place. Low motivation can temporarily grant unspecific consequences, by institutional pathways. The client then socially learns effective group inactivity as a "We", to avert and withdraw participation of interaction in order to avoid seclusion, socially aware and receptive of the conditions of inefficacy, facing them.

4.6. Social Awareness

This chapter will discover how recalled, learned, shared approximations of successful accommodation with another client, in expectations of inhospitable environments by adapting lowered affect, create a pre-existing motivation for termination of expression. This shared, socially assisted view of common conditions verifies subjective, heightened allocation of environments of inefficacy, then set forth evaluative action, toward naming trauma objects. Social awareness is the slow, recalled process of partially discovering self in the situation (Herbert-Mead, 1934, p.224) objectively affected by external structural directive. Clients slowly or suddenly, become implicitly aware of others in the social ecology of inefficacy. In combined social awareness, clients slowly, objectively, explicitly and partially become aware of the inefficacies in conditions, verified by others experience. When it is combined social awareness, the survey of the setting includes like others in recognition of the "We" identity, fully or partially aware of inefficacy, constricted by external mandate in the environment, preceding a seclusion. Mental health clients make others aware to not continue or start emotionally reacting, and develop awareness of the opposite of expected consequences that the institution creates which can prevent seclusion, developing low affect as social acting. This pre-decision and set determination to conceal posture, is visually made known among awareness of other clients. This visible low profile is operationalized by low manner demeanor, in order for multiple clients to draw assertions of external reasons statements of social inefficacy inhibiting capability, for emotional affect moderation, as an action of successful agency, as a joint action intention (Tuomela, 2002b, p.30). This awareness begins quickly or slowly, as it can exist below the level of consciousness (Rosenberg, 2004, p.19) of coming conditions. It can manifest itself in partial

view of social reality, and incorporate composer to emotional expression in motivation systems not yet fully monitored, outside of full primary attention and realization. It is always possible for a client to simply invoke an unaware response, or generate a quick utterance to a question or social cue, or learn without full apprehension to not ask for talk, well beforehand. When social needs are not established as met for many clients, they learn not to ask for their redefinition, specifically to subdue socially expression, well aware of the environment of inefficacy, and clients can collectively consider this a protective defensive measure.

This long pause presented in the next data extract, indicates the temporary unawareness can become keenly known, as social consciousness in a mental health client, silently observing a still motionless awareness of inefficacy, in another. The client then communicates this as a social awareness strategy, to adapt social self to an environment of inefficacy in recall. The seclusion emotional suppression theory can be a beforehand avoidance of coercion, and a preliminary socially consciousness, calculating a more focused approach to accommodate inefficacy, or long-term canceling engagement to psychiatric misrepresentation of need. Bellow, clients observed each other in low affect, and recalled remembering the other client, appearing exhausted and motionless, but both in a motivated and cognitive frozen motion, by way of displaying a low affect preceding awareness of restrictive or constrictive conditions. Preceding a seclusion episode, human need and want is controlled, especially confidential social expression; however the reacting to this by the client is temporarily strategically subdued, in order for the hospital to bring into a coercive environment of inefficacy, overriding consent and refusal out of participation. The inpatient social setting may be pre-determined to incur want, so the unsuccessful search for client participation, indentures low affect in the telling, as the frustration and anger of inefficacy of the able agent is called, mis-represented or defined as an infraction.

In the next data extract, "restricting all my possibilities" imposed by staff is followed with a long pause (Line 485) (44.42) that acts as resolve in social awareness (Line 486) before pausing, in the remembrance of a fellow client (45:05). Maija is aware of the "We" cohesion of the other client, then socially aware of the recalled in-efficacious conditions of confinement in the area around the room, facing them.

481 Maija: I was only there that first night and just for a few hours,
482 and I guess the benefit was that I finally then, uhm, what do you
483 call it, I finally surrendered and decided okay, I'll just go to
484 sleep then, so it would have been a way of restricting all my
485 possibilities (44:42)
486 Maija: But, but (45:05) confined (…) the man or woman I knew from seven years
487 back she was confined I think two or three times a day.

The self- report of ones constricted subjective possibilities is set aside as peripheral and the inefficacy of becoming objectively confined is hesitantly presented

as central preceding a pause (Line 486). The client surrenders to sleep as to eliminate explication of emotional trauma, giving a clear indication of a successful agency power, to protect oneself from a negative clinical set consequence (Line 483, 484) pre-motivationally determining the carrying out, of emotional self- regulation of the possibility, of clinical harm (Line 484, 485). The pause after enforcement of motivational helplessness abandons the problematic search (Line 485) and the pause before a social and common, combined account (Line 486) sets forth a satisfied search, for a shared experience of another patient. The beforehand pause helps describe an unsuccessful search, so there is low motivation in its recall. A social perception of inefficacy straitens out the trauma, resting in a long pause (45:05) after (Line 486) repeat of the fear to stutter the word, in its temporary irretrievable form, "but", twice in preparation. Traumatic pausing before and after words of traumatic objects after this point, have to do with the pre-motivational working up the emotional courage, and fighting through the suppressive blocking of the word, to utter them through inaccessibility balanced by trauma regulation. From this juncture in this chapter, there are reduced pauses of less time before and after words, seeking combined restoration, and ownership of treatment from the imposed lack of participation and enforced collaboration, and resting from trauma laden objects.

The pause indicates the description of suppression of help in recall of the other client (Line 486-487) and it can be re-directed into low affect situated calmness, high affect expression in told memory at a later time. The second pause (Line 486) (45.05) comes before personal alignment with a social awareness, and (Line 485) refers to suppression episode of one's own experience in inefficacy, and then comparing the similarities to someone else's (Line 486) experience of clinical malice (Line 487). The socialization of the surroundings inefficacy and its knowledge about "how to act" becomes explicit (Luhmann, 1989, p.33). The word "confined" (Line 486) is resolved, and the heightened performance of perception of social awareness of inefficacy, begins to draw pre-motivational external reasons statements to remain clear of coercion, correspond to neutral agreement to maneuver structural conditions, and develop awareness of social identities capable experience, to justify this.

The suppression finds resolve in social awareness of being free from confined compassion with another's perspective, sharing the same environment of inefficacy (Line 486-487). Specific details of it are identified in coming central attentiveness, emerging from secondary peripheral suppression. The pause serves to first blunt (Allen, 1993, p. 287); (Spiegal, 1991, p. 261); (Steinberg, 1995, p.1) the distressing emotions and temporally escaped inward flight (Kluft, 1988, p.139). The word "restricting" (Line 484, 485) with a long pause afterwards (44.42) toward the highest point of resolution (Line 486) (45:05) is used to describe first, constriction in the open area from own perspective (44.42) then restriction from learned acquirement, of another clients perspective (45:05) that suppresses the mental health client in present recall. Social awareness of inefficacy emerges out of suppression, and tells of being enforced by professionals then confined as a "We", in specific reference to the isolate conditions. The pos-

sibilities have been taken away from the self, and reproached after talk was requested and denied, in remembrance of approach of these words, deeds, and treatment objects. In recall the pause is after, in order of sequence of events substituting for care, not attained after the request was made. However, when describing the experience of inefficacy lead from constricted area to restricted area, two to three times a day socially learned from another person's perspective, a time freeze precedes before the word "confined". It is an attempt to take back the treatment object from inflicting trauma and imposing self-identity, realize, establish, and develop social identity awareness, of common inefficacy around the room, through the connection recall of a memory of the fellow client. It might be a way to pause, and prepare to take the treatment object back as a "We", as a partially realized social identity, are being secluded, recalled of projected order of events, and a new way to begin to socially endure, being expectantly confined in a future tense. The "We" social identity acknowledges own capability demonstratively, by naming non-reflexivity in the setting.

Through pre-motivational exhaustion, Maija pauses then intercepts the recall of adverse external conditions as a self, and combines the attribution of the unaccommodating environment, as a social-self recalling the fellow client's exposer, to the trying environment. Then after the pause, Maija becomes increasingly pre-motivationally focused, and calculated resetting determination, telling of the dangerous environment (Line 487). The account after the pause is how "We" accommodate, an endeavoring environment in recall. Maija's recall of the other client have been suppressed to distract self-report, because she had seen the other client not utter a word, being led to the seclusion room and the direction of the trauma treatment item, as confinement receives the central description. The second pause tells of trauma preparing to utter the word "confined", as it is commonly withstood as social restriction. The pause (Line 485) is hesitant in emotional cessation as helpless, and abandoned to silence after lowered self -report, then transformed into an opposite expression of social empowerment (Line 486) of the awareness of the impact of inefficacy, on treatment outcomes. Before "Uhm" and "What do you call it" with a minimal level of suppression (Line 482,483) is temporarily unattainable in the recall of having restricted possibilities, as pre-motivational low affect, helplessness, and surrendering and indecision (Line 483) due to the setting, may help with a re-visiting of the social acquisition of an experience, of being "confined". The remembrance of being in the seclusion room, is presented by the gathering of phenomenological knowledge of "being in the other persons shoes", in order to protect traumatized self. This pause resolve before uttering the word confined (Line 486) consists not with own trial and error, but checking experience with inefficacy in the area around the room, constriction in seeking help that is denied, and developing connective memory of a fellow client as social awareness, to substantiate a pre-antecedent motivation to avoid, indicated by the pause to withdraw. This is in the middle of the interview, where the pause time has been sufficient to focus, and identify a verbal approach, through external allocation of isolation of the problem, psychiatric staff constricting able human agency.

This presents the beginning of the process of social awareness of Maija, expressing a solution, of the recall of another client, and socially learning how to respond to common conditions of social inefficacy, from their visible experience. Realize that the other client, whose name was not revealed, brings awareness for the memory could be clouded, due to the trauma long ago. The recalled description of the silence employed at the time due to the absence of the quiet friend, in and around seclusion (Line 480) exists as a present suppressive mental state, indicated by the pause. The recollection (Siewert, 1998, p.68) of the silent friend is experienced as a present recall of the deterrent, in low affect silence. The past observed other clients' silence around the room, is communicating low affect to avoid coercion. It was important for the other person remembered, to win Maija's social consciousness of inefficacy around the room, and their experience with restriction within isolation, in order to protect self and the other person, not say or remember who, as peripheral detail. Every day forgetting is natural of trauma and suppression and in so doing, protects self from inefficacy as central at the time in recall.

In sum, this pre-motivational conviction to re-live confinement, from another perspective is the awakening to a shared external reasons statement, for developing social identity, to clarify own constriction and make each other more reciprocally aware, of methods to avoid coercive confrontation in the future. The dangerous social conditions have not been persuaded, by the specific trauma expression of the other client, but the inability to exert choice, and fall prey to multiple seclusion, had been made visible. Recall of trauma temporarily blocks out a realization of mental health clients' focused details of the other person, but brings forth a central description about the other person in their environment, and moves to be altruistic naming obstacles of inefficacy in the setting, for the benefit of others. Social self is protected, by temporarily acting to help others, develops the combined awareness more quickly, of inefficacy forcing them into resigning in a pre-motivational decision to "give up" the intent to talk with a professional, at the current time (Line 483) and enact long-term expressional inactivity, due to the inefficacy, of the area. The new, re-surfaced aware combined, pre-motivational resolve about the setting of inefficacy comes out of suppression, to more accurately socially identify the trauma object. The client is then stripped of emotional expression, as a current mental state, but later adapted as a pre-motivational strategy to avoid becoming "confined". The client then can re-approach psychiatry to talk with a pre-motivational moderate, leveled affect guarding against angered confrontation to negotiate status, consents, and refusals.

4.7. Combined Social Awareness

This chapter presents how in memory, Maija seeks direct, objective, explicit combined validation, and reinforcement of common experience with inefficacy from other clients. Maija becomes conscious of other clients acutely aware of the

inefficacy, calling for the silent plan of action for withholding talk, in the adverse environment, creating the little to no choice setting in recall. Maija also recalls other numerous combined patients joined knowledge, of how to withstand the lure of acting out in emotional expression, in clinical conditions that design this expectancy. The frozen lapse in the following is substituted by the "uhm" to illustrate the impossibility of communicating with the staff, and the pause (…) takes place after a description of being treated by staff (Line 530) as Maija's agitated expression of They (other clients) or "WE WERE" (Line 528) very aware becomes central in awareness, of the social constructive process to ascribe deviance to communication underway. The new knowledge of self in the situation, does not distance self from others, rather comes into concert as a group as a process (Jacobs, Masson, & Harvill, 2002, p.301 with a common external setting, affecting many similar to self into combined social awareness. There is a compromise to leveled affect in the annunciated tone of recalling the other client's awareness (Line 528).

> *526 Maija: I think throughout the whole process yes, uhm, to take time to*
> *527 try to find out if you can communicate, because what I found with*
> *528 many of the other mental health clients, uhm, was that they WERE very aware of*
> *529 what was happening to them all the time, still they were being*
> *530 treated condescendingly by the staff, it wasn't (…).*

Now the mental health client has established confirmed, objective, combined social awareness as an "I" (Line 527) of the unwritten rule of avoiding the ploy of clients open expression and transposed this as consciousness of a "WE", that is checked in recall, with other clients as being very aware as WE WERE socially aware, and all enduring the same setting of inefficacy. Combined awareness includes staff attempting the fashioning of the client's agitated and disoriented emotional reacting, beforehand in recall. The question "if you can communicate" is posed (Line 527) and rejected as a combined intention to avoid talk, because of the future consequences (Line 530) of being treated in a condescending way. Maija abruptly stops description of the low affect pre-motivational posture, of the other clients to rejoin in memory, the self-suppression of the seclusion emotional suppression theory (Line 530). This supports collective antecedent motivation to withstand the interaction of being treated condescendingly, in order to avoid the producing of the problem, and readiness to combine and socially employ disuse of expression, to solve the problem. The checking of the co-occurrence with the other clients, substantiates a social identity (Line 528) being treated condescendingly (Line 530) as an objective experience.

The verifying of co-occurrence brings to combined awareness an overt, front stage clinical design of assigning unintelligibility to a covert backstage function of staff, a structural interactive, provoking a reaction of clients for rejection and agitated opposition and a new awareness is caste of this widespread, constructed functional process. The antecedent motivation to not emotionally react was in place, to be aware of developing enough foresight, to pre-

avoid the pre-arranged psychiatric encounter, and arrive at pre-determination to know self as social. Maija recalls combined social awareness of other clients employing specific silent opposition, to these external constraints of inefficacy. The other clients were practicing low motivational composer as indicated (Line 529,530) "still being treated". Sacks (1992a) presents a character (or characters) appearing in memory having good grounds (p.183) to be aware, and introduces via action to withhold expression. This is really a social process; remembering the other clients, Maija becomes aware where the grounds and the assessment of the external conditions of inefficacy compel, and substantiate combined consciousness. This is communicated as a memory to me in recall. Maija now insists social expressiveness accelerating into created reacting among other clients, frequently happens with a constrictive social environment, and employing low affect silence as learned helplessness, is a perfectly understandable way to adapt. A mental health client through the process of recall communicates combined, checked, social identity awareness of inefficacy, despite the institution's conditions, that attempt to produce and impose an individual identity by the helper, as treating the group identity (Line 528) in a condescending way for communicating (Line 527). This is visible and apparent to other mental health clients. The emphasized tone of voice might have been contrived as agitated deviance, if this part of the interview had been heard or seen by staff.

This links a subjective attributive awareness of social inefficacy, with the objective awareness of experience of the clinic labeling unintelligibility to talk, within checked, confirming allocation of a clinical antagonist invoking a reacting, among other clients in recall. Utilizing a function of nurses withdrawing communicative interaction (Line 527) and treating condescendingly (Line 530) for the specific purpose of creating unmet need, and provoking a reaction, the demand for talk serves as a justification for coercion. Maija becomes aware of multiple other clients verifying the near impossibility of exerting agency, in situations of social inefficacy, with constricted and restricted route of effort, imploring the impact of the conditions, and the creation of no or limited interaction. However, the known experience is not enough to end the process of talking (Line 527) resulting in being continually mistreated (Line 530) all the time (Line 529). The "uhm" (Line 526) is a pause of increased motivational drive that prepares and positions mental health clients as being aware of the bleak social relations attempting to create the reacting. Maija is taking time to find out "if" you can communicate discovering a combined awareness, that communication is not wise (Line 527) as a pre-textual no delivery, to emotional expression of the seclusion emotional suppression theory.

Maija (Line 527) speaks of taking time to formulate the pre-motivational decision to not talk, and time to consider the new cognitive issue, to simply silently endure being treated condescendingly, as unintelligible in the setting of inefficacy. A combined consciousness of socially expressed need is realized, made aware and learned among same membership (clients) in recall. This culminates in a common social acquiring of the solution of masking expression, derived from the imposed problem of no consensual talk. A visible example is

made of the combined abandoning of expression (Line 527) and confirmation of others consciousness (Line 530) of inefficacy. The data indicates psychiatric staffs sit and wait for mental health clients to approach to beg for talk, find out if one could engage in talk (Line 527) social expression, and what is attempted to be created in the setting can be something clients become aware of, in order to avoid. The trauma is hardly expressed to be met with a sudden stop (Line 530) a defensive denial, and the unfolding of the event (Saunders & Arnold, 1993, p.188) is cut short by suppression. The client becomes aware that the need to socially express, initiate participation, or be corrected for not doing this, by staff can be deduced and reacted to as already pre-defined as learned helplessness, or anger transformed into disorientation or agitation. This provides an opportunity to take down and seclude, where the request in another context, might be normatively understood by others.

In reducing interaction, to create rules designed to be broken, Sacks (1992b, p.34) speaks of personal or staff limiting conversations, they are reported by mental health clients to be not directly connected, or dependent on beginnings, middles, of endings of quality conversations, creating non-consensual treatment, against the clients will. This develops little to no quality coordinated work with mental health clients, and it is presented in their combined awareness in recall of psychiatric staff, in this study. The recalled short cognitive or heightened agitated descriptions are shut down of low motivation, restated of mental condition at the time, and re-lived in communicated recall, possibly because they are shut down to talk of staff, due to the structural and relational absence of coordinated work, and communication. As no participating work is instituted, no consent to collaborate is given or invited by staff, but rather instructions that may transmit a no-consent return from a collection of clients, thus generating a widespread coercive consequence, for failure to abide according to the unstated instructions. Below, the client experiences distressing recollections in a temporarily irretrievable inattentive range, toward common estrangement from treatment, and positions the word trauma the first time (Line 477) as peripheral inattention. Then, the secondary formerly suppressed mental state of being "traumatized" becomes central, with a pause (42:24) (Line 477) and then its relief, of frozen time.

476 Maija: By definition, you're admitted against your will, then that's a
477 trauma and you have all this traumatized (42:24) because
478 (…) experience I talked to a lot of people, and everybody was
479 like, (sighs, whispers?) (…) this is strange, they tricked me and
480 they don't, like this was a common story.

Clients fight against this self-identity imposition, as combined awareness of social identity, by naming a shared definition of being held against ones will (Line 476). Maija demonstrates a "We" identity (Line 476) as a common "You" (Line 477). Maija clearly first verbalizes the word describing the visible, combined experience of being traumatized; it is secondly followed by a long time freeze (42:24) (Line 477) to recover, before comparing it with combined others experience (Line 478) as a current mental state. After that, the mental health cli-

ent attempts to describe the justification for the trauma, which is followed by a frozen pause, and is only resolved by identifying it to a combined story of inefficacy, and normalizing to other clients (Line 480) where the pause is before the perspective of the experience of multiple other people. The use of "They" don't (Line 479, 480) indicates widespread lack of staff collaboration with clients, and is stuttered, stated twice with a suppressed effect in recall (Line 479) (signs, whispers) and common knowledge of the social construction to create the non-consent, as a "trick" (Line 479) of psychiatric staff. Maija speaks of personal trauma, suggesting the pause resides after the word traumatized, in order to recover from its utterance then switches focus to a social account, and experience of a lot of people (Line 478) to normalize and reduce the terrible account. When Maija is about to describe the trauma as endured with another client, as a combined story (Line 478) the pause (Line 477, 479) turns into a resolved point, where the mental health client feels a bit of resolution, as well as the absence of help indicated by a pause. This resolve puts forth a confirmatory search of other clients (Line 478,480) that is of positive promise, because Maija receives feedback about seclusion widespread use.

This experience of being "tricked", becomes known in combined awareness of a causal, external, institutional functional force of inefficacy, clinic presented self-blame that provokes the expression of want. This invokes the reaction that talk cannot be shared with staff, and that immediately finds collaboration with lots of other clients understandably, as a common situation. The combined account of everybody is not specific, detailed reasons of qualitative describing of widespread agency that requests and receives help, rather being "tricked" (Line 479) had been commonly imposed on everybody, followed by a pause or sighs or whispers (Line 479). This indicates cancellation of detailed self-account, due to suppression and a low quality pre-motivational quick, specific social environmental descriptive experience as strange (Line 479) with increased knowledge of the institution, creating the imposed reality. The client takes time, to work up the courage to utter aspects of the clinics structurally, established deception of a "trick", by pausing in sighs and whispers (Line 479). When referring to being tricked and "They don't" there is a pause interpreted by the word "like", after referring to the staff, the mental health client as a social identity combined with the experience with inefficacy of a lot of people (Line 478) recalls socially learning from other mental health clients, about the constructed process or order to formulate adaption, the seclusion emotional suppression theory indicates. The pause indicates that suppression is a present and long- term manifestation of seclusion, as well as creates a prolonged need to revisit the trauma, with more calculated venture after the words first utterance (Line 477).

The therapeutic alliance must exist with a level of confidentiality because there are long-term traumas, of mental health clients that need to be kept private due to endangerment. They themselves cannot utter the trauma, because the social world is public and this may create self-suppression, over a long period of time that can give rise, to long-term suppressive mental states. Foremost

of the seclusion emotional suppression theory, is withholding trauma expression in order to hastily, and quickly come into helplessness and exhaustion, and condition consideration of the new pre-motivational issue of disuse of traumatic expression. The fear of stigma associated with an unintelligible re-definition; a client's fear of this can avert mental health status becoming conventionally judged synonymous, with deviant symptomology. Individuals then re-approach clinical expression, but also view their trauma becoming open to public social awareness, joined as combined with others experience. A combined strength, public visibility of mental health clients demanding social and material needs met, and further recognition of rights, can protect and empower other clients, and make aware combined, checked awareness of the structure producing the problem of inefficacy, assures that Maija's requests for talk are not an individual's fault.

In conclusion, research practitioners can be aware that a pre-existing motivational bias, among mental health clients about how to avoid coercion, then avoiding the words associated with the trauma, disavowing casual neglect of responsibility for poor treatment outcomes. The client's restrictions are overwhelmingly due to poverty conditions endured by themselves, and professionals can severe compulsory treatments when delivering services, to vulnerable populations with care. Clients express problems originating with the clinics empty interactive design publicly, or privately. One or more clients may be in visible or hidden danger, because of a kind of "gag order", of traumatic content to utter matters protected of the confidentiality that now seek talk, and cannot find that may more so protect doctors, practicing psychiatric oppression (Szasz, 2004, p. 60). Deemed the disorderly, clients speak of coercive practice that make visible, the inhumanity of psychiatric pressure of enforcing a public deviant assignment, to a hidden mental health label. This process becomes a self- fulfilling prophecy when a client commits a motiveless crime, in the outpatient setting for example often without confirmed, checked, socially learned, prevention strategies to avoid the configuration of a deviance assertion to a mental health concern.

4.8. Creating the Disorderly

This chapter explores instances of the clinic providing incomplete explanations for its refusal of arriving at participatory consent. Its structural hindrance to agency creates unreformed direction that cannot be followed, in order to structurally intentionally create duress, via agitation and disorientation. This is transformed into an infraction to rules to client non-collaborative action, thus a subsequent involuntary status and seclusion as experienced by the client. A frozen lapse between relating the message and receiving the message is a visualization, that separates Maija from being given the chance to adhere, communicates the separated direction that Maija got when she was not allowed, to participate in the process. Rather, this constructs a reacting, justifying a seclusion to

take Maija away from the open ward, without clear instruction. I attempted to use the clients' language, and asked for clarification of what is meant by the "trick ".

502 Q2: Okay, let's move on a little bit with the questions okay.
503 Let's see, to this trick, what are the disadvantages of this trick
504 to your own autonomy and trying to live with your illness, what
505 are the disadvantages to this trick?
506 Maija: If I had at least been given the (…) message, having the
507 message come through to me, that now I'm with the open ward and
508 they expect me to stay number of days or something, for
509 observation or whatever.

A pause separating the shared message sought and not received, inviting the message to come through to her (Line 506). Thus, Maija was failed by the institution's indirect deliberate institutional function of not getting the message, and twice emphasizes not receiving the chance to renew, and forfeit consent (Line 506, 507). The pause separates self-preceding the severed imposition of hypothetically been given the message (Line 506) before seclusion took place, from the open to the restricted area (Line 507). Constructing non-consent when the client is willing to participate (Line 506) indicates mental health clients define their own actions, and not be dictated to by professional re-definition. Under whatever uncertain terms, either in or outpatient aspects of treatment, Maija has the ability to socially express own needs of treatment, and demand to be simply listened to, and can participate. However, the seclusion emotional suppression theory suggests the erratic setting helps develop a course of refraining from expression, to withhold participation as a beneficial eccentric strategy. Conventional belief systems of wellness behaviors are oriented with successful life experience, norms, achievement, and dominant ideological thought as separate to illness behaviors. A professional's confided subjective bias, sometimes immediately assigns victimizing social constructions of individual failure of responsibility, to abide by un-indicated norms. Told normative bias, already understands inability to maneuver little to no choice settings closed to agency, and dismiss lengthy or short descriptive socially shared external reasons, for disuse of expression. Creating non-deserving and deserving clients, psychiatry might conventionally (Rapely, 2003, et al.) reduce to bias a person's impoverished status due to the fault of the individual, and this is traumatic to the client. Often set aside from mental health treatment, there exists a lack of knowledge and denial about casual, objective, social, environmental, and scientific conditions that impact oppressed populations.

Because of the nature of class distinction in conventional talk, separating normatively defined unintelligibility and cognitive rule of dialouge, professionals act as authoritarians Maija indicates. The primary function of the social institution is to create a role as disciplinarian, correcting unreformability, and supervising incorrectibility. This supervisory role sets apart the professionals disclosed subjectivity of being in advantage from the client, and forces another de-

viant role, apart from the mental health client in regard to ideology, autonomy, perception of efficacy and agency, attainment, roles, life experience, work ethic, language, and communicated thought in regard to re-definitions and rationalizations of illness or wellness behavior. These diverge with the client, among the many dimensions of unequal social relations, as reflected in the broader contemporary societies, socially constructed in the role of helper, and its relationship with the helped, bound by creating non-conformability out of indecisiveness, due to settings of inefficacy. The primary function of any social institution, is to create professionals to assign, and first label social expression as deviance, then act as the disciplinarian to mental health clients, to further enforce suppression of agencies power to create collision with inefficacy, thus creating a disorderly client, marked by pausing in lowered self-report of "I" in the situation.

A frozen lapse (Line 511) in the following extract is an attempt to be willing, to communicate the lack of decision making. It is a pause residing before a description of the trauma object of being "observed" seeking its restoration as a treatment object. A collaborative hypothetical projection is separated by the pause (…) after a description of self or "I". The "I" identity is repeated six times in created indecision, it is resolved by a presumption of who else, could not get the clinics message or a "We" (Line 513,514) socially aware of the setting, irrespective of knowledge of rules. Maija was able to convey with the doctor outside of adherence, and communicates it between a visualization of forbidden participation, what the staff could have explained, but did not. This suggests the creation of indecision in the hospital setting.

510 Maija: I think I could have been able to make myself decide, okay
511 I'll go along with this (…) them observe me for four days and I'll
512 go to bed now, but like I can't tell you exactly what they told me
513 or said or whatever, but I never got that message, you are now
514 required to stay here.

After stating in recall the ability to make a decision (Line 510) but could not, due to the no consent constructed to be non-participatory (Line 512) the pause verbally communicates consent, that is distanced from "Them" (Line 511). The pause separates consent (Line 511) from collaboration (Line 512) due to absence of communication (Line 512,513,514). The pause resides after Maija sought help, and later it was not attained or never got that message (Line 513) about the involuntary nature of the hospitalization, by being unaware of its requirement (Line 514). The pause exists to represent help sought, not achieved. Maija has a hesitation stated as a "whatever" (Line 513) after what they did not explain to the client, and further suppression and insists Maija (or I) never got that message (Line 512, 513) as if, it was explained that Maija may have been willing to cooperate with a corrective treatment style. Maija in the extract above, first looks to combined membership among doctors and the staff, clients are not brought into a participation of talk, in order to create an infraction to rules, and no consent is created in self-deciding (Line 510) in recall. The consent and deci-

sion to participate exists then, as in the present inquiry by saying okay (Line 510, 511) despite the application of coercion. This passage indicates a recalled, credible ability to consent, however not the constricted capability.

Maija is not given alternative paths to make a choice as this is reported as traumatic, and might have offered consent if allowed to participate (Line 510-511) and this would have led to voluntary status, if the rules designed to not be followed, were simply announced or informed. This traumatic process relies on separating the group cohesive process, and creating an individual deviant, and non-accordance with rules that are absent. Maija is in the context where it is assumed that she as an individual is not be able to make decisions for self, based on restrictions in the social environment. It may not bring a person to self-realization, to find relief from isolation by doctor collaboration, by way of acknowledging a mental health label upon a like population, and it may simply create deviance applied to a mental health self-identity. Maija might need to refuse treatment and refute concocted self-fault as an un-assisted individual, once set apart her social group. Non-corrective rules, find common justification in Maija hanging on to dispel the individual fault, attributed her actions assigned by the institution. Posing the statement as occurring frequently (Line 510) is exhibited as being consistently able, to exert decision. This distant non-interactive model fails to eradicate social identity, as a "We" from "Them" (Line 511,512) (client to staff) indicated by the data, as a client defensive measure from the application of deviant labels. The pause (Line 511) separates consent of "let"as allowing, from "them". There is an incompatible alignment between clients to staff. Luhtanen and Crocker (1992, p.315) conceptualize a model, of collective identity, in which an individual identifies with a social group, constituted self-esteem of memberships. The therapeutic alliance is supposed to build strengths confidentially, but may avoid forming collective agreement (client to staff) inhibiting combined client's (client to client) accurate attribution, of a visible objective social world of inefficacy and the lack of agency in conforming behavior, limitation and exclusion as the beginnings of social awareness and identity.

Social group membership as a disorderly collection of individuals, in combination with the professional for example, have a negative consequence for both personal identity and emotional adjustment (Crocker and Major, 1989, p.622-623) such as internalized negative stereotypes associated with group membership, in self-evaluation. Crocker and Major (1989) also say that understanding oneself as part of a disadvantaged group undermine performing capably in some domain, but lower motivation to do so. They also indicate that blocked opportunities to attain a goal such as a structural design of inefficacy, decreases the perceived value of the goal and in-group comparisons. Competing striving goals in in-opportunity with a doctor or other mental health clients, leads to knowledge of discrimination, that undermines personal motivation and personal agency to effect change, in the social environment or hospital setting (Crocker & Major, 1989, p.622-623).

Below, the statement of the constricted social environment and the professionals creating disorder is not identified, with defined rules. A frozen lapse tries to communicate what Maija and staff could have talked about in a participating process, but the frozen lapse separates Maija's involvement of the process and the staff's (They) (Line 513) "persuasive talking".

513 Maija: And so, they didn't even give me that information that it's
514 past ten o'clock now {mental health client's name} nobody's going anywhere
515 from this place after ten o'clock, (…) they did a lot of
516 persuasive talk.

The first time "They" had been identified as an obstacle to free agency is when Sanni (Interviewer-Translator 1) dictated it onto Esko (Line 149) in Chapter 3.2. Enforcing consent is described, rather complained not to be arrived at mutually (Line 515-516). No direction to "fall in line" disables individual freedom of movement, creating ambiguous non-responsibility ascribed a corrective deviant label. The clinic reluctant to provide talk (Line 513) infers that information is withheld, to construct no remedy to fault of rules, despite the recalled willingness to cooperate. The frozen lapse separates self and "They" (Line 515) or staff, noting lack of collaboration in recall. Again, the pause happens before an imposition of coercion between personal, and shared participation. "They" or staff is stated again (Line 513,515) which is the rejection, and deconstruction of dominate ideas, and a new commitment to mental health social identity (Line 514) as nobody is getting the information from the institution. It suggests that a social need for who, or whatever defines this is created, but is not solved by the psychiatric staff's ascription of official no help, no message, just imposing and enforcing by persuasion, trying to subdue opposition of fabricated self-fault, suppressing exclamation of inefficacy that quickly becomes silent at this proposition, because it may depend on a client's false acceptance of personal responsibility, to avoid seclusion.

Notice in this partial consciousness, resides in identification with social identity (mental health clients name) contrasted, and separated with information that was not received by anybody (nobody) (Line 514). Maija begins to formulate awareness of external reasons of structural creation of staff by avoiding (They) rules that cannot really abide by, multiple clients by not relating information (Line 513) and creates the disorderly in the self-identity, as a replacement for social awareness among mental health clients. This description is more than generalizing social relations of staff; it is a beginning of awareness of the social creating the setting of disadvantage, of non-specific guidelines that generates a formal emotional reacting, resulting in Maija's constructed non-consent (Line 516) that have to be persuaded. A social identity as "nobody" is separated from "them" or "they" by a pause (Line 515). The clients name (Line 514) is set next to "nobody" is going anywhere, based on created non-conformity of multiple clients.

Awareness of little to no choice of effective agency power in settings of inefficacy may be underestimated by researchers. This growing awareness of cli-

ents as groups demonstrative ability, to make visible the clinics limitations in poverty of choice, capability, and consequent trauma within client's structural ecology, frustrate the pre, during, and after stages of the helper role. In creating the disorderly, psychiatry and nursing impose and enforce assumptions of efficacy in the social reality upon disabled people, who understandably are directly impacted by objective widespread inefficacy, and constructed non-maneuverability, whereas professionals are typically independent of obstacles in agency. These assertions are bound by justifications of divergence from, or embracing a traditional work ethics conventional standards of sick leave, productivity toward adherence rather than punitive compliance, opportunity of open individualist attainment of wellness, achievement of self care, contemporary ideology of so -called disease like behavior, and normative elite cognition defining unintelligibility and assuming such, even before the context is set in place, for example. No fault of the individual, driven by little to no choice estimations, may quickly find acceptance of external causal attribution within hegemony of a group identity, among clients. Fairclough (1992, p.9) states that elite discourse, points to clients embedded in the social ecology of social practice, and concepts of ideology and especially hegemony, in the sense of mode of domination based on alliances, the incorporation of subordinate groups, and the generation of consent, and refusal as part of an everyday population that is, for example subjected to agencies constriction, by widespread trauma and poverty.

Fairclough (1992, p.39) further points out that the organizing of exclusion in hegemony among human beings, for example is a practice of institutions that is produced, reproduced, contested, and transformed in language, and is discovered by mental health clients as creating unequal social relationships (client to staff). This may be the case because it is the role of psychiatry and nursing to explain structural scarcity to mental health clients, in a cognitive elite rationalization of deserving, non-deserving poor. Psychiatry and nursing does the duty of creating disorderly non-deserving rationalized treatment failure, by variation from unspecific rule, while not possibly sharing the same experience, fate or basic ideological premise that explains individual trauma and poverty. Social scientific, philosophical and ideological terms do not capture the emotive distress that is communicated by Maija that is directly affected by created lack of expedient choice, and incapability to express trauma in the setting. This can be misunderstood as part of the stigma of living with illness.

Perceptions of open efficacy, rationalizes privilege and poverty of free reign of ability, justifying disadvantage and created insufficient agency. The data suggests failure to employ the seclusion emotional suppression theory, to understand clients pre-motivational stance low affect distance deferring coercion, warns no explanation of social inefficacy created to offset the exertion of agency, result in agents colliding with correction. Moreover, the emphasis is on the failure of the mental health client's personal agency to decide and engage to participate, even during the social construction of lack of opportunity, and obstruction to freedom of movement, as non-abidance to norms. Little to no-

choice outcomes are not due to a lack of ability, or capacity to participate as an individual, although clinics compel this explanation to clients, but testify a level of the consciousness among clients of the socially situated objective constriction around the room. The restriction of agency in the social environment, exist as the beginnings of awareness of inefficacy, affecting broad layers of human beings as social exclusion in the outpatient area, where clients are fighting so desperately to get.

Clients become quickly aware of obstacles facing them, develop accurate levels of perception of agency to integration, and develop shared external statements of objective scarcity in social settings and constraints, in almost any social environment. Clients tell of health professions that are discovered to assert human agency in the pre-seclusion area, most often visibly presents individual merit within social efficacy and opportunity in social environments, to indicate the clients' created error at reform are more so due to, a failure of exertion of agency. However, psychiatric staff views as told of by these clients, are rationalized to be won according to opportunity in the social environment, step in on the clients behalf to compensate for in-decisiveness that is non-responsive to obstructed agency. Professional's views presented by clients are rationalized by merit, often utilizing a cognitive morality (Coulter, 1973, p.152) justifying inclusion making normative assumptions of individual agency and social efficacy, presented as un-falsifiable. This takes staffs rationalizations it is told to immediately exclude, correct, identify, and in-dignify, so-called proper conduct to communicate trauma of the disorderly, and in doing so makes it self-normative. This cannot justify between professional positions independent of inefficacy in the social environment to some clients, and the inclusion of others, based on rationalizations of dominant individualist ideology centered in achievement, in outcomes of success. Exclusion has more in common with clients that have been affected by widespread poverty, inability to communicate trauma, and its impact on motivational systems, that does not readily respond to an exertion of agency. The seclusion emotional suppression theory ventures recognizing this socially constructed inequality, even at its primary level, ushers forth a motivational pre-disposition to disuse of agency.

Departure of individual merit is labeled as an aspect of deviance, and dismissed as unintelligible, that quickly find a corrective sanction assigning a failure of self-responsibility, un-reliability, and un-teachability (Douglas, 1984, p.98) to refrain from talk. In order to critically examine the difference between professional and client told subjective knowledge about inefficacy and open efficacy, it is an assumption of the health professional that the social environment is a place, where everyone who exerts decision and motivation, achieves goals. A punitive treatment program lives off the social expressive value that is generated by mental health clients, and is quickly rationalized by deviant labels, and scant explanation to not provide talk therapies. It is discovered in the interviews the professions fail to articulate external reasons (Williams, 1981, p. 107) statements about non-maneuverability in inefficacy to clients, for exerting effort that fits their experience, of unsuccessfully accommodating human agen-

cy. There comes to exist in clients a growing awareness that their efforts are less awarded because of exclusion, sometimes by mental health clients' hard, enduring, emotionally costly, endless successive, so-called failed attempts in little to no-choice settings. These conditions do not readily elicit opportunity to communicate emotional trauma, and acting out with these assumptions with this under-estimation deliberately create the context, where its expression is quickly become sanctioned, as unintelligible therefore deviant, for example.

Maija who has been secluded recently and over a long period of time, develop rejection of their traumatic oppressive treatment failures to ascribe deviance, as experienced by "self". A dissociative experience can separate self, isolated from own contextual social broader sense of "We" (Braun, 1988, p.4). The extent to which members of many other devalued groups do not develop a new identity such as "We", social and combined awareness, and internalize values of the dominant culture as deviant individuals, means they are at an increased risk of poor personal self-esteem, and emotional health (Katz, Joiner, & Kwon, 2002, p. 420). The social process of labeling a mental health client, as so-called pathological and deviant by identifying reasons to seclude, reside outside the checked confirmation of other clients' group (client to client) demonstrative behavior, and contrary to allocation of social inefficacy. There are limited ways of conforming to group norms other than by residing among a group, and among mental health clients there is active social learning of a process that require a motivational pre-decision to reject individual ascription of fault, that goes above and beyond what is measurable of isolated self-identity, identifying social environmental considerations of inefficacy. Regarding an inpatient mental health client as an individual deviant irreproachable to rule, brings a client into more agreement with professional re-definitions of treatment, by holding back opportunity to talk, challenging the demand to be heard. In this study, it brings about a long-term solid rejection and deconstruction of professional language of treatment, affect actions in the maintenance of trauma, and a desire for the individual's self-awareness of their experience as socially common that Maija for example, insists is shared among many people.

Finally, a negative transference in traumatic recall from health problems toward problems with treatment, can be explored about the supportive atmosphere of the group identity, and identification to a same affiliated client group identify is failed to been taken away. Aspects of negative transference toward the group analyst (Keiffer, 2001, p.92) or psychiatric staff, creating the disorderly by ambiguous rule for example, explores common rejection of professionals, practicing the sanctioning of conduct. The trend toward dispelling incapable individualization, of mental health clients come to common light to reject assigned deviance and its trauma evidently, when clients are asked an open-ended question to describe self. Mental health clients refuse to abandon social concepts of self, in order to defend themselves from deviant, medical imposition of dominant values of meaning making (Green, 1999, p.120) of reform based corrective illness and treatment assumptions, consistent with a conflicting world view. These surfacing external reasons statements for considering

and evaluating the impact of the construction of disorderly conduct, becoming more knowledgeable about the social institution attributing fault, for failure to withhold expression. Through refuting deviant ascription, clients become acutely aware of this process, as a predominate function of the hospital and socially shared. Clients come to avoid the misplacement of a deviant assertion to understandable requests to talk justified as unintelligible, by rejecting normative conventional rule of language that distinguishes a punitive authoritarian role (staff).

4.9. Constructing Implausibility by Cognitive Rule

This chapter explores inhibition of expression, for fear of clinic applied stigma to a created request for help deemed implausible render Maija to cease from talking to staff, avoiding of a label of unintelligibility. Maija is in fear of the request applied a breach in conduct by the staff member, outside of normative constraint to cognitive rule. Normative convention as cognitive rule ascribes the eccentric to actions, deeds, requests, expressions of needs as unquestioned, to those to whom make statements that it cannot understand. A client's request for help is often disregarded as implausible, and in order to assure insistence of this, is instigated as reason for seclusion. As behavior and language of madness repertoires are asked to conform to so-called proper conduct, they are set aside as ignored, and misunderstood from normative cognition that conducts rule of normativity, before anyone asks a client to account what happened to them. A mental health client's actions have understandable reasons, although they may sound as bizarre reasons for acting to the ordinary stresses of living. Normative reasons for so acting "normal" among people present both unchallenged, unquestioned already attested to, what is considered normative, and present those that dispute normative reasons for so acting as an agent, as the exceptions from the norm. These are common assumptions are accepted as standardized, commonplace, and regarded shared by many. These reasons presuppose shutting down incomplete detailed explanations of such, as cognitive and behavioral rule. Clients come to a rudimentary awareness of a "They", delegating and supervising treatment failures, based on re-assignments of labeling requests to talk unintelligible.

A mental health client's reasons for so acting are perfectly rational, although the way they are explained are outside the normative narrative. It quickly becomes conventionally, already understood and presumed predominately known, to label conduct and language as implausible or unintelligible. This label is applied even when mental health clients are describing the objective reality and traumatic events that had occurred, and are infallible from combined verified actions, that occurred. It is important that professionals begin to understand that we simply are listening to mental health clients though a told subjective bias, or hearing mental health clients wrong, as they attempt to make sense of the social reality. This becomes important, because the client's actions are

quickly labeled as simply being the reasons for actions that are erratic, in order to turn away their requests to talk, labeled as apart from the norm. These stipulations are heard outside the context where they incurred, as professionals can be unfamiliar with little to no choice environments inaccessible to the product of effort, therefore needing no further explanation of them due to bias of open efficacy. Mental health clients need to be understood as capable of making credible, valid claims about their own and others' actions, conduct and accountability of deeds, according to normative versions of ordinariness. Fear, the seclusion emotional suppression theory says, governs disuse of expression to avoid a non-normative label eluded as deviance, to requests to talk.

Mental health clients' views of the social world are that there is an over saturation with the traumatic truth, and what they communicate is part of this. These psychiatric events of restraint and seclusion in the community and as an inpatient happen every day, and we are vitally needed to listen to social expression of it, before they happen. Appraising client's social expression as normal, aid the client to prevent compulsory treatment methods, and identify a favorable context to articulate trauma objects. Any professional member or mental health client member employ what is normal or abnormal, without reference to what it is, and what it stands for. The problem is to solve this with a co-occasion (Sacks, 1992a, p.58) to account for what is normal. Sacks (1992a, p. 58) says this goes on without further specification of what is really (ab) normal. These are measuring categories with a value or not, equipped with a notion of incompleteness, and a notion of absences of what really happened to the client. They begin to partially know the construction of the social reality, through deconstruction of stranded identities, according to rejection of relayed subjective awareness of normative clinical definitions of client erratic behavior, therefore in need of correction. These deviant aspects rely on creating the social reality, of fabricating a self-identity as outside conventional norms, at an already arrived at partnership between a primary deviant or mental health ascription, that does not make sense to a client's told subjective understanding, of their actions. This enables someone else to quickly formulate characteristics of a client, then entire populations, and their descriptions incomplete. This allows those who hold normative convention of the quick rationalization of responsibility achieving merit, and the departure from this as irresponsibility. This justification quickly diminishes an effort to reconciliation between participation with a professional, to the creation and maintenance of bias of no fault expecting negative outcomes, and the reasons for such. There is devaluation to a mental health client first, after which the psychiatric staff has to demonstratively, residing in quick bias exclude something about the person and their sub-population.

In this research, social expressiveness, dimensions of illness, treatment and aspects of deviance provide answers for any untold inconsistencies, rather than staff talking to and supporting them, when they break away from conventional pre-motivational bias, of normative assumptions of fluidity of environments. When clients establish an externalizing awareness, they can point out a causal context where behavior is structurally manipulated, to produce a reaction. This

reaction is seemingly already answered for, already explained, requiring no further explanation, commonly held biased views of "other than rational behavior" rooted in conventional, already arrived at assumptions. This happens in disregarding current or future considerations in order to carry out the action of unmet need for talk for example, to produce the reacting of the client that may or may not be justified in the seclusion reaction. The process dismisses a secondary importance to the client's action such as its deception, set to create the deviant reacting, to be corrected. This result in ascribing a non-correctable, non-cooperative label to a mental health client based on the inability to make decisions, due to the constricted environment and failure to control emotional composer. The assigning of deviance to almost any pretense toward independent action and deed deemed implausible, due to the institutionally created, almost certain treatment outcome failure, and insight to this primary function is shrouded as a lack of client compliance to insufficient care, suggestion or rule.

The problems of closed communicative relations, between psychiatric staff and mental health client is what Sacks (1992a, p.203) suggests an attempt to otherwise conventionally set apart from normative actions, use to tear down quickly, a social value into a less material value, by increasing or devaluing the combined social aspect, and postponing its material dispensation to the individual. This carries consequences for the existence of all professions gathered around mental health, as the value of care for an applied deviant category carries little or no responsibility, for representatives of many state institutions to afford better care, as this becomes rash social control. Sacks (1992a, p.165) says reliability can come from checking co-occurrences not of behavior of self, but of category membership to credit accounts of one's own peers such as other clients, to particular built into sequences of events that can be made in preparation, that can be constructed in a social environment. These shared structural and social impressions are influenced in motivational systems such as in the seclusion emotional suppression theory, and assuming this covert expressionist manner happens frequently in public health in every contemporary society, whether in the streets or in the facility, among aging mental health and disabled clients. This careful, calculated affect aspect of the theory, partially explains clients assumed affect closer, in order to avoid becoming socially shaped as inordinary, thus in need of correction, then potentially a forceful intervention such as restraint, for example.

When mental health clients seek collaboration with a distant, reluctant psychiatric professional, in order to find an external attribution of closed settings as an objective world view, opposition to inefficacy is enforced as an individual contention inferred or labeled unintelligible, and this is made by staff in a one-way, announced and shut down conversational context. Psychiatry confronts a collection of self-identities, rather clients presumptions about non-regimented efficacy collide, with a checked objective confirmation of inefficacy that has developed socially aware ideas of agential impact, assessing discordant social dis-arrangements. Many externalizing constraining obstacles and ideas to adapt are unique in telling, of traumatic and stressful events and adapting to

bizarre ecologies inside and outside personal experience, may not rightfully be discredited by psychiatry. Fernando (2003, p.157) writes that in the process of making a diagnosis of an individual, professional judgments are hypothesized as symptoms of illness, by interpreting feelings and beliefs that are so-called out there by psychiatry, as not separable from the mental health clients and their self-identity, but which occur concurrently (p.156) as inseparable from constructed bias of a person, as they position themselves as the perceiver of the person and situation. These social traumas suffered in ailing settings are a part of the mental health client's perception of the external constricted reality of inefficacy that is terrifying, because of surfaced subjective bias of rejection of projected failed outcome conventionally attributed to self-fault.

Description of individual held selective bias of a poor outcome is acknowledged, and socially held general bias of the chance of a favorable outcome is dismissed, of determining level of agency to merge into a constrictive setting. Many not dare consider the trauma of seclusion for very long, as clients accept suppression, emotional regulation, and the dismissal to disengage expression. Social awareness developed by cognitive and motivational explication of inefficacy, is a normative way for clients to structurally and self-suppress, cancel emotional expression of duress of closed systems, as the seclusion emotional suppression theory asserts, a taken for granted and an assumed normative way, to avoid becoming consumed by its traumatic awareness.

Explanations of non-rightful claim of fault, of individual sufficiency do not make sense to other persons' cognitive and motivational script, whose position in society rests in advantage and justifications for such. On one hand, is an incredible claim of inefficacy and lack of agency in subjectivities, and on the other, credible claims of efficacy and open agency in conventional dialogue. A professional can make the mistake from a position of privilege to set apart from the norm, cognitive meaning of disadvantage. Swartz & Swartz (1987, p.395) insist that appraising the context makes incoherent speech intelligible, and can give psychiatric professionals the ability to recognize, and become aware that they are a listener, that constructs implausibility in a specific context that is constructed, to disfavor initiative, ascribe more or less quality and value to what a mental health client says, and justify own position as they socially express it, that do not reside outside of common held experiences. Ascription of unintelligibility aids the suppression of talk, and the quick dismissal of further cognition not making sense, or contrary to what is expected of normative behavior due, to the exhaustive motivational labor of listening, often consolidates a rapid, biased view of implausibility onto a client. This quick pre-motivational cancellation of expression, reinforcing bias does not consider completeness in detail, of the justification of imposing the threat of seclusion upon an in-abiding individual client, more so generalizations of a population, with an incidence and prevalence for isolation.

One of the highest points of pre-motivated strategy of suppression to trauma in the next extract, is the sudden identification with a "We" social identity of illness and recovery. Speaking to someone outside of the revolving door,

helped the client to quickly deliberate a new pre-motivational issue of the seclusion emotional suppression theory, and assume steady, dull affect. Already preaware of the constrictive inefficacious environments, the client develops an understanding of low agency outcomes and formulates external reasons statements to avoid talk, and maintain neutral affect and avoid seclusion. As staff members are supposed to clearly communicate the consequences of behavior outside the boundaries, the mental health client in not requesting talk therapies in the data presented below, has been enforced with a suppression that withholds her recall (Line 470) as pre-motivational emotional regulation.

470 Maija: No, and I don't know exactly how the staff communicate this
471 information because I made (laughs) I made sure that I was (…) as I
472 told erm, I contained my feelings, except when I talked to my
473 friends on the phone. And to, yeah, (…) tell if I would have let out
474 those feelings to the staff, their reaction would have been to
475 seclude me.

Now Maija has refused to seek trauma expression with psychiatric staff (Line 472) for fear of the attempt to be configured as unintelligible, thus met with seclusion. Maija has enacted a pre-motivational low affect emotionally leveled, effective route of strategy to avoid a confrontational psychiatric encounter, explains the seclusion emotional suppression theory. Maija has also identified the area around the seclusion room as closed efficacy, irrational to request talk, known to many clients. Staff communicate the little to no-choice ecology somehow (Line 470) as a human suppressive device. (Line 470,471,472) Maija was told as a joint venture to contain feelings as a "We", and it may be communicated to an "Us". There is open exchange among same members, but suppression as a consequence is employed between staff and the client from their separated perspective, avoiding interaction. The consequence known to the mental health client is that the staff makes a reaction of seclusion (Line 474, 475) simply for communicative emotional expression, so it is withheld as an antecedent motivational pre-decision of disuse of action, explains the seclusion emotional suppression theory.

The containment (Line 472) is an antecedent property in not asking for talk, especially when thinking it through before asking, and speaking of what would have happened, if they had expressed emotion to staff (Line 474). There is pre-motivational disengagement and surrender expelling the pressure and counter pressure to strangulation emitted at the laugh (Line 471) a pause (Line 471) and a hesitation (Line 472) before communicating self-suppression, of contained feelings. The laugh accommodates to an eccentric irrationality (Ellis, Harper, 1997, p.2) releasing the description of adaption to a bizarre ecology that relies on clients' already established pre-motivational bias, to avoid psychiatric staff in the situation. The pause (Line 473) and the "yeah" is a self-confirmation before a pause, that signifies antecedent motivation of accepting inaction of telling of the past pre-decision in recall.

The client recalls withholding own expression recalling "containing feelings" with a pause (Line 472) or "erm", a long- term state of composer, reliving the even temper. In the client's recall of the events, their feelings at the time of telling staff are preceded before with a frozen suppressed time in seconds (…) twice before "telling" of something to staff. The client expresses no understanding, of an awareness of how staff communicates. However, it is sure that it was told, somehow communicated not to express emotion by staff (Line 471, 472,473) as combined awareness, and infers that it is received by patients as socially learned, from each other as well. The seclusion emotional suppression theory explains the mental health client speaks of containing (Line 472) feelings as masking expression and participation, to not let the emotional talk be ascribed as a reason to seclude. Notice that the suppression follows after a personal experience of telling, and before the social experience of being told, here an ("erm") that is followed by a laugh, that releases the dissonance, and acts to terminate any further motivational effort to be read, or interact with the emotional expression of staff (Line 471, 472) a description that is short of staff enforcing, to not socially express in the setting. The client expresses (Line 473) avoiding the social interaction with staff, telling that it would be met with staff reaction (Line 474) by labeling the social expression of feelings, as deviance with seclusion (Line 475). The client advances ideas of subduing interaction with staff, as a "We" intention, and combined client awareness, as public unspoken knowledge of the closed setting invoking the reacting.

Clients develop combined, sound identity of social awareness, by becoming conscious of staff assigning in-correctability, and normative implausibility to requests to talk. Clients become aware that staffs correct the individual departure from attainment of self-efficiency to withhold talk, and direct agencies failed attempt at engaging non-reflexive social environments, such as the pre-seclusion setting. Staffs assist to re-create the client reaction, to conscript deviance and illness to social expression, and mental health clients tell of communicative shut down across membership lines, by staff's hidden opportunity in being unresponsive. Clients tell of staff imposing various ways in which mental health clients or "We" refer to the action of definition (Sacks, 1992a, p. 574) of what "They" do, in order to formulate structural, and desolate relational external conditions. Participating consent is overridden by establishing infrequent actions, or constructing unknown periods of isolation creating the client's failure to reform by in-correctibility, according to someone else definition of unclear rules. The pre-established supervisory social setting is already in place long before, during, and long after, and it can still exist without the current presence of clients, for example.

Mental health clients are shut down of communication for fear of seclusion, and its opposition rendered unintelligible, even in its remote association with coercive objects in memory as shown in the first theoretical chapter (Chapter III) as a long-term effect of suppression in pre- motivational affect. This silence is discovered to result of this transmitted communicative shut down device, which can be transferred to the client, by staff's cognitive rule to refusal to

talk, and shutting down requests. This transfer is "picked up" by the client, by position of unknown structural destination of place in the area around the room, and held responsible for rules designed to be broken, in order to create involuntary status. It is not necessary to refer to seclusion as a consequence to an unavailability to talk, for example, what "We did", or "I did", or "did not do", and it is does not serve as anything optional through conversation, and is more due to the social structure, closed down interaction due to what Sacks (1992a, p.575) calls quite restricted. This involves absences that diverts attention from self- report of what one, or anything one did, was directed to do, or did not do. This created cause, inefficacy to congenial talk, effect a client emotionally reacting by demanding talk, and unknown consequence, seclusion, is bound to permit the client to defend own action, outside of the already pre-established setting. A client adopts no response, while the structure institutionally designs an individual driven avoidance, then checks and co-confirms this with others in combined social awareness, sometimes in recall. The seclusion emotional suppression theory states client's adaptive pre-motivational non-response fits the inefficacy of the environment, more so than not knowing how to abide by seemingly acceptable conduct.

In order to create the cognitive non-correctable, the constrictive settings could for example, set many clients in separate rooms for a time, as multiple individuals with no direct impact on each other. After released into the open area, multiple clients could be agitated at each other (as seen in chapter III) or at a professional, as any real concern by the clients in this clinical manipulation is deemed unintelligible and collective expression, a deviant label. In order to correct the created non-corrective, little or no conversation is imposed upon mental health clients, as cognitive rule is enforced in one-way conversation around the room by creating rules, and little or no way to abide to them, within a constricted structure. It can guarantee little to no interactive returns, by any quality of present or future actions, only to reiterate the doctor's representation of directional goal, confined by institutions' rules and laws, possibly governed by cognitive correction, at their non-abidance. Psychiatric staff as told by mental health clients in recall, are unable to show anything but incapability, of what they are trying to do, and abide by minimal constraint by rule governed explanations (Sacks, 1992b, p.27) that the mental health client does not really have to understand, or agree with them. The revolving door is created in order to ratify almost any supposed action, including requests to talk, even those that may seem at the time to be irrelevant, to a mental health client. It can illicit the opposite, sadness into rage at a later time and confrontation, assigned an agitated ascription.

At last, suggested assumed implausibility to client's speech that the mental health client learns not to react or demand talk in the context of inefficacy, due to the suppression and its impact on motivational systems, points out communicative retention is socially learned as a subjective understanding by watching other client's, as social awareness. Also socially acquired learning of an objective experience is checked, confirmed, and co-occurrence as combined

social awareness as a "We" in recall, but is not often learned with, or by professionals. Clients also undertake the seclusion emotional suppression theory to subdue, and suppress traumatic content and its expression, by the pre-motivational power of active monitoring of affect and concealment, neutralizing the traumatic impact of inefficacy of the environment, until a safe time to seek its therapeutic assisted exploration and recall. Re-bounding from low affective propitious, a client increases concealing performance in identifying traumatic items. An explosion of detail oriented description of obstacles in the constrained environment results, if not for the client developing strengths to identify in memory, then master telling of items in the traumatic setting in future expectations of unfavorable treatment outcomes.

4.10. Unintelligibility as Deviance a Primary Function of the Institution

In this chapter, Maija demonstrates the dispelling of auxiliary inattentive and the coming of attentive awareness of front stage, and backstage primary functions of the hospital of withholding care assigning deviance, and the contradiction of a secondary function, an expected helping environment, awarding talk therapies. The experience of a constructed non-participatory environment, contribute to pauses around diminished sense of peripheral self- report in the situation, indicated by temporary hesitant inattention in recall due to seclusion, reflecting central structural creation of the preliminary client reacting, resultant in seclusion. The client's interviews also explain how an implicit voluntary participation is abandoned, so that the creation of an explicit punitive treatment regimen can be carried out, by constructing an involuntary status onto a client. A sudden awareness is adopted by the client that seclusion is not effectively a therapeutic device, according to a re-definition by psychiatric staff, and how an adherent Maija is forced to accept an involuntary status around seclusion, rather than a requested, voluntary therapeutic one. Clients hold fast to the emotional suppression theories low affect effort to conspicuous expression, as a tactic to later confront the therapeutic alliance carefully, when the danger of coercion has past.

Bowlby (1973, p.138) contends that social needs such as attachment and proximity to detachment to objects (p.140) of trauma for example, and their expression are not the causes of instinctive behavior. They constitute the selection pressures under which behavioral systems serve, which mental health clients are expected to abide as normative, and any departure to this can be unfalsifiable and unintelligible as a rule and practice, governing primary norms of the social setting. To be aware as coercive pressure mounts, and be conscious of the social construction of deviance as a prevailing problem of clients, is in itself, pre-determined to avoid the institutional pre-established re-definition, of what is wrong. Avoiding seclusion use compels the suppressive absence, and acute forefront realization of the client's explanation of emotional responding, to a

way around the seclusion room. Before talk of the labeling process is avoided, requesting help as a goal is derived as implausible and unintelligible, therefore a deviant way around normative reason. Mental health clients set goals, and they do so embedded in the constrictions of poverty likewise to others in fettered ecological systems, and a person becomes aware through a process of retelling that these goals misrepresenting wellness behaviors are not integrated of institutional systems, already in action.

A socially constructed institutional re-definition of socially expressed need, is what Bowlby (1973, p.138) calls mis-identification and interference by an active system, that is in collision with a mental health client's set determined goals, which is the suppression of not achieving talk, and second, realizing the created need as a cycle. This is incompatible with the first client's set goal as this indicates, the hospitals structural intent (p.138) as this is in-completion with arriving at, agreed upon social needs. The client then formulates a long-term pre-motivational determination and intent, to exemplify the seclusion emotional suppression theory, to counteract eruption and containment of expression, subdued with a tactful implicit posture, rather than be formally applied deviance to traumatic expression. These conditions bring forth low motivational searching for talk, indicating retained inattentive capability to express trauma as the first goal, and its attentive unsuccessful pressing urgency to communicate it, as the second, is unsettled with Maija. These capability constrictions and unrealized abilities exist just below the level of awareness, indicated by separating traumatic treatment items, with pauses. Another type of pressing, set goal that is limited in time, that is structurally brought about as Bowlby (1973, p.140) says, is followed by an intended mental health client's cessation of activity, conflicting with created reacting, as this can partially explain low affect and disorientation, in hesitation of utterance of estranged traumatic objects. This is incompatible with a client seeking a responsive, reflexive treatment plan, but client intended lowered affect auspicious, serves to deter the application of a corrective label, assigned almost any voluntary initiative, toward higher tier care.

Maija below is learning to adopt low motivational affect, and retention of expression, as a defensive measure. Maija demonstrates below, how the situation is not alleviated by asking professionals for help, and the extract illustrates that not withholding expression, results a growing awareness, of the created treatment failure. An opposite assertion of low composer demanding talk is met with a negative answer, from psychiatric staff. A request to speak is configured contrary to institutional norms, unintelligible and non-abiding to rule i.e. deviant. The need is bred, to increase the likelihood of a compelled search for talk.

531 Maija: ...and I felt I really need somebody to talk to, I could sort
532 of now need my support person to come to (…) so I went to the
533 office and I said that if I now at this minute would need a
534 person to talk to me for half an hour, is it possible. And I got a
535 negative answer. They said no.

A description of the inefficacy of the setting to recognize talk, becomes central (Line 534-535) secondary to the imposed lack of agency, to find help (Line 531-534). The institutional primary function to deny talk, and usher in problems in its absence constructed deviant, is made aware by the staff to Maija (Line 535) and the forthcoming auxiliary humanitarian function (Line 532,533) is dispelled. The yearning, needing, and wanting talk at the point of its absence are indicated by the pause (Line 532) that is brought out of suppressive inattention at the plan of action, to approach staff (Line 532,533). A pause (…) (Line 532) separates the formally suppressed effort, at trying to initiate support from a search for the helper. Unsuccessful beforehand attempts to suppress the need (Foucault, 1973, p.155) to share the experience with a nurse are followed by a pause (…) (Line 532) until set into visible motion. The pause tells of the unavailability of the help coming, a distant pause, and then Maija requesting help in recall. After the approach to voluntary care, the requests are denied and transformed into an involuntary rule (Line 535). Maija requests a voluntary confidential conversation (Line 533,534) as a therapeutic application of isolation, and is denied, as the seclusion is re-formulated back into an involuntary application of a deviant label. Maija configures a social aspect to the seclusion but cannot, and it retains its material de-valuation of care. This rejection contributes to the construction of an involuntary status, as it was a voluntary request transformed into a clinics compulsory refusal to talk, and to non-participate with psychiatric staff.

The first primary, functional, structural denial of participation is from the psychiatric staff: without explanation and agreement, it shuts down and transmits no consent to a client, in turn exercises denial of voluntary participation. Coercive paternalism is applied a person to whom agency is stripped of capability, after constructed involuntary status is applied, not necessarily under environments of efficacy, where participation is more readily recognized. Other times, it is a structural arrangement to over a longer period of time, "bleed mental health client's needs" by a lack of participatory conversation. To initiate a reacting to a refusal to talk sets into motion an involuntary coercion process, before a voluntary clinical confidential talk to prevent these things, could begin. The client must maintain ownership of a shared therapeutically guarded private, and agreed upon voluntary treatment plan of action, and if this is not permitted, its formal assisted refusal (Cohen, 1993, p.1029) can be made visible by the client. The seclusion emotional suppression theory states there is room to re-approach psychiatry again, with lowered calculated expression, before the refusal is transformed into compulsory force. The theory explores agitated expression of right and consent is minimized, and makes delicate opposition to involuntary status respectfully vocal, in order to protect self and others, from coercive labeling of so-called erratic conduct.

The seclusion emotional suppression theory explains, mental health clients can be aware of each other, and make presuppositions or avowals (Coulter, 1979, p.54) proceeding from conclusive end-of the- continuum cognition before, within, and long after the clinics seemingly exclusive outcomes intent toward seclusion. Clients can make antecedent motivational pre-decisions, to not ex-

press fear or anger that corresponds to concealment, before they are primarily re-fashioned to a created, conventional involuntary practice. The avowals (Coulter, 1979, p.54) of mental health clients to avoid or pursue, are pre-made in lowered silent pre-motivation in the face of determining forces, such as social institutions that are supposed to, but do not always, represent or guarantee human rights, consents, assisted refusals, and needs. This pre-averts, and pre-avoids through expectant low motivational mannerism, and moderate confrontation, the institutional socially designed pre-arranged, re-defined, manufacture of non-consent, right, and mis-representation of needs, as they are already established by the institution. This avoidant, re-directed composer maintains ownership of refusal and consents, to be used at a later time to re-approach psychiatry again, and through social acting, shroud anger and helplessness, that avoids the transformation into agitation and disorientation, and hope to drive self up to a higher level of care.

The seclusion emotional suppression theory insists low affect pre-motivation is in place, before decisions of inaction of agency are met, to offset social environments that are irresponsive, to a level of effort. The beforehand incorporation of antecedent motivational low affect socially learn disuse, from emotionally expressing confidentially to another person, relating covert manner of trauma and takes a pre-determined motivational stance to avoid talk, carefully formulating initiative steps to participate, after a careful analysis of how to avoid inefficacy in the setting. In addition, the seclusion emotional suppression theory draws an example from Coulter (1979, p.27) imploring that a client adopts pre-avoiding, pre-averting, and preparing an adaptive defense of the hospitals structural and relational establishment, creating adjacency of either deviance and mental health ascriptions or both, can be explicitly intentional (p.40) and presupposed (p.12). Logically as an institutional function, they pre-decide a client away, or be weary of confrontational insistence to demand confidential talk from a hospital. Among this vulnerable small proportion of the population, seemingly determined by the desolate structure, they become aware that needs and rights are not recognized, rather re-defined by the false justification of deviance, as a primary institutional function. If seclusion is an exclusive outcome, determinism of the structure, is bound with cause, effect and re-directed consequence of clients actions, and it is made pre-aware among the human species, to simply not respond to becoming conditioned to excitement, over or under-stimulated to reactive action, and enact emotional in-expression. A client therefore avoids an imputation of mental health and deviant labels, to ordinary problems with living, until a later time where excitability, channeled by balanced affect, is met by higher tier help.

Rules or law in the pre-seclusion area, for example are not constitutive of client's ordinary use, and comprehension of simple everyday conversation is withheld, and only be exceptionally (Coulter, 1979, p.45) granted, like acknowledging a request other than a psychiatric staffs silent return to a clients expressed need to talk, that elicits an outburst. There is staff to client transmits no return, to expressed non-consent around a locked door, suppression in its re-

membrance, and explicit rules in the visible construction in the inpatient setting regarding restriction. Association with publicly visible trauma of isolation is prone to be mis-understood, as agitation or disorientation. Avoiding this, relies on the client practicing self-restraint from social expression, and a form of self-suppression in order to avoid emotional lack of containment, the seclusion emotional suppression theory conveys. Clients then view their problems of life more so commonplace and visible, not held privately by self, but social, apart from the original open efficacy agential ideal version, once shared with the professional.

In the next extract, the insistence to talk after a long time of suppression creating low affect, finds a support person appointed, and a re-surfacing opposite effect of the suppression made talk more expressive in the interview, and in recall. This can be dangerous, because hesitant talk and making requests can result in seclusion. Maija indicates by an implementation of the seclusion emotional suppression theory that talk can be withheld, in order to later account more value, to a helping interaction.

536 Maija: They're not looking at me, they're not connecting with what
537 I'm saying, and they dismiss you the minute they find a way to,
538 and this is the experience I had? Of the staff so throughout the
539 ten days I was there, I did not feel trust with any of them,
540 although once I was appointed my own nurse I talked quite freely
541 and quite abundantly with her because I had just a need to get it
542 all out, (…) her job was to see that (…) feel like this was the
543 kind of person I could turn to later on.

Communicating the lack of connection (Line 536) and being dismissed (Line 537) pleas for talk are counted as unintelligible and irrelevant by staff, and detached and de-void of an interactive experience (Line 538). Suppression of basic need to talk arises from peripheral inattention, and notices centrally that the staff is not looking at Maija (Line 536). Social interactive needs are stripped, by the hospital as a primary function (Line 539) to be re- defined at a later time. Two frozen lapses preceding and following the recall of trauma expression, a description of the nurse has separated and suppressed the client from talk or "getting it all out", as the "nurse's job" (Line 542) until a later time, indicates awarding the partnership, as a secondary auxiliary function, of the setting. Maija's experience tell (Lines 536 to 539) of enforced emotional suppression (Lines 540 to 543) speak of expression that is gathering momentum, due to the release of the emotional labor of the suppression, that could pre-motivationally contribute to becoming more effectively careful in the telling, in the untold future. The communication of Maija's feelings has been suppressed by a frozen lapse, preceding the description of "emotions" that the client is recalling (Line 542). The pauses separate and abandon the disconnectedness of emotional expression, and client collaboration with the job of the professional. Finally, after being dismissed quickly by multiple staff members over the course of ten days, as the institutions primary function, Maija recalls one encounter where talk was

permitted, although the combined collaboration is replaced with a second pause on (Line 542) indicating an absence of mutual current action, rather a hope to deploy low affect and no emotional expression, in future interaction in recall.

The description of staff not looking, connecting (Line 536) listening, being dismissed (Line 537) as an ascription of unintelligibility, and lack of trust (Line 539) brings forward, a past recalled pre-motivational disposition to withdraw talk, a low motivational rejection of the effort to be heard, and a collective awareness that expressiveness will not be recognized (Line 538) by a quick dissolving of motivational involvement of elaboration, by joking. Even though the suppression lasted 10 days (Line 539) and beyond, Maija has been rising into opposite, emotional elaboration, as a result of the suppression or former inhibition that did not surface in agitation, rather made freer the client speaking (Line 540). An awareness to dispatch the pre-motivational decision, to attempt to reapproach therapy again is voiced (Line 543) stipulating increasing affect performance at withholding speech for a long time, until that need is acquired, reformulated into talk with a nurse. There is lack of stability and confidence expecting to see the nurse again, at an in-indicated time (Line 543), as this interaction happened once (Line 540) in the past, and the example is not posed, as happening frequently.

Fear of asking for talk ascribed an unintelligible label by, "dismissing what you say the minute they find a way to" (Line 537) and consequent deviance label, Maija has compound intensive obstacles, in this social environment of inefficacy, for instance, hidden to visible problems in their primary ecology, which become long-term life struggles that complicate life. However, among the so-called vulnerable this can create strengths, of compensations endowments that resonates amazing abilities, to identify and endure inefficacies in social environments, in the mental health clients' defined social reality that are contending for social power, and can be a challenge to authority, to whom defines agencies chances negotiating the social reality, and must be taken seriously. The opportunity to learn from mental health clients cannot be missed by professionals, as we must start from where the mental health client is, and attempt to understand much of what is already ascertained as convention, and normative of our own position of advantage, in the way of proposed open efficacy around the room, can be considered opposite and inconceivable to clients own subjective, and others' objective social reality. Heise (1988, p.267) says that judgment of unintelligibility like by "dismissing you"(Line 537) can result of an analysis of open or closed settings, and their reflexive navigation of mental health clients agency, for example is intrinsically social.

Clients find lack of immediate, realized agency in therapeutic help, and are more so accurate in identifying expected uneventful emergence with closed settings, where clinicians are typically not intuitively receptive to external evaluations, of stripped agency and unaccommodating efficacy as a primary function of the setting. It involves a comparison of minds in which one is treated as authoritative and the other deficient, as the judgment is relative where each

party is certain about own validity: one is sure that the other person is wrong where the thinking of one party is reified, and the thinking of the other party is stigmatized, and the selection gets settled in a contest of social power, where the loser is subject to social control. This becomes a competing world view, among clients and staff depending on the absence of client participation, to reinforce what is normative to a deviant assumption, which is seldom questioned. An example of this is the difference between claim of ownership of consent, and refusals at each step of treatment, professionals recognizing refusal in involuntary status in settings of inefficacy, reaffirming or declining consent in voluntary settings in settings of efficacy, and not assuming each status implies permission to treat. It is important, that a client's consensual status is not the sole excuse that treatment failures occur.

Primarily, little to no social worth transformed into material value is attributed to clients' talk, it is affected by suppression, to take an active part in the comparison of minds; it is interrupted by the seclusion process, where problems with treatment residing in failings of individual sufficiency, are substituted for building further exceptional intellectual strengths. Heise (1988, p.270) also contends that psychiatric professions aim, to maintain a reasonable balance between the breakdown of social commitment, and to define the limits of individuality as a belief system of social value that only presents one perspective, that points to the direction of what society, considers valuable. Heise (1998, p.270) presents that factuality is not part of the diagnostic process, rather a judgment of falsity is part of the control process. Delusions are mental constructions about the social environment that are so egocentric that they have no social currency, but also important is the value the psychiatric professionals hold when they take no position in competing knowledge systems, and deem any challenge to this to be of no social value, that supports what Heise (1998, p.271) calls the person's thinking, not using falsity as a criteria. The value of judging delusions by way of labels, takes the quick way out by primarily taking away authenticity, from what Heise (1998) calls mental health client reality. This increasingly relies on the opinion of psychiatric professionals, to ascribe more deviant aspects to mental health clients that are rejected by clients, residing in clients externalizing statements of inefficacy, around the room. This assertion assigns devaluing of agency, social institutional increase of wrongfully attributing infractions to self-responsibility, and increasing refusal of society to provide service allocation as a primary function of the institution. Primarily taking away social value by not listening or interacting much with a client, and taking away any credibility from what a mental health client says long in advance, in the presence of and withstanding most of anything they say and do in the future, is already established and unquestioned in the labeling process, configuring cognitive rule.

The differing value between psychiatric professionals and mental health client's opinion of an environment's efficacy, such as the area around the seclusion room, is the case, as the psychiatric professional's views of the social reality as an advantageous "equal playing field", can be most often presented as unfalsifiable and normative. These rivaled contentions become aware in a client.

The suppression seclusion revolving door process can enforce primary dictates by psychiatry and nursing as a control process, also presenting freedom of responsibility, and reflexivity to modified behavior, in the pre-seclusion area as un-falsifiable, rationale and normative, reflecting commonly held belief systems that suggest, seemingly, no such thing as social inefficacy to able agency. Maher (1992, p.27) argues that the assessment of the plausibility of beliefs, such as efficacy in an environment, is typically made by a clinician, on the basis of so-called common sense and understood as normative. These claims are not made on the basis of a systematic evaluation of data, and it increasingly points to degrading public language, reluctant to provide allocation of scarce resources, and their supervision. Clients hold, constricted environments to be closed to exertion, and insist this be true for just about anyone and socially share this with others, and regard it as un-open, from anything other than from a group identity perspective.

With regard to pre-existing assumptions of implausibility as a primary function of the institution, Georgaca (2004, p.90) says that there is a contradiction that on the one hand, the implicit assumption of the diagnostic criteria for delusions, is that such beliefs are un-falsifiable. On the other, mental health clients' claims of an environment's inefficacy are understandable. Clients may not adhere to rules of rationality or correspond to some external reality, but draw culturally shared systems of understanding (p.91). It might be already understood, and pre-decided that clinicians accredit more social and mobile value to the normative explanation of delusional speech, than the madness scripts itself. If clinicians normatively devalue eccentric conversation, they might act to become aware of conventionally accrediting its "official" diagnostic explanation, equally less social value. Soyland (1994, p.119) writes that psychiatric professionals make accounts of mental health clients that range from passive, which involves some specific psychiatric label for a type of person, and a second kind of account that features more social and personal information. The second kind include beliefs such as desires, stresses, or social conflicts depicting the mental health clients as active agents, without a psychiatric label, that come closer to assessing client ecological systems. Soyland (1994) also says that depicting a social account, is used to justify the necessity for using a bio-chemical account, and what is missing is what actually happened to the mental health client, and the term chronic is used as a negative term suggesting the mental health client is resistant to treatment, that in itself is a well-defined label. Barrett (1988, p.291) explains that in order to accomplish integration between the label and the person, the diagnostic label pervades the total identity, of the mental health client. Barrett (1988, p.292) also insists that the primary transformation into a labeled identity, is required by the staff to replace the social identity, which disregards where the mental health client is as a whole, including a separatist account of humans as unintelligible, and an individual ascription resides outside of a normative group absent, or apart of homogeny.

Foucault (1974, p.152) says that so-called abnormal people are socially constructed as individuals to be corrected. Further, whether a person can be

subtly, informally, dismissed and disciplined is discovered in this study, to be dependent on a primary expedient demonstration, that the person complies with an individualist value system within social efficacy, with little other explanation. There remains a question whether mental health clients, can be primarily constructed toward a self-identity, grounded in failures of agencies responsibility, and self-reliance rooted in deviant correction away from social identity, around individual labels pervading mental illness, deviance and recovery, by visible isolation. Social institutions enact incidences extracting plausibility from cries for help, from this population one client at a time, separate of own recognition, of socially sharing experience of disease and recovery. This enforces compliance along a compelled collaboration between psychiatry and nursing and the labeled individual, rather than from a client social perspective. Another purpose of this study is to understand the clients' meaning, of the constricted social reality as in-efficacious, as these assumptions form the basis of clients understanding of the social environments external reflexivity, to individual agency and responsibility, and forecast accommodation level of effort, governed by pre-motivational low or high affect.

Awareness of the hospitals primary function of creating punitive care, among the most impoverished mental health clients, motivationally postpones eruption of compromise of level affect, that's explanation may be saturated with an overemphasis of individualism, over- medicalization, criminalization, behavioral, neurological, and biological pharmaceutical ideas, of treatment and illness. Identities of clients in this research are ordinary human beings, voicing genuine problems with treatment. Seclusion is public social control disguised in the name of helping people. In closed and open environments, inadequate treatment is emphasized more, upon the capability of individual clients, and from the incapability of groups of clients to conform in settings of inefficacy, in formulating treatment outcomes, for example. Individual therapy primarily imposes "normatively", of failures of individual responsibility, based on its failure to define itself in the face of social identity and clients cultural competency (Rivera & Erlich, 1998, p. 2). An assumption of an opportunistic, advantageous social setting affording wellness aids in the definition of the so-called bizarre external reasons for emotional containment, in in-efficacious environments that challenge conventional notions of blaming the individual, for poor treatment outcomes. Normativity of individual's conformed conduct presents itself as un-falsifiable, and binds itself apart from the seemingly collective eccentric social expression of trauma, sometimes clinically or culturally contained.

These ordinary (Antaki, 1994, p.1) common, taken for granted assertions are seldom questioned otherwise, and quickly explain away and silence critical examination of social institutions, creating the irresponsible unsuccessful client as non-deserving, and producing lack of services, even among the once deserving poor. These normative claims of mental health clients, cast underway the social institution to not recognize human need, consent, assisted refusals and right, as a primary function even though the client is endangered by beforehand visible poverty of efficacy, by visibly and publically vocalizing socially ex-

pressed trauma, respective of perception of lack of agency. Trauma that is not visibly presented is relevant to the mental health patient, as hidden social explanations of illness and trauma are unaccounted for, held apart from items of diagnostic criterion, and social philosophical explanations of reacting to poverty are callously construed, as deviant explanations. This exists partially because relevant social expression in the therapeutic alliance is taken, and a complete explanation therefore absent (Sacks, 1992a, p.588) and cut short, by hesitant construction of the cognitive in-corrective.

Finally, individuation is a step in the process of enforcing and labeling personal responsibility, to social constructed labels of deviance and mental health, and is interested not so much in the un-reformed aspect of behavior, rather the destruction of social manifestations of consciousness, as combined social expression. This suggests it is an inconsideration of material value of therapy by way of coercion, because among this population no real long-term value can be derived by clinicians, because of its emerging downward mobility of deserving patient's impoverishment, but by withholding talk a client, retains talk's social value. Maija received infrequent long-term therapy as an outpatient, and this seclusion revolving door process in order to deny it, surprised her. Therapists engaged in clinical social work research, can work with the profession of nursing and psychology, who have predominately waged a medical behavioral model of treating mental health clients, to make aware the importance of clinical training in biological-psychological-social cognitive talk therapies, among vulnerable populations. Clinical social work research can suggest abandoning involuntary work, and recognize voluntary consent, assisted refusals and genuine participatory treatment among clients, that have encountered the traumas of this socially constructed, compulsory "treatment".

4.11. Discussion

A goal of this chapter is to explore both clients socially constructed, and evolved emotive pathways (Mallon & Stich, 2000, p.133) of social expression, and further study the absence of social attachments (Bowlby,1973, p.138) indicated by pause suppression, both as a current mental state and structurally created (Holstein & Gubrium, 2008, p.355). Emotional composer enacts an opposing strength, from emotional excitability to pre-motivational moderation, to formulate bias about social consciousness of no individual fault for insufficient care, as a primary function assigning unintelligibility, deviance and involuntary status. This new awareness develops client's strength, to resist structurally created deterrents to participatory talk therapy models of recovery. A primary function of the institution, by way of failure of achievement of self-sufficiency, first submits to the client's self-identity, a temporary auxiliary deviant label. It is vital, to understand client's rejection of psychiatric normative conventional assumptions of deviations to open agency, integrating environments of efficacy, and find clients demonstrated ability and mutual combined social awareness in

other clients, to challenge normative assumptions about being held back by constructed incapability, even in recall. Descriptions of inefficacy, in recall produce pauses around traumatic words. It is integral to explore how clients' social identity guards, against the alleged labeling of non-corrective, non-reformed diversion from individual responsiveness to institutional rules. It is my duty to briefly explore how involuntary status is constructed, within the inpatient setting. It is important to examine how the area around the seclusion setting, is primarily ascertained by the institution as efficacious, and by clients as inefficacious, both clients in the setting and its functionaries contrasted with each other. Clients and their caregivers are competing for rational explanation of fault for perception of lack of agency, in the only presented seemingly favorable treatment outcome.

The seclusion emotional suppression theory suggests, researchers can explore how a mental health client develops before being on the scene, or on the scene, a subjective then receptive to others combined antecedent motivation, to rest in low affect in-disturbance, and create own pathway to avoid a coercive psychiatric encounter, well before seclusion or hospitalization takes place. Avoiding the inpatient setting, a motivational pre-decision is enacted to carry out a longstanding, very strong dispose, withholding conversation of trauma content, due to self-suppression ensued by the setting, that is agreed upon by combined acceptance, and carried out as an intention (Tuomela, 2005, p.349). This is presented by Maija following through a social process, in recall of a past common experience in the inpatient setting, with other clients that tells of a social value of being aware, of collective external statements of inefficacy. These shared meanings of inefficacy introduce reasons to demonstrate to others, the clinics created non-participation, even though the client is able, willing and independent to exert choice. Freedom to exert choice is unrealized and unrecognized due to low levels of social environmental responsiveness. The clients determine the best adaption is to conceal expression (Richards & Gross, 1999, p.1033) to avoid coercion. This antecedent pre-motivation to avert provocation and not emotionally react can be all present, throughout the inpatient setting, preceding a manipulation of fixed social conditions. Clients become increasing aware, identifying externalizing statements about the clinic creating of the functionally weighted setting, coming into an objective social awareness of other clients, equally as aware of the silent plan of action, to transpire inefficacy. Social learning between clients includes descriptions of like others incapability to navigate in-efficacious settings, and its closed projected evaluation in remembrance formulates bias (Webster, 1993, p.270) of a client, of the futility of expression where it is unacknowledged. This bias insists no fault in non- maneuverable settings, establishes avoidance of unfavorable outcomes by withholding talk, precipitating a seclusion episode, and is signaled by long pauses interrupted by traumatic content.

The seclusion emotional suppression theory can achieve a researcher's awareness, that clients can simply generate the opposite, opposed (Wegner,1994, p.34) emotional expressional regulation counteracting motiva-

tional affect, of what the social institutional construct produces to regress, into agitation and disorientation. This allows the client by pre-decisive motivation, not reacting to scarce environments. The seclusion emotional suppression theory further suggests, antecedent motivational disuse of expression empowers self and others, to not allow rights and needs to first become re-defined by the hospital, by becoming aware and refusing to want and express need to speak, what the clinic cannot wholly provide, over the lifetime course of illness. Social expression is structurally contextualized as deviant, in the open area around the room. Problems of living need not be re-defined with psychiatric labels, and with social awareness a client can come to understand pre-motivational avoidance as an agency, defeating coercion as a common solution. The self as social then arises out of secondary subjective awareness, to strong primary identification to reject imposed labels. Then clients embody long-term visible communicative social opposition to coercive methods, socially constructing declining recognition of human needs, further creating the re-generation of seclusion revolving door.

Theoretical Considerations

There are pre-decided external reasons (Williams, 1981, p. 107) for intending these colliding goals (Croyle & Sande, 1998, p. 473) partially explaining, the processes of Maija's withholding talk, and the social institution's positions. The sensitivity to inefficacy forcing clients to intentionally hold back talk in unfavorable social conditions, through emotional self-restraint, override the structural constrictions created in the inpatient setting. These constrictions attempt to exacerbate agitation and disorientation and create suppression, when and where social and confidential talk is called for, in order to protect a client. There are social institutions in place, that already pre-establish penultimate, structural functional, and distant social relations rooted in conventional constraints, labeled in ordinary talk. These unequal social and dis-advanced structural relations are normatively required for the creation of non-recognition of voluntary consent, that placate disobedience among human beings, in order to rationalize, reinforce and reproduce deviant and unintelligible assertions to clients spoken health concerns. These may be structurally established, and do not rely on interference in interactive social relations, but on no or little one-way directional ultimatums such as an announcement, or its absence of rules, to attest to created failure of self-responsibility.

Many motivational actions, in-actions and reasons evolved into people derived from the fashioned deprived social setting, seem non-normative. However, they are reasons of human beings that fit above, and beyond the level of expected affect style, to immerse into of the objective social world, where poverty to free rein of movement and resultant trauma, is socially and spatially designed. External normative reasons (Dancy,1994, p. 9) explain to an individual, then groups limited agency to shape outcomes such as this, contribute to explanations of comprehending motivation-encompassing reasons by way of an agent, Maija for example, becoming aware of other client's external normative

reasons of beforehand, situated and in retrospect, surveying settings of inefficacy. A client develops social awareness by becoming acutely sensitive to sociological-environmental surroundings impact on treatment outcomes, and determining level of agency and combined agency to transpire, and rise above these fixed obstacles. This justifies to the client then like others, to not wager costly effort to meet it, without withholding expression, sometimes by simple observation alone, that can be the knowing and speaking of the social construction of agencies collision with the un- abiding, unreformable labels, attributed to ordinary behavior underway. This provides goodness of fit with past experience, and makes a person more aware of others demonstrative accounts of inefficacy, and similar able ability, the coming obstacles that apprehend uncertain ethnographies and structural locations in the same way. Mental health clients comprehend social roles of illness awareness in other clients, in what can be a misrepresentation to contemporary society visibly, of an individual's opposition to scarcity, and what is temporarily hidden and suppressed of clients, labeled as a psychiatric or social disturbance.

Blame for a client's lack of conformity of adherence and in-corrected to compliance, is immediately reduced to an explanation of individual fault and lack of effort, within social efficacy in maxim precept. Visible mobility, due to a presumed unrestricted or socially efficacious social environment responsive to human agency, is commonly assured as normative, and often unfalsifiable in dominate social ideologies. This normative inference in public language, affects a population of people and the psychiatric professions, and in the absence of a lengthy explanation of inefficacy, comes an overemphasis on failures of reform based ideologies of individual responsibility and attainment, compromise to self –sufficiency to emotional containment, cause for unfavorable outcomes. Maija exhibits the seclusion emotional suppression theory that assumes silent reasoning, to withhold expression produces social awareness about external conditions. This awareness depends on subdued pre-motivation that is already present in the mental health client, before the awareness is expressed in an exhaustive, angry or helpless response. The social setting compels the pre-assumption that these external reasons for withholding emotional expression, affect pre-awareness of little to no choice environments and social inefficacy of other clients demonstratively, and receptacle to them, in the same way. Clients assume visible, not necessarily mutually communicated shared agreement of the comprehension of external reasons for disuse of expression, pre-determining communicative inaction requiring the client to pre-decide avoidance, and sharpen maneuverable tactics, toward destitute conditions developing learned helplessness. The seclusion emotional suppression theory derives an example from this pre-motivational position that develops socially shared external reason statements, about communicating becoming aware of the clinic, creating the reacting in the stranded setting.

Clients testify to winning over the learned consciousness of another client, and confirming incapability to refine behavior due to un-open environments, before bargaining hard earned motivational effort, and re-directing that emo-

tional labor to composer. The seclusion emotional suppression theory dawns dissension of predicted activity into non-participatory exhaustion, predisposition of disuse of response to cues and reacting, readies the client to premotivation to terminate agitated exploration quickly. Long-term strengths of the client hold fast that emotional expression will not be acknowledged, demonstratively in systems of inefficacy. Low affect can shape a poor outcome, and poor outcomes can shape low affect. Low affect acts in context with a trying environment, as the person is reluctant to explain or persuade other than from a collective identity (Tuomela, 2005, p.349) all withstanding the harsh objective external conditions. This process of discernment of the impact of the environment among professionals, comes less quickly. This comes with a learned awareness of structurally created lack of adherence, concocted as involuntary non- compliance equipped with a protective, preventive strength of pre- motivational lowered affect preceding refusal, avoiding the first hospitalization.

The seclusion emotional suppression theory silently serves social learning in another, and jointly carries out (Tuomela, 2005, p.351) conspicuous expression of trauma and actions, to carefully re-approach psychiatry again, under different circumstances, to avoid the constructing and labeling of non-consensual behavior. This avoidance is devoid of capability to behave according to absent rule, therefore withdraws, motivationally pre-anticipating the next coercive encounter. A client rejects the re-definition of stigma from failure of agency, in little to no choice environments, to emphasis social responsibility, in a newly established symbolic interaction, depending on an ongoing evaluation of cost benefit, risk exchange likelihood versus unlikelihood, that the product of effort is realized of individuals, within unprolific social environments. The constricted encounter simply does not have to occur, or incur at all, and this awareness can be in the first place, during, and after experiencing substandard treatment and over a long-time held, as pre-motivational persistence to reject poor treatment outcomes, attested to structural deterrents among long-term clients, as suggested by the interview of Maija. The seclusion emotional suppression theory is beneficial to both involuntary and voluntary patients, as both struggles with high and low affect enabling capability before and within inefficacy, that is more accurate to share an expectation of the impact of the environment, to shape a better treatment outcome.

A contradiction exists, that the elimination of restraint and seclusion resulted in saving a hospital institution's resources (Goldstein & Lebel, 2005, p. 1109) over a one-year period. The ongoing practice of restraint and seclusion can decrease the responsibility of the hospital system to provide beforehand, preventive, outpatient resources to clients and social supports during, and over the entire duration and lifespan of illness and recovery. Its practice over relies on re-defining eligibility requirements, to two tier systems resources for poor people, and degrading care for advantage, these interviews with clients indicated. Coercion may force hospitals to deny talk therapies, thus relying on over-medication, and unpaid damage to property, due to clients suffering agitation that might exhaust more resources, than providing basic talk support. Because

of the reduction of resources in preventive practice, coercive measures act as suppression of evolutionary, emotional expressive pathways of adaption, of coping within the uncertain inpatient world. Resistance is encountered, because many therapists' interpretations of the mental health clients' traumatic social worlds, transgress the bounds of normal illusion, normative or healthy denial, and healthy suppression. If trauma is suppressed in structural restriction of talk, the unresolved trauma intensifies in expressed, or unexpressed resurfaced opposite differential human strengths, including increased long-term suppression, or expounded, confrontational public expression.

A question still exists if the institutions illusion of social efficacy, and the sometimes shrouded, made visible expression of external lack of structural inclusion, is healthy in the interest of taking away material value among different social layers of clients, and at the same time unhealthy to mental health client individuals or groups. Clients can question how a clinician defines or redefines, listens, and re-explains this to individuals while often presenting open efficacy and the successful client as the only social process occurring. The institutional, functional, intentional, individualization process of the therapeutic community imposes dominant scripts of self-efficacy in the constricted setting that quickly draws inferences of self, but cannot readily elaborate about same social composition positions of advantage, along this same justification. The label suggesting non-reformed incapability to respond to rules, according to rigid non- maneuverability rationalization for seclusion, and formally marking opposition to this unintelligible, might be consistent with mental health group identity in lay terms. This does not seek to confirm explanations of "beyond correction"of the population that can be already attested in cognitive conclusion, in psychiatric terms as well (Rapley, McCarthy & McHoul, 2003, p.427). Incapability of individual responsibility relies on quick case examples, or sweeping generalized, standardized statements, grounded in bias eluding to open efficacy, and common agency mastering constraints. In the process of seclusion, clients hang on to social dimensions of identity, that relies on universal recognition of emotional disuse of expression that challenges the institution, that attempts to speak on behalf of those, whom it can fail to enforce silence.

In closing, the seclusion emotional suppression theory attests, there are deviant labeling confections derived from illness behavior, in dominate ideological assumptions alive in the awareness of the human species. Surfacing expressed common told bias of no wrongdoing in the process of seclusion equip a client, to precipitate an avoidance of hospitalization, in order to deter the seclusion-suppression revolving door. The theory assures, this client already attested decision exists as antecedent pre-motivational quick terminating motivational withdraw of action, indicated by frequent pauses, in trauma recall. As pauses indicate a retreat and advance in recalled expression, a person feeling stigmatized of departure from self-efficiency, pre-avoid, and plan to advance with low affect conducive manner, and high affect active calculative discrimination, demanding receptacle treatment, the seclusion emotional suppression theory promises. This prospective emotionally stature posture immersion into the set-

ting, takes back the definition of eligibility to key vital social programs, that they would be entitled for, or put clients in jeopardy, by reacting confrontationally in motivational high affect, to the application of stigma (Crocker & Major, 1989, p.608). The theory teaches these avoid and approach expressions, are manifest in passive or aggressive opposites, due to structural and self-suppression balancing a neutral affect, carefully guarding against a rebound or "boomerang" effect of dull to eruptive affect, through the regulation of emotion. A beforehand, complete avoidance of the inpatient setting is a means, to escape normative public stigma, associated with ill and deviant labels, until a client re-approach to the therapeutic alliance, brings the clients confidence and trust.

V CONCLUSION

5.1 Theoretical Findings

Assessing the entire project, I undertook to pay strict attention to what mental health clients were saying, in a place where decision making capability is hindered, and a client is placed against their will. It is my hope that future researchers and practitioners will more-so pay attention, to what mental health patients say. It was an effort to get the hospital institutions to regard this study, and the client voice as valid and reliable. It was an uphill battle against multiple blockades, such as the primacy of evidence-based service provider research regarded as the foremost value, and client centered research, commonly held secondary in credibility, to academia. The evasive nature of the hospital, and Ethics Committee or IRB (Internal Review Board) to hide all requested information on the part of the hospital, and prohibit a full inquiry of any documents of the institution over multiple years of time of waiting, was among the many barriers we had to overcome. It was a long hard effort, to simply put forward the project and client's voice with authority, in a place where maltreatment had been repeatedly confirmed, by the local police.

Revisiting the research question of the study, brings forth central exploratory findings, of how mental health clients process the trauma, in short- or long-term recall, when asked about restraint and seclusion episodes, as structural and social relational isolation. Client's testimony discovered, and specifically answered the six themes spelled out in data analysis, aimed to capture the client's perspective. The area around the seclusion room, contributes to low affect or agitation, external evaluation and rejection of identification with the hospitals re-defined problems with providing inadequate outpatient preventive care, current involuntary placement, and exclusion of talk therapies. When clients emotionally react to settings devoid of talk, and social expression is inhibited by the formal reaction of like others visible seclusion, the suppressive forces around it temporarily move a mental health client, to pre-motivational retreat, into low affective auspicious, and conceal emotive expression. Clients draw on

social identity, to fight against the isolation around the room, and imposition of the hospitals eliciting and labeling the consequent emotional reacting, in little to no choice constricted and restricted environments as deviant. This encourages more emotional reacting, as cyclical form of social control, to induce high agitated and learned helplessness, as pre- motivational affective states.

Clients also indicated in these recalled, traumatic descriptions resonate with pausing, bias of staff being non-reachable, and quickly closed down in the setting, serve to induce the emotional reacting by the unavailability of talk, provoke demanding talk in order to produce a problem, in which the hospital does not serve a primary function of service provision, but the primary creation of social control and deviant labels. Clients process this in secondary awareness of auxiliary labels of mental health rejecting the deviant ascription, as it is enforced by a subtle departure from individual self-efficiency, and self-responsibility. Clients defend themselves from their requests to talk, and forced medicine reactions re-defined as unintelligible and deviant resultant in seclusion and consequent lowered, suppressed self-report, to social acquiescence of awareness of inefficacy, the predominate impact on poor outcomes. Client's interviews reflected a healthy suspicion, and skepticism of being provided adequate care, therefore an avoidant, inactive pre-motivational retracting adaption to subdue emotional expression of trauma, suggested a preventive course of agential action. It was also suggested that clients become aware, that the hospital does create, and produce the emotional reacting as a structural function, in order to assign deviant labels to increase level of coercion, in order to shut down participatory talk, and create non-consent to construct involuntary status. Clients testify of this enriched with suppressive pausing, to reduce full awareness of level of trauma in an emotional regulatory, pre-motivational protective maintenance of affect.

In analyzing the data, I theorize the motivational consequences of withholding talk enforced by psychiatric staff signaled by clients pauses, highlighted in Chapter Three, is reflected in the recall of a professional denying care to a client and transmitting this imposed silence, by simply refusing to listen to a plea for help. It is integral to report this phenomenon, pointing to numerous findings underlying themes throughout the study, such as the unwillingness to alter an antecedent pre-motivational course of route, of avoidant adaptive prevention of psychiatric crisis. This solid pre-motivational apprehension is in biased opposition to the stigma of deviant labels ascribed mental health symptomology. The silent interactive social relation between staff and clients of withdrawing talk and employing forced medicine, is a functional institutional prerogative, to unknowingly provoke a client into emotional reacting, thus creating and reproducing seclusion episodes. These actions by staff are told by clients to be rationalized by a label of unintelligibility, attested to requests to talk. Further credit to re-enforce these themes, lies in clients' unwillingness to abide by self, and like others blame, attributed the individual for failures of self-sufficiency in social settings of inefficacy. The shared "We" common manifesta-

tion of experience, of the inpatient settings fails to provide clear rules to follow, in order to avoid the stigmatic labeling of a deviance attestment.

These phenomena appear in its analysis, to be organized around surfacing attempts, to emotionally regulate despair, sadness and anger of short, exhausted descriptions of seclusion experiences. This experience of client frustration resurfaces again in the interview recall, in extended opposing motivational expression and pauses of long-term retreat, before and after quick cognitive abandonment in inaudible, but visible cognitive explicable utterances of spite and joking, for example. Staff informally constructs unintelligibility, to the absence of participation, and cognitively diminish created non-compliance to non-consent within unknown rule onto the client in established involuntary status. Clients tend to emotionally react to this, by shutting down motivation to describe the recalled occurrence that reappears in traumatic suppression pauses long after the event, and telling of the event. They also are pre-formulating a motivational bias of anger and frustration of no fault unwillingly cast in the procession of seclusion, to avoid that cognitively shuts down description. The memory of denied talk is determined to speak out without negotiation, against seclusion in counteracted motivational determination, by resisting acting out with anger, because the suppressed reality fuels some inattentive regulated expression.

Clients are imposed to no communication by the institutional and social relational setting, and this can be transmitted by psychiatric staff to increase and extinguish motivational and cognitive systems of clients, to divert asking for help. Clients then move to conclusive termination, by shutting down motivation or expounding expression over the top of containment, by seeking out similarities in recalled like others behavior, in same settings. These surfacing expressions, and their attempt at submergence in pausing, are helpful at organizing the data, specifically to point to client's emotional description of the seclusion process. Limited sources of data are supplied, because the suppression of traumatic content and this can be partially remedied in a prodigious study, of low affect emotional composer.

In analyzing my role in analyzing the interview data, I wondered if when a client is closed to any consideration to collaboration, from a professional's or researcher's suggestion, in order to understand that professionals, as it is told by clients, may be unable to win clients over to our perspective of the social reality of assumptions of fluid agency, in this closed environment. This is important to determine a client's degree of awareness of level of agency and impact of inefficacy on proposed successful treatment outcomes. It was important for me, in studying the data to not consider any combined negotiation of an evaluation, of ability versus capability of navigating trying conditions, as an aspect of illness. Rather, a client's combined acute realization and awareness of the little to no choice social environment, forms a part of the objective social reality. With a former attempt to isolate a client, they are still motivationally reluctant, to describe reasons for silent regulation of expression, and these situated positions in recall were evident in analyzing treatment objects, interrupted

by pausing. In this research, it is integral to explore why communication of temporarily shutting down of long explanations, as emotional regulation about the inpatient area in recall, leads to present short pausing cognitive dismissals in anger. Mental health clients report staff non- participating with clients, coupled with the quick surfacing of an antecedent motivation to terminate to listen, and quickly conclude. The institutional terms and deeds located around the accompanying pauses, tell of what treatment needs have been formerly and further intend to become temporarily submerged in suppression. The absence of power of self comes to light, in explaining how clients reject imposed lack of agency and choice, in describing ontological understanding, of a driven environment of inefficacy.

These former suppressions are relevant to the client experiences, and rely on how they are being distanced from secondary to attentive focus of treatment objects. Reporting these findings are instrumental in bringing the patient back into participatory treatment. Low description of self in the situation resides in peripheral inattention, while central issues of inefficacy surface demonstratively as traumatic objects, as closed institutional pathways. The client's temporary inassessable attentive range of emotions do not indicate underlying disinterest (Shibutani, 1978, p. 411) because the clients actively seek participation in research, treatment and recovery. This temporary inability avoids the deviance assessment, moves to explain coming into knowing and further objective awareness, of suppressed items of trauma treatment, diminishing peripheral self-report. Mental health clients are quick to communicate shut down themselves, possibly because they are communicably withdrawn talk on the other side of the wall, on the inside of the inpatient setting, and how this is transmitted and resurfaces becomes important, to the analysis of findings of the data. The pausing phenomena is revisiting a memory closely connected with a setting that is a stranger to help, and this becomes a long-term pre-motivational manifestation commitment, to search out adaptions to endeavoring environments. A phenomenological process develops helping to understand the awakening an awareness of emotional regulation to deploy low affect, as a socially learned deterrent to seclusion. An evaluaton of the efficacy of the environment becomes central as the clients limits self -report of effectiveness of agency.

Clinical construction of divergence from self-responsibility cannot serve to answer with completeness, an external reason (Williams, 1981, p.107) for a client's emotional re-stringency. Clients contend the clinic contriving lack of self-responsibility to withhold talk as deviance, have been unsuccessfully imposed, as former causal external reasons for seclusion. These are rules ensued upon the individual that are constructed to not be able to be followed, or made to be broken to set the cycle in place. This constructs departure from individual responsibility, ordered conduct and agency (Rogers and Pilgrim, 1997, p.23) as deviance, and consequent client knowledge of reluctance of the institutional health system's social responsibility to acknowledge anything but primarily, a deviance ascription. Clients become aware that enforcing self-identity to create the disorderly, and to fashion unintelligibility, is necessary from the primary

position of the hospital, in order to make a person take responsibility for the process avoiding seclusion that is not their fault, and under which self-responsibility cannot abide by unknown rule. This is attempted and failed, by creating an emotional reacting due to lack of simple resources or compulsory medicine, then the formal reaction of seclusion; however it does not depend on the client doing anything wrong. They are unspecified rules made to emphasis lack of responsibility for self in an environment that assumes a non-compliant involuntary status. The reacting is visibly sanctioned implausible, and many times these rules can only be broken and the consequence implicated wrongfully, in order to create and supervise deviant upon mental health labels.

The external conditions in the social environment around the seclusion room, and in the community, threatens to indirectly create the need for talk, in order to create a fraudulent cause of agitated incidence. The consequence is seclusion, or more dangerous events such as criminalization, or death due to restraint. Clients can be endangered and at risk to be harmed, during and after the process is set, as this also contributes to the growing awareness of these external reasons statements, to avoid the fixed situation entirely. Other clients become receptive to be "clued in" by other clients, to the inefficacy around the room, and pre-seclusion settings cuing the insistence to talk, as indicated by the interview of Maija. The process of criminalization of the mentally ill is part of the social construction of reality. Clients are neglected of vital needs such as talk and medicine monitoring before and after hospitalization, placing them at high risk of seclusion and restraint, as an in or out- patient.

The seclusion emotional suppression theory serves to partially explain, how socially constructed pre-motivational exhaustion, and contributes to increased intensity of performance in maintaining conspicuous composer. This leveled affect is held fast in motivational systems, beforehand and long after application of the deviance label, by construction of agitation via forced medicine and unintelligibility by dismissing pleas for talk. Levied affect makes possible more specifically articulating self-selective and other clients generalized bias, to avoid talking to staff. This lowered affect preliminarily disvalues description of qualified agency and brings attention to features of inefficacy to provide optimal goodness of fit in exclusive settings, as a precaution. This bias of no self- fault for seclusion nor that of like others, predispose motivational drive governing disuse to expression, due to the emotional suppression theory as a current state, and governing trauma recall. The seclusion emotional suppression theory demonstrates, these low motivational pauses due to exhaustion may, rather than explode in agitation, develop into a medium, level opposite force that can carefully intensify precise navigation toward a request for talk at a later time. Clients balance increased performance of emotional labor, concealing emotional reacting. The methods of qualitative clinical inquiry allowed time, for the client to surface formally suppressed recall of traumatic items of isolation around pauses. Clients then found social attachment bonds in fellow clients, strengthening external reasons for identifying precise items in structural constriction. This furthered an emancipation of this dull, paused mental state

into cautious social expression, awareness of social responsibility of other clients, and brought closer the recalled traumatic event.

Traumatic pain silently endured in pausing, had already been reached to the point of helpless exhaustion and harbored anger in this data, and was unable to reach expressed help in recall. This anger presently and formally exists as a pre-motivational suppression of words, associated with the recalled traumatic experience. This in-attentiveness of traumatic content is used as a benefit to emotional regulation, unwilling to alter a pre-determined pre-motivational course in not reacting in emotional expression, as long as it is avoidant of the deterrent, the threat of seclusion. The expectation of further seclusion is ruled by bias to avoid by precaution to eliminate self-fault attributed to seclusion, and are signaled by pausing consisting of cognitive and motivational exhaustive refusal of reconsideration, terminated cognitive listening, repeating words, distanced cognitive waiting. This suggestion is closed to elaboration, and quickly concluded the misrepresentation of professional re-definitions of needs, actions, causes, consequences, and reactions. Clients are dispassionate of relating detail of agencies causal attribution of self in the beforehand situation, focusing on the inefficacy of the setting, a rationale for withholding emotional expression. In resisting these exacted labels to human conduct, the clients in this study are driven into contempt, and abstention from explanation, then exhaustion and anger in expectant re-engagement of the agitated recall task. Clients emerge into antecedent motivation as a low affect auspicious, to avoid and carefully advance recall of past and expectant, far reaching treatment terms associated with trauma, the seclusion emotional suppression theory explains.

There are reasons that are maybe seemingly irregular, that terminate client and staff participation, based on the consequences of withholding talk and refusal to start well beforehand, and look toward increased pre-motivational drive to covert emotional manner, to re-engage psychiatry later, under more favorable conditions. This becomes a shared estimation of social environments, embracing the incapability to enact choice among clients, well aware of the clinic creating the non-consensual and configuring non-recognition of able refusals, to participate in settings of inefficacy. This involuntary status of clients is discovered by creating indecision by inhibiting capacities capability, not ability of clients that extenuates externalizing strategies, for confronting inefficacy. This insinuation of non-responsibility to emotional cessation around the room is discovered to become a deviance ascription, and cause for seclusion. The conditioned attribute resides as a subjective secondary application of the label that is not accepted, by the client. Emotional regulatory adaptations to poverty employed by these patients is discovered to draw on a non-normative rationale. Lowering responsiveness to clinical evasiveness can draw on reasons to avoid, are considered by clients, to be in-ordinary about an erratic setting based on assumed mutual help. These human beings affected by poverty of freedom of movement, and restricted trauma expression, are strongly equipped to have endured these common social conditions, to more accurately identify them, con-

firming own and others demonstrated held back ability, by structural constriction.

A client's adaptive rational in the abstraction of memory, emotionally distances, and delays objects associated with trauma treatment, and describes these in attachment, and detachments in recall. In this study, mental health clients regard talking and collaborative participation as a social need that is beyond reach, and in an institutional setting their needs become socially constructed as behavioral problems, that are enforced with psychiatric seclusion. Individual personal agency adapts withdrawal and low affect, and incorporates emotional regulation to specify trauma objects, saturated with the intensity of suppression, describing seclusion indicated by before, and afterwards pauses. In recall of the event, the mental health client changes self-monitoring and self-focus, and because of exhaustion, anger and the emotional labor of withholding expression of a lack of human agency, they attribute avoiding, resisting, and rejection of imposed external agents, to be an effective pre-decided course of action. A pre-decided rationale to reject institutional solutions includes avoiding seclusion, and talk therapies for a while. This solid pre-motivational bias, rested in presumed allocation of closed structural pathways, becomes an antecedent motivation that reduces the labor of exhaustive cognition of description of self in situation, and indentures emotional regulation formulating avoiding in exclusive environments, as an agent of change.

Interviews at the clinic, eliciting responses to an assessment of this restricted social environment, reluctantly produces pre-motivational exhausted, quick abandoning cognitive statements of confinement compounded with pausing, sudden stopping, and total incapability to utter a word as reasons not to pursue alternative agents of change. The motivational low affect maintaining cognitive skepticism to consider the hope of talk, helpful at best are presented by mental health clients as hypothetical, hopeful futures expectations, and distant past brief encounters without much commitment to them. Looking forward to the opportunity to talk, remains unanswered as an uncertain pretense of estimation of waiting time, and its enduring cognitive labor in expectation of time passing, when this will be allowed. The object of sought help not achieved in inattentive focus, resolves after a long pause to central attention in visualizing prospective events, when talk can be attained or anticipated. The seclusion emotional suppression theory presents client's attributions of past and present exposure to these coercive treatments, amounts to developing a motivational rationale of pre-decision, to reject and refuse requesting external help. Endured suppression in the past aids expounding over top of emotional containment articulating a specific socially defined place, in deciding what kind of treatment is best in combination with a re-approach to psychiatry and nursing. Maija demonstrates how a client succinctly develops better self-initiative in projected opportunity to request to talk. As recall of an uncontrollable outcome increases, motivation decreases into low affect, and personal agency evaporates. Seeking alternatives, mental health clients draw future unstable hypothetical sugges-

tions apart from present help, sometimes with stronger commitment, due to the release of the effort to contain composer.

Deterrence relies on a pause, in order to assess the avoided consequences of the possibility of seclusion in recall, and its averted prospect for self and others as central socially learned adaptions to the setting of inefficacy, the clients indicate. The pause represents as peripheral self- report around central items of the deterrent, contributing to the avoidance of the seclusion. Clients are aware they are secluded for talking, and avoid emotional expression that can be acquired through social learning. In the constricted area, according to the mental health client who had never been secluded, shared perspective in recall of the estrangement of staff, is accompanied by a long motivational pause, existing after the utterance of the definition of the treatment object, as the word "seclusion". Suppression before and after the word "seclusion", tells of a learned, present mental state of deterrent fear. The pause time in communicating memory may be a temporarily traumatic setback, a perspective as an alone individual, and is relief brought to the conflict of isolation to the "I" identity. Then a "We" identity becomes a social strength in memory recollection, aware of other client's low mannerisms to dispatch in recall and in anticipation of the social conditions they face, until the end of the interview.

It is important to point out that these are not inconsistencies drawing on the specifics of a seclusion event, and may not be events in the past because of the long-term effects of suppression, but a current long-term future pre-decided mental state. Recall develops a pre-motivational disposition that dismisses any clinically placated fault describing before or during events in retrospect, because the coercion is traumatic in the re-telling. This trauma, along with total suppressed incapability to retrieve the word (my) "needs", made visible before and after pauses, indicates departure from participation that can be constructed of the isolated setting. This suppression of needs, act as a motivational rationale, to disregard any future alternative to a seclusion episode as avoidance, and moves to not persuade, terminates specifics of the setting of inefficacy around the room. Reasons for seclusion constructively suggests the bearing for responsibility for the seclusion wrongfully rests partially, with failed agency and neglect of self-efficiency. This rationalizes the client's clinical assignments of deviance, attested to requests to talk's insistence, culminating in redefinitions of agitation and disorientation, via reasons to seclude that the clients later reject fault, in retrospect. "How to act" or how to incorporate low affect composer, is socially attained from memories of shared, similar action of others within sparse conditions, devoid of interactive social relations.

5.2 Reflection of Findings

Client's emotional regulation of frustration and anger in recall, surfaces in learned helplessness, and an outburst or reacting can happen that is met by institutional sanctions answered by seclusion, and the mere threat of this, rein-

forces its suppression. These freeze pauses around traumatic content, are communicated by a temporary inability to self and structurally suppress these human expressions. Unexpressed anger emerges as emotions such as visible sadness or crying, that can create visible punishment, because one can be secluded for talking, which can be widely known to mental health clients. This socially learned knowledge to conceal emotion, is employed to avoid normative castigations of clients conduct, according to a conventionally and client held system of stigma, clients indicate. Mental health clients regulate negative emotion, and adapt suppression of rage for example, as a mechanism to avoid the visible consequence. In extrinsic emotional regulation, there is a considerable amount of cognitive labor to conceal expression, and self-suppression that can create long-term negative consequences, especially under harsh environments. Inauthenticity in respect to displayed or hidden affect noticeable in pauses, create contradictions in the way a mental health clients' resurfaces opposite emotional affect, and this increases dissonance so one cannot show spontaneous affect, and this creates dissatisfaction over time, that is really inconsistent with evolutionary human needs, of social expression.

Marshall (1972, p.789) confides that responding to constricted conditions, creates the likelihood of increased negative expression, as the expected expression does not happen in a void. Rather it is regarded, defined, and labeled as a departure from institutional norms onto a client, when it happens under a different context, or as Marshall (1972, p.790) says, surrounded by attitudes, and expectations eliciting varying responses from the environment. The question is, who defines the varying responses, from high affect into agitation, or low affect into explicated disorientation, or rather formally reacts, either professionals with seclusion or mental health clients with hostile expression over a period of time, under a visible suppressive deterrent to talk. Once the negative emotion is expounded, the mental health clients do not acknowledge responsibility as the process insist rationalize seclusion, in owning or disowning agitated emotions. However, heightened or lowered affect serves a defensive purpose, in first self-identifying clients cause to socially expressed needs unmet that is coo-berated checking out this occurrence, with other clients in this data. These trying conditions also inhibit positive high affect expressions, of identifying a real mental health illness emergency to be constructed implausible and deviant, by the constricted environment itself.

The seclusion emotional suppression theory, helping to discover findings contends that assuming low affect when agitated, contribute to frustratingly pre-deciding immediate pre-motivational cessation of participation, of naming trauma objects. Low affect description continues to become aware of accurate external reasons that their own personal agency, won't likely effect change under exhaustive conditions, such as in the inpatient hospital setting. The seclusion emotional suppression theory asserts that the person then start to emit external reasons statements for avoiding, the inhospitable environment with increased renewed vigor and stamina, due to offense of the constructed non-compliance, as a growing shared manifestation among other clients. Christian-

son (1992, p.297) states that rather than show an impaired memory performance at states of high levels of emotional arousal like a seclusion episode, people retain detailed information from high arousal, exhaustive emotional states quite well. Easterbrook (1959, p.191) says that a restriction of the range of cues utilized during high stress, reduces relevant information or processing of external events, such as pausing around descriptions of inefficacy. The visible, cut-short low affect information voicing adamant derision with inefficacy, around the room are shared intuitively, among other clients, whom contextualized non-consent, and non- acknowledgement of refusals, had taken away capability to affect agential change, due to the constricted setting.

Retrieval effect of forgetting words, through prompts of scant settings in recalling assisted cues, result in total incapability to utter a word associated with trauma, delay, pausing, stuttering, sudden stopping or distancing words to cope with stress (Lazarus, 1993, p.9) in identifying trauma objects, in terms of regulated emotions. The seclusion emotional suppression theory points out that the planning to advance environments of high tension, tells that long-term mental health clients can acquire antecedent motivational awareness assuming low affect, to know enough to not seek oppressive psychiatric encounters, with ordinary life stressors long beforehand. Clients focus on awareness, developing external reasons statements for avoiding emotional expression revolving around trauma laden objects. Mental health client's exhaustive or agitated refusal, balanced with composer after roads of arduous conditions, offer social learning, and are keenly receptive to assist other clients in the antecedent pre-motivational deterrent by being simply physically and visibly present, in stature, stoic affect. Although a motivational pre-decision is not often fully conscious, it manifests itself due to the suppression of emotion in pausing that resurfaces in a more tempered posture to temporally offset the exposure to trauma. This results in a client taking a direct 180 degree turn toward facing trauma, to increase balanced affect performance, to voice cautious opposition for someone else's benefit.

Mental health clients may distance attachment with members of the helping professions in recall, as a present mental state. Detachment of relationships, can be contributing to an understanding of affiliation or the rejection, of dominant value's institutional-individual socially constructed denial, that directly reflect the macro world as the natural place of repression and suppression and, unnoticed or temporarily hid, is clinically brought to attention. Socially constructed limited human agency may distance external attributions, and might generate significant absences come to light, that recall the contexts in which institutions create the setting, around the seclusion room where suppression is brought to consciousness, and assumed and taken for granted as commonplace. The clients description in context can function pre-consciously, but under no social pressure might become conversation objects of focus, as the perception may be proscribed both by institutional language, or adaptive cultural strategies to withstand illness and poverty; they may be first unspecified, and then brought to self-consciousness in recall. The culture socializes individuals affect-

ed by social institutions to repress and suppress, and reproduces conditions of insecurity, crises, and denial as on-going. Furthermore, structural and relational suppression may create pausing, as self-experiences of trauma communicated in retelling an event of seclusion, and the trauma may have been suffered in the past, and require present significant recall performance and suppression regulation, in order to take time to retell its accurate description.

Aristotle has said avoiding previous foreseeable acts results in emergence of character, as well as helping to attend that to the social learning of another (Barnes, 1984, p.21). In addition, disowning a present negative emotion, for the purpose of avoidance of a foreseeable consequence, is discovered to make an agitated person, for instance, over time control or regulate continually weighing up and reweighing up the cost and benefit of displaying low or high affect, when emotions that have evolved to adapt are not compatible, with the socially constructed surroundings. An inner locus of control, and ability to emotionally regulate suppression over time, with persistent saturation of the stimuli or unresponsive setting, becomes increasingly difficult. The seclusion emotional suppression theory contends, emotional regulation of trauma has a temporary cost for the human species (Richards & Gross, 1999, p.1033) and evolution has prepared humans to exemplify to the socially constructed world, by equipping us with defenses that allow withstanding hostile environments over a long period of time, and with harbored expression, voicing opposition, avoiding them, and advancing carefully. Clients in this research, encounter external reasons statements (Williams, 1981, p.107) for terminating descriptions of inefficacy, that point to motivational futility in the exertion of individual agency, to accommodate trying environments. Stripped agency leads to proclamations of nihilistic expressions, accompanied by pauses, forced at the clinics attempt to derail clients social and agential capability to change, in order to create involuntary status, one client at a time.

5.3. Implication of Findings

I hope that these findings influence the abolition of seclusion, and bring about the direct practice of voluntary participation, by consistently checking, and rechecking status of assisted informed educated consents and refusals. Restraint and seclusion can be stopped and talk therapy models adopted before more public independent testimony of coercive practices, brings legal liability to the collaborative model of clinical social work and psychiatry. These combined disciplines can be among the first, to bring clients into a partnership with the therapeutic alliance rather than coercive treatments. Trauma expressed of the revolving door testifies of failures of this partnership, and failures of treatment deception, because a person can be exposed to an environment as a structurally induced experience absent of talk, in one given time and still hold these mental states, and immediately become expected to act differently, according to a different context. The danger is to drive a mental health client into agitated disdain

of expression, in one clinical closed context, then a failure of cognitive containment and motivational confrontation in an open site, and a fatal coercive intervention, results by restraint. Containing contempt and scorn, created in the setting has its own rationalization, as it balances re-emergence of silence, and expression. Anger can balance the low affect auspicious, and may reduce the cognitive expenditure in doing so before its expression is re-defined as agitation. One view, is whether the rationality of a person's cognitive labor from inhibition in refraining from expounding hostility, no matter how bizarre the circumstance, is accessible from a perspective that extends beyond the mental health clients' or agents' own psychological states before, in anticipation, and preparation of evaluating, and engaging the setting. The setting imposing non-participation and little to no talk, is understood by clients as bizarre, both in recall and as a pre-motivational precept, and can arise in formally suppressed states, to agitated confrontation. Mental states generate motivating reasons (Audi, 1986, p.511); (Dancy, 1994, p.15) to withstand the eccentric environment, and re-cooperate of low affect traumatic states long after recovering, from the difficult setting.

Clients tell these mental states go far beyond their adaptive role, in terms of strengths or opposite balancing affect strengths, which clients expect quick assertions be made by themselves to not look at disturbances that invoke trauma, in order to avoid A-rational actions (Hursthouse, 1991, p.58) such as indirect aggression through agitation. This avoidance strength depends on a kind of stress inoculation, to survive a highly traumatic social situation to come. Clients stress the assessment of dangers in the social setting, according to reading someone else's pre-motivational low affect, that justifies a bizarre reason for emotional in-expression, is communicated to offer social learning to another, in order to warn them before engaging the danger. Although, a yet to be affected outsider, merely point to normative pre- assumed understandings of the setting, as situation-ally all-inclusive and favoring agency, and this protects, and guards the subjective awareness, from a sudden full immersion with the social reality of trauma, from the exceptional instances of like others, successful experience in environments of efficacy. This might not satisfy the incomplete explanation, to one's own rationalization, that inefficacy is not expected, or was not the case. Researchers can be aware, that a defense of the traumatizing of seclusion can be to reevaluate constrictive conditions, such as inefficacy around the room, in order to formulate a new cognitive issue, to generate reasons (Dancy, 1994, p.6) to balance composer, based on high motivational opposing strength. This mediates between emotional high and low affect, to allocate a beneficial time and place to articulate suppressed traumatic specifics.

Interviews revealed the practice of cognitive and motivational withdrawal, may benevolent other mental health clients, in order to alleviate dissonance of elaborate cognitive expenditure, of the unavailability of talk therapies. A client may check collective social expression, because less processing of constricted human agency, and less statements of detailed descriptions of own ability of personal attainment, become impossible for the clinic to inhibit. The cognitive

labor of self-suppression of the frustrating position of being kept from agency is found in this data to be widespread, to challenge conventional notions of failures to open efficacy. The increasingly discouraged, unsuccessful search for fluid agency ends quickly in recall, and terminates the prospective future of processing hypothetical solutions for seclusion. This costs cognitive effort, in accuracy driven statements in recall. The resolve in contradictions in little to no personal human agency, when non-participation is created, is resolved by answering as a collective, or "We", as this costs less cognitive accuracy reasoning, than answering for lack of choice, as an individual or "I". In finding other clients confirming the impenetrable social constraints as common, this gives rise to heightened affect that can be voiced, not so much to persuade, rather no negotiated paths are outward-spect favorable to agency, unable to change the situation of constricted placement. These assertions of the unyielding efficacy finally uncover accurate helpless self -report in the telling, and contain contempt, offense, anger, and distance frustration at non -negotiable terrain. The external impact becomes the central influence on projected outcomes, and self-agency secondary. The construction of deviance is rejected as a hidden primary function of the institution and does not correspond with primary or secondary deviance perception of the clients. Clients bare an implicit mental health status after the explicit application of the deviance label fails. Clients told, that when recalling the other client's experience with awareness of social inefficacy, a description of external reasons (Davidson, 1980, p.107) of environments impact of being "contained" is not suffered as an "I", rather "We". No pathways are considered, due to motivational exhaustion of anger that might at a later time, resurface as helplessness, and its emotional regulation.

Clients demonstrate that a motivational predisposition such as seen in high and low affect, evaluate the little to no choice environments, in turn shape foreseen affect. Incorporating low affect to avoid seclusion can be socially learned coupled by reasons (Tuomela, 2007, p.15) to act conspicuously, similar to other clients. Socially assisted avoidance of high-risk emotional expression, includes becoming visibly helpless or defenseless, or surfacing as potentially and dangerously confrontational. These reasons become refined, as externalizing details of inefficacy, for terminating a near futile exertion of agencies effort. In recall, descriptive accurate assessment of individual expression follow, as inattentive, that is at first dismissed, to save consuming emotional labor, and to reduce dissonance. The need to talk can be mis-attributed as the re-definition, for better conversation with professionals, then after a while it is abandoned, after which resolve is found in concern for fellow clients. This need to talk develops normative reasons for avoiding coercion, and developing joint actions of avoiding a clinical force, creating deceptive low outcomes, that may be considered clinically manipulative. Clients explain an inattentive, counter-polar compensation for mediary low affect, overwhelmed by this stimulus, emerges and become attentive, that increases affect performance, in order to face trauma, in uneven proportion to the effect of former suppression. Due to suppression, premotivational cessations strength becomes seemingly absent, and does not ex-

plode and can become increasingly calculative and discriminatory in balance of emotional regulation of anger and agitation, with regard to socially expressing trauma objects and inefficacy of inpatient settings, clients revealed.

The seclusion emotional suppression theory present, low motivation manner of clients in held-back agential placement in disadvantageous settings, set into counteracting opposites level the affect uptake or down take of projected anger and exhaustion. Agitation and disorientation transformed into deviant attestment need never be set in motion again toward seclusion, with antecedent pre- motivation dispose enacting guise to expression of trauma objects. This pre-determined cessation of expression, long beforehand, is discovered to cancel motivational and cognitive effort preceding placement, intercepting restraint and seclusion, in the inpatient setting. Long before, a mental health client can make a pre-decision, not to be impacted by clinically designed provocation, but respond by low affect under set conditions that can resurface, and potentially determine a formally suppressed competing mental state. This former suppressed state surfaces, in the motivational overseeing containing frustration likely ascertained as agitated, therefore deviant. Antecedent motivational low affect social acting of the client, accompanying extra dangerous conditions to come, begin to develop low to dull composer, not to engage in visible emotional expression of trauma objects, in the first place. A decrease in drive after alternatives are exhausted, require more discrimination of responding, to socially constructed environmental cues, resulting in a temporary withholding of trauma expression and resolved mental state indicated by pauses, that protects the mental health client. Helping to understand the clients trauma recall, Christianson (1992, p. 298) states that the optimum intensity of motivational drive and expected, or unexpected motivation stimulus begins slowly, then increases with cues at a peak, just like an inverted "U". This focus can make stronger the emotional labor to ingenuity of expression, and counter attitudinal affect, in the client. However, the motivation to mediate expression according to stimulus falls, with the increase in difficulty and discrimination of the use, of what can be provocative social cues, within confined environments, of intense stress and emotion. These pre-motivational efforts to regulate these powers leave only a few attentive resources available, and actively responding to them is impaired, by a decrease of motivational affect, to retreat or advance, as a pre-ordinate motivation, the seclusion emotional suppression theory contends. Heightened agitated affect lead to a pre-motivated drive to terminate quickly fitting into lowered affect, to adapt to a dire setting.

The seclusion emotional suppression theory stipulates, that increased pre-motivational drive due to formally suppressed objects, increase attention to discriminatory detail in a mental health client, similar to limited capacity to not look at trauma, leads to what Loftus (1980, p.81) says is a narrowing of ability of focus. This increases performance of cognitive labor to withhold expressions high affect agitation, with extraordinary strength, even when the client is in the process of withstanding discordant social conditions, after a lowered motivational stance due to exhaustion. A more motivationally predisposed client then,

builds self and combined strengths both in recall and present adaption, in order to prepare the defense and approach the central object of trauma, with increased focus and performance. Clients visit trauma items, then equip self with social learning to take time and heal, and not revisit the object of trauma for many years, as a longer standing intended pre-disposition. Avoidance precedes with antecedent motivational low affect, to well beforehand be more adaptable in emotional reaction that can be more prepared, due to opposite balancing and countering ability to accede to environments of inefficacy. Formally suppressed items of inefficacy ignite pre-decision to regulation of emotion, use or disuse of expression as environmental constraints convey. Clients enhance non-reactive performance to expected, or unexpected social cues, with enhanced cognitive and long-term pre-motivational tranquil precision. They voice opposition to seclusion with more intensity for a long duration of time, when sensing with others, that the setting is disadvantageous.

Clients explained long term unexpressed trauma of restraint and seclusion, among the aging populations of mental health and disabled communities needs to be acknowledged, as they say it is widespread. Mental health clients and professionals are, however, temporarily unaware of institutional design presiding before, instigating outbursts of agitation and disorientation as causal, and develop a stronger awareness that is shared among clients, of what suppression around seclusion is. This awareness carries antecedent motivation preceding the next coercive psychiatric encounter, hospitalization or risky outpatient setting, thus being able to avoid it. Mental health clients develop methods to bring consciousness of inefficacy out of the long- after suppressive effect of reverse and delayed pauses, due to anger representing efforts to submerge affect, in the recall of full disunion with staff, confronting the suppression seclusion revolving door. Inhibition of trauma then arise out of the pause, and become helped by social work clinicians simply assisting mental health clients to develop the skill of not reacting, or more so carefully responding. Also important is for clinicians to help clients become self-sufficient in management of the pre-motivational effort of subduing symptoms of illness, such as develop dullness or neutral (Ellis & Ashbrook, 1998, p. 34) affect, that would end up in a confrontational encounter, if not for this emotional regulatory effort. The symptoms of illness are exacerbated, by falling into the revolving door, and the clients are locked up in the room, while experiencing the trauma of illness. Much of the traumatic suppressive after effect of non- expression, such as pausing of psychic pain, exists long after the mental health client, has been released from seclusion. There is a preceding awareness that can help mental health clients stay out, and prevent the continual re and de-hospitalization cycle, inpatient and outpatient criminalization by way of seclusion, and extra-legal death due to restraint. Mental health clients together with professionals, can develop an antecedent motivational low affect strength before, to deter or avert the preceding, presiding, and after procession of the suppression seclusion revolving door, by way of a quick pre-motivational bias to avoid its expected poor treatment outcome attributed to self- fault. This pre- disposition is determined not to allow

the institution to carry out a pre-arranged re-definition of social needs, by lowering affect into trauma expressions equilibrium. This is a protective measure to guard against the misrepresentation of assisted refusals and rights, based on assumed non-consents in the involuntary setting, even after enforced medicine had already begun, and never allow the institution the next chance to carry out the construction of deviant labels processes again.

5.4 Limitations of the Study

The limitations of the study are that it does not seek to discover traumatic items, buried by the seclusion revolving door, serving as an unexplored suppression substitution and transference of the problems, facing the client in the first place. These problems are unknown, and present themselves as unresolved or unaddressed. It is unknown what the structural and relational mechanism is really suppressing, so it can only be stated that problems with treatment, are the core issue, and that the reason for initial visit is suppressed, to past and current insufficient care. In addition, the study does not explore other human powers that may also be suppressed, resurfacing as disproportional, compensations motivational and cognitive strengths. These strengths can be unknown formally submerged articulated intellectual and physical strengths, extraordinary capability of subduing emotional expression that can resurface into unknown opposite strengths, intensifying becoming other regulating capabilities. These regulating capabilities can further make the client confrontational, or withdrawn. Another limitation is that presiding low affect clients' states exclusively induced by over or under-medication, especially forced medicine is often inaccurate of surveying unaccommodating settings. The likelihood of competent agency, to integrate inefficacy with precise estimated chances of success is hampered, due to the overwhelming disabling nature of this state. The study also does not address risk taking models, where with the aid of a mental health clinical social worker, the client may approach psychiatry again, but emphasizes to do so, would require more precise assistance, in maneuvering through institutional pathways. Furthermore, the substitution or transformations of current problems, facing the client into problems with treatment make this risk assessment and its implementation, inaccurate.

One limitation was the small amount of interviewees and small amounts of data, partially due to the temporary tendency to suppress private information about maltreatment. The study called for patients to tell of trauma, and it was expected to not draw many respondents due to the fear of this undertaking, and limited sources of data where struggled to understand due the suppression of trauma, as content for the study. Another weakness is that this study is in no way evidence based, but relies on the design of the inpatient setting, a seclusion room within its surroundings, to create the phenomena. I wanted to study the "ignoring" of public reaction to unrestricted visible expression, but time did not allow. As clinical group work must be approached with

further study, it also has its problems with unexpressed traumas that may endanger the client. Confidentiality may need to be extended to individuals that have, for example, endured institutional and social trauma, where clinical trauma is disclosed, and social trauma suppressed.

5.5. Reflections and Practical Recommendations Based on Findings

In my emancipatory approach to research I have focused on items of trauma within the client's world, drawing attention to important recommendations to future research. In doing so, an important question for me to ask myself as a clinical social worker is: How ethical is it to ask mental health clients recall of a traumatic event, such as being lead to the seclusion room? A good place to start to answer this question is, to arrive at the ethics of the seclusion practice itself, as clients will be actively searching out memories associated with it. An electronic literature search was made to Cochrane Collaboration Database (2007) concerning the value of seclusion and restraint from medical, psychological and social science databases by Sailas & Fenton (2007). The search produced 2155 citations including quantitative studies, all of which could report no positive benefits of these methods. The search indicated a lack of qualitative data assessing the effects of seclusion and restraints, on people living with schizophrenia or similar psychiatric disorders and made recommendations for more exploration and discovery by researchers, to utilize qualitative methods in order to ascertain the detriment to clients, served by psychiatric inpatient care.

Bonner (2002) found several nurses and half of the patients found restraint experiences "reactivated distressing memories of earlier traumatic event."(p.472). Bonner also concluded that more research is needed, to understand the psychological effects of restraint experiences. The combined collaborative goal of doctors, staff and clients is to treat mental illness by the most effective treatments and a goal is to explore if this intervention, and even if it's recent remembrance has the potential to traumatize or re-traumatize people. The nurse who is often the implementer of physical restraint must be responsible, and knowledgeable to accreditation agencies, patient rights laws, state standards and law and facility protocols. In this trauma recall, details of the event include distant and often violent encounters with nursing staff. Trauma and injury can be experienced by nursing staff as well (Lee, 2003, p. 425). In England for example, this researcher found there were about 13% of minor injuries sustained by patients, compared to 21.6% of injuring sustained by the nursing staff during physical restraint episodes. The nursing staff's injuries were more serious than the patients, and included bruised ribs, back injury, broken nose, dislocated arm and a black eye; minor injuries were scratches, bruises and grazed skin (Lee, 2003, p.425). Hopton (1995, p.111) suggested that indirect aggressive behavior by the distressed individual as a response to being restrained, may be justifiable anger at the restraint intervention.

Descriptive analysis to the motivation for employing coercive measures is established in Finnish research. Hansson (et al.1999) carried out detailed research on the justification on seclusion and restraint. They take the position that indirect violent behavior of the patient, stands as theoretically the most accepted justification for coercive measures. The authors carried out a study at three Finnish university hospitals utilizing retrospective chart review of 18 – 64 year old patients (n= 1543) during a six month period in 1996. Hospital databases, seclusion records and personal medical charts medication schedules, and nursing files were all evaluated. The data specified use of seclusion and restraint, number of episodes during a treatment period, motivation for each episode as documented by staff, total time spent in seclusion and restraint, type of admission and diagnosis.

"Violence" was categorized as predicting violence or threatening an act, or attacking or breaking property. "Agitation" or "disorientation" as a motivation for restraint was characterized, as patient's behavior in an agitated, exited or restless way, pacing, reaction in a strained way, excluding verbal – with violence or committing violent acts. The motivation for seclusion was differentiated to include disorientation, acting in a confused, chaotic or irrelevant, noisy behavior, soiling clothes, undressing publicly, or uncontrolled sexual behavior.

The study found that the main motivation, for seclusion and restraint was agitation and disorientation in (43.6 %) out of 482 episodes. It was more frequently the reason for restraint (16.1%) than seclusion, (11.8%). Agitation or disorientation motivated (76.3%) cases of restraint and (42.1%) cases of seclusion. Threats of violence toward staff were more frequently reported (51.2%) and not staff (44.6%). The agitation or disorientation in combination with substance use disorders (75.7%) outweighed the schizophrenia group (72.3%) or mood disorders (70.6%) for motivation for seclusion and restraint. Actual violence was not associated with use of restraints. Among the diagnostic group, agitation and disorientation was the primary reason for seclusion and restraints in (46, 8%) of first episodes and (52.6%) in second episodes and (5.0%) of third. Threatening violence was the main criteria justifying their use in (86.7 %) of cases, concerning the 11th episode on. In a quantitative study by Frueh et al. (2005) the researchers presented data suggesting that of the clients meeting for criteria for sanctuary harm, and of those in their experience with the inpatient setting, 9% were sexually assaulted, 31% physically assaulted and 63% witnessed trauma. In addition, 65% were transported in handcuffs, 60% put in seclusion and 54% had been restrained.

Robins, Sauvageot, Cusack, Suffoletta-Maierle, Frueh (2005) researched use of restraints, seclusion and forced medications among adult mental health consumers by exploring perceptions of traumatic and harmful events that occur in these settings. Fear of physical violence, and arbitrary nature of rules, depersonalization relating to clinical staff, lack of fairness, and disrespect were among the themes reported by interviews with respondents. Findings indicated that mental health consumers perceived treatment in psychiatric settings as harmful and more research is needed to understand consumer's perceptions of

sanctuary harm. The harmful experiences in the hospital may result in an exasperating psychiatric symptoms, a difficult recovery process or reduced participation in subsequent mental health treatment. The Finnish authors assert that persons diagnosed with psychiatric disorders possess the necessary cognitive abilities to make autonomous decisions regarding their participation in research, where the voice of their experiences with these measures can be clearly heard (Koivisto, Janhonen, Latvala, & Väisänen, 2001). Bringing patients with psychiatric disorders into the process of decision-making about partaking in the research process is possible, and patients can be competent to exert their basic human rights.

Historically, the nursing profession has been actively involved in try to reduce restraint use for over hundred years (Nursing World, 2001). Traditionally, nurses are confronted with the ethical and legal issues of using restraints efficiently to reduce harm done to the restrained, and to others. Restraint is seen as justified "as long as the force used to restrain the person is less injurious to all parties than the aggressive or self-destructive behavior, restraint of the individual is ethically correct action to take" (Hopton, 1995, p.111). Hawkins (2005, p. 19) found that there were many negative emotional reactions that arose from staff, during a restraint physical intervention. Nurses were concerned with variables such as "getting it right", and experienced sheer physical exhaustion among many other factors during a restraint episode. It was concluded by this researcher, that there was detrimental effect to both parties. It may be the intervention meant to help patients, induces trauma instead. In general, society and medical personal want to control certain behavior that is seen as indirectly violent and threatening. However, using restraints can be at-odds with the personal liberty of patients, their feelings of psychological safety, and the staff's clinical treatment goals of healing trauma. Physical safety is gained for both staff and patients, but the sense of psychological safety can be lost, treatment goals are compromised, and in some cases, further psychological trauma is inflicted on the patient being physically restrained, secluded or forcibly medicated (Jones, 2006, p.12).

Future research might include preventive measures such as competent outpatient care, which can be studied to how it specifically helps, decrease coercion. As many episodes of seclusion can be a direct consequence of psychiatric medicine oppression, and lack of talk therapies, both in the community and in the hospital, future studies in clinical social work might take more concern as public health specialists, in order to stand in between, and further work together, with the client, psychiatry and nursing. An important aim of clinical social work is to make these professions more legally liable for client's agitated indirect aggressive motiveless crimes and death, due to the process of restraint and seclusion. It is recommended clinicians obtain a full assisted, educated, renewed, informed consent even in an involuntary setting before recommending a client take medicine, because agitation and disorientation can be brought on by medicine side effects, and lack of talk, in order to monitor these. It is recommended to look into motiveless crimes, to determine if a client committed agi-

tated, or a disoriented lack of decision making before arriving at mutual consent of the doctor prescribing medicine, and lack of monitoring side effects through little to no talk, in order to make the professions more liable.

In order to eradicate extra-legal oppression of clients, it might be possible as a suggested course of policy, to open a professional guided legal inquiry to examine entire caseloads of mental health clients accused of agitated, manic, and disoriented lack of decision making culminating in motiveless crimes, during the duration of reckless over and under medicine treatment, and the absence of combined psycho-social support. It is also important for future research, to consider helping psychiatry advocating for the implementation, and interceding of legal cases involving motiveless crimes, and deferring them to the hospital. A mental health court in Finland could be established, to offset the stigma of these motiveless crimes. Further studies might develop an independent impartial auditing commission, to investigate unexplained deaths behind locked doors, patrolled by restraint and seclusion. These future studies may broaden the work for the discipline of clinical social work in a similar way to the abolition of drug offenses, for ADHD populations accused of drug crimes, and open the jail and prison doors to mental health clients, criminalized by psychiatric oppression. The value of this research might help researchers and practitioners, assist clients avoid death, due to restraint or fatal shooting by first respondents, because of visible proclamation of emotional trauma.

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APPENDIXES

Appendix A. Notice to Recruit Participants Posted in the Inpatient Mental Health Client Setting (Translation)

INVITATION FOR THE MENTAL HEALTH CLIENTS TO PARTICIPATE

Volunteers are invited to participate in the study, which deals with mental health client personal experiences concerning forced care, seclusion, holding and forced medication in the presence and together with psychiatric mental health client hospital care.

The name of the study: Forced Care Directed to Psychiatric Mental health clients.

Responsible for the study. William James Vennola-Stover. Questions are answered in number xxxxxxx. Telephone is answered in Finnish, the study interview is conducted with the assistance of an interpreter. If you are interested in participating in the study, please register by calling this number.

THE PURPOSE OF THE RESEARCH.

The purpose of the research is to study the experiences of psychiatric mental health clients who have experiences in forced care and forced medication. The contents of the study is collected by interviewing mental health clients who have ended up being treated with forced care by representative hospital staff.

The purpose of the study is to clarify what kind of medical care, psychotherapy, recovery, alcohol or drug dependency care a mental health client has receive before searching care from the hospital.

This confidential information helps to determine, what type of influence is the actions may have in the recovery program for the care facility staff and doctors.

Only the interviewer and the interpreter has a permission to see your confidential information. All the information that you give to the interviewer is kept and handled in an absolute confidentiality.

PARTICIPATION

Your participation in this study is completely voluntary. You do not need to answer in the questions if you do not wish to do so. You have a right at any time during the interview and without giving any reasons interrupt participat-

ing in the interview. Refusing to participate in the study or interrupting it does not have any effect in the continuation of your care.

The study is conducted in the hospital setting. If you wish to have further additional information of the study, you can contact the staff. They can also give you a phone number, where you can call to get further information both the study and the confidentiality of this research (study).

By filling out the personal form and consent agreement, you will take part in the interview lasting 1-2 hours with the researcher and interpreter. The interview deals with forced care measures in psychiatric hospital. The interview will be recorded and notes taken with your permission. The researcher can contact you even after the interview in order to clarify the confidential information. For this purpose you are asked to leave your contact information.

At the end of the research, you will receive the results in this research.

Kiitän osallistumisestasi tutkimukseen

Thank you for your participation to this research.

Appendix B. Mental health client Written Consent to Participate in Research (in English)

Consent form to participate in the research project

The name: Forced treatment for psychiatric mental health clients

My name is _____I have been asked to participate in a research, that is conducted by W.J. Vennola-Stover, MSW, for the purposes of doctoral degree at the University of Jyväskylä. I can contact him by calling XXXXXX or by email XXXXXXXX The project is being directed by Prof. M.M. from the University of Jyväskylä, XXXXXXX

The interviews will be held in hospital settings and will happen under the approval of XXXXX Psychiatry Department and will be held when convenient for the mental health clients.

The collected information from the interviews will be used in the research project, which deals with psychiatric social work and it will be conducted in the Jyväskylä University social science and philosophy department.

I have received, read and understood appendix A. that tells about the research. From that informational form I have received enough information of the research. (Forced treatment measures towards Psychiatric mental health clients.), and of the collection of information handled and used and submitted for the research project. In addition I have been told verbally what this contents of this information is, the purpose of this research is and what it deals with. I have been sufficiently answered to all the questions concerning this research.

Only the interviewer and his interpreter can view my information. My name or initials are not included in the final research.

I do understand that my participation to this study is voluntary. I do not have to answer the questions. I have a right to anytime during the study and without giving any announcement to interrupt (quit) my participation in the research. Refusing to participate or quitting the interview process in the middle will not have any effect my status as a mental health client.

I am aware that if I quit the information I have given cannot be used as part of the research material.

I know, that the researcher will in addition to the interviews, will use a questionnaire that will deal with my experiences of forced treatment care in the psychiatric hospitals. The search can contact me after to clarify some information, for which I will provide contact information voluntarily, if I wish.

I will give permission for my data in the questionnaire, for the purpose of collecting information for the benefit of the research.

All the information that I have given will be treated confidentially. The information collected will be anonymous in such a manner, that finding out the identity of the mental health client is not possible later on either.

In this research the information cannot be handled anywhere else except in the place where research is done. Confidential information is dealt in such a manner that only the research and his interpreter has the right to see the questionnaire and its responses.

All the written responses or translations are kept in locked drawer. Information is kept only for 2 years after the end of the research project, after which they are destroyed. If I want to end my participation in the research, I can do it anytime. I can do so by writing to the research in a letter, all the research done in such case is destroyed.

My participation to this study can be a part to develop a better care for psychiatric mental health clients. The results of this research can be published in scientific publications, but my name is not in any part of the research results.

My initials here_____confirms that I after the end of the research, will receive one page feedback for participating to this study.

(If I have questions of this project, I can call (XXXXXXXX)

I have had enough time to consider participating in this study.

Information for this study was given to me by _____Place _____/20XX

I hereby confirm by signature to this study and consent voluntarily as a study subject (person)

_____ _____

Signature Date

_____ _____

Text your name Text your name

_____

Signature of researcher

Original signature of research study consent and copy of study, invitation to participate are kept in the researchers archives. Invitation to participate and a copy of the signed consent are given to the research study person.

Appendix C. Mental health clients' Interview Guide (Translation)

Describe your experiences when you first time were brought to the hospital and placed in seclusion or forced medication? Describe the next day or weeks after?

Describe the benefits and disadvantages? (During seclusion or restraint when in the seclusion room) Describe them in as much detail as possible?

What abilities or strengths do you have to make decisions concerning your care in (seclusion and restraint) hospital or out patent mental health client care?

What methods of care has helped most prior to coming to the hospital, in your opinion? Describe and why?

How has use of alcohol, drugs self-medication or aggressive behavior caused ending up in the hospital where forced actions (seclusion or restraint) have been used? Describe?

What would be a better alternative to involuntary care (forced actions) (seclusion or restraint) in the hospital? Describe?

How psychiatric care (seclusion or restraint) does helped your recovery from your illness? Describe?

What in your opinion has helped most in your recovery from your illness? Describe?