

Seclusion In Psychiatry : Nurses' and Patients' Point of View

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Abstract :

Introduction : Seclusion is the involuntary confinement of a person alone in a room or an area where the person is physically prevented from leaving. Seclusion continues to be prescribed in the care of psychiatric patients suffering from schizophrenia, bipolar disorders or major depression with suicide ideas.

Discussion : The use of seclusion needs to be examined in the care of mentally ill people. Clinical advances have played a significant role in the emerging best practices. Clinicians insists on the use of seclusion with a strict protocol that provided parameters for its use.

Conclusion : Seclusion in psychiatry is controversial. Critics argue that it is draconian and infringes the patient's human rights whilst supporters assert that it is a last resort measure used to manage the risk posed to others. Seclusion may only be used for the management of violent or self destructive behavior. While expert therapeutic interventions were described by clinicians, they are contextualized within a framework of power and control - a framework that stands in stark contrast to contemporary philosophies of nursing care, providing impetus for a reconsideration of the use of constraining practices in the care of mentally ill people.

Key-words: *Seclusion - Restraint - Indications - Contraindications - Patients' point of view - Nurses' point of view*

1. INTRODUCTION

Historically, seclusion is one of the oldest enduring approaches in the treatment of mentally ill people, first described by Soranus, a Greek philosopher of the second century AD (McCoy and Garritson, 1983; Muir-Cochrane, 1996). It is used today despite contemporary mental health nursing philosophies of humanism, individualism and the therapeutic nurse-patient relationship. Within this context it is perceived diversely by mental health professionals and patients as an anachronistic nursing activity, with no place in current treatment modalities (Sallah, 1992; Topping-Morris, 1992), as a therapeutic tool, and as an effective management strategy in violent situations (Gutheil and Daly, 1980; Chu and Ryan, 1987). Increasing attention given to the rights of those with mental illness to quality care provides opportunity to review the significance of seclusion in the management of disturbed and violent patients.

Alty and Mason (1994), in their text *Seclusion: A Break with the Past*, provide a unique synthesis of the current state of play in regard to the use of seclusion worldwide. In particular, they emphasize their personal and professional shame in recognition of the failure of current trends in the care of mentally ill people to answer some of the most fundamental questions regarding the use of control mechanisms. They also draw attention to the paucity of research into aspects of the seclusion experience, acknowledging that much of the debate is either opinion or anecdotal in origin (Pilette, 1978; Brennan, 1991; Sallah, 1992). Reasons for such lack of attention may include discomfort in reflecting on values that underpin existing mental health approaches and the historical influences of institutionalized psychiatric care.

This paper explores the contemporary use of seclusion, through a review of the literature. Given the dearth of convincing evidence concerning the efficacy of seclusion, concerted attention regarding the nature and application of seclusion is long overdue in the search for quality care for our most seriously ill clients.

2. SECLUSION TODAY

Seclusion is the forced isolation of a person for an arbitrary period of time, in a room that is purpose built, with few furnishings except a mattress and a bed (Thorpe, 1980; Baradell, 1985). Interestingly, many authors define seclusion in ambiguous terms, as if clear definition is not required (Binder, 1979; Schwab and Lahmeyer, 1979; Soloff and Turner, 1981; Hodgkinson 1985). There is very little research into the nature or effectiveness of seclusion and little evidence of uniformity between its use in the United States of America, Europe and Australia (Tardiff, 1984). Common indications for its use are assault and/or behaviour that is destructive to the environment (Whaley and Ramirez, 1980; McCoy and Garritson, 1983; Baradell, 1985; Chu and Ryan, 1987; Myers, 1990). Discussions in the literature suggest conformity regarding duration times of seclusion from 1 to 3 hours (Roper et al., 1985; Soliday, 1985; Baxter et al., 1989; Kirkpatrick, 1989).

Existant research presents an unclear picture as to whether seclusion is currently used as an adjunctive treatment in the care of acutely disturbed individuals or whether it is used solely as a mechanism of behaviour management (Plutchik and Larasu, 1978; Campbell et al., 1982; McCoy and Garritson, 1983). To date its therapeutic nature has not been proven. Redmond (1980) describes the use of seclusion only as a last resort which implies its use as a management tool and not a therapeutic intervention. Furthermore, use of seclusion in this way may reflect a sense of helplessness by clinicians, that they have failed in their endeavours to assist disturbed patients.

It is not surprising therefore that the popular press has made association between seclusion and solitary confinement or punishment, a point not lost on other workers calling for urgent review of its use (Brennan, 1991; Alty and Mason, 1994). While Gutheil (1978) detailed a foundational, theoretical construction as a rationale for the seclusion process that include the interrelated principles of containment, isolation and a decrease in sensory input, he also makes pertinent comment in stating : « In my experience the rationale for the use of seclusion has passed so thoroughly into clinical practice on psychiatric wards that its principles are now more implicit than articulated.»

If the purpose of seclusion is seen to be to prevent a person who is acutely disturbed from harming themselves, it remains unclear as to when preventive interventions would most effectively commence; when the patient's behaviour is disorganized or potentially violent or when the threat of violence is certain (Ritter, 1989). Indeed it is recognized that factors associated with the accurate prediction of patient violence by clinicians are also poorly understood (Morrison, 1993; Finnema et al. 1994).

3. INDICATIONS AND CONTRAINDICATIONS

A number of authors have expressed opinions about specific indications and contraindications for seclusion. APA's task force report on seclusion and restraint (1985) described the indications as prevention of imminent harm to self or others when other means are ineffective, prevention of substantial damage to the physical environment, prevention of serious disruption of the treatment program, as a contingency in the behavior therapy of dangerous behaviors, to decrease stimulation, and at the patient's request. The least controversial of these is prevention of harm to self or others, with which many authors concur (Edwards and Reid, 1983; Palazzolo, 1998), although the criterion of imminence is not always specified. Kilgalen (1977) and Tardiff (1984) cautioned against the use of seclusion (as opposed to restraint) for suicidal or self-mutilative patients. In national surveys on state policies for the use of seclusion, Tardiff and Mattson (1984) and Fassler and Cotton (1992) noted that most respondents cited danger to self or others as the primary indication.

A smaller number of authors included prevention of property damage (Gair, 1980; Tardiff, 1984; Fassler and Cotton, 1992; Fisher, 1994), protection of the ward milieu from socially unacceptable behaviors (McCoy and Garritson, 1983; Fassler and Cotton, 1992), decreasing stimulation (Gutheil, 1978; Kinsella et al., 1993), and the patient's request (Bursten, 1975; Whaley and Ramirez, 1980) among the indications for seclusion. Outlaw and Lowery (1992) stated that these interventions should not be used simply to maintain the therapeutic milieu in the face of agitation. They maintained that because violence cannot be accurately predicted, such a policy would result

in the unnecessary restraint of patients who would never have become violent. Several authors saw maturational deficits in self-control manifested by impulsive acts as possible indications for seclusion (Gair, 1984; Whaley and Ramirez, 1980).

One of the more controversial indications is as a systematic contingency in a behavioral program dealing with violent behaviors (Plutchik et al., 1978; Fisher, 1994) because such a regimen could violate the criteria of imminent danger and last resort use and would also base release on a specified time period rather than clinical condition. In Fassler and Cotton's survey (1992), only 50% of the responding states permitted seclusion as a «therapeutic» modality. Other indications cited for seclusion included minimization of medication during observation of patients with agitated (possibly toxic) delirium or psychosis (Tardiff, 1994) or when treating episodes of violence in psychotic pregnant patients (Miller and Resnick, 1991), preventing injury during emergency administration of medication (Citrome and Green, 1990), and preventing injury during therapy sessions with violent personae in patients with multiple personality disorders (when used with the patient's consent) (Kinsella et al., 1993; Baxter et al., 1989). Kuehnel and Slama (1984) viewed prevention of aggression and self-mutilation not responsive to other interventions as the primary indication for seclusion in the developmentally disabled. Hodgkinson (1985) observed that although the indications for seclusion in the elderly are the same as in the general adult psychiatric population, the risk of complications is greater.

Contraindications cited for seclusion include conditions such as encephalopathies that could be exacerbated by decreased sensory input (Fisher, 1994), as a substitute for treatment (Mattson and Sacks, 1978), as a punishment (Bursten, 1975; Gutheil and Daly, 1980; Tooke and Brown, 1992), as a response to refusing treatment or activities (Stilling, 1992), as a response to obnoxious behavior (Sines, 1994), for staff convenience (Soliday, 1985; Strutt et al., 1980), and when experienced by the patient as a positive reinforcement for violence (Myers, 1990). However, Campbell et al. (1982), using seclusion as a positive reinforcer, were able to reduce self-injurious behavior in three profoundly retarded patients.

Contraindications cited for seclusion include medically unstable conditions (Tardiff, 1984; Campbell et al., 1982).

4. ISSUES OF POWER AND CONTROL :

Andrew Scull has written extensively about the history of the asylum and society's treatment of mentally ill people, tracing approaches to care from the 1700s (Cohen and Scull, 1985; Scull, 1979, 1984, 1993). Prior to the reformist movement of the 18th century, mentally ill people were cared for by their families or in poor houses. Societal attitudes of fear and derision towards individuals labelled «deviant» resulted in mentally ill people being subjected to physical controls including incarceration and torture. As «madhouses» increased in number, strategies to subdue patients included shackles, whippings and other restraint devices such as seclusion. The introduction of moral treatment by the philanthropist William Tuke in England and the physician Philippe Pinel in France heralded an era in which attitudes to mentally ill people changed, with a belief that existing treatments for them bore some efficacy. Scull (1979, 1993) hypothesized that the growth of the asylum at this time was in fact not a consequence of reform, but merely a historical shift in the approaches of social control of disturbed individuals.

Scull (1979) views the containment ideology as a consequence of capitalism, supporting paternalistic interventions designed to control the poorer classes. Thus, asylums became dumping grounds for «deviants» removed from public view. Alty and Mason (1994) make useful comment that while humane treatment was espoused as the central approach to care, seclusion and other forms of restraint continued to be used in asylums. It is evident that seclusion continued to be used throughout the 18th and 19th centuries as an effective means of control. The prevailing climate of custodial care and a despondent medical profession facilitated its continuance.

Sociological and philosophical frameworks provide useful insight into the contemporary controversy surrounding the use of physical controls in the treatment of mental illness. The French philosopher Michel Foucault (1967) depicted the structures of organizations and power within them as socially created. The evolution of the asylum and the development of administrative and judicial structures during the 17th century is detailed in his text *Madness and*

Civilisation. He explored the notions of examination, surveillance and observation, all of which had direct impact on the way that mentally ill people were cared for in asylums. He described the «panopticon», an architectural construction for prisons (designed by Jeremy Bentham) which embodied the above principles. The spatial arrangement of the panopticon allowed for constant scrutiny of both inmates and guards with neither knowing when they were being observed or by whom (Cheek and Rudge, 1995). This facilitated a climate of conformity and compliance for all individuals within the institution. Indeed, psychiatric hospitals today have perpetuated this «gaze» in ward design (Lawler, 1991; Cheek and Rudge, 1995).

Foucault's genealogy of modern power is embedded in the «social practices that constitute everyday life in modern societies» (Fraser, 1989). Unequal power relations are constructed through the dissemination of ideology. In psychiatric institutions, the dominant medical model of care supported paternalistic interventions, through which the patient is constructed as a grateful but powerless individual.

Goffman's (1961) text *Asylums* was definitive in focusing on the social world of hospital patients. This ethnographic work delineated new sociological and political constructs, such as total institutions, a social system comprised of a large number of individuals isolated from everyday life. Goffman (1961) coined the term institutionalization as the social processes that affect individuals within the institution, facilitating dependency on the institution and a loss of personal autonomy and identity. Patients were subjected to «a rather full set of mortifying experiences, restriction of free movement, communal living, and diffuse authority of a whole echelon of people» (Goffman, 1961). Goffman depicts the institution in similar fashion to Foucault as a functionalist representation of historical developments associated with the existing moral climate. The roles of both patient and nurse are defined through these social structures as mutually oppressive, with the patient role reinforced as inferior, weak and blameworthy (Goffman, 1961). The status quo is reinforced through the meting out of punishment to those who do not conform to the standards set by the institution.

Furthermore, others have suggested that high levels of control in psychiatric institutions enabled staff to maintain high levels of efficiency, in a conformist environment designed to maintain the status quo of the ward routine and reduce anxiety associated with the working environment (Menzies, 1970; Brown, 1973; Beardshaw, 1981). It is not difficult to find examples of these social processes in psychiatric hospitals today; the threat of seclusion, increased medication, or the removal of privileges if patients are non-compliant.

More recently, support for this standpoint is found in the work of Morrison (1989, 1993) and Rosenhan (1973), who have identified how staff operationalized the value of control within a model of care that was strictly authoritarian. Morrison's work identified an emphasis on carers' values of control and safety, labelling the role that carers utilized as «enforcing», and including the strategies «policing», «supermaning» and «putting on a show» (Morrison, 1989). The bureaucratic need to maintain safety resulted in a stringent adherence to the ward routine and a rigid rule structure.

It is within this context that seclusion has remained a common tool in the control of acutely disturbed patients in psychiatric hospitals. The practice has continued, applied in an inconsistent fashion, without sustained critical reflection, legitimated by the institution and indeed the nursing profession as an effective means of managing «out of control» patient behaviours.

5. NURSES' AND PATIENTS' VIEWS ABOUT SECLUSION

Pilette (1978) suggests that seclusion has managed to avoid the questioning eye of the mental health practitioner. In the 18th century, seclusion was implemented as a punishment for controlling the physical body (Foucault, 1973) and to intimidate and exclude (Farrell and Dares, 1996). Today, its therapeutic effects on the mind is espoused by nurses in favour of its use (Muir-Cochrane, 1996).

However, this claim has not been justified. The patients' experience has rarely been considered. The few articles that report the views of patients on seclusion suggest that many perceive it negatively. For instance, Heyman (1987) found that nurses reported being satisfied with the

seclusion process, seeing it as helpful for patients. In contrast, a majority of patients in the Heyman study perceived seclusion as more a punitive measure than a helpful one.

Tooke and Brown (1992) also indicate that staff and patients perceived seclusion differently. In their study, nurses thought that the seclusion process benefited first the patients, second the secluded patient, third the hospital, and last the staff; whereas, patients assigned most benefit to the staff, then to other patients, the hospital, and with the secluded patient last. These authors found that nurses judged seclusion to be necessary, generally therapeutic, and rarely a punishing experience. Yet patients generally found the experience of being secluded by a nurse punitive. Patients in Heyman's (1987) study reported that they spent far too long in seclusion. They chose 15 minutes as the preferred length of time. Nurses thought 8 hours was the time patients should remain secluded.

The typical seclusion room, especially so in the special hospital, is often small, stark, with plainly painted walls, no furnishings except a mattress on the floor. Windows are either shuttered or high on the wall. Doors are solid, opening only from the outside. Patients are observed through a small observation window in the door. Toilet access is usually by request only. A similar description could. Equally apply to a solitary confinement cell (Binder and Mc Coy, 1983).

Patients in a study by Norris and Kennedy (1992), suggested the following changes to the seclusion experience : requests for music; better bathroom facilities; a method of summoning assistance; better decor; and more comfortable temperatures. In the penal setting, reduction of temperature has in the past been used as a means of punishment (Thoenig, 1972).

It may be argued by some nurses that seclusion, like some medicines, has a value despite it being unpalatable. However, the question needs to be asked, does the end justify the means in this case? Many nurses value seclusion as it affords the patient «time out» from social and sensory stimulation, believing it will help stabilize the patient.

In contrast, Stilling (1992) suggests that social isolation alone can produce serious stress in individuals. Norris and Kennedy (1992) report that many patients felt anger, fear and anxiety prior to and on the way to seclusion and a third of patients reported continued agitation during seclusion. A majority of negative feelings predominated among patients when asked about their seclusion experience in the study reported by Tooke and Brown (1992). In another study, patients reported feeling bitter about their seclusion experience one year later (Wadeson and Carpenter, 1976). In a review by Fisher (1994) seclusion may result in high anxiety and other deleterious physical and psychological effects on those contained.

In the penal setting prisoners experience similar responses. Gunderson (in Lucas, 1976) reports that prisoners may experience high anxiety prior to and during seclusion. In addition, prolonged periods of seclusion may affect the person's thinking, their visual perception may become disturbed and they may experience hallucinations (Grassian, 1983; Strutt et al., 1980).

McNeil (1994) suggests that prolonged sensory deprivation may be one factor in accounting for the production of hallucinations. This is predicated on the theory that hallucinations occur when the level of sensory input is insufficient to organize the filtering mechanisms of the brain but there remains enough arousal for conscious awareness. According to Lucas (1976) «confined inmates often report extreme boredom, restlessness, irritability, anger, unrealistic fears, anxiety, depression and physical complaints rarely reported by subjects in control conditions». In short, confinement can lead to a loss of contact with reality, persistent vivid dreams, sexual thoughts and speech difficulties (Craig et al., 1989). Both prisoners and patients, it seems, report broadly similar dissatisfactions with solitary confinement and seclusion, respectively. And the physical characteristics of each seclusion setting are broadly similar. As the act is defined and enforced it would be easy for a nurse to be seen implementing either seclusion or solitary confinement. Points of contrast lie in the difference between the respective «keepers» views. In the penal setting, solitary confinement is largely regarded as punishment whereas in the mental health setting its therapeutic values are espoused by some, although there is evidence that at least some staff may view seclusion as punishment for unacceptable behaviours (Alty and Mason, 1994).

6. CONCLUSION

If seclusion is to continue, whether in its present form or as a form of intensive care, a thorough understanding of its' theoretical and therapeutic nature is necessary to reflect contemporary mental health nursing philosophy that purports humanistic, holistic and individualized approaches to care (Sines, 1994). The lack of consistency in the application of seclusion, its efficacy when used alone or as an adjunctive treatment and the prevailing legal and moral issues surrounding its use point to the need for further scrutiny of a practice condemned by many as punitive, coercive and anachronistic. There is impetus therefore for a collective reconsideration of the continuation of its use by clinicians and academics alike in the search for progressive strategies in the care of our most vulnerable clients.

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