Enacting a counter story: seclusion in psychiatric nursing

“We never use the seclusion room unnecessarily, so if they tell us that we have to reduce seclusion, that is impossible!”

- A fellow nurse -
Abstract

Narratives are important in the field of nursing. In this article we present the story of a nurse on seclusion in psychiatry. The methodology used in the article is inspired by auto-ethnography. The first author is the narrator of the story. She presents her experiences, first as a nurse in psychiatry, and later as an academic researcher of psychiatric practice. The story shows the force of a dominant story in nursing practice. It also shows that a counter story can be developed. It expresses the ambivalences which come along with the development of the counter story and the doubts about its effectiveness in practice. Finally, it shows how a counter story can be put to the test and can gain credibility for a larger audience. We conclude that stories are not just a matter of words. Stories contain guidelines for action and are embodied in practices. To create a basis for developing a new practice, a story has to be enacted in practice.

Introduction

In the field of nursing, the life-story and narrative of patients are regarded as important to adjust care to their needs and identity, and to enable patients to gain a voice and find a new balance in life (Benner, 2000; Hall & Powell, 2011; Heliker, 1999). Illness narratives of patients may conflict with the professional narratives of the staff, which are often oriented on medical and therapeutic interventions (Frank, 2002; Kleinman, 1988). Narratives have a performative function; they are not just ways to make sense of and endow meaning to experiences, they also guide our actions and practice (Widdershoven & Sohl, 1999). Stories imply responsibilities towards others (Walker, 2006). As such narratives may establish and re-establish a practice, and important roles, relations and values within that practice.

Narratives are not neutral, but reflect personal standpoints and value commitments. Feelings and emotions are part of stories and can be understood as embodiments of what people value in life, what is important for them (Nussbaum, 2001). In the literature on narration a distinction is made between dominant stories and counter-stories to understand the dynamic role of power in processes of narration (Abma, 1998; Frank, 2010; Giroux, Lankshear, McLaren & Peters, 1996; Stanley, 2007). Dominant stories are stories that are taken-for-granted in a practice. Dominant stories express roles, relations and values that are no longer contested, and structure the way in which practitioners act and behave. Power structures are thus reflected in the dominant story of a practice.

Counter-stories resist and counter act the values and notions of dominant stories. Giroux and others (1996) emphasize that counter narratives counter “official” and “hegemonic” narratives of everyday life. Counter narratives are according to these authors: “little stories of those individuals and groups whose knowledge and histories have been marginalized, excluded, subjugated or forgotten in the telling of official narratives” (p. 2) Counter stories are often unheard and unpopular, precisely because they contest the values that are taken-for-granted. Voicing counter stories can be difficult and dangerous because such stories are not well-understood by members of the community of practice, and oppose existing power relations. Counter stories tend to be silenced and excluded to maintain the status-quo. Nevertheless, counter stories can become more attractive if practitioners no longer identify with the dominant story, if they experience their narrated identity as unreal with their lived world and search for new understandings of their practice and their role in it.

In this article we present the story of a nurse which shows the force of a dominant story in nursing practice. It also shows that a counter story can be developed. It expresses the ambivalences which come along with the development of the counter story and the
doubts about its effectiveness in practice. Finally, it shows how a counter story can be put to the test and can gain credibility for a larger audience.

The methodology used in the article is inspired by auto-ethnography (Ellis & Bochner, 2003; Reed-Danahay, 2007). Auto-ethnography is the critical introspection and analysis of the personal experiences of the researcher in order to understand a cultural practice. In this case the first author acted as a researcher, investigating her experiences first as a nurse in psychiatry, and later as an academic researcher of these practices. In both roles she experienced what it means to care for psychiatric patients and how to act during moments of crisis. In both roles she had to deal with the practical, moral and emotional challenges of seclusion. Her experiences as a nurse were reconstructed in hindsight. Her experiences as an academic researcher were recorded in a logbook and field notes, which she could draw on when writing her story. The other two authors were involved in the research from the very start, and acted as critical peers, discussing her experiences with her and jointly interpreting them in the research team.

The story is told in the first person form to express that the first author is the owner and narrator of the story. However, the other two authors were actively involved in developing the counter story and making room for it in psychiatric practice, and in stimulating the development of new ways of dealing with seclusion in collaboration with practice. After the presentation of the story we will analyse the core values in the dominant and the counter story, and reflect on the process that led to the transformation of the plot line.

Dominant story: Seclusion is part of psychiatry

I was eighteen years old when I started studying nursing. My first internship was in a mental health care institution. Until that time I had never been in contact with psychiatry. I worked on a ward for long-term care and patients had complicated psychiatric symptoms as well as behavioural problems. On the ward there was much aggression. There were two seclusion rooms. On the first day a colleague showed me the ward and the seclusion rooms. I still remember what she said to me when we stood in one of the seclusion rooms: “I always pay attention how I close the door of the seclusion room. I want to do that gently. If you go into the seclusion room and listen, you will hear that the sounds are very loud and hollow. Closing the door can be very frightening for patients.” I was overwhelmed and shocked; patients were locked in a bare room! I found it hard to imagine that patients could be healed in that terrible room.

The two seclusion rooms were used almost every day. On my second day a patient threw a glass through the living room of the ward. The nurses literally dragged him along the floor to the seclusion room. This is not what I expected from nursing. I wanted to care for patients and not lock them up. After a few days, I got more used to the seclusions and after a few weeks I assisted in cases of seclusion. Seclusion became a part of my work in psychiatry. I forgot my doubts about the use of the seclusion room.

I liked working in psychiatry, and my third internship was at an acute admission ward. On that ward, seclusion was daily routine. According to my colleagues, the seclusion room was important for dealing with difficult and aggressive patients. They stressed that the seclusion room was not used unnecessarily. They made clear to me that patients were free to do as they liked, as long as they would not cause trouble. In case of danger, however, the patient would have to be put in a safe place to calm down.

A few months after this internship I got my diploma: I was a nurse! I started working at a psychiatric ward of a general hospital. During my work I studied part time mental health sciences at the university. Due to the study I became more critical again. I learned about other ways of dealing with aggressive patients. Also I learned that psychotic patients can become more anxious and psychotic in a bare room. Slowly my doubts about seclusion came back. I was curious about the experiences of both patients and caregivers with seclusion, and I decided to study this subject for my master thesis. For this study, I interviewed patients and caregivers. For patients, I learned, it is traumatic, and most of the time caregivers experience conflicts between the values of safety on the ward and freedom of the patient.

Having read more about the issue, and having listened to and analysed my interviews with patients and nurses, I became convinced that seclusion is not good care. Most of my colleagues did not understand. One colleague said: “We have always done it in this way, why do you think this no longer is good care?” My colleagues asked me to explain how to act in a different way. According to them it was impossible to avoid seclusion. What could I say? Nevertheless, for each seclusion I questioned the necessity and asked whether there were alternatives. My colleagues started calling me “the anti-seclusion nurse”.

Developing a counter story: ‘The best captains are ashore’

After completing my thesis, I got a job as a researcher at the university. My research entailed studying and supporting projects in psychiatric practice which were intended to reduce the number and duration of seclusions. These projects were instigated by the
institution management, as a response to societal discussion about the high rate of seclusion in the Netherlands. I studied the projects in two mental health care institutions. My colleague, trained as philosopher, studied three other mental health care institutions. I organized interviews and focus groups with stakeholders. I talked with lots of patients, nurses, psychiatrists, therapists and family members. Again the interviews with patients confirmed that seclusion can be traumatic, and that many patients experienced seclusion as a punishment for bad behaviour. I was impressed by a patient who explained:

“The seclusion room is an awful place. I was constantly afraid and had bad thoughts all the time.”

Patients also indicated that they felt lonely and missed contact with nurses.

During the first period of my research, nurses in the institutions knew no alternatives for seclusion. Restless patients were often secluded immediately at admission without any communication. Seclusion was experienced as a necessary and unavoidable intervention. As I was questioning them, nurses tended to defend their way of working, telling me that patients were never locked up without good reasons. A typical remark was: “We never use the seclusion room unnecessarily, so if they tell us that we have to reduce seclusion, that is impossible.”

The nurses had a reactive way of working; they would only act when situations had already been escalated. When they saw that a patient was heading for crisis, they would not think how to prevent escalation. There simply were no alternatives for seclusion.

In the mental health care institutions where I did my research, the official policy was aimed at reducing coercion and seclusion, but there were no guidelines for this. The professionals on the wards, nurses in particular, had to develop alternatives and methods to prevent seclusion themselves. They started discussing options and experimenting with a more proactive way of working. Instead of controlling patients, they interacted more with patients, focusing on signalling a possible crisis and taking measures in advance. During admission there was more communication with the patient and hospitality became regarded as important.

Through these new initiatives in the mental health care institutions, I became increasingly convinced that seclusion could be prevented. Nevertheless, when my close colleague in the research team was critical about what was going wrong in the mental health care institutions or what could be done to prevent seclusion, I tended to defend the nurses. As a philosopher, what did she know about working in psychiatry?

She had not experienced how difficult it is to deal with psychotic and aggressive patients in psychiatry! I was in two minds. On the one hand I was convinced that it was possible to prevent seclusion. On the other hand being a nurse myself I identified and sympathized with the nurses knowing how difficult it is to handle psychotic, manic and aggressive patients. My role as a researcher felt being “a captain ashore”. As a researcher it is easy to say what caregivers have to do in practice. More and more I was wondering whether I would be able to put the interventions into practice by myself.

Enacting the counter story: ‘The proof of the pudding is in the eating’

I enjoyed doing research. But I also felt I had to prove that the research made sense to the practitioners and was meaningful for practice. I had to be able to act in line with the recommendations I wrote down in my research reports, to prove my credibility. After a year of research I returned working as a nurse on a psychiatric ward of a general hospital for a month. I kept a diary on a daily basis of my experiences and my interactions with patients in crisis. In the third week at the ward, the admissions of Hans (pseudonym) was announced.

Hans was a forty year old man, was mentally disabled, had a lot of somatic complaints and was manic. The ambulatory crisis team told us that Hans was aggressive. My colleagues said: “This is a seclusion customer again!” Forced emergency medication was agreed with the psychiatrist. Hans lived in a institution for mentally disabled people. He was brought to the ward tied on a stretcher by four policemen. In the ward, he shouted, swore and was very threatening. My colleagues proposed to assess in the seclusion room whether or not Hans could stay in a room on the ward or not. I said to them this would not be a good start, since it would implicitly say to the patient: ‘We do not trust you. First let’s see that you can behave properly, otherwise we have to leave you here in the seclusion room.’ I tried to convince my colleagues that this would increase his stress and anger. In the end, my arguments were accepted.

We brought Hans on the stretcher to a room. I tried to make contact with Hans. Initially I had no success. He remained aggressive and threatening. When there was some first contact with Hans, I asked the nurses of the ambulance if they thought Hans would become dangerous if the belts of the stretcher would be loosened. They explained that his aggression had mainly been verbal. Based on this information, I asked the nurses of the ambulance to loosen the belts of the stretcher. There was not much time to consult with colleagues. It was primarily my decision. I felt very responsible for what would happen and hoped I was right. First I said to Hans:
I talked to Hans, and tried to make eye contact. Several times, I tried to hold his hands. When the belts were loosened, the tension disappeared and I introduced myself. Hans accepted this and he said: “My name is Hans.” I asked: “Shall we sit down?” Hans shouted and at some moments he was still threatening, but he sat down. I asked: “You must be tired, would you like a cup of coffee?” And yes, he dearly wanted a cup of coffee. I continued: “I imagine you have experienced a lot over the last days, you can tell me if you want to.” Hans began to tell his story and his tension decreased even more. I began to trust him, and he started to trust me, and opened up and showed his vulnerabilities. He told me he was worried because he did not take his medication for the diabetes, and I said: “I will go and see. I notice that you are very restless, shall I give you some medication so you can relax a little bit?” “Yes, please!” he answered. Finally, Hans took his medication. After eating something, he fell asleep. When he woke up, he was still restless, but not aggressive anymore. During the rest of his admission he stayed at the ward and was not secluded.

This approach was also new for me. Before, safety came first and I would have decided to seclude a patient like Hans. But, as I had learned as a researcher, it is possible to create safety in contact with the patient. When there is contact, it is easier to make a risk assessment, and to respond openly to the situation instead of reasoning from prejudices. Most of the time patients are aggressive because of fear. If the patient feels safe and confident, aggression will decrease. Also, my own fear decreased when I was in contact with Hans. I understood the importance of not becoming entangled in his anger by using coercion, and ending up in a power struggle. A calm and friendly approach was better, I experienced. Hans needed time to acclimatize. By taking time, I could also focus on the needs of Hans and create trust.

I realized this approach would not always be successful. But it was enough to know that the recommendations in my research were valid and helpful in the reduction of seclusion and restraint. My research made sense. After working as a nurse for a month, I decided not to continue, since I had become convinced that I could make a better contribution to the improvement of nursing practice as a nursing researcher.

Core values in the dominant and the counter story

The story presented above shows the power of narratives in psychiatric practice. Stories entail a world-view, which is considered evident by people involved in a practice. They stress the importance of certain values and beliefs. For a long time the dominant story on seclusion in Dutch mental health care was that seclusion is a therapeutic measure for patients who are threatening their own safety or those of others. Seclusion is regarded as not very intrusive or even positive for the patient, since it may calm the patient as he will no longer be confronted with external stimuli. In this dominant story, two values are crucial. The first value is safety. The situation on the ward has to be secure, both for staff and for patients. “We cannot allow aggressive patients on the ward” and “we must protect ourselves and other patients against aggression” are norms which express the value of safety. The second value is freedom. Patients should be allowed to decide about their treatment and be free to move on the ward. If a patient does not want medication, this should not be enforced. As long as a patient keeps quiet, he is allowed to do what he likes.

In theory, freedom should prevail, unless this endangers safety (Prinsen & Van Dleden, 2009). Only if a patient becomes aggressive, his freedom is to be restricted for the sake of safety. The value of freedom is based on the notion that a person, including a person with mental health problems, is autonomous and sovereign. The patient’s autonomy should be respected. Others should therefore not interfere with or limit the freedom of a person. Freedom is interpreted in terms of negative freedom (Moser, Houtepen & Widdershoven, 2007; Widdershoven & Berghmans, 2007). In line with this negative notion of freedom, nurses do not pro-actively deal with crisis situations. Interference would imply a limitation of the patient’s freedom. On the other hand, if situations get out of hand, nurses feel legitimized to overrule the autonomy of the patient with reference to the values of safety and security.

In practice, safety is the dominant value. For this reason, patients are immediately secluded in case of imminent danger. For security reasons many patients are secluded at admission without a conversation or a risk assessment. In the dominant story, there is no attention for prevention of escalation. As long as the situation is safe, the patient is free to do what he likes. When the situation becomes dangerous, seclusion is the only option.

Although the value of freedom is advocated in the dominant story, it is highly illusory in practice. The patient is not free to leave the ward, but is expected to stay until he is cured. This is evident in the case of involuntary admissions, but also if the admission is voluntary, the patient will be prevented from leaving, for instance by explaining that
he cannot return if he decides to end treatment. Moreover, there are many rules at the ward. These rules are deemed necessary to prevent unrest at the ward, and to make sure that all patients are treated equally. The rules lead to many conflicts between staff and patients. When a patient does not follow the rules, he risks being secluded. So, while officially seclusion is said to be a safety measure, in actuality seclusion becomes a form of punishment for patients who do not behave according to the rules set by the institution.

The narrative tells that the value of safety is so important to nurses that they do not follow the rules to prevent seclusion. They regard seclusion as a form of punishment for patients who do not behave according to the rules set by the institution.

In the counter story, crucial values are care and contact. The role of nurses is not to control or guard safety, but to care for patients. They should be open for patients’ needs and respond to them, rather than forcefully acting in case of danger by putting the patient in a seclusion room. In the counter story, the relationship between safety and contact is different from that in the dominant story. In the dominant story, safety is regarded as a precondition for contact. Safety is created by technical-power measures that place the patient at a distance. The patient is isolated, locked up, completely dependent on others. We can see this in the case of Hans; it is the nurse who gives trust and support to Hans, and enables him to regain his dignity and freedom, becoming more in control of himself. The notion of positive freedom allows for the care and support of nurses, and even ‘compassionate interference’ in situations that might escalate (Verkerk, 2001). Positive freedom gives room to nurses for more pro-active behaviour, and helps to prevent the forceful overruling of the autonomy in the stage where it is too late. The story about Hans shows that such compassionate interference is based on trust (Sevenhuijsen, 1998; Tronto, 2008).

Transformation of the plot line

The story presented above shows the power of narratives in nursing practice. The dominant story on seclusion was so powerful, that nurses could see no alternatives to realize the values of safety and freedom than to use the seclusion room. They regarded this as the normal way of dealing with crisis in psychiatric patients. Even if they felt doubts about it, they did not know what else to do. When the values in the dominant story were questioned, the response was one of surprise and disbelief. Yet, counter stories did exist, for example in the doubts about seclusion. Such counter stories may gain power. At first, the counter story was marginal to psychiatric practice, and was only told by a few ‘anti seclusion nurses’, anti-seclusion patients (http://tekeertegendeisoleer.wordpress.com/) and critically-engaged outsiders (Landeweer, Abma & Widdershoven, 2010).

When more participants in practice started to doubt the dominant story, the counter story gained significance. Yet, doubts remained and critique could easily be ignored by stating these were only ideas of academics who knew nothing of the psychiatric practice. The redefined values appeared attractive to some, but raised questions how they could be realized in practice. The nurse researcher, telling the counter story, was doubtful about the feasibility of her ideas and the values she came to endorse. She putted her ideas to the test by returning to work on a psychiatric ward. By taking time and trusting both herself and the patient, she was able to solve the crisis with Hans and to prevent the use of the seclusion room. This convinced her that she was on the right track, and she decided to continue her research in that direction. Being a peer her experience had authority for other nurses (Haidt, 2001; Landeweer, Abma & Widdershoven, 2011).

The story presented above shows that narratives which at first seem inescapable may lose attraction. A dominant story may raise doubts, at first by people who are not socialized in the practice, newcomers, such as nursing students doing their internships, academics and patient advocacy groups. Such doubts will normally be countered by professionals who have worked longer in practice. Yet, doubts may remain, and gain importance. This can result in changes, in which the counter story becomes more attractive and may even reach a position of dominance (Abma & Widdershoven, 2005). Such changes can be compared to revolutions in science, as described by Kuhn (1970).

Although the story presented in this article describes the experiences of one person, the transformation of the plot is not the result of her actions only. The story is part of a historical and social process involving many people and stories. So, the story presented here not merely expresses the unique standpoint and moral development of one person, but is inevitably related to other personal and communal stories. The story is one voice in a chorus of stories.
Conclusions

Stories play an important role in nursing practice. They express fundamental values which give direction to the actions of professionals. The values in a dominant story tend to be regarded as self-evident. The norms which follow from these values are seen as inescapable. In the margin of the dominant story, a counter story may be developed. At first, the counter story will not gain much attention, and will be silenced by the dominant story. The counter story may, however, gain importance, as the dominant story becomes less convincing. In the end, the counter story may win, and become the new dominant story.

This article presented a story on seclusion in psychiatry. The dominant story implied that seclusion is unavoidable as nurses need to secure safety at the ward. The counter story stressed the importance of care and contact, and the need to prevent seclusion by developing alternative ways of dealing with a patient in crisis. The article shows that the counter story at first came with doubts, but in the end gained credibility. The example of the nurse’s interaction with Hans shows that seclusion is not unavoidable, but can be prevented by establishing contact and gaining trust.

Stories are not only verbal. They contain guidelines for action, and are embodied in practices. A dominant story delineates a pattern of behaviour which is realized by participants in a practice. A counter story can only become credible if it can be shown to lead to effective actions. Thus, stories are not just a matter of words. They are related to practical actions. By putting the counter story to the test, and showing that it actually could be realized in practice, the dominant practice of seclusion was effectively challenged, and a basis was created for developing a new practice of dealing with patients in crisis.

References


