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Original article

## **Patients' Experiences of Seclusion during Admission in Psychiatric Settings in KwaZulu-Natal: A Qualitative Study**

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### **Abstract**

#### **Background**

In South Africa, seclusion is one of the practices used in the management of disruptive behaviors in psychiatric settings. Despite its continued use, seclusion is always subject to controversial debates, and patients who undergo it express a range of negative experiences.

#### **Objective**

To explore the experiences of patients regarding seclusion during their admission in a psychiatric hospital.

#### **Methods**

A qualitative descriptive design was used. In-depth interviews were conducted with ten patients attending a community psychiatric clinic in KwaZulu-Natal. Interviews were analyzed using content analysis.

#### **Results**

Two themes emerged from the findings: controversial views of seclusion and negative experiences of seclusion. Seclusion was considered more as a punishment measure which was often used abusively, than a therapeutic intervention. Participants expressed loneliness, humiliation, and powerlessness following their seclusion experience. Limited patient-staff interaction and communication worsened patients' negativity towards seclusion.

#### **Conclusion**

Findings from this study underscore the need to review practices, policies and procedures regarding the use of seclusion. Seclusion should be only used when the need is absolute and as the last treatment option. Open communication between the care providers and the patients should be emphasized during the time of seclusion.

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**Keywords:** Seclusion, disruptive behavior, aggression, psychiatric setting

## Introduction

Patients' aggression in psychiatric settings can prove to be the most difficult and frightening experience for both the patients and the health professionals. Aggression often manifests through different forms of disruptive behaviors, such as, verbal abuse, breaking things, threats and physical assault addressed to self or to others. [1] To manage patients' disruptive behaviors, seclusion has been among the commonly used practices worldwide, including within western contexts,[2–5] as well as in African contents.[6–9] Seclusion involves the placement of an individual patient alone in a locked, contained and controlled environment for a specified length of time, with the aim of controlling unsafe and disruptive behaviors.[10] When appropriately used, seclusion has proved to be an effective therapeutic intervention, for example to withdraw a manic patient who is overstimulated by his environment, or to calm patients who have escalating psychotic behaviour, when other means of control have not been effective or appropriate.[11]

Despite its continued use, seclusion remains a controversial measure that has received widespread attention from an ethical and clinical standpoint. From an ethical and moral standpoint, seclusion is consistently contested as an unethical, immoral and coercive method that violates patients' rights for autonomy and freedom, while it bears little therapeutic value for the secluded patient.[2,12,13] From a clinical standpoint, the use of

seclusion in psychiatric hospitals remains accepted as a last resort therapeutic strategy in the management of highly disruptive patients who cause a threat to themselves, other patients and staff.[2,14,15]

Congruent with these controversies around the use of seclusion, available evidence is also mixed in terms of patients' perspectives towards seclusion. Predominantly, negative experiences of patients towards seclusion have been reported. Some patients experience seclusion as a form of punishment, right depriving, degrading and traumatic experience,[3,9,14,16] while a relatively small number of patients report that the isolation of the seclusion room provides them with relief from perceived persecutors and sensory overload and allows them to calm down.[14,17,18]

While a growing number of patients feel that seclusion is a punitive practice and has no place in contemporary psychiatric care,[2,14,17] health professionals continue to rely on seclusion as alternative solution for the management of disturbed patients.[4,13,19] However, much of this literature emanates from studies conducted mainly in western contexts such as Australia, Canada, US, and some European countries,[2,4,5] and little is known concerning how patients from different psychiatric contexts such as the Sub-Saharan Africa experience seclusion. The use of seclusion in South Africa is regulated by the

Mental Health Act No 17 of 2002,[15] which stresses the appropriate use of seclusion as a last resort treatment and not as a punishment.

Few studies conducted in South Africa,[6,9] reported seclusion to be frequently used within psychiatric settings and to be associated with various negative experiences. A retrospective study conducted within one South African hospital revealed that 112 patients had been secluded over the period of six months.[6] Similarly, in a study conducted in the Western Cape Province, 28 participants out of 36 reported having been secluded during their admission. This appears to be the only study that could be located related to experiences of patients in terms of sedation, seclusion and restraints within the South African context.[9] Hence, limited evidence is available regarding patients' experiences with seclusion within the South African context, and an understanding of patients' views on seclusion underscores needed further exploration for its continued use.

This study aimed at exploring the experiences of patients regarding seclusion during their admission in a psychiatric hospital.

## **Methods**

### **Design**

A qualitative descriptive design,[20] was used. According to Sandelowski (2000), the focus of qualitative descriptive study is the description of phenomena, events and experiences as they happen in the naturalistic

context. Qualitative descriptive studies offer the researchers a comprehensive summary of events, while allowing them to stay close to individuals' descriptions and the meanings they attribute to their experiences.[20] Since this study aimed at understanding the phenomenon of seclusion from participants who have been secluded during their admission in a psychiatric hospital, qualitative descriptive approach was deemed relevant to focus on qualitative aspects such as views, experiences, and understandings from the participants' viewpoints and in the context in which the event takes place.[21]

### **Setting**

This study was conducted in a community psychiatric clinic attached to a regional hospital in the Province of KwaZulu-Natal. The hospital has ten services, amongst which is the community psychiatric service, which has four wards and one outpatient department. The outpatient service receives both new patients by referral and existing patients who are treated at the community clinic on a monthly basis. It is in this outpatient department that this study took place. The clinic has been chosen purposively because it caters for many patients discharged from this regional hospital and surrounding hospitals for follow-up visits. This therefore enabled the researchers to reach many respondents who had experienced seclusion during their admission.

## Sample

A purposive sample of ten patients attending a community psychiatric clinic in KwaZulu-Natal for follow-up was selected. They were recruited at their third to fourth follow-up visit after discharge from a previous admission during which they had been secluded. This period was preferred so that participants were able to articulate and recall their experiences of when they were admitted, all the while being stable enough to relate their experience in a more coherent way. Participants were recruited in the study after confirmation from the clinic staff about their mental status. Adult patients, who previously had been secluded during their admission to a psychiatric hospital, who were able to express in English, and able to articulate and explain their experiences to the researcher were included in the study. Patients who had been discharged in less than four months, as well as those whose mental status was noted by the clinic staff as not stable were excluded from the study.

## Data collection

Data was collected using in-depth semi-structured interview. An interview guide prepared using ideas from the literature,[22] was used. One interview was held with each participant individually and each took approximately 30-40 minutes. Interviews were audio-recorded with respondents' permission, and notes were taken during interview to emphasize key observations and non-verbal clues. A quiet, private

room was made available to the researcher during data collection period. During interview, a "do not disturb" sign was posted on the door to minimize disturbance and to allow participants to feel free to talk, while preserving their confidentiality.

Interviews were scheduled during the clinic hours when participants were coming for their monthly visits at the clinic during the month of May of 2015. Participants were seen by the Primary Investigator (PI) after they have been seen by their doctor or the nurse. Participants who met the inclusion criteria were directed to the designated office to meet with the PI. Each interview started by establishing a relationship with respondents and explaining the objectives of the study. The PI explained the research purpose, the inclusion criteria and the potential benefits/risks from participating in the study to each participant. If the participant expressed willingness to participate, they signed the informed consent and were interviewed by the PI.

## Data analysis

Audio-recorded data were transcribed verbatim by the PI progressively in order to identify key categories as they emerged. After verification of the transcripts, they were entered into *NVivo* 10 software program for data management. A content analysis method,[20,23] was used to analyze data. The unit of analysis was an interview. Analysis was done by reading the interview transcription many times, identifying the content of the transcription

which dealt with the participants' views and experiences of seclusion. Sentences and paragraphs that seemed similar were grouped into meaning units.[23] Next, meaning units were condensed and assigned to codes. Codes were then analyzed for their similarities and differences, and they were grouped into categories. Categories were further analyzed and condensed into themes, linking together recurring and regular meanings,[23] describing participant's views and experiences of seclusion.

### **Rigor**

Measures for establishing rigor in qualitative study including credibility, transferability, dependability, and confirmability,[21] were used to ensure trustworthiness of the findings from this study. Credibility was achieved through choosing participants with varied and vast experience of seclusion and through member-check done during and at the end of the interview to check the accuracy of the data with participants. The PI transcribed the data, and this allowed enough immersion with data before the actual analysis starts. Additionally, during analysis and reporting of findings from this study, excerpts from raw data were outlined to ensure that themes are supported, and data interpretation remains directly linked to the words of the participants.

Transferability was ensured by maintaining detailed notes of the research process, the data collection method, participants recruitment, as well as contextual information about the setting within which the study was conducted. To achieve dependability, two team members coded the data differently, and an independent research team member reviewed and approved the preliminary codes and categories before final analysis was completed. Confirmability was achieved through a constant reflexive approach during the conduct of the study to delineate any previous misconception that they PI might have regarding seclusion. To maintain an unbiased perspective on the findings, three research team members were involved in the analysis.

### **Ethical considerations**

Ethical approval to conduct the study was obtained from the Bio-Medical Research Committee of a University in KwaZulu Natal. A written informed consent was obtained from each participant before the interview. Only participants who gave their consent voluntarily were included in the study. Anonymity and confidentiality were maintained by not mentioning any name throughout the research process, instead, pseudonyms were used. Only the research team had access to the recorded interviews and de-identified transcripts, which were stored in password protected computer.

## Results

The study sample consisted of ten outpatients attending the clinic for follow-up. Seven participants were male, while three were female. Out of ten participants, only three were secluded for the first time, whereas seven had been secluded same as recently as in their previous admission. It was found that participants who had been secluded many times discussed about their first experience of seclusion in more details, as this was the most significant one for them.

Generally, participants expressed negative feelings about their seclusion experience and all of them expressed a wish to never go back into the seclusion room again. From the multiple readings of the transcribed data, nine codes were extracted from participants' ideas, which were in turn grouped into four categories. At the end of the analysis, two main themes were highlighted as illustrated in table 1 below.

**Table 1. Codes, categories and themes**

Themes	Categories	Codes
1. Controversial Views on seclusion	Seclusion as therapeutic	-Seclusion used as a protection -Seclusion used as alternative treatment method
	Seclusion as a punishment	-Abusive utilization of seclusion -Inadequate seclusion environment
2. Negative experiences of seclusion	Emotional impact	-Loneliness -Humiliation -Powerlessness
	Limited staff-patients' interactions	-Lack of communication -Unmet needs

### Theme 1. Controversial views on seclusion

This theme emerged from patients' personal answers on what they understood as the reasons associated with seclusion use. It was found that generally, participants acknowledge the role of seclusion in the management of psychiatric patients displaying aggressive behavior. They were able to notice and relate seclusion to the patient's

behavior in the ward prior to seclusion experience. Two controversial categories emerged from this theme: seclusion as therapeutic and seclusion as punishment.

## Category

### 1.1: Seclusion as therapeutic

#### 1.1.1 Seclusion used as a protection

Some participants shared that health professionals decided to put a patient into a seclusion room because they realized that he may need it as a time-out. All participants were able to recall the specific reasons that led to their seclusion. Many of them recognized the disruptive nature of their behavior before they were put into the seclusion room, as illustrated by the following statement from one participant:

*“I was experiencing high episodes of the bipolar disorder, where I assumed that I can do absolutely everything, [including] being disrespectful and not abiding by the rules ....so I needed to be brought down....”.*

Other participants also perceived seclusion as a protective measure used by staff to protect them and all those who may be affected by their behaviors. The following participant acknowledged the risk that might be caused by one patient’s behavior in an environment like a psychiatric hospital:

*“Seclusion is often important because a patient may cause a danger to himself, to fellow patients and even to staff in a closed environment within the hospital”.*

Seclusion was also experienced by some participants as a safe

environment where they could gain control over their actions. They revealed that although seclusion itself is not a good experience, it has its positives aspects. One of the participants shared his experience of self-initiated seclusion because he felt a need to take a time-out in the seclusion room since he was unable to cope with a noisy environment of the ward. He explained it this way:

*“I was feeling that people were against me..., and I went into the seclusion room to be alone. I was feeling suffocating because they were too many people around me, and I needed a time out” .....*

Following this self-seclusion, this participant described the therapeutic effect of seclusion that he experienced. He continued:

*“It helped me to lighten my mind, it is like... in this room of emptiness, it allowed me to feel free of all contacts with other people...., so for me it was an isolation that cleared my mind from what was happening, I felt safer and much calmer when I went outside”.*

#### 1.1.2 Seclusion used as alternative treatment method

Some participants reported that despite being given a sedative injection or despite other efforts of nurses, the patient could still display disruptive behavior and may need to be taken into seclusion room to calm down. This was demonstrated by the following participant who felt that

seclusion was used because medication was not enough to stabilize them:

*“Sometimes even if you are taking medication, your mood can be up and down, like that time, although I was on medication, I was crying and screaming a lot, then they [nurses] put me there [in seclusion room] to calm down”.*

From the above statements, some patients understood seclusion as used for therapeutic reasons, either as a first-choice method or when other therapeutic methods have not been successful.

## **Category**

### **1.2: Seclusion as punishment**

#### **1.2.1 Abusive utilization of seclusion**

Unlike the above statements of participants who positively perceived seclusion, many participants perceived seclusion as negatively used and equated it to punishment. These participants related their seclusion to the inappropriate behavior they displayed in wards; hence, they were being punished for that undesirable behavior. They believed that the use of seclusion was often not justified, or it was mostly used for nurses and staff sake, not for the patients' benefits. The following participant illustrated it this way:

*“Seclusion room is like a jail where you are put to be punished because of your bad*

*behavior and to keep you from disturbing them[nurses]”.*

The process through which patients go while being secluded was also based on by participants when describing seclusion as a punishment. The following participant highlighted:

*“When nurses are putting you into seclusion, they use force as if you are a criminal”.*

This process and the behavior of nurses while putting patients into seclusion room obscured the potential benefits of seclusion, but rather, reinforced the perception of it as a punitive measure. The following responded summarized their experience:

*“It was a horrific experience. .... I had to be undressed, naked and pushed into the room then locked inside”.*

#### **1.2.2 Inadequate seclusion environment**

On a general note, most participants were very critical to the physical characteristics of the seclusion rooms. This was common to all settings where patients had been admitted and secluded from. The following participant gave a description of the features of the seclusion room and their negative experience of seclusion:

*“The seclusion room itself is a very grim, dark and smelly room; it feels like a lot of dirty, smelly people have been in the room, you know...this makes you uncomfortable”.*

Another prevailing assumption among participants was that seclusion room could be easily compared to a holding cell, a jail or a prison. Another participant described their experiences this way:

*“The small size of the room, the high up windows with burglar guards, dim lights make the room look like a cell in a jail. The question that came in my mind was: Oh! What am I doing here?”*

Participants also confided that due to their perception of seclusion as a place of confinement, they nicknamed it “*Khulukuthu*”, a Zulu name to mean a prison.

Paradoxically, one participant, who voluntarily secluded themselves found the negatives features of seclusion as described by other participants helpful for them because at that time they needed to be alone. They disclosed it in the following:

*“Being in that dim light single room, I felt a real isolation and away from the noise and interference by other patients..., which was what I desperately needed at that time”*

## **Theme 2: Negative experiences of seclusion**

Participants expressed a wide array of negative emotions that were associated with their experience of seclusion, such as loneliness, humiliation, fear, anger, and rejection.

These emotions were experienced by participants before, during and after seclusion experience.

## **Category**

### **2.1: Emotional impact**

#### **2.1.1: Loneliness**

The feelings of loneliness were prevalent among almost all participants. This was described as being confined alone in a darkroom, where communication was only made possible by a specified event in the ward such as mealtime, as illustrated in the statement below:

*“I felt alone in that dark room..., you cannot imagine how it feels being locked alone in there, with no ways of getting out, if not waiting for the nurses to give you food when it is mealtime”.*

Similarly, but giving emphasize to the boredom nature of seclusion room, another participant shared the following experience:

*“Seclusion room is a very lonely place, where you do nothing but facing the empty walls of the room, with no hope of getting out”.*

The feeling of loneliness was also associated with the feeling of abandonment and rejection when participants were locked alone in the seclusion room, as one of the participants reported:

*“When I was inside the room, and after they had locked the*

*door from the outside, I felt abused and forgotten”.*

Seclusion was also perceived as a form of reinforcing the existing loneliness and rejection of patients with mental disorders. One patient explained it clearly:

*“When I was left inside the seclusion room, I had the same feelings as I had before when my family took me to the hospital. I felt they were both doing so to keep me away from them, therefore pushing me away from society”.*

### **2.1.2: Humiliation**

Some participants reported that being put into seclusion was degrading, and it let them with a feeling of shame and humiliation, as one participant described:

*“It wasn’t a good experience because your privacy is violated, I was supposed to be stripped naked, you don’t feel clean because you did not have a chance to bath for about two or three days, and you have to stay in the same room where you urinated...”.*

Another participant reported the same feeling of humiliation associated with their experience of being secluded:

*“They forced me to take off my clothes and just pushed me inside the room, I felt totally naked”.*

Feeling humiliated was also reported by one participant when they were taken out of seclusion. They stated:

*“When I was taken out of the room, others were looking at me as if I did something terrible; I was very ashamed of what happened”.*

### **2.1.3: Powerlessness**

A sense of powerlessness following participants’ seclusion experience was noticed. The following participant compares it with being unable to make his own judgment, waiting for others to do on ones’ behalf:

*“I felt powerless to see others forcing me to go inside that room and to think that they are also the ones to know when I can go out of the room”.*

Another participant had this to say:

*“When you are inside the seclusion room, staff do not allow you to have your personal belongings like towels, shoes, etc; you still depend on them to do these basic things that otherwise you could be doing on your own”.*

Lack of autonomy and powerlessness were also associated with a feeling of insecurity of not being able to control things, particularly the nature of the seclusion room as the following participant narrated:

*“You are forced to stay in a room where the doors are closed from the outside. It is*

*frightening to wait until the time you do not know for someone to open the room for you”.*

Some participants also shared the perceived worsening of their psychiatric symptoms as a result of being secluded. The following participant stated:

*“After I had stayed there for a while, I started hearing the same voices I used to hear while I was at home, this was very scaring”.*

Powerlessness resulted in a feeling of anger among participants. Some of them felt angry especially while they were being put into seclusion room, others had the feeling of anger while they were inside the seclusion room. The following participants narrated their powerlessness and their attempts to get help:

*“I thought maybe if I could bang the door, scream or shout, then I would get the attention I wanted”.*

*“I thought it was unfair for me to be put alone in that room where no one knows what may happen to me. I started pacing up and down in the room, talking to myself and calling for help”.*

## Category

### 2.2: Limited staff-patient’s interactions

Nurses-patients interaction was explored based on the level of

communication and information given to patient before, during and after seclusion.

#### 2.2.1: Limited communication

Generally, participants shared a lack of communication between them and the nurses during seclusion experience, and this was felt both before, during and after seclusion. Lack of information in terms of why one is being secluded and the expected behaviors while in seclusion room, and the time one is likely to spend into the seclusion room were highlighted. One participant said:

*“Nurses do not talk to the patient before and during seclusion. They do not explain to the patients the time they will stay in the seclusion room, and they don’t even visit the patients and see how they are doing there”.*

#### 2.2.2: Unmet needs

Mixed experiences were shared by participants in terms of care and support provided to them during the seclusion experience. Some participants reported general lack of support from nurses when they needed it such as restroom use and food. The following participant narrated the experience:

*“I was left alone, I felt thirsty and hungry, but none was around to help me”*

In contrast, other participants acknowledged that facilities, water

and food were provided during the seclusion time as the following explains:

*“They [nurses] still care for you and come to see you like at mealtime, lunch time, teatime, and they open for you and give you your meal”.*

### **3. Participants’ recommendations towards the use of seclusion**

At the end of the individual interview, participants were asked the following question: If your experience of exclusion wasn’t positive, what would you suggest that could improve the use of seclusion in psychiatric wards. The recommendations provided were grouped into three categories: Improve communication, improve seclusion environment, and prioritizing alternative strategies. Each of these is presented with supporting quotes from participants.

#### **3.1 Improve communication**

This was based mainly on the statement given by participants on the lack of communication between staff and patients when they were in seclusion. This is supported by the following statement:

*“I would recommend more open communication. I think, any patient, irrespective of what he has done, needs someone to talk to...”.*

Participants also wished to be informed on the wards’ rules to avoid unnecessary use of seclusion. This

was mainly associated with participants who associated seclusion use to punishment. The following participant stated:

*“If patients are well oriented on rules and regulations of the ward and what is expected of them in terms of behavior, surely the use of seclusion room would not happen”.*

Clarification on how long one is expected to stay in seclusion was thought by participants to allay their anxiety as the following participant narrated:

*“Of course, a patient needs to be prepared in terms of how long he will stay in seclusion room, not just to push the patient in that room, or if not done before, tell him after seclusion why he was there”.*

#### **3.2 Improve seclusion environment**

Generally, participants had a shared perception that seclusion room itself needed more improvements in terms of appearance and setting. They believed that patients’ association of seclusion to jail was a result of the nature of the seclusion room, which, if made more appealing, would reduce this negative perception. This is summarized in the quote below:

*“If only the structure of seclusion room can be changed to look more appealing, and user-friendly, then the patient would feel much better and not associate this room with jail”.*

### 3.3 Prioritizing alternative strategies

Some participants reported that they were put into seclusion after the failure of other methods. However, for some other participants, seclusion was decided before any other therapeutic method and they suggested other alternative methods should be tried before:

*“I would recommend that nurses should try other methods such as an injection first to see if the patient calms down, and if he is still displaying violent behavior, then they can take him to seclusion room”*

## Discussion

The purpose of this qualitative descriptive study was to explore the experiences of patients towards seclusion. It included ten outpatients attending a community psychiatric clinic, following their previous admission in a psychiatric hospital in which they experienced seclusion. Generally, participants in this study understood the rationale use of seclusion for the management of disruptive behaviors, but, despite a positive understanding of its use, majority of them still perceived seclusion negatively. Only a few participants acknowledged the positive effect of seclusion. All the participants, irrespective of their perception and experience of seclusion, revealed that they would

prefer not to have had that experience.

These controversial views of seclusion corroborate previous findings on patients' understanding of seclusion. Predominantly, patients perceive seclusion as a form of punishment, right depriving, degrading and traumatic experience that should not be used in contemporary psychiatric care,[2,3,14] while a relatively small number of patients like in this study report that the isolation of the seclusion room provides them with relief from perceived persecutors and sensory overload and allows them to calm down.[3,14,17,18]

Participants in this study who considered seclusion as a punitive intervention associated it with various reasons, such as thinking that seclusion resulted in their disobedience towards ward' rules, a lack of information on the reasons of seclusion use, how long it will last, how the patient is supposed to behave, and the limited nurse-patient interaction during seclusion time. These reasons confirm those found in earlier studies.[2,3,5] It can be argued that when patients are not provided with clear and sufficient information concerning an intervention being applied on them, this likely leads to negative assumptions from patients, obscuring the therapeutic and safety purposes such an intervention might have, and consequently resulting in it being resisted by patients. On the other hand, studies have found that when patients are provided with information, aimed at assisting them

understanding the reasons for seclusion, it allows patients to perceive seclusion use as less arbitrary, and conveys the idea that the intent is constructive in the longer term.[24]

Furthermore, participants in the current study revealed that seclusion room has been nicknamed by patients as “Khulukuthu”, a local name to mean “a jail”. They described seclusion as a small sized room with high windows protected by burglar guards, the dim light inside the room, with a sponge mattress on the floor, doors closed from the outside, and a dirty room which has a nasty smell. This description of seclusion as a holding jail has been reiterated by other studies conducted in the Southern African context,[8,9] as well as international studies conducted in Australia, US and Canada,[14,19,25] in which participants equated seclusion room to a jail cell, and the force used in placing patients’ into seclusion equated to the one used for criminals. Participants in an Australian study by O’Brien and Cole (2004) commented on the design of the seclusion room as a “fish-bowl room” (p.93). Similarly, in a study conducted in Lesotho, participants who have been imprisoned prior their psychiatric admission equated seclusion to their imprisonment experienced.[8] Hence, for patients, spending time in these unpleasant room, coupled with the coercive nature of the patient-provider interactions during the placement of patients into seclusion room obscure its therapeutic intention as patients associate it with being punished for

their disobedience than being cared for.

Majority of participants in this study expressed a range of negative feelings, loneliness, humiliation, and powerlessness following their seclusion experience, feelings that have been reiterated in previous studies. Different emotions associated with the experience of being secluded, such as anger, sadness, fear, abandonment, anxiety, frustration, boredom, confusion, safety, disgust, punishment, resentment, humiliation, degradation, dehumanization, have been experienced by patients both internationally and within Southern Africa during or following their seclusion experience.[3,17,19,22,26] Additionally, one participant in this study reported a sense of deterioration of their mental condition following seclusion, confirming previous findings of patients who reported aggravation of psychotic symptoms, such as hearing voices, thoughts of persecution, and suicidal ideations, following their stay in seclusion rooms.[18,26,27] It sounds reasonable to believe that the confinement nature of the seclusion room and the mental condition of the patient before being secluded could likely reactivate pre-existing feelings of anxiety and fear.

From an ethical perspective, seclusion poses a significant ethical challenge, involving the desire of health professionals to balance between providing quality care to patients, and the necessity of using

force and control in achieving this.[13] Such a coexistence between care and coercion perpetuates the controversial question whether seclusion should have its place in psychiatric care. Mental health professionals who apply seclusion have also reported significant ethical dilemma related to balancing the therapeutic goals of seclusion so that these outweighed its negative side effects, reducing harm and ensuring patients' safety.[28] Within an ethical care, it stands out to reason that the use of seclusion should be guided by strong ethical guidelines and policies. The South African policy guideline on the use of seclusion and restraint recommends that seclusion should only be applied as a last resort intervention when alternative intervention strategies could not work, and if used, it should be done in a safe, therapeutic manner, properly instituted and monitored.[15]

Unfortunately, experiences from participants in this study reported seclusion not being properly used, inadequate features of the rooms, inadequate interactions and communication between themselves and the care providers, unmet needs during the time of seclusion, and perceived seclusion use in a more punitive than therapeutic manner. This calls to question whether the problem might be seclusion itself, or rather the manner in which it is used and monitored. If seclusion should continue to be used, strong measures need to be taken to make it more therapeutic. Participants' experiences are of great use if mental

health care professionals strive to deliver ethical and quality care.

### **Implications and recommendations**

The findings from this study provided rich information on patients' views and experiences about the use of seclusion in psychiatric hospitals. Overall, negatives experiences towards seclusion predominated narratives of participants. Findings from this study offer recommendations for making seclusion more therapeutic.

### **Recommendations for nursing practice and administration**

Reducing the use of seclusion: It could be useful for hospitals and mental health services to consider putting in place a comprehensive plan and policy for early detection and management of behaviors such as aggressive and violent behaviors that could lead to seclusion. The plan could also identify other factors precipitating these aggressive behaviors, such as the design of the treatment setting, or the nurses' attitudes towards patients. If the aggression and violence are imminent to warrant an urgent intervention, mental health providers should consider preferring other alternative interventions which are less harmful before using seclusion. Strategies such as the use of structured risk assessment measures,[29] or intervention to improve quality care during the first minutes at admission,[12] proved to be effective measures that allowed the unnecessary use of seclusion and lead to improved patients care.

Improving the quality of care during seclusion: Mental health services should put in place communication strategies before putting the patient into seclusion. During seclusion, mental health providers should ensure that basic patients' needs continue to be met and keep the patient-provider interaction during the process. Elements for discussion may include the reasons that lead to seclusion, the estimated time to spend in the room, the patients' rights during seclusion, and the expected outcomes. The South African policy guidelines on the use of seclusion recommends a regular observation of every 30 minutes to attend to any needs of the secluded patients.[15] These guidelines should be carefully respected, and a committee of quality improvement in the use of seclusion should be put in place in each hospital to monitor the adherence to the prescribed policy.

Participants in this study mentioned a lack of post-seclusion discussion with care providers. It is recommended that a post-seclusion debriefing intervention be initiated and made mandatory as a therapeutic intervention for any seclusion incident in the ward. Post-seclusion debriefing interventions proved to allow patients who were secluded to express their emotions resulting from the seclusion in a supportive climate, which reduce the likelihood of complicated trauma-related symptoms.[10,16] Post-seclusion debriefing can also involve those who were involved other than patients, such as the nurses and other patients who witnessed the

incident to deal with it in a constructive manner. This may likely demystify the punitive assumption towards seclusion.

### **Recommendations for nursing education**

Training of mental health care providers on seclusion use: Studies have demonstrated that mental health care providers are often challenged by limited knowledge on dealing with highly disruptive patients, where options are limited,[13] while others highlighted limited competencies in applying seclusion protocols and guidelines.[12] Nursing schools should ensure that pre-service nursing curricula equip nursing students with necessary competencies and ethical decision-making skills related to seclusion use. Hospitals and mental health services should organize regular in-service trainings and capacity building educational opportunities to increase the knowledge and competencies of care providers on seclusion. This will likely improve the quality of care rendered to secluded patients, as well as ease the ethical challenges faced by mental health providers during seclusion.

### **Recommendations for future nursing research**

Exploring the experiences of patients who experienced seclusion is a large topic which cannot claim to be covered in this study. Future researchers would think on doing more research which may involve a large sample of participants and

allow the generalization of the findings. Further researchers should also analyze other aspects of seclusion such as the legal and ethical aspects of seclusion which, though were relevant, did not make the scope of this study. A comparative study on nurses and patients' perceptions of seclusion, which will draw up their similarities and differences would bring a different perspective of seclusion from people who apply it and those who receive it.

### **Limitations**

This study has limitations that ought to be mentioned. The language barrier of the PI limited the inclusion criteria to participants who could express themselves in English, as the topic was considered sensitive to engage a translator in the interview. It was not also easy to identify patients who were secluded during their previous admission as not all the files for secluded patients contained observation on seclusion. Although the intention of a qualitative descriptive study is not for generalizability, the authors acknowledge that ten participants who made the sample size for this study was not enough for the findings to inform policy change in the use of seclusion. Due to the lack of relevant previous studies in South African mental health care context on the use of seclusion, this study drew much literature from international context.

### **Conclusion**

Findings from this qualitative descriptive study revealed that seclusion is experienced negatively with patients, and leave them with feeling of loneliness, humiliation, rejection, lack of autonomy and powerlessness, with a shared impression that seclusion is often used as a punitive measure than as a therapeutic intervention. Negative experiences were generally due to perceived lack of communication and interaction between the care providers and the patients in seclusion.

If seclusion is to be used for therapeutic purposes, its practices, policies and procedures need to be reviewed. Seclusion should be only used when the need is high and absolute and should be only used as a last resort intervention after other alternative methods. When used, open communication between the care providers and the patients should be emphasized during the time of seclusion and after. This will likely reduce the feeling of loneliness and rejection patients manifest while secluded and will help them to speak out their experience after seclusion in a supportive way.

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## Conflict of interest

No conflict of interest to be disclosed

## Authors' contribution

UB conceived the study, conducted it and wrote the manuscript. EB supported the data analysis and contributed intellectual insights to the manuscript. BG, MP, KI, DJA supported the writing of the manuscript and critically revised it.

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