

PSYCHIATRIC IN-PATIENTS' EXPERIENCE OF BEING SECLUDED IN A SPECIFIC HOSPITAL IN LESOTHO

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ABSTRACT

This qualitative, explorative, descriptive and contextual study was undertaken to explore and describe the experiences of psychiatric in-patients who are secluded in a specific hospital in Lesotho. Evidence about the rationale and appropriate use of seclusion as well as promotion of mental health in secluded patients has been expressed and documented in the literature. The mental health legislation of Lesotho does not specifically address seclusion of psychiatric in-patients. This research is crucial because it has not been conducted before and information pertaining to it is limited. Purposive sampling was used. Data were generated through eleven (11) individual semi-structured phenomenological interviews. One central open question was posed to the participants. Patients were interviewed until saturation was reached. Field notes were taken. All interviews were audio taped and transcribed verbatim. Tesch's (in Creswell, 1994:142) method of open coding was used to analyse data. Results were described, pertaining to the categories identified. The main categories were: (1) the experience of being in a prison; (2) seclusion experienced as a punishment, which created an environment where human rights violations were experienced; (3) personnel factors leading to an experience of not being supported and cared for; and (4) emotional responses to the seclusion experience. A literature control followed the description of the results.

OPSOMMING

Hierdie kwalitatiewe, verkennende, beskrywende en kontekstuele studie is onderneem om die ervaring van psigiatriese binnepasiënte in afsondering in 'n spesifieke hospitaal in Lesotho te verken en te beskryf. Bewyse vir die rasionaal en toepaslike gebruik van afsondering sowel as die bevordering van die psigiese gesondheid van pasiënte in afsondering, word in die literatuur beskryf. Die psigiatriese gesondheidswetgewing in Lesotho spreek nie spesifiek die afsondering van binne-pasiënte aan nie. Hierdie navorsing is belangrik in sover dit nog nie voorheen in hierdie konteks gedoen is nie en inligting in hierdie verband beperk is. 'n Doelgerigte steekproeftrekkingsmetode is gebruik. Data is ingesamel deur elf (11) individuele semi-gestruktureerde fenomenologiese onderhoude te voer. Een sentrale vraag is aan alle deelnemers gevra. Onderhoude is gevoer totdat saturasie van data verkry is. Veldnotas is geneem. Onderhoude is op oudioband opgeneem en verbatim getranskribeer. Tesch (in Creswell, 1994: 142) se beskrywende oop metode van kodering is gebruik om die data te analiseer. Resultate is beskryf gegrond op die kategorieë geïdentifiseer in die data. Die hoofkategorieë was (1) die ervaring van gevangenisskap; (2) afsondering ervaar as 'n straf, wat 'n konteks skep vir menseregte-oortredings; (3) personeelfaktore wat bydra tot die ervaring van gebrek aan ondersteuning en sorg en (4) emosionele response op die afsonderingservaring. 'n Literatuurkontrolle het die beskrywing van die resultate gevolg.

INTRODUCTION

The aim of this article is both to give psychiatric in-patients a platform to voice their experience of being secluded in a specific hospital in Lesotho as well as to sensitise mental health practitioners to these described experiences making them mindful of their decision-making and implementation practises when utilising seclusion as a resource for mental health care and treatment.

Seclusion is the process of confining a patient to a single room, in which he/she is alone but carefully observed by members of staff (Fontaine & Fletcher, 1995:122). In a British study, the reported incidence of patients being secluded varied from 1.9% to 66% of admissions to psychiatric facilities (Angold *in* Uys & Middleton, 2004:258) depending on the marked difference in patient populations in these psychiatric facilities.

The rationale for the use of seclusion is based on three therapeutic principles: (1) containment, (2) isolation and (3) decrease in sensory input. When using the principle of containment, patients are restricted to a place where they are safe from harming themselves and other patients. Isolation addresses the need for patients to distance themselves from relationships, which are at times pathologically intense. Seclusion provides a decrease in sensory input for patients whose illness results in a heightened sensitivity to external stimulation (Stuart & Laraia, 2001:650).

However, studies have shown that patients find seclusion degrading, dehumanising, frightening and lonely (Uys & Middleton, 2004:264). Legal requirements for the care of secluded patients vary from country to country. In South Africa, the Mental Health Care Act Regulations (Act no 17 of 2002), section 39, clearly stipulates the grounds for seclusion and control measures to be implemented during seclusion.

The mental health legislation of Lesotho (at the time of conducting this study) did not specifically address seclusion of psychiatric in-patients. However, attainment of mental health by all Basotho, including secluded psychiatric in-patients, is the major aim of the Lesotho government (Motlomelo & Sebatane, 1999:1).

Guidelines for the use of seclusion have been described in the literature and are useful in setting standards for this type of intervention. Guidelines proposed by the Royal College of Nursing (*in* Uys & Middleton, 2004:264) specify the following aspects regarding seclusion:

- the safety of the environment;
- primary and secondary review procedures during seclusion; and
- ensuring privacy, respect and physical care during seclusion.

PROBLEM STATEMENT

The problem is stated through a narrative, which tells the story of a patient who was admitted to a psychiatric hospital and because of the nature of her psychiatric illness, was secluded: "*Fortunately for me, it has been a number of years since I was locked up. It always seemed like overkill. Here I am in a locked facility and I get up in a locked room. I was expecting that next a canvas bag would be put over me and I would be dropped into a river. I can't bring myself to describe the moment by moment struggles and sheer gut-wrenching terror of being put into seclusion. Tears well up in my eyes and I feel a dark opening below me. The faces of the people who put me in seclusion are stamped in my mind ... The whole experience made me feel shamed and that my soul had been dishonoured. The terror of seclusion and the wound to my soul made me want to stay as far away from the mental health system as possible ...*".

When patients become physically aggressive and become a danger to themselves and to others, they are usually secluded in a psychiatric hospital (Shives & Isaac, 2002:152). In the specific context of this study, psychiatric nurse practitioners and psychiatrists base their decisions to seclude patients on existing ward protocols. Here, highly "disturbed" patients such as aggressive and acutely confused patients are secluded.

Appropriate legislation and information pertaining to psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho is limited. Context specific guidelines based on patients' experiences are required, hence the researchers' interest in this study. The research question that arose from the above problem statement is: *What is the psychiatric in-patient's experience of being secluded in a specific hospital in Lesotho?*

OBJECTIVE

The objective of the study with specific applicability to this article is to explore and describe the psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho.

PARADIGMATIC PERSPECTIVE

The paradigmatic perspective includes the meta-theoretical assumptions, the definition of concepts and the methodological assumptions.

The theoretical model used in this study is the Theory for Health Promotion in Nursing (THPN) (University of Johannesburg, 2006:2-8). The goal and main emphasis of this theory is the promotion of health of the individual, family, group and community. This model is specifically applicable within the realm of psychiatric nursing science as the patient is viewed holistically in interaction with his/her environment. The psychiatric nurse practitioner as a sensitive therapeutic agent implements the nursing process as a resource in the promotion of mental health.

Meta-theoretical assumptions

The meta-theoretical assumptions of the Theory for Health Promotion in Nursing (THPN) (University of Johannesburg, 2006:2) on which this study was based are:

- unconditional acceptance of people and respect for human rights;
- sensitivity towards cultures through empathy and caring;
- realising and facilitating virtues such as honesty, commitment, trustworthiness, acceptance of responsibility and accountability, courage and perseverance; and
- promoting co-operation and empowerment by being consumer friendly and helpful through availability and accessibility.

DEFINITION OF CONCEPTS

A **psychiatric in-patient** is a recipient of mental health care service (Anderson, Keith, Novak & Elliot, 2002:515). In this context, "patient" refers to a person undergoing treatment where a psychiatric diagnosis has

been made and implies the research participants. He/she embodies a whole person with dimensions of body, mind and spirit who functions in an integrated manner with the environment (University of Johannesburg, 2006:4). **In-patient** refers to a hospitalised patient (Sadock & Sadock, 2003:938).

Experience refers to things and events that have happened to psychiatric in-patients which influence the way they think and behave (Hornsby & Wehmeier, 2000: 406).

A **hospital** refer to a health care facility that provides in-patient beds, continuous nursing service and an organised medical staff (Anderson, Keith, Novak & Elliot, 2002:515). It is the place where the in-patients are secluded during their care and treatment.

Seclusion refers to the action of separating a patient from others in a safe, contained environment with minimal stimulation (Stuart & Laraia, 2001:867). This method of handling violence is as old as psychiatric care itself and the goal of seclusion is to gain maximum cooperation from the client and minimise violence (Wilson & Kneisl, 1996:830; Uys & Middleton, 2004:258).

Promotion of mental health implies the promotion, maintenance and restoration of mental health of an individual, family and community. Promotion is implemented through the facilitation of mental health through the mobilisation of resources (University of Johannesburg, 2006:5).

Methodological assumptions

Botes' model for research (*in* University of Johannesburg, 2006: 9-14) provides the methodological assumptions for this study. The research addresses a current health issue, the purpose of the study is functional by nature and trustworthiness will be ensured through applying Lincoln and Guba's (*in* Krefting 1991:214) guidelines.

RESEARCH DESIGN AND METHOD

Research design

The design of this study was qualitative (Babbie,

2004:281), explorative (Babbie, 2004:87), descriptive (Babbie, 2004:89) and contextual (Mouton, 1996:133) by nature.

A qualitative design was selected as it focuses on aspects such as meaning, experiences and understanding and reaches the viewpoint of the research participants (Brink, 1996:1996). An explorative design was used as little is known about the phenomenon that was researched (Babbie, 2004:87) and concepts were explored as they are perceived and defined by real people, thus allowing people to speak for themselves (Hoskins, 1998:4). A descriptive design provided a description of the phenomenon of interest, namely: psychiatric in-patients' experience of seclusion in a specific hospital in Lesotho. In a contextual design, the researcher studies the data in the setting of the environment in which it is gathered (Mouton, 1996:133) for the contextual significance thereof. Thus supporting this study being limited to a specific hospital in Lesotho.

Research method

The research method included one of purposive sampling according to set sampling criteria (Burns & Grove, 2001:376), semi-structured phenomenological interviews (Brink, 1996:119 & 158), field notes (Wilson, 1989:434-435) and open coding using Tesch's descriptive method of open coding (*in* Creswell, 1994:142).

DATA COLLECTION

The sample of this study was purposively selected (Burns & Grove, 2001:376; Polit & Hungler, 1995:235) and comprised of eleven (11) local (Basotho) in-patients. The sampling criteria were: (1) adult in-patients (older than 18 years of age); (2) informed consenting participants; (3) participants orientated and in contact with reality at the time of the interview. The demographics of the sample were as follows:

- four males and seven females;
- their ages ranged from twenty to forty-three with an average of 30.7 years;
- the psychiatric diagnoses of patients included in the sample were: Paranoid schizophrenia (four), Bipolar mood disorder (three); Psychotic disorder/mania (two) and Depressive episode with psychotic symptoms (two);

- patients were orientated to time, place and person at the time of the interview;
- the number of times these patients were admitted to a psychiatric hospital ranged from one to nine times;
- the frequency of seclusion experienced ranged from four to nine times; and
- the lengths of their seclusion experience ranged from two days to three weeks.

A pilot study was conducted which included an interview with one (1) purposively selected participant who met the selection criteria. In this way the feasibility of this data collection method as well as the interviewers' skills and the specific technique were determined and confirmed as appropriate (Talbot, 1995:74).

Data were collected by means of individual semi-structured phenomenological interviews. The following central question was asked of each patient in his or her mother tongue (Sesotho) at the beginning of the interview: "*What is your experience of being secluded?*" Thereafter, non-leading probing questions were asked. Semi-structured phenomenological interviews were used as a means of data collection because it was well suited for descriptions and explorations of patients' concepts related to their experiences of being secluded, which were complex and sensitive experiences.

Saturation of data was obtained after the eleventh (11th) interview was conducted as evidenced by the repetition of themes (Streubert & Carpenter, 1995:317). Interviews were audio taped to provide a permanent full record of questions asked, probes used and patients' responses/reactions to questions. They were then transcribed verbatim in Sesotho. Four types of field notes were collected (Wilson, 1989:434-435), namely: observational notes; theoretical notes; methodological notes and personal notes.

DATA ANALYSIS

Tesch's method of open coding (Creswell, 1994:142) was employed. All data derived from transcribed interviews (Polit & Beck, 2004:332, 572) and field notes (Polit & Beck, 2004:382) were reviewed in the context of the entire interview sessions with words, phrases, descriptions and terms central to research topic noted. These were coded and analysed separately by the

researchers as well as an external independent coder who has extensive experience in qualitative research methods and psychiatric nursing science.

The raw data were analysed in Sesotho. Categories and subcategories were established and described according to significant themes, which emerged. To enforce subcategories and provide referential adequacy, direct quotations of some patients' responses have been included.

LITERATURE CONTROL

A literature control was performed and the results of this study reflected in the light of present literature to establish similarities and differences, and recontextualise the data appropriately to the research design (Morse, 1994: 34).

ETHICAL CONSIDERATIONS

The following rights of all patients were ensured throughout:

- the right to self-determination and no harm;
- confidentiality and anonymity; and
- assurance of quality research (Democratic Nurses Organisation of South Africa, 1998:2.2.3).

This was implemented in the study through: (1) obtaining relevant informed consent from all appropriate stakeholders; (2) omission of all names and identifying data from any documentation; (3) destroying tapes after they had fulfilled their research purposes; (4) adhering to the principles of good scientific research under the required supervision; (5) complete and comprehensive reporting of the research method and data obtained.

TRUSTWORTHINESS

Lincoln and Guba's (*in* Krefting, 1991:214) strategies for credibility, transferability, dependability and conformability to ensure trustworthiness of the study were implemented throughout. This was done by means of:

- Prolonged engagement by interviewing until every interview was saturated, meeting patients before the interview and spending time before the interview to build a trusting relationship with

participants.

- Membership control through summarising and clarifying during each interview and including a literature control.
- Peer examination through using an independent coder and credible supervision during the research process.
- Triangulation of sources consulted (national and international), use of different types of field notes, eleven (11) semi-structured phenomenological interviews and employing an independent coder.
- Providing a dense description of the research method as well as the data.
- Authority of the researchers being a psychiatric nurse practitioner with extensive experience in the field, theoretical and practical preparation in research methodology as well as interviewing skills, conducting a pilot study.
- Providing referential adequacy and a conformability audit through adding appropriate quotes, addendums to the study and safekeeping relevant documents as appropriate.

RESULTS AND DESCRIPTION OF RESULTS

The results are based on four (4) main categories and eight (8) subcategories that emerged from the data analysis. Table 1 reflects the main - and subcategories of psychiatric in-patients' experience of being secluded in a specific hospital in Lesotho.

Category 1: Psychiatric in-patients' experience of being in a prison

Patients explained that they experienced seclusion as being in a prison because in their opinion only prison inmates are locked up and are deprived of freedom of movement.

The patients who were imprisoned prior to their experience of being secluded clearly revisited their imprisonment when they were secluded. The memories and negative emotions related to imprisonment were triggered by the similarity for them between a prison cell and a seclusion room.

Table 1: Main and subcategories of psychiatric inpatients' experience of being secluded in a specific hospital in Lesotho

CATEGORY		SUBCATEGORY	
1	Psychiatric in-patients' experience of being in a prison.	1.1	The experience of being in a locked up area as in a prison related to previous experience of imprisonment.
		1.2	The experience of imprisonment related to the physical structure of the seclusion room.
2	Seclusion experienced as a punishment, which created an environment where human rights violations were experienced.	2.1	The experience of being humiliated and ill treated.
		2.2	Lack of information related to being secluded.
3	Personnel factors leading to an experience of not being supported and cared for.	3.1	Non responses when assistance within the seclusion room is requested.
		3.2	Physical needs not being met.
4	Emotional responses to the seclusion experience.	4.1	Negative emotional responses to the seclusion room experience described as: Anger; Sadness; Hurt; Frustration; Powerlessness; Dismay; Fear.
		4.2	Positive emotional response to the seclusion room experience described as a sense of calmness.

1.1 The experience of being in a locked up area as in a prison related to previous experience of imprisonment

One patient stated, *"When I was secluded it was like I was in a prison. You see, Madame, I was once imprisoned at ... because of not having an identification book (passport), we were locked up, eating food and passing stools in the same room, do you hear that?"* (Voice loud and nostrils flaring).

Imprisonment often implies the unwilling confinement of a person (Townsend, 1996:843) thus likening seclusion to imprisonment for the participants.

1.2 The experience of imprisonment related to the physical structure of the seclusion room

Patients experienced the structure of the seclusion room as likened to that of a prison as one patient said: *"...the windows of that room are high up the wall and are very small. I wanted to see people outside but in vain because of ... small windows on a tall wall that I could not reach ... just like those that are in prison"*.

Category 2: Seclusion experienced as a punishment, which created an environment where human rights violations were

experienced

Patients experienced seclusion as a punishment and did not see the therapeutic value thereof. Many patients asked the researcher whether: *"the seclusion room (was) a place of therapy for patients or a place where (they) were being tortured?"* Their experience and understanding of seclusion was that it was a means to punish them, whenever they deviated from the nursing personnel's orders, making this a very punitive and negative experience for them.

Stuart and Laraia (2001:650) confirm this experience by stating that many patients who experience seclusion find it to be a negative and punitive experience. Blyth (2007:1), a nursing student, witnessed an incident where seclusion as an intervention was used when a patient lashed out at a nurse. Her experience was that seclusion had been used as a form of punishment, as well as a tactic to cope with staff shortages. The Mental Health Care Act Regulations (no 17 of 2002) 39 of South Africa stipulates that seclusion shall not be used as a form of punishment. Furthermore, using seclusion as a punishment, divorced from the treatment interests of the client, cannot be justified and it represents a serious mismatch between the needs of the client and those of the treatment setting (Wilson & Kneisl, 1996:828).

2.1 The experience of being humiliated and ill treated

Patients reported that they felt humiliated because they had to clean their own faeces, as one patient stated. Humiliation was also related to not being able to go to the toilet and having to defecate on the floor. Sanford, Gournay and Hancock (1996:125) confirm that many patients being secluded find the seclusion amongst other experiences, to be humiliating. Expecting patients to furthermore perform demeaning act by having to defecate in the exclusion room and then clean this, significantly adds to seclusion being hugely humiliating.

Patients complained that they experienced ill treatment, which was related to being insulted, beaten, shouted at by the nursing personnel and even forcibly placed in the seclusion room. As stated by one patient: *"You know nurses used to beat me. They slapped and punched me ... when I refused to be secluded. They insulted (me) and pushed me in the seclusion room. I cannot mention those insults, they were bad"* (voice loud and shaky). The Mental Health Care Act (no 17 of 2002) of South Africa, section 8 states that the person, human dignity and privacy of every mental health care user must be respected. In Section 11 of the Act, it is stated that every person, body, organisation or health establishment must take steps to ensure that users are protected from exploitation, abuse and degrading treatment.

For some patients the ill treatment was related to being secluded for a long period: *"I was secluded for three weeks!"* According to Mohr (2003:564) the maximum timeframe in which seclusion may occur should be limited to four (4) hours. Patients may be released from seclusion when their behaviour is under control and they no longer pose a danger to themselves or others (Kneisl *et al.* 2004:816). If seclusion for longer than eight hours is required or more than 12 hours intermittently over a 48 hour period, review procedures should be performed by including a person not part of the usual treatment team (Uys *in* Uys & Middleton, 2004:264).

2.2 Lack of information related to being secluded

Patients said that they did not know what the reason was for their seclusion, or what it entailed, as nursing personnel provided no explanation of their reasons for secluding them. Even after they were released from

seclusion no explanation was provided. One patient complained that his visitors were not informed of his seclusion. This lack of information further leads to suspicion by the patients with regard to the nurses' intent. A patient related the following experience: *"They (nurses) took my belongings, including my briefcase, which had important documents. They did not explain as to where they kept them. I concluded that they were reading my documents and were prying into my privacy"*.

The Mental Health National Health Trust (2005:7) states in their seclusion policy that patients who are being put into seclusion should be informed of the reason for doing so. Techniques to de-escalate aggression is a core skill for mental health nurses working in acute settings. Basic skills underlying de-escalation is talking and listening to patients (Blyth, 2007:1). If other interventions have failed leaving only seclusion as an option, the patients should be approached by one nurse who provides a clear, brief statement of the purpose and rationale for seclusion (Kneisl, Wilson & Trigoboff, 2004:816). Following the termination of seclusion a nurse and/or doctor must meet with the patient to discuss the seclusion and the events that led to it (Mental Health National Health Trust, 2005:9).

Category 3: Personnel factors leading to an experience of not being supported and cared for

Patients' experience of not being supported and cared for was related to their experience of nursing personnel making only the most necessary and limited contact with them. One patient stated that: *"... nurses would come only in the morning, lunch time and supper time, and medication time!"*

Patients related their experience of the negative attitude they received from the nursing personnel who did not communicate with them at times of entering the seclusion room. When nurses assess the patient who is in seclusion, they should enter the seclusion room and participate in a verbal exchange with the patient (Kneisl *et al.* 2004:816). Frequent staff contact decreases the patients' sense of loneliness (Keltner, Schwecke & Bostrom, 1995:131).

Patients experienced the personnel to be unfriendly, in their words: *"their faces showed no peace"*. Active

friendliness implies that nursing personnel initiate interaction with patients and respond positively. The negative attitudes of nurses lead to anti-therapeutic behaviour by them, such as rigidity and withdrawal (Uys, in Middleton & Uys, 2004:227).

3.1 Non-response when assistance within the seclusion room is requested

Patients expressed frustration with the non-responsiveness of nursing personnel to their requests for assistance. As stated by one patient: "... I would hit hard on the door calling on top of my voice, for nurses to come and help me but they did not come".

3.2 Physical needs not being met

Patients reported to have experienced body pains and uncomfortable sleep due to the hard surface they had to sleep on and lack of a pillow. They also experienced coldness in the seclusion room because blankets were not enough and it was wintertime. The Mental Health National Trust (2005:9) states in their seclusion policy, that the seclusion room should have adequate heating, lighting and ventilation. Furthermore a safe mattress, chair and bed linen should be provided (Mental Health National Health Trust, 2005:9). Nursing personnel must provide a comfortable environment (Stuart & Laraia, 2001:650) throughout a patient's seclusion.

One patient stated that he was "suffering from diabetes mellitus thus requiring more frequent toileting needs and meals". According to him these needs were not sufficiently met. Some patients reported that they could not eat the food because their hands were dirty and the nursing personnel would not give them a chance to wash them before eating. One patient stated: "I could not eat the food with dirty hands...I decided to stay hungry!"

Physical care should be provided throughout the period of seclusion (Uys, in Uys & Middleton, 2004: 264). Once a patient is placed in seclusion, checks should be performed, including routine care activities, meals and toileting (Kneisl, et al. 2004:816). The Mental Health Care Act Regulations (no 17 of 2002) section 39 stipulates that a patient must be observed every thirty minutes and a register should be kept.

There should be a ready supply of clean drinkable water and use of the toilet should be managed under

supervision of the nursing personnel (Mental Health National Health Trust, 2005:8).

Category 4: Emotional responses to the seclusion experience

Most of the emotions experienced as a result of their seclusion were negative. Only one patient had a positive emotional response.

4.1 Negative emotional responses to the seclusion room experience

Anger: Patients expressed their anger related to eating food in a dirty room. One patient stated: "... I was angry to eat food in a dirty and bad smelling room".

Sadness: Patients' sadness was related to the negative attitude of the nursing personnel. One patient related: "They pushed me into the seclusion room ... I felt sad".

Hurt: The experience of being hurt was related to a humiliating experience as explained by a patient: "One confused patient had passed menstrual blood on the floor. The nurses ordered me to go and clean the floor of that patient".

Frustration: Patients experienced frustration, related to the bad living conditions in the seclusion room as one patient stated: "You know, being secluded is like locking up a person in a stinking toilet!"

Powerlessness: The experience of powerlessness was related to being unable to report their painful experiences to higher authorities. One patient said: "... I did not know what to do and who to turn to for help..." (tears filled her eyes).

Dismay: The dismay was related to loneliness in the seclusion room: "I asked myself a question: 'Where are other people?', there was no answer, I was by myself!"

Fear: The fear of patients was related to sleeping on a bed, which in their perspectives was shaped like a grave/coffin. A patient said: "That bed looked like a grave. I was so afraid ... I had a feeling that I was in the process of dying". The fear was also related to anticipation of being raped when separated from others in the secluded room.

The literature confirms these experiences, stating that feelings of anger, frustration, helplessness, powerlessness (Videbeck, 2004:182), sadness (Sanford *et al.* 1996:126) and fear (Uys & Middleton, 2004:264) are common in patients being secluded.

4.2 The positive emotional response to the seclusion room experience described as a sense of calmness.

One patient experienced a sense of calmness in the seclusion room. The patient enjoyed being alone, as she had time to pray, something she could not do when she was with her fellow in-patients. She stated: "... *the only thing I liked is that I found a good time to pray because I pray ... where there are no other people*". Sanford *et al.* (1996:126) and Blyth (2007:1) confirm that some patients found the experience of seclusion to have a calming effect on them.

LIMITATIONS OF THE STUDY

A significant amount of patients were diagnosed with disorders where psychotic episodes are present. One of the selection criteria of the sample were that the participating psychiatric in-patients should be well orientated to time, place and person at the time of the interview. It should however be considered that the patients were sharing experiences of seclusion during a time in which many of them probably would have been acutely psychotic. Their ability to remember the incident of seclusion might be affected by their impaired memory (Sadock & Sadock, 2003:276) during the psychotic episode. This might be viewed as a limitation to this study.

CONCLUSION

The explored and described experiences of psychiatric in-patients being secluded in a specific hospital were met with eagerness to participate in the hope that the study would improve the therapeutic use of seclusion and the care given during seclusion.

The implementation of seclusion within this specific context seemed to be divorced from the treatment intent for seclusion as a means to reduce disruptive stimulation and provide the client with a contained well-defined space for reassurance and protection (Kneisl *et al.* 2004:814). Basic physical, psychological, interpersonal

and spiritual dimensions of care and treatment of patients before, during and after seclusion were not effectively adhered to. For patients who were secluded, this culminated in feelings of humiliation and negative emotions. When a sense of calmness was experienced, the use of seclusion seemed to have a more positive therapeutic effect for patients. This should guide nurses in their attitudes, words and actions, before, during and after using seclusion as a therapeutic intervention.

The above description of experiences calls all stakeholders, from the nurse implementing seclusion to the appropriate persons implementing policies and legislation in this context to action, in improving the care of psychiatric in-patients being secluded in a specific hospital in Lesotho.

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