Original Article

Experiencing Seclusion in a Forensic Psychiatric Setting: A Phenomenological Study

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ABSTRACT

In hospital settings, and especially in forensic psychiatric ones, restlessness, aggression, and even violence are familiar issues to healthcare workers. Under these circumstances, the need for restrictive measures (seclusion, mechanical/chemical restraints) is sometimes needed. Although such measures should be considered as exceptional interventions, they continue to be widespread in general, psychiatric, and forensic psychiatric settings. Although there is a great deal of literature on a myriad of issues associated with the use of seclusion, very little research has focused on the lived experience of the seclusion room in forensic psychiatric settings, whether from the patient's perspective or from the perspective of nursing staff responsible for these patients. Such an examination could help ameliorate the experience of secluded forensic psychiatric patients while informing nursing staff about the impacts of seclusion. This article reports the results of a federally funded qualitative, phenomenological research study conducted in a Canadian forensic psychiatric environment. Our results show that the "structure of place" matters for both patients who experience seclusion and nursing staff who work therapeutically in these settings. "Place" is irreducible to the physical "space" in which bodies find themselves; this study of place took into consideration the ways the lived body experiences seclusion and interrelates with others. Although there can be no doubt that many patients who experience seclusion are oftentimes objectively at risk, with a heightened potential to self-harm and to harm other inpatients and nursing staff as well, as our study participants attested, the bodies secluded in this space are not "objects."

KEY WORDS:

experience; forensic nursing; nurses; patients; phenomenology; seclusion

In hospital settings, and especially in forensic psychiatric ones, restlessness, aggression, and even violence are familiar issues to healthcare workers (Holmes, Rudge, Perron, & St-Pierre, 2012; Perron, Jacob, Beauvais, Corbeil, & Bérubé, 2015). It is also understood that some psychiatric illnesses are aggravated by various stimuli that induce disruptive behaviors (intense psychomotor agitation, irritability, etc.) that can be a threat to the welfare and safety of others or to the individual himself or herself (Grassian, 2006; Holmes & Murray, 2012; Jonker, Goossens, Steenhuis, & Oud, 2008; Whittington & Higgins, 2002). Under these circumstances, the need for restrictive measures (seclusion, mechanical/chemical restraints) is sometimes the only solution because they serve to protect the patients as well as those around them. Although such measures should be considered as exceptional interventions, they continue to be widespread in general psychiatric settings (Muir-Cochrane & Gerace, 2014) and also in forensic psychiatric settings (Holmes & Murray, 2011; Murray & Holmes, 2013a, 2013b). Although there is a great deal of literature on a myriad of issues associated with the use of seclusion, very little research has focused on the lived experience of the seclusion room in forensic psychiatric settings, whether from the patient's perspective or from

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the perspective of nursing staff responsible for these patients. Such an examination could help ameliorate the experience of secluded forensic psychiatric patients while informing nursing staff about the impacts of seclusion. In this article we report the results of a federally funded qualitative, phenomenological research study conducted in a Canadian forensic psychiatric environment.

Literature Review

Recent statistics suggest that roughly 24% of individuals admitted to a mental health bed in the province of Ontario will experience at least one type of control intervention with acute control medication reported as the most commonly used form of control (58.9%)[1] compared with physical/mechanical restraints (20.7%) and seclusion (20.4%; Canadian Institute for Health Information, 2011); specific Canada-wide statistics for forensic settings were not available at the time our research was conducted. Despite sustained scrutiny, the use of all forms of restrictive measures in psychiatry remains a symbol of the control ascribed to health professionals, especially nurses, in the management of mentally disordered persons who are perceived to be dangerous or difficult (Duxbury, 2000; Wynaden et al., 2001). This holds true for the practice of seclusion in particular (Wynaden et al., 2001), especially given the widespread criticism and lack of evidence for its rationale. Undoubtedly, the humanitarian, ethical, and legal issues associated with the use of these interventions make them controversial management strategies (Goethals, Dierckx de Casterlé & Gastmans, 2012; Mohr, 2010; Strout, 2010). Indeed, for some researchers, the use of seclusion is one of the most controversial management strategies available (Holmes, Kennedy, & Perron, 2004; Hui, Middleton, & Völlm, 2013), particularly in forensic psychiatric settings.

Mason (1994) defines seclusion as "a form of environmental confinement in which a patient is secluded against his/her will in a room, with no furniture, except for a mattress, and which he/she cannot leave as the door is locked from the outside" (p. 54). Mason also outlines three common reasons used to justify the use of seclusion: (a) therapeutic purposes (e.g., removing a patient from an overstimulating environment); (b) safety issues (e.g., preventing a patient from engaging in acts that are dangerous to themselves or others); and (c) punitive purposes (e.g., behavior modification). These three justifications are common throughout the literature on this topic. The use of seclusion has the potential to erode important ethical concepts such as respect, dignity, and empathy, although these concepts are meant to underlie ethical healthcare practices.

The physical space of many seclusion rooms is also problematic because these spaces are not only inadequate but also unhygienic. Floor materials, beds, lighting, surveillance devices, and an absence of fresh air circulation can make the seclusion room experience horrendous for secluded patients as well as for staff members who must cope with not only an inhumane environment but also one that makes it increasingly difficult for patients to maintain a proper level of hygiene. It is worth mentioning that this description of the physical space of seclusion rooms does not necessarily apply to all countries but is a reflection of what is reported in the literature as being experienced by patients.

Moreover, secluded patients have been found to report a range of emotional states, from anger, anxiety, guilt, frustration, persecution, and resentment to feelings of relief, control, or happiness (Horsfall & Cleary, 2003; Taxis, 2002). In this context, nurses are regularly confronted with the effects of seclusion and are forced to navigate between care and control (Alty & Mason, 1994; Holmes et al., 2004). In a seminal research study conducted several years ago, LeGris, Walters & Browne (1999) concluded that "unfortunately, nurses, more than any other health care professionals, have been found to support the continued use of seclusion, believing it to be necessary and therapeutic for patients" (p. 458). For many authors, seclusion represents an uneasy juxtaposition of therapeutic and repressive objectives; for others, the term "therapeutic seclusion" is an oxymoron because it can be traumatizing for patients and may also undermine the therapeutic process as well as the therapeutic rapport developed between patients and staff (Holmes et al., 2004; Mason & Chandley, 1998; Miller, 1992; Norris & Kennedy, 1992). For these reasons, among others, the use of seclusion in diverse psychiatric settings raises numerous ethical issues. This being said, recent literature provides more humane guidelines regarding the use of seclusion in psychiatric settings. For example, the Department of Health (2015) gives specifications regarding the physical features, safety, and use of seclusion rooms, stating that, in England and Wales, seclusion should "never be used solely as a means of managing self-harming behaviours" (Department of Health 2015, p. 300).

According to our literature review, although the field of bioethics is neither conceptually nor methodologically monolithic, its various strands nevertheless tend to take for granted the truth of personhood or subjectivity as it is derived from Enlightenment reason—including the belief that the "mentally well" individual exercises autonomy and rational agency. In other words, the conventional subject of bioethics is ideally a stable and coherent self, sovereign in its ethical judgments (Murray & Holmes, 2009). From the clinic to the classroom, the standard bioethics textbook continues to be Beauchamp and Childress (2012), who

[1] *This number is likely an underestimation of the use of chemical restraints as instances where acute control medications were used in concert with other forms of restraint; these instances were not tabulated under the acute control medication group but rather integrated to the other form of restraint.*

propose four well-known bioethical "principles" that speak to nurses' moral dilemmas related to the duty of care to preserve life, health, and safety. These principles are respect for autonomy, nonmaleficence, beneficence, and justice. Although the three latter principles are not reducible to the first ("respect for autonomy"), each nevertheless presumes the existence in some form of a modern subject/agent founded in rational autonomy. Derived from the Greek *auto-* (self or own) + *nomos* (law), "autonomy" describes the way that the self is conceived as governing or conducting itself. Thus, the self is considered to be fully autonomous only when it governs itself according to rational principles that have been conventionally (and institutionally) recognized as such. One might be recognizably "human," but one is not considered fully autonomous when ruled by emotions or bodily urges; such an individual might forfeit certain "rights" and risks being ostracized socially and/or politically. Rational autonomy therefore presumes that one acts and is acted upon in a very particular way. In the medical context, rational autonomy is a strange convention in part because its philosophical underpinnings continue to be dualistic, founded in a binary logic that sees agency as a mental activity of free will and bodies as no more than resistant, brute matter or a heap of "spare parts." Indeed, current research in critical bioethics indicates that "autonomy" is sometimes experienced as a violent, unethical imperative (e.g., Holmes & Murray, 2011; Mol, 2006; Murray, 2007, 2009; Murray & Holmes, 2013a, 2013b).

Theoretical Framework

When seclusion is chosen as the appropriate course of treatment, forced isolation seems to impose "autonomy" by limiting or cutting off social interaction to leave the patient alone with his or her own thoughts. However, given the complex interrelationship between mind and body, it seems doubtful that "autonomy" could be respected or restored through bodily confinement if nursing care is absent (or impeded) during confinement in the seclusion room. The body inevitably occupies space and place, in intimate proximity with its meaningful environment. For this reason, our research project used a phenomenological approach (theory and methodology) to the ethics of body and place (Murray & Holmes, 2013a, 2013b).

Phenomenology

Husserl (1970) argues that dualistic thinking fosters a dangerously abstract form of "reason" and rational autonomy. Such rationalism is dangerous because it conceives of bodies and life itself as mere physiology—bodies conceived reductively as *Körper* in the geometric or material sense and life conceived as bare biophysiology. Against this understanding of bodies, Husserl distinguishes the body as *Leib*. *Leib* is translated as the "lived body," a body that is situated in the "life world," a bodily life in which bodies coexist through empathy, in meaningful community with others, and in intimate proximity with the world. Following Husserl and his successors, our research starts with the lived body that exists in a spatiotemporal relation with others and with its environment. More specifically, we focused on the ways that the lived body and place have been elaborated. Merleau-Ponty (1962) discusses the manner in which the lived body (*corps vecu*) is "geared into" the world through perception; Heidegger develops a relational understanding of care (Heidegger, 1962) and place in terms of "dwelling" (Heidegger, 1971); and more recent work includes distinctly embodied analyses of medicine (Leder, 1998; Nancy, 2009), solitary confinement in prison settings (Guenther, 2011, 2013), ethics and ethical "know-how" (Varela, 1999), and cognition (Varela, Thompson, & Rosch, 1991). Although the literature is transdisciplinary, what remains consistent is the refusal of Cartesian mind–body dualism. We take up the insights of this tradition and apply them as an ethics of the body (Schildrick & Mykitiuk, 2005) in the domain of health care. Rather than seeking recourse in the principle of rational autonomy, phenomenology allows us to locate ethical agency and comportment as relational, incumbent upon the ways that bodies and places interact, informing one another, to provide "the structure of subjectivity" (Malpas, 1998).

Place

In the context of health care, a phenomenology of body and place must consider the fact that bodies are located in institutional places, such as forensic psychiatric settings, that are laden with significance. Foucault's (1967, 1973) work on the clinic and the medical gaze is seminal, as is his work on biopolitics (Foucault, 1994, 2008). This work helps to situate the seclusion room as a nodal point in the intersection of bodies and places of institutional power. Most nurses will be acutely aware of the extent to which forensic psychiatric settings are rife with power relations (Holmes & Jacob, 2012): who controls access, who sets the agenda, whose interests are served, and how those lower in the socio-institutional hierarchy are treated in ways that continually "remind" them of—and keep them in—their "place." However, there are also subtler forms of power implicated in, and inextricably bound up with, the notions and practices of (nursing) "care" itself. Foucault (1991, 1994, 1995) has contributed substantially to our understanding of this "microphysics" of power relations, illustrating that healthcare professionals work within a state apparatus—multifaceted administrative systems (the justice and healthcare systems, for instance), each of which conceives the well-being, security, and health of the population as their official mandate (Castel, 1998).

Goffman (1998) describes the existing tensions and contradictions between the therapeutic demands of care

and the imperatives of social control and order at the heart of "total institutions"—especially psychiatric institutions and corrections. The completely encompassing or totalizing character of "total institutions" is symbolized by the barrier to social intercourse with the outside world, one in which all modalities of life are explicitly and meticulously regulated: Daily practices are tightly scheduled, regimented in time and space, for the institution to function efficiently in terms of service delivery—increasingly neoliberalized—as well as in terms of mandated outcomes (Goffman, 1998).

The multiplex dimension of place is an essential theoretical element of our research of the lived body: the importance of the location of the body (forensic setting), the fact that the organization of space is dependent on human development, and the fact that certain types of relations between bodies and places may all constitute expression of pathologies (be they personal or institutional). According to Fisher (1992), many studies have focused on stressors in the environment, some suggesting that environmental overload (screaming, crying, psychomotor agitation from peers, etc.) may account for the stress-inducing attributes of a particular space. However, our phenomenological perspective moves beyond these observations to study the ethics of the lived body (patients and nurses) in a forensic psychiatric institutional environment that is highly regulated.

Methodological Considerations

Research Design

A modified Interpretative Phenomenological Analysis (IPA) was chosen as the preferred research design (Murray & Holmes, 2013a). IPA is a qualitative method originally developed for studies in health psychology (Colaizzi, 1978; Reid, Flowers, & Larkin, 2005). Although it is a relatively new methodological approach, in recent years, it has become increasingly popular in the human, social, and health sciences (Larkin, Watts, & Clifton, 2006; Smith, Flowers, & Larkin, 2009). The goal of this phenomenological approach is to understand the ways in which individuals perceive the world around them and make sense of their lived experiences. Focusing on the body and its perception, IPA offers an alternative to cognitively oriented health psychology "by looking in detail at how individuals talk about the stressful situations they face, and how they death with them, and by close consideration of the meanings they attach to them" (Smith, 1996, p. 270).

Data Collection and Analysis

In-depth, semistructured interviews (n = 26) were conducted to obtain detailed information on the lived experiences of forensic psychiatric patients/nurses who have experienced/used seclusion rooms. To this end, interviews were designed to gain access to the bodily phenomenon of being subjugated to chemical restraints, to "give voice to" the intimate experiential understanding and elaboration of this experience, and to understand the subjective processes and meaning-making of this experience. All interviews were digitally recorded with the permission of participants. Two different interview guides were used, one for inpatients and one for nursing staff; however, both interview guides used similar open-ended and nondirective probes. Our project adapted IPA methods described in the detailed handbook published by Smith et al. (2009). As they suggest, IPA can complement traditional methodologies because it affords insight into a subject's intimate experience of body and illness, psychological distress, personal identity, and the effects on these of treatments such as seclusion: "the IPA researcher is engaged in a double hermeneutic because the researcher is trying to make sense of the participant trying to make sense of what is happening to them" (Smith et al., 2009, p. 3). We ended up using content analysis principles to code, categorize and "thematize" our qualitative data (Guest, MacQueen, & Namey, 2012). All authors were actively involved in the content analysis process (codes, categories, and themes), and all authors agreed on the analysis, organization, and presentation of the data.

Participants and Study Location

Study participants included 13 forensic psychiatric inpatients who had experienced a period of seclusion in the 6 months before the interview date and 13 forensic psychiatric nurses who had provided care to a secluded patient in the 6 months before the interview date. All nurses were recruited after a short face-to-face group presentation of the research project. Patients were recruited directly by a research assistant after accessing the medical files. The only other inclusion criterion was that participants were able to recall their seclusion experience and were willing to discuss it. The research was conducted in a mid-size Canadian forensic psychiatric facility.

Ethics

The research received research ethics board clearance from both the hospital and the university. Participants were thoroughly informed of the research project, and all signed the consent form in a free and informed manner. Participants could refuse to respond to specific questions or simply withdraw from the research; however, none did. Researchers were fully aware of the sensitive nature of the research related to the experience of seclusion, especially from patients' perspective. As a consequence, distressed patients would have been referred to the head nurse in case of distress. Similarly, nurses would have been referred to their Employee Wellness Program. No distressed reactions occurred in either set of participants.

Results

We have decided to present our research results in sequence beginning first with patients' interviews followed

by nurses'. Using the principles of content analysis (Guest et al., 2012), three main themes emerged for both groups of participants. For patients, the themes are "experiencing seclusion," "assessing quality of care," and "space of confinement." For nurses, the emerging themes are as follows: "resorting to seclusion," "observing and assessing patients," and "experiencing seclusion."

Inpatients

Experiencing Seclusion

The first theme that emerged from interviews with patients was how they personally experienced seclusion, including their reactions to being secluded, how they felt seclusion impacted their mental state, and whether they felt seclusion rooms were necessary in a forensic mental health setting. Patients responded differently to being secluded, and their responses may be dependent on their mental state at the time as well as whether they understood why they were being secluded and what this meant for them. As one patient mentioned, reactions to seclusion may be quite different depending on whether the patient understands that it is intended to help them and not to harm or punish them:

> I understand my circumstances. For someone that doesn't, it could be very hard on them, I think, to be inside of a room like that. (P10)

Some patients did report having relatively positive experiences while in seclusion either because it made them feel safe or gave them an opportunity to deescalate or to restabilize on medication or because they simply spent their time sleeping.

> I was kind of happy to be in there. I knew I didn't have to worry about anything. (P2)

> I was pretty sick when I first got there. I hadn't taken medication in about four months. I was pretty sick. But, after three months, my medication caught up with me, you know. I was 100% better than when I went in there. (P1)

However, some patients reported that being secluded was a negative experience, with the most common complaints being boredom, loneliness, and discomfort.

> It's very negative. You feel really bad when you're about to go in there and when you're in there, because you have nothing to do. You just lay there for hours, not being able to talk to anybody. It's very overwhelming. (P5)

> Nobody likes the seclusion room…it's confined… it's boring. It's a little bit demoralizing. (P7)

> It was pretty overwhelming at first…there's still a smell, a lingering odor of someone else being in there. And just the discomfort. (P10)

Because many patients found their time in seclusion to be a negative experience, it is not surprising that they also felt that being secluded did not improve their mental health but rather might actually have been detrimental to them.

> I kind of felt really, really depressed, you know? I was always alone…and I didn't like it at all and…eventually I started to break down. (P12)

> It's scary being locked in any room where someone has to come and turn a key for you, so it could probably definitely cause a lot of stress, particularly if you were in there for an extended period of time. (P10)

> We all have programs in this building, we're all doing things, so they're really taking away from what we're doing…we miss all the programs, we miss our job, we miss outings. (P4)

Interestingly, although some patients found seclusion to be a negative experience and did not think it was beneficial to their mental health, most still understood why seclusion rooms would be necessary in a forensic psychiatric setting.

> When you have patients that don't want to follow the rules or people that have negative symptoms…it's pretty much a necessity. (P7)

> I think it can be a great tool for people, it keeps people safe…. Personally, if I was in a state where I was going to hurt myself or someone else, that's a better option, to be put in one of those rooms. (P10)

However, there were patients who felt that seclusion rooms were not a necessary tool or felt that they were sometimes overused by staff.

> Nothing is important about seclusion rooms. It's just wrong. They treat people like animals. It's just like keeping a dog in a cage. You keep that dog in a cage for so long and as soon as you let him out, he's just going to run around and go crazy. (P12)

> You see so many guys from jail brought here… and you can see that they seclude them in the seclusion room for a long time, or even days or weeks. And it's like, why don't they just give us the medication and leave us alone? (P4)

> I think at times it may get misused a little bit. Sometimes, particularly on stressful days, staff will put someone back in there when they could be interacting with that person and helping them, rather than using the seclusion room. (P10)

Assessing Quality of Care

The second theme emerging from the patient interviews involved their perceptions of the quality of care they received while in the seclusion room. This included the level of attention that patients received from nursing staff, the impact of seclusion on patients' feelings about and attitudes toward the nurses who secluded them, and the major differences they found between being in the seclusion room and being out on the unit.

Most patients felt that they received less attention from nursing staff when they were secluded in part because it can be quite difficult to get the attention of the nurses when in the seclusion room. The only way to attract the attention of a nurse is to yell or bang on the seclusion room door. Not only is it difficult to hear the patient through this door, it is possible that nurses may interpret the banging or yelling as a patient acting out rather than simply trying to get the attention of a nurse. This was upsetting to patients as they felt that they were being ignored or that their needs were not being met.

> Whenever I wanted to speak to the staff, I'd have to bang on the door or yell. And then, I never really knew if they were going to come or not. (P2)

> Sometimes, you can knock on the door and they won't check up on you. (P12)

> The staff don't come to you when you need help. (P5)

Although we did not specifically ask patients if they thought being secluded impacted their therapeutic relationship with the nurses, it seems that their attitudes toward the nursing staff are often negatively influenced by being secluded.

> They keep you in there too long sometimes. They don't really talk to you, they don't care. They have their minds made up. (P5)

> [Nurses] are just as capable of violence as the patients are. (P3)

> They put you in there to kind of seclude you from staff, patients, necessities…so, obviously, they're not going to care for you. (P4)

With regard to hygiene, patients were not permitted to shower as often when in seclusion because they had to be escorted from the seclusion room to the shower and supervised by staff. Patients were also not permitted to have any personal hygiene items while in seclusion.

> I didn't get very many showers. I'd maybe get a shower…[every] three or four days. It was pretty bad. (P2)

> I hate it...they take away your clothes, and… everything you usually have like a nightcap… shampoo and all that. So it's more like a police station cell. (P4)

Patients also found significant differences in the quality and quantity of food that they received while in the seclusion room. The food provided to patients in seclusion is not the same as the food provided to patients who are out on the unit. When secluded, patients received only their set daily meals and were not able to access any snack foods if they were hungry in between these times, which they can do when out on the unit. In addition, all the food provided to patients in seclusion comes unsealed because plastic wrap has been used in the past to flood the toilets in the seclusion room, meaning that patients are unable to save any leftovers.

> I don't like being in the cell thing, because you're not allowed snacks and stuff. (P7)

> I didn't get as much to eat, and that I didn't like. (P2)

Space of Confinement

The final theme that emerged from interviews with the patients involved their thoughts about the seclusion room itself and how the level of comfort and privacy afforded to them influenced their experience of this physical space.

Almost all patients commented that the seclusion room was too cold, especially because the floor is cement and patients often have their shoes removed for safety purposes, leaving them in either socks or bare feet. Depending on the risk of harming themselves, patients may also have their clothing removed and replaced with what is referred to as a "baby-doll gown," which is made of a thick, heavy, tear-resistant material. The gowns are worn like a sleeveless vest, fastened with Velcro, and primarily cover the upper half of the body. As one patient described them:

> They're like [a] potato sack. Once you're naked, you put it on. It only goes like past your bottom and it's very uncomfortable. It's like a crazy suit almost. (P4)

Patients also mentioned that the mattress in the seclusion room is not very comfortable as it is placed directly on

the floor. In addition, patients are not given pillows to sleep on, and some patients will be given baby-doll gowns instead of blankets if nurses feel that they are at risk for harming themselves.

> It really sucks. You're sleeping on the floor on a mat. And the mattress isn't great…and there's no pillow. You got to use [the] baby doll and that's what you got to sleep. It's really hard. (P5)

Most patients were unhappy that the light in the seclusion room was left on 24 hours a day, as this made it difficult to sleep.

> [It's] too bright at night…it's like having a desk lamp on the entire night. (P10)

> At like, 5:30–6:00 PM, our night light goes on and that stays on for the whole night and it's really hard to fall asleep with it. (P5)

Interestingly, although many nurses agreed that the seclusion rooms should be made to be more private (we report on this below), some patients felt that it would be good to have cameras to increase their safety while in seclusion as well as to get the nurses' attention or show the nurses they are ready to come out.

> Maybe a camera would help because…you go into a quiet room and you lie there and think: "They think I'm still upset when I'm not upset." (P4)

> If they had cameras, it's better for your safety, because anything could happen in there. (P12)

Nurses

Resorting to Seclusion

A major theme that emerged from interviews with the nursing staff was the reasoning behind their decision to seclude a patient and the factors that were involved in making this decision, such as protecting the safety of all patients and nursing staff or because a patient actually requested to be secluded. One very important finding was the strong and unanimous opinion of nursing staff that seclusion rooms should only be used as a last resort.

> If I had to do it, I'd be comfortable with the decision, because it would be the last resort. (N5)

> It's always the last resort any time I've ever made the decision to seclude someone. That's always been the last resort. (N7)

> It's a last resort…the last thing you want to do is lock somebody away in a room. (N8)

> I don't think that I ever put anybody in seclusion that I had a choice not to. (N11)

Because seclusion rooms are intended only as a last resort, nursing staff stressed the importance of using alternative strategies to deescalate the patient's behavior before deciding to seclude. One suggestion for reducing the number of seclusions is to ensure that nurses are vigilant in looking for signs that a patient is becoming agitated, aggressive, or psychotic so that they are able to intervene early before the patient's behavior escalates.

> My big thing is being proactive in your approach to somebody getting, you know, agitated or something like that. If you see them pacing the halls or mumbling to themselves…you know, if we can take care of them before we have to [seclude]. (N3)

> Sometimes you can see a situation building. So obviously we try and intervene as early as we can. Try to, you know, de-escalate somebody verbally, offer medication, offer them quiet time, maybe just somebody to talk to them. But if they're truly floridly psychotic and there's just no communication, then we would just end up, you know, putting them into seclusion. (N9)

Once nursing staff notice such signs as reported, they can intervene and employ alternative strategies to de-escalate the patient's behavior before it becomes severe enough to require seclusion. Some of the alternative interventions that were suggested by nursing staff included conversing with patients in an attempt to calm them down, and/or to understand the cause of their behavior, as there may be a simple way to remedy the situation. Another strategy involved bringing the patient to their room or another quiet area to remove them from any external stimuli that may be negatively influencing their behavior. Nurses also mentioned that they may be able to negotiate with the patient by informing them that, if their current behavior continues, they will have to be secluded.

> There's usually quite a bit of negotiation before we actually put them in seclusion. We try to talk to them and just remove them from the stimuli; we get them in a quiet area. Most times, that's all it takes. (N2)

> We always try non-violent crisis intervention. We always try talking with them. We always try all the other stuff. This is not a first choice by any means. (N4)

If these deescalation strategies are not successful or a patient's behaviors have escalated too quickly to allow for

an early intervention, nursing staff will need to consider using the seclusion room. All of the nurses who participated in the study said that safety is the number one reason for deciding to seclude a patient. This includes the safety of other patients on the unit, the nursing staff, and the patient him or herself. When asked why they would seclude a patient, nurses gave the following responses:

> Safety for the individual, from harming themselves, and also for staff and other residents on that particular unit of the floor. (N1)

> It's generally the safety of the person being secluded, as well as the other patients or residents or/and staff. (N7)

> They've either acted out violently or were threatening violence towards somebody. (N8)

Nurses were adamant about the fact that they do not enjoy secluding patients and do not derive any personal pleasure or benefits from doing so. In fact, as healthcare professionals who are dedicated to helping and caring for their patients, having to make the decision to use a seclusion room can be difficult.

> Getting into mental health was to help people. And having to put somebody in seclusion is something that I'd rather not have to do. (N3)

> You're trying to give [the] patient best care. Sometimes best care is in a quiet room away from a stimulus, one on one, when you've tried every other means. (N5)

Despite some past research, which has indicated that nurses may seclude patients as a way to show their power and control, the nurses participating in this study consistently emphasized the fact that the use of seclusion rooms is not meant to be punitive but is rather a therapeutic tool used to stabilize and protect patients.

> We never enjoy putting somebody in seclusion, ever…we do know deep inside it's the best thing…. It's always for safety and it's just a tool that we have. (N4)

> It might appear to look like we're restricting somebody's liberties and rights, in other ways, I think we're also encouraging them to get better. And sometimes you have to do things in a little bit less than ideal way. (N9)

In addition to protecting the safety of patients and staff on the unit, there are situations where a patient will be secluded for their own protection. Experiencing psychosis or other mental health disturbances can cause patients to become violent, not only toward others but also toward themselves. In addition, patients may put themselves at risk for being harmed by co-patients if they start to show certain types of problematic behaviors while on the unit. Therefore, nurses may decide to seclude a patient as a way of removing them from an unsafe environment.

> Sometimes, we'd put patients in the seclusion room because they were at risk of being harmed by other people. Just for their own protection. (N11)

> If [people]…were only able to be here to see the reasons why we do what we do sometimes and… that there is no other choices, that you have to keep this person safe, no matter what. As ugly as it may look, at the end of the day, that person is still alive and still able to talk, breathe, look at you, able to call their mom or dad. (N13)

Similarly, there are times when a patient may request to be secluded because they feel it is in their best interest. Although this may seem surprising, it was actually a fairly common occurrence, usually when patients felt out of control or paranoid, overstimulated by their surroundings, or being scared of other people on the unit.

> Some patients will come up and say, "You know what? I just need to go to the seclusion room"… because they have this sense of security, because they feel that they've lost control. (N3)

> You can have a seclusion room where somebody maybe actually likes to be there. They feel comforted…away from what was aggravating them. (N5)

Observing and Assessing Patients

A second theme that arose from our interviews involved nurses' observations of how patients experienced seclusion, including their reactions to being secluded, the impact of seclusion on their mental health, and the quality of care they received while in the seclusion room.

Not surprisingly, every patient experiences seclusion differently. However, it appears that there are factors that can have a significant impact on this experience. Nurses reported that patients' reactions were often partially dependent on the reason(s) why they were secluded. For example, patients who are experiencing acute psychosis may respond to seclusion with increased violence or anger, whereas patients who are being secluded because they are overstimulated by their environment may be more likely to calm down once in the seclusion room as they are no longer being exposed to the overwhelming external stimuli.

> If they're angry or had been aggressive, sometime they will…kick at the door, yell at the person outside, or just…yell in general. (N2)

> Most of them, it de-escalates them I find. Once they get in there, they just settle down…lie down on the mattress and relax. (N12)

Also important is whether patients understand why they are being secluded, what being secluded means, and how it will impact their immediate future.

> You kind of have to say, "This is the reason this happened. You were out of control. And, you know, we helped you maintain that control as well as the safety of everybody else. So I hope you can appreciate that. And, you know, if you get out of control, know that we have the ability to do this again, but also you have the ability to come and talk to us if things are not going along the floor. So, you know, you don't have to lose control again." (N3)

Nurses typically felt comfortable with their decision to seclude a patient, when necessary, because they believe that the seclusion room can have a positive impact on a patient's mental health. Multiple explanations for this improved mental state were found, including the fact that seclusion gives patients a chance to destimulate, to be temporarily removed from the environment or from people they were reacting to, and to regain a sense of control and/or a feeling of safety.

> Sometimes they're comforted by the seclusion room. They know that they go in there, they're going to calm down. Nobody can fight them in there, nobody can get them. Sometimes…they're reacting out of fear too. (N4)

> I do think seclusion can be in the best interest of the patient. Because sometimes it's like we can't answer for ourselves. If we're out of control physically, mentally, emotionally, we sometimes can't make the best decision for ourselves. (N5)

> You see the benefits of it as a therapeutic technique…you see how agitated someone is and then the next day, they're calm, they're out. (N7)

> You do see them get better. Some guys come in and they're locked up because they're just out of control, and then you see them leave and they're like…wow! (N10)

One issue that is of particular importance is whether the quality of care that patients receive while in seclusion is significantly different than the care they receive when out on the unit. It was found that the nurses were quite divided in their opinions on this matter. Some nurses felt that the quality of care was increased when a patient was secluded because they received more attention than they normally would and because nursing staff were more acutely aware of their needs.

> They're on constant observation, so there's someone always monitoring the person. Whereas, you know, on the ward, things get busy sometimes. You don't always have the time for certain patients. (N7)

> I'd say it's a higher level of care…when they're in seclusion. They're being discussed regularly and routinely with staff. (N8)

> Their needs are met, you know, a lot quicker than they are if they're one of the 17 patients, sort of milling around on the ward. (N11)

Other nurses believed that being in seclusion would decrease the quality of care received by the patient because it is simply impossible to provide the same level of care given the constraints of the seclusion room. However, it was emphasized that nurses do attempt to provide the highest level of care possible within these limitations.

> I mean, it's different, right, obviously. But we try to maintain the best care possible, given the constraints. (N3)

> Of course the care is not going to be as good as it is when they're out and about on their normal routine. We do provide as much as we possibly can. (N13)

> Sometimes, they don't shower as often as when they're out. So I guess it's decreased somewhat. (N10)

Experiencing Seclusion

The final theme that emerged from the interviews with nursing staff involved their personal experiences with seclusion, including the impact of seclusion on the therapeutic relationship with patients, the emotional impact that secluding a patient had on the nurses, and whether the nurses felt that there was a need for seclusion rooms in forensic psychiatric settings.

To effectively care for their patients, it is important that nurses develop and maintain a therapeutic relationship with the individuals under their supervision. As one nurse commented:

> I think the more we…have a rapport with an individual, the happier everybody is. (N9)

In fact, in one nurse's experience, having a good relationship with a patient can actually help to reduce the likelihood that they will require seclusion:

> There are some patients that I can't talk to because we don't have a rapport and it wouldn't matter what I said to them. But there's others that I can just take by the hand and walk them out of the situation to their room and calmly, quietly have a conversation, have them come out 10 minutes later and they're fine. (N5)

However, there are many factors that can make developing a therapeutic relationship with a patient challenging, even under "normal" everyday circumstances. For example, some patients may be resistant to engage in a relationship with nursing staff because they do not want, or feel they do not need, to be kept in hospital and thus may regard nurses as captors. Alternatively, patients may have mental health or developmental issues that make it difficult for them to engage in any type of relationship with nurses. The ability to maintain a therapeutic relationship becomes even more challenging when a patient's behavior escalates to a point where they need to be secluded as patients may blame nursing staff for secluding them, possibly leading to anger, resentment, and/or distrust. This is also a challenge for the nurses as they must attempt to maintain a positive relationship with patients, even when they have been threatened, harassed, insulted, or physically injured by them. Thus, not only do nurses have to move past their own feelings toward the patient, they must also attempt to help the patient regain trust in them to preserve their relationship. A nurse commented on this experience:

> "When I get out, I'm going to punch you. I know what kind of car you drive." They'd be making all these threats. (N1)

Nurses highlighted that, for them to be able to maintain a therapeutic relationship with patients, it is important to look past the problematic behaviors and understand that what they're seeing is the illness and not the actual "bad" behavior of the patient.

> They could be cussing at you…spitting at you…hitting you. But you got to put all that aside because you know that's not the "real" person you were talking to the day before. (N13)

Other strategies for maintaining or rebuilding this relationship included trying to prevent patients from having to be secluded in the first place, debriefing with patients to explain why they were secluded, and discussing ways to avoid being secluded in the future.

> I think it's important for them to know that you're concerned about their welfare and that you're just not doing it to be punitive. (N3)

> I always work with a debriefing…"I really didn't want to put you in there anymore than you like to be there, but this is what was happening, this is what we had to do." (N11)

Regardless of whether nurses have a meaningful therapeutic relationship with a patient, it was found that putting someone into seclusion is typically an emotional experience for nurses, no matter how many times they have done it.

> You know, it's interesting that a lot of people will look at people that put somebody in seclusion and think of it as, "Oh, you're the jailor." But I think that each type of situation that we have to deal with, there is, you know, an emotional component to it for the staff. (N3)

> Once it's all over, you can be quite shaken up…there's times it can be quite traumatizing. (N9)

> You feel for them, you know. They're in this square box. If I was in that square box, I'd go crazy I think. (N10)

> I try to always place myself in their shoes…it's got to be the most degrading and most embarrassing thing I think a person could ever experience. I try to make it as less noticeable or less degrading as possible. (N13)

The reasons for these emotional reactions naturally differed between nurses; however, one shared explanation was the fact that secluding a patient can put their own safety at risk as well as the safety of their coworkers and all the patients under their care, including the individual being secluded. Perhaps, because of this fear of harm and injury, the most common emotional response described by nurses after having secluded a patient was a feeling of relief, more specifically, a relief that everyone on the unit was safe.

> I think there's always a bit of a relief, knowing the person's in, they're safe, and everyone else is safe and…that you're going to see the person eventually de-escalate. (N7)

> I usually feel better when a person that needs to be locked is locked into seclusion. It just brings down the anxiety and tension level for staff and patients, and the safety is increased. (N12)

> I felt very happy when the door locked, usually. Usually because somebody's gotten injured…like patient or staff. Or it's about to happen. You can see everybody just immediately relaxes once that door gets locked. It's like, "Oh, okay, everyone's safe now. No one's going to get hurt. We got it under control." (N8)

Despite the fact that nurses do not enjoy secluding patients and given the emotional impact it has on them, all nurses in the study thought that seclusion rooms are a necessary tool in a forensic psychiatric setting.

> I absolutely would say it's a necessary tool in this environment. (N4)

> It's necessary and we do use it, you know, when we must use it. (N2)

> I just think seclusion rooms should continue and I think there's a lot, there's a lot of value in having them. And I think that over the years we've certainly all, all the people that have worked on this place and have had to seclude patients have found that the patients benefit from it in the end. (N6)

> I guess the thing is, if they ever got rid of the seclusion rooms here, I wouldn't work here. I feel that strongly that they are a useful tool, both for us and for the clients. (N8)

One reason for this importance is that, when patients first come into the unit, the nursing staff usually knows nothing about them, their typical behaviors, or how they will react to various situations. This unpredictability makes it difficult for nurses to determine how best to care for their patients. Furthermore, some patients are very ill when they arrive, potentially making their behaviors even less predictable, and some patients come from much more hostile environments, such as jail, shelters, or on the street, which may have made them accustomed to being violent or aggressive to protect themselves. Having the option to put patients in seclusion for a day when they first arrive gives nurses a chance to assess the behaviors and attitudes of their patients as well as to "stabilize" them before they join the rest of the ward.

> They come in and they're, they're unwell. And obviously, we haven't gotten a handle on them. We don't know what, what's going on with them. They don't know what's going on with the unit. (N3)

Discussion

Our results show that maintaining a meaningful therapeutic relationship was very important for both patients and nurses. The latter were fully aware of the risks of jeopardizing a good therapeutic relationship if the patient was transferred to the seclusion room but also said that they often had no choice, given the patient's clinical condition. Patients also expressed very clearly that they felt abandoned by nurses while in seclusion; they reported ruminating about their aggressive feelings toward nurses. Best clinical nursing practices would direct nurses to remain in regular contact with secluded patients, be they psychotic or not. Regular visits and short verbal interactions would alleviate the sentiments of loneliness and abandonment expressed by patients, while providing nurses the necessary clinical information on them and developing or maintaining the therapeutic relationship. The use of seclusion in psychiatry constitutes a last resort nursing intervention (Muir-Cochrane & Gerace, 2014) equivalent to an intensive care situation. Nurses' physical presence at the bedside is of utmost importance.

Moreover, a clear understanding on the patients' part regarding the reasons that lead to the use of seclusion may affect positively or negatively their experiences; some patients reported that they did not understand why they were secluded in the first place. Keeping in mind that some may refuse to understand or are too distressed to understand why they were transferred into the seclusion room, a postseclusion debriefing with the secluded patient should be part of all nursing interventions involving seclusion. Furthermore, if the seclusion "incident" has created turbulence among other inpatients present on the unit at the time of the procedure, postseclusion debriefing should also be offered to them. This would permit nurses to improve the unit climate and to decrease anxiety and anger among patients, while educating them on the use of seclusion in (forensic) psychiatry.

If the seclusion experience is usually difficult for patients, our results show that it is also difficult for nurses. In forensic psychiatry settings, nurses must continually balance the use of control (repressive measures) and therapeutic nursing care; the environment in which they practice and the potential violence patients can display influence inexorably the way they practice. Forensic psychiatric nurses often run the risk of becoming too punitive given all the forces at play in their context of practice (Holmes & Murray, 2011), but our research results show that most are aware of that risk and try to mitigate it as much as they can. In effect, nurses interviewed during this research clearly stated that they were concerned about the welfare of their patients and felt traumatized by the whole seclusion process. They too would benefit from a debriefing session after a seclusion episode.

Although this study did not involve asking about mechanical restraints, the issue of seclusion rooms versus restraints came up at times during interviews with patients and nurses. Both typically agreed that seclusion is a much

better option than mechanical restraints, with patients mentioning that restraints had a more negative effect on them. As nursing staff pointed out, when in restraints, patients are unable to feed themselves, use the bathroom, or even "scratch their own nose." Control is perceived as more restrictive when using mechanical or chemical restraints as Mason and Chandley (1998) reported. In addition, it was mentioned how traumatic mechanical restraints can be for patients with a history of physical or sexual abuse. On the basis of these comments, it was quite evident that, although seclusion rooms are intended to be used only as a last resort, both nurses and patients felt that seclusion was a better option than mechanical restraints and that physical restraints should be reserved for patients who are engaging in self-harm while in seclusion.

During our research, both patients and nurses expressed a number of recommendations regarding the use of seclusion. Sometimes, the same recommendations were shared by both groups of participants. We have selected the most pertinent ones to end this discussion. In effect, most nurses were dedicated to increasing the number of seclusion rooms available for each unit. Their rationale was based on the fact that, if a unit-dedicated seclusion room was full and other patients become in need of it, there is nowhere to remove them to except their rooms, which often contain objects that the patient may use to self-harm. Paradoxically, the same nursing staff insisted that the use of seclusion was a last resort intervention and that knowing their patients well and establishing a meaningful therapeutic relationship remains the best way to avoid the use of seclusion. Although nurses' recommendations may sound paradoxical (increase the availability of seclusion rooms vs. ensuring meaningful relationships), we understand that their competing discourses speak to the tensions (between nursing ethics and security needs) when caring for potentially dangerous patients in forensic settings. This conflict between two sets of values has been largely reported by other researchers (Holmes & Murray, 2011, 2012, 2014; Mason & Chandley, 1998). Given what was reported by nurse participants (and, to some extent, by patient participants themselves), it is fair to say that additional seclusion rooms would not necessarily increase their use but would provide nurses the clinical tools to deal with potentially dangerous and at-risk patients. Keeping in mind that forensic psychiatric settings are often the last bastion for mentally ill and potentially dangerous individuals, transferring patients from one unit to another when the particular unit's seclusion rooms are occupied poses additional challenges and risks both for staff and patients involved.

Moreover, although the purpose of the seclusion room is often to destimulate patients, many nurses agreed that providing some sort of calming stimulus, such as the option of soft music, would actually be good for patients in seclusion. Providing some type of stimulus, such as a television, radio, or reading material, was also the most common recommendation coming from patients in this study when questioned about the comfort of the seclusion room. Patients felt that having some type of stimulation would be beneficial for them as it could help to ease their complaints regarding the boredom and loneliness associated with being in seclusion. Rhodes (2004), in studying mental health in relation to total confinement in prisons, reported severe detrimental effects on secluded persons ranging from boredom and violence to exacerbation of psychosis.

Finally, many nurses mentioned that they would prefer the seclusion rooms to have padded walls, as opposed to hard cement walls. Not only would this provide increased protection for patients who are secluded, it would also help to protect nursing staff because putting a patient in a seclusion room is not always an easy process, especially if they are psychotic at the time. In addition, if the seclusion rooms were padded, patients who were trying to self-harm by banging their head or punching walls would not necessarily need to be placed into mechanical restraints.

Conclusion

It is clear that the "structure of place" (Malpas, 1998) matters for both patients who experience seclusion and nursing staff who work therapeutically in these settings. "Place" is irreducible to the physical "space" in which bodies find themselves. A study of place must take into consideration the ways the lived body experiences seclusion and interrelates with others. Although there can be no doubt that many patients who experience seclusion are oftentimes objectively at risk, with a heightened potential to self-harm and to harm other inpatients and nursing staff as well, as our study participants attest, the bodies secluded in this space are not "objects." They experience the seclusion room acutely, and as a lived body: including the emotional (e.g., boredom, frustration), visual (e.g., the effects of 24-hour lighting), olfactory (e.g., the lack of hygiene, the lingering "smell" of other patients), tactile (e.g., concrete walls, uncomfortable mattress, ambient temperature), and auditory (e.g., screaming and banging on doors) dimensions of the experience, for example, form part of the "world" in which patients find themselves and through which they derive meaning. Other comments touch on less tangible aspects, such as care and dignity (e.g., wearing a "baby-doll gown," feelings of being "abandoned" by nursing staff). The negative impacts of these phenomenological dimensions can be mitigated somewhat through meaningful, therapeutic interactions with nursing staff, during the seclusion experience itself, as well as by debriefing patients and nurses postseclusion. Although the practice of seclusion is ethically freighted and (often) clinically needed, we must add that it was never the intention of our study to pass judgment on the practice itself; rather,

we have worked within an existing institutional framework to try to understand the experience and to allow both secluded patients and the nursing staff who care for them to "give voice" (Larkin et al., 2006) to this intimate experience and to elaborate on it with a view to improve the current conditions of seclusion. It is clear, however, that a principlist ethics that values the restoration of a patient's "autonomy" rather misses the point of the lived body and its intersubjective world.

Seclusion should be a last resort, and nurses in our study report that it is used most often as such. However, even then, seclusion should not be practiced as "isolation," especially over long periods. Bodies and minds are never isolated from each other (mind–body dualism is deeply problematic, clinically and phenomenologically) or from the worlds they inhabit; isolation implies an absence of intersubjectivity, an absence of the lived relations on which meaning is built. Lived bodies are not objects among other objects. Thus, nurses occupy a privileged position in this relation, which embodies trust and communication rather than repressive or punitive gestures. In our view, trust would be preserved (or reinstated) when aspects of physical nursing care are provided, including personal hygiene and nutrition, monitoring vital signs, and relevant nursing care following a combination of "rapid tranquillization" with the commencement of seclusion. In addition, ensuring privacy and dignity during seclusion and planning care (in advance) with patients in the event of violent behaviors would also work to preserve a trusting relationship between nurses and patients.

One goal of our study was to shift the ethical discourse surrounding the abstract, psychiatric "objectivity" of minds and bodies in seclusionary spaces—and to think of these, rather, as places where lived bodies find themselves, occasionally and temporarily, as part of a larger program of care and treatment. "Our phenomenological approach takes the lived-body and its relation to place as a *condition* of subjectivity, and therefore as the necessary ground upon which ethical relationality makes sense" (Murray & Holmes, 2013a, p. 20). In this regard, we found that our participants—both patients and nurses—have themselves provided a rich discourse that helps us to think in this direction, helping to close the gap between bodily experience and discourse on that experience. They themselves provide some terms by which to better understand the subjective processes and the meaning-making associated with seclusion in forensic psychiatric settings. If their words seem on the surface to express "thoughts" and "beliefs" typically taken as mental "content" or "cognition," a close reading reveals that they are deeply informed by the irreducibility of bodily experience and to therapeutic caregiving in these environments—places in the world, which are often marked by fear, trauma, distrust, and vulnerability.

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