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Editorial

Attitudes toward Seclusion in Psychiatry in the Elderly

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Editorial

Seclusion of a patient who has been admitted to an institution for psychiatric care is one of the possible interventions from a range of treatment and care strategies. Seclusion is used in different kinds of institutions, for example, in psychiatric hospitals, institutions for mentally handicapped persons, and judicial institutions. Seclusion is a controversial issue in the care of psychiatric inpatients, having provoked moral debate for several decades. Seclusion is associated with neglect and abuse; thus, the issue provokes emotional reactions on both sides of the debate. According to Mattson and Sacks [1], it is interesting to observe that many who argue for the use of seclusion use theoretical bases for their points, whereas those who argue against seclusion use moral or anecdotal evidence. This overview is concerned with seclusion of patients during their stay in an institution for mental health care.

The majority of the literature originates from English-speaking countries, especially the United States. The greater part of the published articles deals with seclusion and use of mechanical restraints, for instance, fixation. The distinction between these two concepts is not always possible in the reviewed publications. It is evident that there are differences in the way seclusion is used. These differences are based on national and state policy and legislation.

In recent literature, voluntary or involuntary confinement of patients is described as seclusion, isolation, solitary confinement and time-out. In many publications, little or no attention is paid to the definition of the concept.

The practice of restraining patients has had a long history in the behavior management of aggressive individuals with mental illnesses. Thus, there is a notable absence of debate in the current psychiatric literature relative to whether we ought to be restraining patients. This question has been lost in a tradition in psychiatric nursing that justifies restraining patients as a means of providing safety on a unit. Although safety on a unit is important, concern for the person and his or her needs are primary. Because little is known about the impact that restraint has on the patient, restraining psychiatric patients may violate the moral imperative of nursing, which is to promote the well-being of the patient throught excellent practice. Furthermore, excellent practice requires an understanding of the meaning that our practices have for the patient; thus it is essential that we understand what being restrained means to the people we restrain.

Isolation addresses patients' vulnerability to forms of pathological intensity of relationships in which they severely misinterpret the actions of others or experience paranoia. Seclusion brings a feeling of relief from the interpersonal torment of Interactions with staff or other patients. For paranoid patients, seclusion may be the only place they feel safe from "persecutors". Seclusion provides patients with a smaller space to master, an accomplishment that may enable them later to master larger spaces. Isolation provides seriously mentally ill patients, who are hypersensitive to sensory input, with some relief from sensory overload [2].

Implications for practice include a need for detailed observations and comprehensive documentation by staff of the interactions of psychiatric patients prior to seclusion. A formal review of each seclusion on each ward might help the staff identify ways to interact with patients to help patients avoid unnecessary seclusions and to accept those which staff agree are necessary.

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