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# Rethinking risk: A narrative approach

Anne Felton and Theodore Stickley

## **Abstract**

### *Purpose*

The assessment and management of risk is central to contemporary mental health practice. The emergence of recovery has contributed to demands for more service user centered approaches to risk. This paper examines the potential of narrative as a framework for understanding risk and safety in mental health care.

### *Design/methodology/approach*

Narrative theory is adopted to structure a debate examining the potential role of a narrative approach to risk assessment and inform future practice.

### *Findings*

There is a danger that even within services, people with mental health problems are understood in terms of their riskiness perpetuating an image of service users as 'dangerous others'. This is confounded by a disconnection with individual context in the risk assessment process. Narrative centralizes the persons' subjective experience and provides a contemporaneous self-account of their identity. This situates risk within a context and creates possibility for greater understanding of coping, strengths and resilience.

### *Originality/value*

There has been a call for new ways of working with risk in mental health which facilitate safety and recovery. There is limited examination of what this might actually look like. This paper presents narrative as an approach that may achieve these aims.

## **Introduction**

Risk assessment and management in mental health care is a contested area. Both risk assessment tools and the judgement of professionals have been criticised for a lack of accuracy and reliability, drawing into question the evidence for the approaches currently adopted (Morgan 2008, Wand 2011, Fazel et al 2012). Yet risk remains a core component of mental health practice (Szmukler and Rose 2013, Lee et al 2017). The development of recovery orientated care has fuelled a critique of the role risk plays in decision making and the impact it has on creating unnecessary restrictions alongside inhibiting individuals' opportunity for recovery (Stickley and Felton 2006, Szmukler and Rose 2013). Services are being challenged to develop a new approach to risk which facilitates safety whilst moving away from the focus on the perceived harms caused by people with mental health problems (Boardman and Roberts 2014) and facilitates greater opportunity and choice for individuals. This article draws on narrative theory to examine the potential of narrative as a means to move towards a co-produced understanding of risk and safety.

## **Risk and Other**

The assessment of risk emphasises categorisation, in which something is recognised and rated as a potential cause of harm (Higgins et al 2016). Within mental health care it is a process which all people who use services are exposed to (Langan 2010). Risk assessment disproportionately emphasises the risks of harms caused by the service user. Social theories of risk can contribute to understanding how this arises as they highlight how risks are selectively recognised (Douglas and Wildvsky 1982, Lupton 2013). The concept of 'Otherness' has been adopted to examine the process by which some risks are emphasised in society whilst others are ignored. Douglas and Wildvsky (1982) highlight how risk and therefore fear are associated with different, often marginalised social groups such as people with mental health problems. Otherness from a psychological perspective arises from the projection of what is undesirable and repressed within ourselves onto others, enabling us to act out the hostility and fear that we actually feel about ourselves towards others (Kearney 2003). That which is seen as different from self and strange is the focus of concern and potential danger, a risk (Warner and Gabe 2004, Lupton

2013). What is unknown therefore becomes threatening and needs to be kept at a distance. Mental health service users are perceived as the source of potential harm, either to themselves or other people. This operates at social level through the association between mental illness and danger perpetuated by the media (Quintero and Miller 2016). However, it also operates at an organisational and professional level as service users are increasingly understood in terms of their riskiness (Scott et al 2011).

The social process of 'othering' also creates exclusion and is a means of discriminating against oppressed groups (Krumer-Nevo and Sidi 2012). It is characterised by a distal relationship between self and others, value judgements, for example other is bad, and a lack of awareness of the social-cultural context of the other. The dominance of risk assessment and management in health services and the emphasis on the risk posed by people with mental health problems situates them as a dangerous risky other. The assessment process which identifies, segregates and rates factors that are associated with risk perpetuates the prominence of professionally defined characteristics that are associated with danger and difference. The individual context and subjective experience can become invisible in line with Krumer-Nevo and Sidi's (2012) definition of 'othering'. This creates a self-perpetuating process as professionals and organisations are tasked with containing risk whilst also maintaining distance to protect from the fear and danger associated with other.

Such definitions of risk promote a narrow and deterministic view of distress. Being designated a risky other can create feelings of shame and impact negatively on identity and self-esteem (Bennison and Talbot 2017). Through this the potential of these definitions to actually increase the possibility of harm must be acknowledged. Being treated as a risky other entails objectification in which the subjective experience of the individual is increasingly invisible (Felton 2015). Care processes become dominated by understanding based on a disembodied set of risk factors, and the need to monitor and contain the danger (Rose and Szmukler 2013). Scott et al (2011) contend that Western mental health care has shifted from a 'therapeutic' consciousness' to 'risk consciousness' which results in the continued exclusion and alienation of people who experience mental health problems both outside and within services.

Collaboration between professionals and service users is recognised as the benchmark of quality recovery orientated mental health care, yet the participation of service users in developing a shared understanding of risk remains rare (Coffey et al 2015). Connecting with the individual's experience of distress and the events that may pose a threat to safety is not prominent within formal and informal approaches to risk assessment (Felton 2015, Higgins et al 2016). Professionals can fear creating further trauma and distress by engaging in dialogue with service users about harms or experiences which have been categorised as a risk. However, this means that risk assessments are routinely taking place without peoples' participation or even their knowledge (Langan 2010). Narrow professionally and organisationally defined areas of risk are consequently perpetuated. Yet appreciating the context of actions contributes to a richer and arguably more accurate understanding of those experiences which creates greater possibility for choice, opportunity and recovery. Shifting the paradigm within which risk is dealt with in mental health services could also reposition those with the label of 'mentally ill' as people not 'risky others'. Engaging with the narratives of people who experience distress and their network provides a powerful means of achieving this (Bennison and Talbot 2017).

## **Narrative**

A narrative is an interpretation of experiences as told by an individual or narrator. Narration is a dynamic activity that creates a new interpretation of events as situated by the persons lived experience (Ricoeur 1991). Narrative can create a connection between an individuals' past, present and future and therefore develop a temporal structure for events, providing a context which may have been lost (Mishler, 1986; Frid et al 2000). Listening to individuals' narratives and adopting this approach to understand harm, threats to safety but also opportunities for growth creates potential for new ways of working with risk.

As narrative approaches gained momentum in the social sciences, some working in the healthcare arena recognised the limitations of rationalist frameworks and sought to introduce similar approaches in health care (Hurwartz et al., 2004). Some of the earlier contributors include: Balint (1959), Kleinman (1988), Brody

(2003). Frank (1995) identifies three fundamental illness narratives: restitution, chaos and quest. Restitution narratives are those of the person anticipating recovery; chaos narratives are enduring with no respite; quest narratives are those where people discover that they may become transformed by their illness. What is common to all types of illness narratives is the focus upon the centrality of the telling of the patient's experience. This is for both epistemological and sense-making functions (Gabriel, 2004). The epistemological concerns itself with furthering knowledge of illness from first-hand experience and the sense-making is more to do with making sense of illness, or extracting meaning from the experience, thus infusing hope. Whilst these narratives identified by Frank are in relation to physical illnesses, it is widely thought that the existence of hope is key to the mental health recovery process (Leamy et al., 2011). Enabling a sense of understanding and meaning in mental healthcare is one way of inspiring hope amongst people in mental distress.

According to one of the key narrative theorists, Ricoeur (1991), it is through interpretation of narratives that understanding is achieved. Interpretation is enabled by a process of dialogue in which explanations can be clarified and agreed. It is facilitated by listening and empathising as well as questioning and critically examining the relationship between the narrative to its setting (Frid et al 2000). The role of mental health professionals becomes to engage in the individual's narrative and to build a collaborative understanding of experience.

### **Narrative, Risk and Mental Health**

A recovery approach to mental distress acknowledges the central role of narrative and integral to the risk assessment process should be the person's narrative (Barker and Buchanan- Barker 2005). In order to consider the possibility that the person should be author of their own perceived risk, we need to firstly acknowledge the role of identity in the experience of mental distress.

Authorship of a narrative is the expression of individual identity. To impose a risk assessment on another is to also impose a counter-narrative. As such, the counter-narrative (more usually informed by a person's history) is not the narrative constructed by the individual but rather it is a professional narrative paternalistically imposed. Not only could this undermine identity but in the

context of risk assessment contribute to inaccurate understanding of the experiences (and therefore the meaning of these in relation to potential harm and safety).

According to Ricoeur, the word 'identity' however can be understood in two ways. Firstly, identity can be understood as something that is fixed or something that is permanent but changing. It is this latter meaning according to Ricoeur, that we create our narrative identity (Ricoeur, 1988:246). Thus, a river may have a historical identity but is in fact in a constant state of change. Identity is thus mediated between these potentiality conflicting views of self (Gergen and Gergen, 1988). Narrative is therefore a way of balancing both the self that is constant and the self that is changing as we are able to make sense of ourselves through the stories that we tell ourselves (and others) about ourselves.

The narrative therefore is a product of our constructing, deconstructing and reconstructing of ourselves and of our identities (Denzin, 2000; Benwell and Stokoe, 2006; Holloway and Freshwater, 2007). The fact that our narratives may change and be re-constructed is not negative, for Bruner (1990) asserts that the changeability of our stories allows us to make meaning of our experiences and to re-position our social identity when required (Davies and Harré, 1990; Benwell and Stokoe, 2006; Mishler, 2006). The opportunity for new narratives and interpretations are important in terms of risk, particularly in relation to historical incidents of harm caused by or to an individual. The reinterpretation of events provides scope for people to come to terms and move on in accordance with the principles of recovery. Engaging with people's own interpretations of these also enables professionals to consider the meaning of such events in the context of people's current circumstances. Offering interpretations without this perspective for example through structured risk assessments alone could limit the relevance of these interpretations as they lack information about context and contemporary meaning. In terms of risk therefore, what is more important than an identity based upon a third person historical account, is a contemporaneous self-account of the person's identity in the (ever changing) present. This approach to risk assessment is highly consistent with contemporary developments in mental health practice. For example, any recovery-orientated or strengths-based approach requires intense

listening to the person's story. In a recent study focusing on shared-decision-making, the aspect of "listening to people's stories" is found to be important (Fisher et al., 2017). It is this kind of listening that may facilitate a co-produced understanding of safety and harm.

The key here for the professional is that listening to the narrative, he/she is not in the role of judge, but as listener. It is widely held that narrative not only elicits stories, but also facilitates empathy (Riessman, 1993; Bochner, 2001; Elliot, 2005; Holloway and Freshwater, 2007). It is in the act of giving the person a platform for their narrative that the person may feel prized (Rogers, 1951). During the process of telling their story, the person may find meaning that was otherwise undiscovered. This concept is articulated well by Wolgemuth and Donohue (2006) who propose an inquiry of discomfort (after Boler, 1999), which emphasises the proactive and transformative potential of practice for the professional and the person who is being assessed. To a degree this recognizes that these conversations may be difficult and at times uncomfortable for the practitioner as well as the individual as they may relate to areas of social taboo (for example suicide), previous trauma or experiences associated with shame. However, the roles of narrator and listener also emphasise the core therapeutic skills of mental health nurses to develop a rapport and hold discomfort and uncertainty. The fostering of these skills within nurse education is important.

This therapeutic component is intrinsic and not overt. A narrative approach to risk-assessment is therefore essentially a relational process and the context should not be ignored (Mishler, 1986; Gubrium and Holstein, 2000; Wolgemuth and Donohue, 2006). Poetic license is expected in narrative (Gabriel, 2004) and truth is not usually considered as synonymous with objective scientific truth, but constructed (in the telling) and subjective (Riessman, 1993). "The 'truth' of our stories is not the historical or scientific truth, but rather something which can be called narrative truth" (Shkedi, 2005:11). In risk-assessment professionals should not be attempting to ascertain objective truth, rather, they should attend to the detail of both how stories are constructed and what is being told in order to interpret meaning, rather than 'truth'. This requires a shift in expectations of risk assessment to be considered as a process that builds understanding of harms, threats to safety, resilience and coping (and therefore

support and interventions required to address these areas). Rather than scientifically valid predication of future events. Once the professional can understand the meaning of the client's narrative, then a co-constructed risk assessment can begin to emerge. Therefore, a narrative-based risk assessment is both interpretative and phenomenological (Ricoeur, 1981; Emden, 1998) and potentially transformatory (Wolgemuth and Donohue, 2006).

### **Narrative, Risk and Subjective Experience**

Narrative understanding builds bridges between different experiences (Sarangi and Candlin 2010). Narrative can also be a means to connect the self and other, enabling us to recognise the other in ourselves (Kearny 2003). Engaging with the person's narrative and forming a narrative approach to risk assessment, therefore undermines the position of people with mental health problems as dangerous risky other, facilitating understanding and professionals' connection with the individuals' lived experience.

Subjective knowledge is important to decisions about risk. Prior experience and knowledge are significant factors in how individuals manage uncertainty and overcome the limitations of reductionist 'rational' risk calculations (Kemshall 2014). Trust, hope and faith are key features of decision-making in situations of uncertainty. Drawing on the emphasis on experiential knowledge it has been argued that risk can therefore only be understood as part of an individuals' biography (Skinner 2000, Zinn 2005).

Where uncertainty and complexity are high, experiential knowledge has an increasingly important role. Such knowledge is defined by Ballergeau and Duyvendak (2016) as 'knowing otherwise' and is built through lived experience for example of mental distress or trauma. This expertise is a unique resource providing an otherwise inaccessible perspective on experiences of survival and resilience in adversity. Individuals who have experience of 'Knowing otherwise' interpret problems differently to professionals. Notably a recognition that behaviours which may be labelled as irrational or irresponsible make sense in the specific context, frequently reflecting how individuals have developed coping

strategies in challenging situations. This knowledge grounded in individuals' experience can be employed to interpret and manage new challenges (Ballergeau and Duyvendak 2016). Although the authors argue this is more likely to be in negotiating risk in longer term recovery. A narrative approach to risk assessment therefore involves accepting that there may be contradictions and tensions within a person's narrative, in line with the foundation in narrative rather than objective truth. Zinn (2005) describes such inconsistencies as 'biographical structuring' in which the threats posed by illness and distress are therefore able to be recognised alongside opportunities. Narrative approaches create capacity for acknowledgment of strengths, resilience and 'positive risks'. Adopting such an approach would reflect a paradigm shift, underpinned by the principles of recovery, which values the significance of lived experience in understanding and managing risk.

### **Risk and Narrative Structure**

Narrative can have common structures and purposes. Temporal arrangements and the function of narratives in control have specific relevance for a narrative approach to risk.

#### *Temporal*

Time span is often a core feature of risk assessment and has become a key challenge for service users who can struggle to escape the impact of a 'risky' past on how they are understood and treated by services and society (Sawyer 2017). Temporality is also a key characteristic of narrative structure (Ricoeur 1980) and can therefore be seen to have significance for narrative understandings of risk in mental health. However, instead of chronological temporal approach to defining risk level, narrative enables a process of interpretation and reinterpretation of past events, present experiences and future possibilities to develop understanding. Distress and the experience of threats to safety can be set periods of disruption and change which create potential for both positive and difficult outcomes (Skinner 2000). Narrative can create order to these experiences and events. West et al (2013) research exploring the narratives of people who 'self-hurt' showed the importance of temporality in framing the experience. For many participants, the past framed

the appearance of the present, though crucially this was past lived experiences as narrated by the individual in which their biographical experience gave meaning to their present actions of self-hurt. They also showed that the perceived threats and benefits of self-hurt varied depending on the time-frame that the experience was being interpreted through. The authors highlight that certain time-frames presented self-hurt as a means to manage risk, particularly of experiencing stigma and against a loss of identity and self-hood. The context of the self-hurting experiences were consequently revealed. Such insights gained through engaging with people's narratives demonstrate the potential of this approach to risk. Notions of risk are broadened to those areas that create a threat for the individual and traditional 'risky' behaviours are reinterpreted in the context of life experiences. Risk assessment should therefore involve inviting individuals to share such stories which enables a construction of these experiences to also be represented in documentation. Through open discussion this creates the possibility that new understandings of resilience and threats to safety can be built, outside the traditional narrow definitions of risk such as aggression and self-harm.

### *Control*

Narrative is means to connect with experience and creates "sense-making" of threats and, coping (i.e. risk). Adopting a narrative approach to risk in mental health practice, generates the potential that a person experiences more control of their identity construction; as events and experiences are given meaning rather than existing as objective disembodied risk factors. Skinner (2000:164) highlights that through narrative understanding of risk one can "take charge of self .... by simply pinning these worlds down by definition, delineation and description". Having the opportunity to take back control, enact choice and build positive identity are common aspects of recovery (Kartalova-O'Doherty and Doherty 2010, Raptopoulos 2012, Morgan et al 2016). By engaging with people to listen to their narratives and facilitate a personal and individualised relational understanding of risk opportunities for control, choice and construction of identity are created in the care process. Adopting a narrative based approach to risk may therefore go some way to begin to address the tensions evident between risk averse cultures and recovery.

## Conclusion

There is a danger that even within services, people with mental health problems are understood in terms of their riskiness perpetuating an image of service users as 'dangerous others'. Additionally, a central part of people's distress is being overlooked without this connection to individual experience and within risk assessment it is argued that narrative has the potential to improve care and promote emotional security (Barker and Buchanan-Barker 2005).

Adopting such a narrative approach in mental health practice entails engaging in dialogue with individuals' and their networks about their safety, security and distress. The persons' narrative should therefore be visible in the assessment of risk both through informal professional approaches and documentation systems, informing safety plans and support that are agreed.

## References

- Baillergeau, E. and Duyvendak, J.W., (2016) Experiential knowledge as a resource for coping with uncertainty: evidence and examples from the Netherlands. *Health, Risk & Society*, pp.1-20.
- Balint M (1959) *The doctor, the patient and his illness*. Pitman, London
- Barker, P.J. and Buchanan-Barker, P., (2005) *The Tidal Model: A guide for mental health professionals*. London. Psychology Press.
- Benninson G, Talbot D (2017) Directions for policy and practice from lived experience *In* Stanford, S, Sharland S, Rovinelli Heller N, Warner J (eds) *Beyond the Risk Paradigm in Mental Health Policy and Practice*. Palgrave Macmillan Education. London
- Benwell B and Stokoe E (2006) *Discourse and identity*. Edinburgh University Press, Edinburgh
- Boardman, J. and Roberts, G., 2014. Risk, safety and recovery. *Implementing Recovery through Organisational Change Briefing Paper 9*. Im Internet: <http://www.imroc.org/wp-content/uploads/ImROC-Briefing-Risk-Safety-and-Recovery.pdf>; Stand: 18.10.
- Bochner A P (2001) Narrative's Virtues. *Qualitative Inquiry*, 7, 131-157
- Boler M (1999) *Feeling power: Emotions and Education*. Routledge, New York
- Brody H (2003) *Stories of Sickness*. Oxford University Press, Oxford
- Bruner J S (1990) *Acts of meaning*. Harvard University Press, London

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A. and Barlow, S., (2016). Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expectations*. 20(3), pp.471-483.

Davies B and Harré R (1990) Positioning: The Discursive Production of Selves. *Journal for the Theory of Social Behavior*, 20 (1), 43-63.

Denzin N K (2000) "The practices and politics of interpretation" (897-992). In: N K Denzin and Y S Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.) Sage, London

Douglas, M. and Wildavsky, A. (1982) *Risk and Culture, An essay on the selection of Technical and Environmental Dangers*. Berkley. University of California Press.

Elliott J (2005) *Using narrative in social research: qualitative and quantitative approaches*. Sage, London

Emden C (1998) Theoretical perspectives on narrative inquiry. *Collegian* 5, 30-33

Fazel, S., Singh, J., Doll, H. and Grann, M. (2002)'Use of risk assessment instruments to predict violence and antisocial behaviour in 72 samples involving 24,827 people: a systematic review and meta-analysis *British Medical Journal* 345; pp.1-12

Felton, A., 2015. *'Psychiatry is a risk business': the construction of mental health service users as objects of risk: a multiple case study inquiry* (Doctoral dissertation, University of Nottingham).

Fisher, A., Manicavasagar, V., Sharpe, L., Laidsaar-Powell, R., & Juraskova, I. (2017). Identifying and Addressing Barriers to Treatment Decision-making in Bipolar II Disorder: Clinicians' Perspective. *Australian Psychologist*.

Frank A W (1995) *The Wounded Storyteller: Body, Illness, and Ethics*. University of Chicago Press, Chicago

Frid, I., Öhlén, J. and Bergbom, I., 2000. On the use of narratives in nursing research. *Journal of advanced nursing*, 32(3), pp.695-703.

Gabriel Y (2004) "The voice of experience and the voice of the expert – can they speak to each other?" (168-185). In B Hurwitz, T Greenhalgh and V Skultans (Eds.) *Narrative research in health and illness*. BMJ Books, Blackwell Publishing, Oxford

Gergen K and Gergen M (1988) "Narrative and the self as relationship". (17-56). In: L Berkowitz (ed) *Advances in experimental Social Psychology*. Academic Press, San Diego

Gubrium J F and Holstein J A (2003) *Postmodern Interviewing*. Sage, London.

Higgins, A., Doyle, L., Morrissey, J., Downes, C., Gill, A. and Bailey, S., 2016. Documentary analysis of risk-assessment and safety-planning policies and tools

in a mental health context. *International journal of mental health nursing*. 25 (4) 385–395

Holloway I and Freshwater D (2007) *Narrative research in nursing*. Blackwell Publishing Ltd, Oxford

Hurwitz B, Greenhalgh T and Skultans V (2004) *Narrative research in health and illness*. BMJ Books, Blackwell Publishing, Oxford

Kartalova-O'Doherty, Y. and Tedstone Doherty, D., 2010. Recovering from recurrent mental health problems: Giving up and fighting to get better. *International journal of mental health nursing*, 19(1), pp.3-15.

Kearney, R. (2003) *Strangers, Gods and Monsters*. London. Routledge

Kemshall, H., (2014). Conflicting rationalities of risk: Disputing risk in social policy—Reflecting on 35 years of researching risk. *Health, Risk & Society*, 16(5), pp.398-416.

Kleinman A (1988) *The illness narratives: Suffering, healing and the human condition*. Basic Books, New York

Krumer-Nevo, M. and Sidi, M., (2012). Writing against othering. *Qualitative Inquiry*, 18(4), pp.299-309.

Langan, J. (2010) Challenging assumptions about risk factors and the role of screening for violence risk in the field of mental health. *Health, Risk and Society* 12(2): pp.85-100

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, 199(6), 445-452.

Lee, C, Hartley C, Sharland E, (2017) Risk Thinking and the priorities of mental health social work organisations. In Stanford, S, Sharland S, Rovinelli Heller N, Warner J (eds) *Beyond the Risk Paradigm in Mental Health Policy and Practice* Palgrave Macmillan Education. London

Lupton, D. (2013). *Risk*. 2nd edition London. Routledge.

Mishler E G (1986) *Research Interviewing: Context and Narrative*. Harvard, Cambridge, USA

Mishler E G (2006) "Narrative and identity, the double arrow of time", (30-47). In: *Discourse and identity*,. Edited by Anna De Fina, Deborah Schiffrin, Michael Bamberg. Cambridge University Press, Cambridge

Morgan J F.(2008) *Giving up the culture of blame: risk assessment and risk management in psychiatric practice*. London Royal College of Psychiatrists,

Morgan, A., Felton, A., Fulford, B., Kalathil, J. and Stacey, G., (2015) *Values and ethics in mental health: An exploration for practice*. Palgrave Macmillan.

Quintero Johnson, J.M. and Miller, B., 2016. When Women "Snap": The Use of Mental Illness to Contextualize Women's Acts of Violence in Contemporary Popular Media. *Women's Studies in Communication*, 39(2), pp.211-227.

- Raptopoulos A (2012) Becoming and Expert by Experience *In* Weinstein J (ed) *Mental Health Service User Involvement and Recovery* London. Jessica Kingsley
- Riessman CK (1993) *Narrative Analysis*. Sage, London
- Ricoeur P (1981) "Narrative Time", (165-186). In: On Narrative. W J T Mitchell, (ed.). The University of Chicago Press, Chicago.
- Ricoeur P (1988) *Time and narrative*. (Volume 2) University of Chicago Press, London
- Ricoeur, P., (1991). Narrative identity. *Philosophy today*, 35(1), pp.73-81.
- Rogers C R (1951) *Client-centered therapy: its current practice, implications and theory*. Houghton Mifflin, Boston
- Sarangi, S. and Candlin, C., (2003). Categorization and explanation of risk: A discourse analytical perspective. *Health, risk & society*, 5(2), pp.115-124.
- Sawyer A-M (2017) Negotiating the Interface between Risk Management and Human Rights Based Care *In* Stanford, S, Sharland S, Rovinelli Heller N, Warner J (eds) *Beyond the Risk Paradigm in Mental Health Policy and Practice* Palgrave Macmillan Education. London
- Scott, A., Doughty, C. and Kahi, H., (2011). 'Having those conversations': The politics of risk in peer support practice. *Health Sociology Review*, 20(2), pp.187-201.
- Shkedi A (2005) *Multiple Case Narrative: A Qualitative Approach to Studying Multiple Populations*. John Benjamins Publishing Company, Amsterdam
- Skinner, J (2000) The Eruption of Chances Peak, Montserrat and the Narrative Containment of Risk In Caplan P (ed) *Risk Revisited*. Pluto Press. London.
- Stickley, T. and Felton, A. (2006) Promoting Recovery Through therapeutic risk taking. *Mental Health Practice* 9(8): pp.2630
- Szmukler, G., and Rose, N. (2013). Risk assessment in mental health care: Values and costs. *Behavioral sciences & the law*, 31(1): pp.125-140.
- Wand, T. (2011). Investigating the evidence for the effectiveness of risk assessment in mental health care. *Issues in mental health nursing* 33(1): pp.2-7.
- Warner, J. and Gabe, J., 2004. Risk and liminality in mental health social work. *Health, risk & society*, 6(4), pp.387-399.
- West, E., Newton, V.L. and Barton-Breck, A., (2013). Time frames and self-hurting: that was then, this is now. *Health, risk & society*, 15(6-7), pp.580-595.
- Wolgemuth J R and Donohue R (2006) Toward an Inquiry of Discomfort Guiding Transformation in "Emancipatory" Narrative Research. *Qualitative Inquiry*, 12 (5) 1012-1021

Wolgemuth J R and Donohue R (2006) Toward an Inquiry of Discomfort Guiding Transformation in "Emancipatory" Narrative Research. *Qualitative Inquiry*, 12 (5) 1012-1021

Zinn, J (2005) The biographical approach: A better way to understand behaviour in health and illness *Health Risk and Society* 7:1 1-9