International Journal of Law and Psychiatry 32 (2009) 408–412

Contents lists available at ScienceDirect

International Journal of Law and Psychiatry

Seclusion: The perspective of nurses

J.E.L. VanDerNagel [a,*], K.P. Tuts [b], T. Hoekstra [a], E.O. Noorthoorn [c]

[a] Mediant GGZ Twente Enschede, The Netherlands
[b] Netherlands Institute for Forensic Psychiatry and Psychology, Almelo, The Netherlands
[c] Kenniscentrum GGNet, Warnsveld, The Netherlands

A B S T R A C T

Knowledge of how nurses experience the process of secluding a patient can be useful in improving the quality of patient care and in the prevention of work related stress in nurses. This study describes personal experiences of nurses throughout the seclusion process. The emotions which came to surface in semi-structured interviews with 8 nurses were categorized in three main themes (Tension, Trust and Power) and a stress response curve was identified in the seclusion process, with specific feelings in each phase. Feelings denied in former studies such as feeling superior, anger and disgust were found in the interviews in this study.

1. Introduction

Seclusion as an intervention, subsequent to an aggressive incident or disruptive patient behaviour, is subject to much study and debate. Recent studies question its therapeutic necessity and effect. Beside this, legal and ethical issues dominate the discussion on reducing the use of seclusion and interventions and primarily aim at change of attitude and therapeutic culture.

Far less is known about the perception of the participants in the seclusion process. Even though best practice protocols favour a systematic evaluation of the seclusion with the team, as well as with the patients and their family members, few studies focus on experiences and emotions of those involved.

A Dutch study into the experience of patients (Hoekstra, Janssen and Lendemeijer, 2004) showed seclusion to be a stressful, often traumatising event. Clinical practice suggests that nurses also experience stress and negative emotions to some extent. Describing the perception and experience of nurses while secluding a patient is the main objective of this current study. The willingness and need to discuss emotions with colleagues and others is studied, to understand with whom and how nurses share their feelings subsequent to a seclusion incident.

2. Literature Review

2.1. The Use of Seclusion

By professionals seclusion is often seen as an effective intervention to restrain aggressive behaviour, as well as to protect ward security and atmosphere (Nijman et al., 1999; Lendemeijer, 2000). Seclusion is applied frequently in the Netherlands: one study showed seclusion is used in 25% of the situations, within a sample of 1000 admitted patients (Stolker, Nijman, & Zwanikken, 2004), a figure confirmed in a more recent nationwide study (Janssen et al., 2008). However, international studies show seclusion is carried out in up to 66% of the admissions. Available alternatives, differences in legislation and variable opinions on treatment effect and ethical viability may explain these differences (Betemps, Somoza, & Buncher, 1993). Despite the frequency to which seclusion is used, there is little evidence on the therapeutic effect, since no controlled trails have been performed (Sailas & Fenton, 2004).

According to the Dutch law, the use of seclusion is allowed under the Special Admission Act for Psychiatric Hospitals (Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen (BOPZ)) (Dutch inspection of Mental health, 1994) in specific situations. Only in hazardous situations, such as agression to oneself or others, personnel may intervene without patient's consent. Despite these clear restrictions, daily practice provides an array of reasons to seclude. A comprehensive study showed the following reasons for seclusion (Lendemeijer, 2000):

1. therapeutic motives, such as to reduce stimuli or provide structure
2. containing dangerous patient behaviour (as stated in the law)
3. containing behaviour to protect the therapeutic climate and daily order of the ward
4. seclusion as punishment, often referred to as 'part of a behavioural approach'.

On average, patients subjected to seclusion are younger than other patients (Gerlock & Solomons, 1983; Lendemeijer, 2000). Men are more likely to be secluded than women. Women, on the other hand, are more often secluded repetitively for short periods (as part of a 'behavioural approach') (Lendemeijer, 2000). Patients with severe

* Corresponding author. Mediant GGZ Twente, Postbus 775, 7500 AT Enschede. Tel.: +31 53 4755755.
E-mail address: je.vandernagel@mediant.nl (J.E.L. VanDerNagel).

0160-2527/$ – see front matter © 2009 Elsevier Ltd. All rights reserved.
doi:10.1016/j.ijlp.2009.09.011

psychiatric disorders are secluded more often than those with less severe diseases (Betemps et al., 1992; Gerlock & Solomons, 1983). Hospital and environmental variables, such as staffing, the possibility to provide alternatives, department culture and staff attitude influence the application and duration of seclusion (Abma, Widdershoven, & Lendemeijer, 2005; de Cangas, 1993; Janssen, Noorthoorn, Van Linge, & Lendemeijer, 2007; Nijman, Duangto, Ravelli, Merckelbach, & Vorel, 1994).

2.2. Perceptions on seclusion

Studies looking into emotions reported by patients shortly after the seclusion incident (Dekker, 1989; Tooke & Brown, 1992; Lendemeijer, 2000) show negative feelings such as anger, depression, helplessness, sorrow, anxiety, confusion and humiliation. A qualitative study into emotions of patients some time after the seclusion event (Hoekstra et al., 2004) shows mixed feelings as well as incomplete coping.

Few studies have looked into the perception of seclusion by nurses. Studies into the reactions of patients and staff (Soliday, 1985; Tooke & Brown, 1992; Muir-Cochrane, 1996) mention on the nurses´ side: the feeling to do the right thing, a safety reassurance, but also: feelings of regret later on, aversion and fear of hurting the therapeutic relationship. Feelings of shame are experienced because of the inhuman nature of seclusion, as well as a feeling of failing in alternative interventions (Steele, 1993). Anger, revenge and the incentive of punishment are mostly denied by the nurses, while patients do attribute these emotions to nurses (Dekker, 1989; Heyman, 1987; Tooke & Brown, 1992). Several studies (Abma et al., 2005; Broers & De Lange, 1997) advocate attention to nurses' perceptions. As put forward by (Broers & De Lange, 1997): 'When nurses acknowledge their feelings of personal concern, they can avoid their feelings to have an unwanted unfavourable influence on their contact with the patient.'

3. Objectives and main questions of this Study

This study focuses on nurses' feelings prior to, during and subsequent to a seclusion incident. The following questions will be addressed:

1. Which feelings do nurses recall concerning seclusion incidents?
2. How do these feelings interrelate, and what determinants can be identified?
3. To which extent do nurses feel a need for and to which extent do they allow sharing these feelings?

4. Method

Because of the explorative nature of the study a qualitative design using the Grounded Theory was chosen. (Glaser & Strauss, 1967; Morse & Field, 1998). This method focuses on the development of theory out of daily practice, by means of theoretical sampling and saturation. Theoretical sampling is the acquisition of data from literature, text sources and interviews, in the process of developing a conceptual framework. Theoretical saturation refers to the point where no new items arise from the data.

A literature search into nurses perception provided several emotions and experiences. These were collected in a topic list used as a checklist for semi-structured interviews. Topics not spontaneously mentioned by the responder were brought forward by the interviewer, checking whether the topic was recognized.

The interviews were recorded on tape, transcribed, and analyzed using MaxQDA software (Corbin, 2008). Relevant sections of the interviews were marked as emotional themes, such as anger, anxiety or happiness. To increase reliability the interviews were analyzed and interpreted separately by two interviewers. Differently appraised items were discussed before finally being classified. In the final construction of the main themes and concepts, external discussion partners participated, to improve reliability of the interpretations. The topic list was adjusted with new information following each subsequent interview. The cycle of interview, analysis and subsequent interview was reiterated up to the point where a saturation in these main categories was achieved and a number of subsequent interviews provided no new main or shared topics.

The study was held within nursing teams of several closed units of a Dutch psychiatric hospital. Nurses with a minimum of one year post-training experience could participate on a voluntary basis. Anonymous processing of data was secured before recruiting responders. First, the procedure of seclusion on the ward the responder works was discussed, in order to set a framework. Secondly, the nurses were asked to describe a seclusion event that had had a profound impact on their feelings. These major events were used as an opening to start discussing feelings. When no new feelings arose, the responder was asked about both the need and opportunity to share these feelings.

Since the interviews in this study were performed by doctors question nurses, responders openness might be impaired. By composing the interview in such a way that it builds up from neutral and impartial, to more sensitive themes, an open and accepting attitude of the interviewers and the guarantee of anonymity, this influence was minimalized. Special attention was paid to the creation of a safe and pleasant atmosphere in the interview.

5. Results

5.1. Overall outcome

Eight subjects were interviewed, 4 male and 4 female. Their age varied between 24 and 56 years, job experience within mental health care between 3 and 27 years. Team members all had higher vocational training, either as a nurse or as a social worker. The interviews were performed in four subsequent months in 2005, with a time frame of two to three weeks between interviews, allowing analysis in between. Responders were asked not to discuss the content with fellow workers. Interview time varied between 50 and 85 minutes.

The 8 interviews yielded 345 relevant text fragments with a wide range of topics, before saturation (Glaser & Strauss, 1967; Belnaves & Caputi, 2001) occurred. Apart from known themes such as fear and aversion, several new topics arose, such as disgust (related to bad personal hygiene), relief (related to withdrawal of threat), sorrow or shame (related to what one does to a patient), but also anger, dislike and feelings of vengeance. Frequently, several conflicting themes were experienced at the same time, leading to ambivalence with respect to the decision to seclude.

5.2. Feelings recalled by nurses, regarding the seclusion incident

5.2.1. Main themes

After analysis and arrangement of feelings mentioned by nurses, three main themes arose: tension, trust and power (Fig. 1). Besides these three main themes, some other themes were hard to classify, and are categorized in a "Rest" group.

5.2.2. Tension related feelings

Within the theme of 'tension', fear for threat from the patient was classified, a fear often felt as physical arousal: *"Tension is felt to some extend by all of us…You may feel it as tension, a surge of adrenaline. A tension in your body, knowing we'll have to act shortly with physical force"*. Also, relief after the incident was classified in this theme: *"It is a nice feeling to spend some time together after an incident; you need it to regain a feeling of ease and rest". "Even though it may seem as unprofessional, you often do think ….pfff, I am glad he is put away. And in most seclusion incidents you sense a feeling of relief. It is over and done with"*.

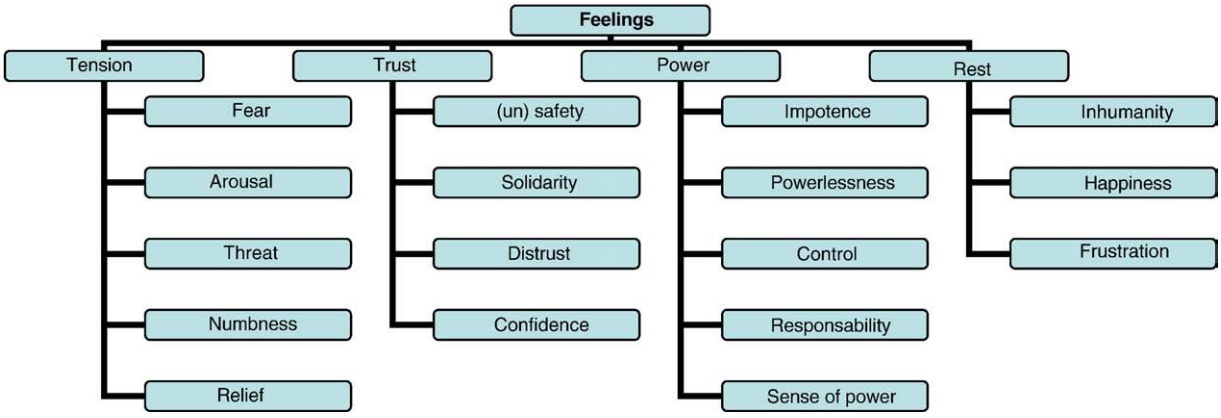

Fig. 1. Main themes in feelings.

Numbness, the absence of emotion, expressed as "don't feel, just act" while performing seclusion, was classified in this theme as well: *"You don't have time to think. .. When it happens unexpectedly and you have to seclude, you must act and you simply do. When it happens, you have no opportunity to feel emotions or think about what you are doing".*

5.2.3. Trust related feelings

The concept of 'trust' is related not only to feelings of trust or confidence, but also to feelings of solidarity and support. Also distrust of several people involved or feeling unsafe, self-confidence and belief of a positive closing of the situation related to the seclusion event are related to 'trust': "*I try to calm down the patient by comforting hem. When I feel I succeeded in this, I feel assured we did the right thing… It was awkward to seclude, but in hindsight it feels okay".* Feeling unsafe is an item mentioned many times *'..Patients are brought to the hospital door, escorted by 6 fully equipped policemen, and then they say: "what about your safety?" Because they've got a gun and pepper spray and we just stand there like that…'*

5.2.4. Power related feelings

The inequality of power and control between patients and staff within the seclusion event, induces feelings related to authority and power, such as powerlessness and a feeling of responsibility for the wellbeing of a patient: "*That you are doing something you actually don't agree on. Once the decision has been made, there is no way back. Emotionally, that can be hard". " Sometimes we seclude a patient because you know no way out. Then I have second thoughts. It would be better if you could think of other ways to intervene, which have the same effect. Even though I do think about it, we cannot do without a seclusion room " .*

Feelings of pleasure related to power, sometimes even power perversion were also mentioned:

"You are fully aware that your behaviour has been terribly antisocial. For me that is a reason to seclude you in a not-pleasant way. I will not hurt him on purpose, but I will jam your wrist in such a way, that as soon as you try as much as kick someone, you will howl with pain."

5.2.5. Other feelings

Apart from the main themes of tension, trust and power, a seclusion is also associated with feelings of inhumanity with respect to the intervention. *" We had a patient that could not even stay out of the seclusion room for a very short time. That is degrading, inhuman".* Nurses relate this to feelings of shame, pity and distress towards what the patient is subjected to: *"Well, sometimes I do think, when for instance there is a man or a woman of about 50 years of age, that you have to grab them tightly, work them on the ground to subdue them. It feels strange, not real, even when you are doing it. Then I think: "Do I have to do that?" Being 27 years old and tell somebody who could be your mother or father what he has to do and… and then struggle! It can feel awkward" …. "I feel it is embarrassing to stand with somebody totally naked and helplessly subdued".*

Feelings of frustration and anger develop themselves against the patient, who bring about unsafe and dangerous situations or towards the doctor who lets the unsafe situation endure. " *I sometimes don't understand things can get out of hand in such a way. They know how that patient can be, so dangerous. Then I read several indications in the conveyance reports. But nobody took measures. For days at a time. Then it happened. Somebody got injured. And afterward they say – "you were right, but we were not allowed to do anything". The patient refused medication and nothing really dangerous had yet happened – indeed ….. yet" …. "Maybe I am not allowed to do my saying, because the doctor has made the decision…But the nurses have to live with it... You have to do it. There are times I cynically tell the doctor to do it himself. Then I feel I am not heard. We see the patient 24 hours a day".*

5.3. Interrelation & determinants of feelings

Literature findings suggested that feelings experienced by nurses are related to personal factors, patient characteristics and situational factors. All of these factors were found in our interviews. Beside these factors, it became clear from the interviews that emotions, perceived by nurses, differed, depending on the phase of the seclusion process. The dividing of the seclusion process in several different phases was a new and unexpected finding in this study.

5.3.1. Phases

The seclusion process can be divided in three separate phases with important differences in perceived emotions (Fig. 2 and Table 1). Tension follows an increase, similar to stress response curves (Gaillard, 2003; Krimpen van, 1993; Schmidt, 1998), with tension rise (before seclusion), a plateau phase (while secluding) and a relaxation phase (after secluding).

5.3.1.1. Phase 1: tension increase phase. Before seclusion, the tension rises which is often related to threatening events or disruptive incidents. This tension may be felt physically, expressed in text

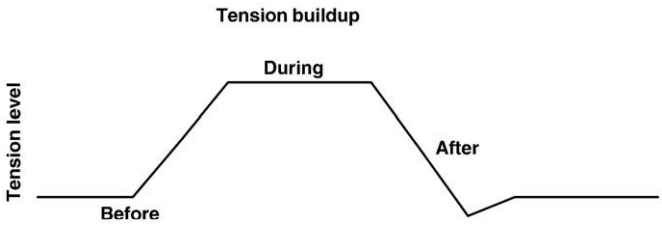

Fig. 2. Phases in seclusion buildup.

Table 1
Classification of themes in phases.

	Tension	Trust	Power
Before	Arousal Threat Fear	Unsafety Lack of solidarity Distrust	helplessness powerlessness
During	No emotions Numbness Arousal	solidarity (with colleagues)	Control feelings of power and authority
After	Relief	solidarity (with patient)	Control feelings of power and responsibility

fragments like: *"… Sometimes it feels very threatening, 'code red'. Then the adrenaline rushes through my veins. '*

At the same time, the decision to seclude has to be made. Collaboration between both colleagues as well as patients is pressurized by unsafe feelings. Prior to seclusion, feelings of powerlessness are an effect of the impossibility to act in a threatening situation and disappointment due a stuck relationship with the patient.

5.3.1.2. Phase 2: plateau phase. During the seclusion event, many things happen at the same time, leaving little time for feelings: *"Once it happens; seclusion is on its way or you're struggling; you have to act, there's no time to think"*. The physical activity of secluding combined with the sensation of action, may provide a pleasant feeling of control and power, which may even turn into power perversion, expressed in text fragments like: *"adrenaline surges through your head, a tension sometimes feels positive. I know it's not done, but the feeling of being on top when somebody is down, gives a great feeling of being in control. "*

5.3.1.3. Phase 3: relaxation phase. After closing the seclusion door, the tension levels drop and sometimes a feeling of relief is experienced: *..'It often happens: the patient is locked behind the door and nurses start to laugh. It's a reaction to the previous tension they experienced… but it's no good to do this in the near presence of the seclusion room. You also have to be careful of how to return to the ward: other patients do observe.. When someone has been taken to the seclusion room and nurses return a few minutes later, laughing out loud… '*

In the three phases of the seclusion process the three main themes can be recognized with specific feelings for each phase. (Table 1)

5.3.2. Determining factors

Several factors influence the intensity and sort of nurses emotions. Literature mentions a number of personal characteristics of nurses, such as sex, age, experience and opinion on the value and purpose of seclusion, as well as patient characteristics. This study shows, consistent with literature findings, that several factors influence the perception of the seclusion incident by nurses, such as patient characteristics, role and position of nurses within the team and the building facilities.

1. Patient characteristics. In general patients with severe DSM Axis I disorders generate more compassion than patients with personality disorders, as is expressed in the next text fragment: *"Well, when were talking about simple anti social behaviour, or patients getting personal towards you, anger does play a huge role. I don't think I would ever seclude someone out of anger, but when it gets to secluding, I am more tens in such a situation than when someone is just really mixed up…"*

Age also influences the perception to some extent, as is expressed in *" Imagine, a man in his fifties, could have been your own father, you have to undress him and fit him into a tear jacket, yeah I do feel uncomfor` then….."*

2. Role and position of nurses during seclusion. The perception of the seclusion process is partly dependent on whether the nurses participate actively or passively. When nurses participate actively, the stress response curve is as described above, with no room for emotions in the plateau phase. Those passively participating remain to experience stress in the plateau phase. Possibly because there is no way for them to influence the process, but also because they can't convert tension into physical action. *".. especially when you are the one standing aside, and you do not need to participate actively, that feels difficult…" "those are the memories that stay with you, when you are in the background, when everybody is busy and you feel helpless and tense, when you cannot do anything to help out."….*

Fig. 3 illustrates these differences.

Frustrations experienced by nurses are sometimes related to the positioning of nurses as very much involved in the day-to-day care of patients, but least authorized in decisions on seclusion. This is expressed in the next text fragment *"... Doctors should listen to nurses. We are not pawns moving around. We are in the crisis, together and in collaboration with the doctor. The doctor is there for the pills, we are there for supervision and coaching… "*

Several responders mention gender influence in the seclusion process and its perception. Female nurses are inclined to show a more protective attitude towards the patient. Female nurses are also said to show better management of aggression. In most seclusion incidents, their role is more passive than active, consequently leading to more stress as an effect of a higher tension curve (Fig. 3).

3. Seclusion room provisions. Sparse arrangements in the seclusion room are a source of stress for patients and nurses: *"…the plastic or card urinals are really old fashioned. A toilet could easily be built into a corner of the front room of the seclusion unit. That would be a more humane solution….."*

5.3.3. The need to share

To share emotions immediately after the seclusion incident is important for the decreasing of tension, but also a means to improve quality of care (Abma et al., 2005). The need for sharing these emotions however, varies between team members, as is expressed in*: "… We all have many years of experience between us. We dealt with these kind of things so often. Still, I suppose everybody gains from talking about it in an open way. …".*

Evaluation of the seclusion process, done within the nursing team itself, and support or interest of other colleagues, either supervisors or psychiatrists, is appreciated greatly, especially in aggravating seclusion incidents. Some of the responders even valued regular evaluation with the patients. Important preconditions mentioned for sharing emotions are a safe atmosphere allowing a vulnerable attitude and enough time and quietness to discuss uninterrupted.

6. Discussion

In the current study a qualitative technique was used to explore nurses' feelings experienced during the seclusion process. As opposed to pre-structured surveys, this technique facilitates the investigation of perceptions and emotions. Following an open interview technique based on the grounded theory, this study revealed a number of general themes, also known from literature. Because many of the themes are supported by literature, it is plausible these perceptions will be recognised by many nurses. In contrast to earlier publications, which state that anger and revenge are denied by nurses, these feelings are revealed in the interviews in this study.

The interviews show that the seclusion process is accompanied by a stress response curve with tension increase, plateau and relaxation. These kind of curves are known from literature, describing stressful circumstances. Repetitive exposure to similar stressors is known to be related to the development of a pathological stress curve. Tension level does not return to normal, amounting to a higher base tension level (Gerlock & Solomons, 1983; Schmidt, 1998). Seclusion could very well compose a risk factor for work related mental burden and ultimately burn-out symptoms, as is illustrated by: *"… These are the cases you take home. It's the first thing that's in your mind when you wake up in the morning. Getting into your car to work, you think about it again…"*

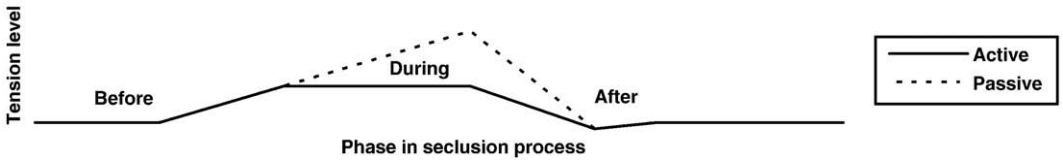

Fig. 3. Active as opposed to passive role and tension level.

Even though nurses have to deal with a number of stressors in seclusion process, their authorisation and span of control is limited. The discrepancy between pressure and span of control constitute extra stress related problems (Place, 1992).

The finding that the role of the nurse (either actively dealing with the seclusion or passively supporting in the background) determines the way the tension curve develops, fits into the theory that active coping styles have a protective effect in dealing with stress. Support from the peer group is valued in various stress theories as an important mediator in dealing with stress (Krimpen van, 1993; Place, 1992; Schmidt, 1998). In the seclusion process, support is experienced by those actively participating, while nurses waiting outside are generally on their own.

Evaluating a seclusion in a safe and open team atmosphere should take more attention and time. Evaluation serves realisation of emotions in the involved nurses and prevents these emotions from subconsciously influencing the dealing with the patient in a negative way. Even though evaluation of seclusion is advocated in many quality protocols, nurses are often reluctant to participate, for several reasons. Dealing with emotions not always fit in with the professional culture of teams working in admission or emergency departments. Work pressure, safety, a limited openness, as well as scarce opportunity, limit the possibility to share feelings.

Limitations of the study. The respondents were recruited from teams from the same hospital, but several worked in different hospitals in the past. However, this is not a representative sample of Dutch nurses, and not all findings may apply to other teams. Inferring from the themes that came up in the interviews, and the nature of answers given (with candid statements of nurses sometimes having 'forbidden' emotions, such as anger and revenge), responder openness was not a real problem.

7. Conclusion

Little is known about the experience and perceptions of nurses in the seclusion process. Feelings denied in former studies such as feeling superior, anger and disgust do arise from the interviews in this study. Tension, trust and power were identified as main themes. The tension increase corresponds with physiological stress response curves. The role of nurses during the seclusion process, but also being the person most concerned with the daily care of the patient, determine experienced feelings to a large extent. Social support and acknowledgement of the impact of the seclusion process on their wellbeing are necessary to avoid stress-related effects on the long run. Because of the emotional burden following a seclusion and the risk of the development of a pathological stress response curve, research into these processes is necessary in the interest of the nurses' health.

References

Abma T., Widdershoven G., Lendemeijer B. (2005). *Coercion and urge in psychiatry, the quality of limiting measures. [Dwang en drang in de psychiatrie. Kwaliteit van vrijheidsbeperkende interventies.]* Lemma bv., Utrecht.

Belnaves, M., & Caputi, P. (2001). *Introduction to quantitative research methods: An investigative approach.* London: Sage publications.

Betemps, E. J., Buncher, C. R., & Oden, M. (1992). Length of time spent in seclusion and restraint by clients in 82 VA Hospitals. *Hospital and Community Psychiatry*, *43*(9), 912−914.

Betemps, E. J., Somoza, E., & Buncher, R. C. (1993). Hospital characteristics, diagnoses and staff reasons associated with use of seclusion and restraint. *Hospital and Community Psychiatry*, *44*, 367−371.

Broers, E., Lange de, J., & de Lange, J. (1997). Strijd in de werkrelatie. Een interactionele visie op agressie tussen patiënt en verpleegkundige. *Maandblad Geestelijke Volksgezondheid*, *52*(10), 977−993.

Corbin, J. (2008). *Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory.* London: Sage publications.

Cangas de, J. P. C. (1993). Nursing staff and unit characteristics: do they affect the use of seclusion? *Perspectives in Psychiatric Care*, *29*(3), 15−22.

Dekker, J. (1989). Stones as bread. *The isolationcel in psychiatry* Utrecht: Cliëntenbond GGZ Stenen voor brood. De isoleercel in de psychiatrie.

Dutch inspection of Mental health. (1994). Special Admissions in Psychiatric Hospitals act : Rijswijk [Geneeskundige Inspectie voor de Geestelijke Volksgezondheid. Wet Bijzondere Opnemingen in Psychiatrische Ziekenhuizen].

Gaillard, A. (2003). Stress, productivity and health Amsterdam: Nieuwezijds publishers.

Gerlock, A., & Solomons, H. C. (1983). Factors associated with the seclusion of psychiatric patients. *Perspectives in Psychiatric care*, *21*(2), 47−53.

Glaser, B. A., & Strauss, A. L. (1967). *The discovery of grounded theory: Stategies for qualitative research.* Chicago: Aldine.

Heyman, E. (1987). Seclusion. *Journal of Psychosocial Nursing*, *25*(11), 9−12.

Hoekstra, T., Janssen, W., & Lendemeijer, B. (2004). Seclusion: the inside story. *Journal of Psychiatric and Mental Health Nursing;*, *11*, 276−283.

Janssen, W. A., Noorthoorn, E. O., de Vries, W. J., Hutschemeakers, G. J. M., Lendemeijer, H. H. G. M., & Widdershoven, G. A. M. (2008). The use of seclusion in the Netherlands compared to countries in and Outside Europe. *International Journal of Law and Psychiatry*, *31*, 463−470.

Janssen, W. A., Noorthoorn, E. O., Van Linge, R., & Lendemeijer, H. H. G. M. (2007). The influence of staffing levels on the use of seclusion. *International Journal of Law and Psychiatry*, *30*, 118−126.

Krimpen van, H. (1993). Stress, een kwestie van inzet Assen: Van Gorcum.

Lendemeijer, B. (2000). *Seclusion in Psychiatry. Aspects of decision making.* Utrecht: Drukkerij Publicard.

Morse, J. M., & Field, P. A. (1998). Nursing research. *The application of qualitative approaches*, 2nd edition United Kingdom: Stanley Thornes Publishers Ltd.

Muir-Cochrane, E. (1996). An investigation into nurses' perceptons of secluding patients on closed wards. *Journal of Advanced Nursing;*, *23*, 555−563.

Nijman, H. L. I., Duangto, C., Ravelli, D. P., Merckelbach, H. L. G. J., & Vorel, S. K. (1994). Personeelskenmerken in relatie tot separatie en afzondering. *Nederlands Tijdschrift voor Psychiatrie*, *36*, 130−138.

Nijman, H. L. I., á Campo, J. M. L. G., Ravelli, D. P., & Merckelbach, H. L. G. J. (1999). A tentative model of aggression on inpatient psychiatric wards. *Psychiatric Services*, *50*, 832−834.

Place, M. (1992). Burnout of nurses in psychiatry. *A study into the American an Dutch literature* Utrecht: Nederlands centrum Geestelijke volksgezondheid [Burnout bij psychiatrisch verpleegkundigen. Een onderzoek naar de Amerikaanse en Nederlandse literatuur].

Sailas, E., & Fenton, M. (2004). Seclusion and restraint for people with serious mental illnesses. *Cochrane database of systematic reviews*.

Schmidt, A. J. M. (1998). The psychological relevance of Seyles stress theory. *the psychology of nervous strain – theory and practice* Utrecht: Boom uitgeverij [De psychologische relevantie van Selyes stresstheorie, in: De psychologie van overspanning – theorie en praktijk].

Soliday, S. M. (1985). A comparison of Patient and Staff attitudes towards Seclusion. *Journal of Nervous and Mental disease*, *173*(5), 282−286.

Steele, R. (1993). Staff attitudes towards seclusion and restraint: Anything new? *Perpectives in psychiatric care*, *29*(3), 23−28.

Stolker, J. J., Nijman, H., & Zwanikken, P. (2004). Separatie: een noodzakelijk kwaad? *Maandblad Geestelijke Volksgezondheid*, *59*, 193−204.

Tooke, S., & Brown, J. (1992). Perceptions of seclusion: Comparing Staff reactions. *Journal of Psychosocial Nursing*, *30*, 23−26.