University of San Diego

Digital USD

Dissertations

Theses and Dissertations

2013-04-24

A Case Study Exploring Restraint and Seclusion Use in School-Age Children on an Inpatient Psychiatric Unit

Michelle Buckman PhD
University of San Diego

Follow this and additional works at: <https://digital.sandiego.edu/dissertations>

Part of the [Nursing Commons](#)

Digital USD Citation

Buckman, Michelle PhD, "A Case Study Exploring Restraint and Seclusion Use in School-Age Children on an Inpatient Psychiatric Unit" (2013). *Dissertations*. 432.
<https://digital.sandiego.edu/dissertations/432>

This Dissertation: Open Access is brought to you for free and open access by the Theses and Dissertations at Digital USD. It has been accepted for inclusion in Dissertations by an authorized administrator of Digital USD. For more information, please contact digital@sandiego.edu.

UNIVERSITY OF SAN DIEGO

Hahn School of Nursing and Health Science

DOCTOR OF PHILOSOPHY IN NURSING

A CASE STUDY EXPLORING RESTRAINT AND SECLUSION USE IN SCHOOL-AGE CHILDREN ON AN
INPATIENT PSYCHIATRIC UNIT

By

Michelle Buckman

A dissertation presented to the

FACULTY OF THE HAHN SCHOOL OF NURSING AND HEALTH SCIENCE

UNIVERSITY OF SAN DIEGO

In partial fulfillment of the requirements for the degree

DOCTOR OF PHILOSOPHY IN NURSING

April 24th, 2013

Dissertation Committee

Susan Instone DNSc, APRN, CPNP chair

Dean Sally Brosz Hardin PhD, APRN, FAAN

Patricia Roth Ed.D, MSN, RN

A Case Study Exploring Restraint and Seclusion Use in School-age Children
on an Inpatient Psychiatric Unit

Abstract

Perceptions of children restrained and secluded (R&S) were explored using Yin's methodology and critical theory. The literature presented reviewed proponent's and opponent's views of the R&S intervention used on inpatient psychiatric units for the containment of violent patients. Despite reports of physical and emotional injury to staff and patient during restraining and secluding children, the intervention is still in use. Using Machover's framework, a semi-structured interview and drawings were used to illicit information from a 12 year old boy about his perceptions of R&S. Then, a presentation of barriers to conducting research is made. Results of the child's perceptions included thematic issues of fear, hurt, a non-therapeutic relationship with nursing, uncertainty and overcoming. Recommendations are made for nursing research, education, practice, and policy development.

ACKNOWLEDGMENTS

During this amazing educational journey I learned so much and am exceedingly thankful to a great number of people.

To my parents Carol Murray, Jack Murray, and Donald Buckman, my friends and colleagues, my Deans, my co-workers, my Employers, my brother Dr. Cary Buckman and his family: I thank you with all my heart for your sustenance and encouragement. You have inspired me, steered me, put up with me and treasured me all the way from beginning to end.

Thank you to my chairperson Dr. Susan Instone for giving several years of her life in helping me learn and achieve. Her graciousness and knowledge of research methods carried me through and helped me finally grasp my goals.

Thank you to my committee members Dean Hardin and Dr. Roth for their offering of expertise and in helping me become a scholar.

I also wish to thank psychiatric patients, both children and adults, for their ability to help me learn, grow, and admire. My life would be quite barren without you.

And to M.T., thank you for your love.

TABLE OF CONTENTS

Page

Title page.....	
Approval pages.....	
Abstract.....	
Acknowledgments.....	ii
Table of Contents.....	iii
Chapter one: Background and research questions.....	1
Chapter two: Literature review.....	11
Chapter three: Methods and procedures.....	33
Chapter four: Results.....	42
Chapter five: Discussion and recommendations.....	64
References.....	73
Appendices.....	86
IRB approval forms.....	

CHAPTER ONE

Very little is known about how children experience a procedure called restraint and seclusion (R&S), an intervention used primarily in psychiatric hospitals (Delaney, 2006). Over recent years much public attention has been drawn to this procedure in an effort to understand whether or not it is a helpful or harmful intervention (Mohr, Mahon, & Noone, 1998). R&S is used to contain and calm a violent or near violent patient and provide safety to the child, staff, other patients, and property. Some have argued that it is a harmful procedure while others defend its use. However, the trend to eradicate or at least reduce its use is gaining popular support at this time. Sourander, Elila, Valimaki, and Piha (2002) reported very little is known about the frequency of use or general rationale that guides the use of different types of restraints in child and adolescent psychiatric treatment. In an attempt to understand the prevalence and determinants of R&S use in children and adolescent psychiatric facilities, Schimmelmann (2011) found only seven publications over the past 10 years even addressing the topic.

R&S is also employed with adults. Both Silas and Fenton (1999) and Bonner, Lowe, Rawcliffe and Welman (2002) reported there is very little research as well as few if any randomized controlled studies to support the efficacy and safety of manual restraint techniques in this population. Furthermore, very few studies have explored the experiences of adults about how they perceive this procedure. In general, there is a paucity of research about R&S uses, effectiveness, and justification for this form of

treatment (Day, 2002), yet many psychiatric hospitals continue to use this intervention. It is clear that more research is needed, particularly when it comes to the use of R&S with children. Thus, as a psychiatric mental health Clinical Nurse Specialist with 26 years of experience caring for this population, I embarked on my doctoral education in order to learn more about what this procedure was like from the children's perspective. I believed that listening to children describe their experiences about R&S would shed light on how it actually affects them and whether or not it is a valuable practice. If, in fact, they revealed that R&S is a helpful and valuable intervention for them, the question then becomes how to best use it. This knowledge is crucial to providing competent psychiatric nursing care to children. Presently, though, I have found that nurses on inpatient units use R&S based on opinion, routine, and hospital policy which may not be appropriate reasons to use such an invasive procedure (Morrison, 1993). Most of the literature concerning R&S use for aggressive children is based on 10 year-old data (Delaney, 2001). Studies with adults and the elderly to understand their experiences of R&S have helped guide professionals in deciding how to update the procedure of R&S and in some cases whether or not to use it at all. Without that same type of information, it is difficult to make a sound clinical decision about the uses of R&S with children.

Proponents argue that R&S is a necessary option to provide safety to an out-of-control person and to teach therapeutic boundaries. Empirical evidence and anecdotal information, however, suggest that R&S may cause harm to children by re-traumatization, producing feelings of fear and shame, sensory deprivation, hallucinations, increased physical aggression, injury to persons or property, and even death (Mohr,

2001). A seven-part investigative expose written by *The Hartford Courant Newspaper* (1998) alerted the public to deaths among adults and children caused by R&S during the previous decade. In that investigation, which is still being referred to today, children accounted for 37 of 147 deaths during R&S. By 2001, Luna found that the R&S rate for children in inpatient psychiatric units in the U.S. had increased to an average of 47 incidents per month per psychiatric facility. These data were considered unacceptable by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) and the Centers of Medicare and Medicaid Services (CMS) (formerly Health Care Financing Administration) which mandated new R&S procedures for inpatient psychiatric hospitals (Huckshorn, 2006). These new mandates require one-to-one ratio monitoring of patients in R&S, improved documentation as to the reasons R&S was implemented, and clear documentation explaining that all other less invasive measures to contain the patient were tried first (HCFA, 1999). Several individual states wrote their own policies for R&S in order to reduce the rates of injury and death. Despite the fact that R&S is a contested, non-research validated procedure, it continues to be used commonly in psychiatric facilities even though there is a gap in the research that informs clinicians of its value as well as indications and contraindications for its use with children.

Definition of R&S

R&S is defined as “any physical method of restricting an individual’s freedom of movement, physical activity, or normal access to his/her body” (International Society of Psychiatric-Mental Health Nurses, 2001, p. 100). Clinical experts, though, differ substantively on the appropriate indications as well as the procedures for R&S.

Restraining and secluding a patient, whether used together or separately, occurs in a seclusion room. Seclusion also can be used as a physical restraint in which “a patient is kept alone in a room, which has sparse furnishings and is usually locked” (Murray and Huelskotter, 1983, p. 524). When children’s behavior escalates and can no longer be managed safely by standard methods, a clinical judgment is made, usually by nursing staff, to restrain and/or seclude them (Gullick, McDermott, Stone, & Gibbon, 2005).

Restraint is a procedure usually carried out by registered nurses, or nurse assistants under the direction of a registered nurse, and involves immobilizing patients by tying them to a bed. Murray & Huelskotter (1983) explained that physical or mechanical restraints are devices such as padded leather, plastic, or cloth cuffs tied to the ankle, wrists, and waist that are used to immobilize an aggressive patient. Immobilization is accomplished by tying each extremity to a corner of the bed with the patient either in a prone or supine position depending on hospital policy and patient condition. Seclusion may involve one of three types: (a) placing a child in a room by himself with the door locked; (b) placing a child in a room by himself with the door held shut either by staff or with a spring-loaded latch and includes using sanctions for leaving the room; and (c) any act of separating a child from the group to a specific place of any size in which his egress to freedom is inhibited in any manner (Day, 2002). Typically, the procedure for R&S goes into effect if a patient shows signs of intent to use physical force after all lesser invasive interventions have been applied. Episodes documented in the *Hartford Courant* investigation reveal how R&S may have been inappropriately used as punishment or for staff convenience. Each hospital in the U.S. has different procedures for R&S, but they

are all similar. A physician's order is required to implement R&S though a registered nurse may initiate the intervention without an order in an emergency. There are numerous new legal issues related to the use of R&S. One of those issues is a new set of regulations presented by CMS. These regulations require the patient who is in restraint and/or seclusion be evaluated face-to-face by a physician within one hour of the initiation of the procedure (Huckshorn, 2006).

Children who are treated in acute psychiatric facilities are usually emotionally wounded and mistrustful; therefore, their behavior can be quite frightening if their main mode of coping is to attack and lash out (Kennedy, 2001). Some have observed that youth are especially at risk for harm during the use of R&S, and children may not be developmentally mature enough to interpret the reason for the R&S process (Howard & Reay, 1998). The use of R&S with previously abused patients may result in re-traumatization due to associations between childhood trauma and the actual R&S procedure (Hammer, Springer, Beck, Menditto & Coleman, 2011). Cause of death and physical injury to children while in R&S is usually asphyxia, blunt force chest trauma, catecholamine rush, thrombosis, rhabdomyolysis, suffocation or a combination of those (Howard & Reay, 1997; Hartford Courant, 1998).

Mohr and Pumarieya (1998) studied youth experiences in R&S; their findings showed that five years after the R&S incident, the children reported nightmares, increased startle response, intrusive thoughts and painful memories of witnessing others being "taken down and restrained" (p. 5). Clinicians and researchers are beginning to question the wisdom of using R&S with children due to the growing body of evidence suggesting that it is harmful.

Research Questions

This dissertation's primary research aim was to discover how a child perceives R&S on an inpatient psychiatric unit and whether it is a helpful or harmful practice. Constructs concerning the contextual, social, and philosophical complexities present in health care settings were taken into consideration when devising the actual research questions which were: (a) What is the child's perception of R&S? (b) Did R&S help this child learn to better manage violent behaviors? (c) How could the child have avoided R&S? Chapters four and five revisit these questions for discussion, reports of analysis, and how nursing science might benefit from an understanding of the topics.

Method

A single descriptive case study method was used in this dissertation in order to better understand a child who had been restrained and secluded within the contextual conditions and culture of care germane to the phenomenon under study, thus, capturing the holistic and meaningful characteristic of the event (Baxter & Jack, 2008; Yin 2003). Yin (2003) based his approach to case study on a constructivist paradigm which, at its most basic premise, states truth is relative and is dependent on one's perspective.

The research case study continues to enjoy a renaissance (Gerring, 2007). Its purpose is to develop a detailed understanding of the case in relation to a stated bound context (Gomn, 2007). Case studies are multi-perspectival analyses which mean that the researcher considers not just the voice and perspective of the participants, but also of other relevant persons involved in the system, their interrelationships, and the interaction between them (Feagun, Orum and Sjberh, 1991).

participant here. And it is clearer now, after deconstruction, why I encountered barriers to research and accessing children for my study. Critical theory is a complex and dynamic philosophical perspective that is increasingly being used to guide nursing research (Vandenberg & Hall, 2010). It emphasizes the importance of deconstruction in uncovering meaning and understanding and is used in this dissertation to help in final data analysis.

The Case

Projective drawings and a semi-structured interview were used in this study to obtain a 12 year-old male child's account of the experience and meaning of being restrained in a psychiatric facility. I asked this child participant to draw about the R&S occurrence and respond to a set of semi-structured interview questions geared toward the experience itself, what was learned during the R&S episode, and any insights on how he might have avoided R&S.

There are several approaches available for obtaining information from children but most literature suggests that drawings and the stories told about them by a child participant are the most appropriate approach because this method reveals more accurately the perspective of a child and causes little if any emotional burden during the interview process (Malchiodi, 1989; Machover, 1949). It is important to gather data directly from the children who have been in R&S so they can describe their feelings and the meaning of this lived experience in their own words. Heidegger (1962) believed that peoples' realities are influenced by the world in which they live. This approach helps the researcher understand more about the perceptions of children in R&S. Wynn (2004) noted that patients who have been restrained are the only ones who can really provide

participant here. And it is clearer now, after deconstruction, why I encountered barriers to research and accessing children for my study. Critical theory is a complex and dynamic philosophical perspective that is increasingly being used to guide nursing research (Vandenberg & Hall, 2010). It emphasizes the importance of deconstruction in uncovering meaning and understanding and is used in this dissertation to help in final data analysis.

The Case

Projective drawings and a semi-structured interview were used in this study to obtain a 12 year-old male child's account of the experience and meaning of being restrained in a psychiatric facility. I asked this child participant to draw about the R&S occurrence and respond to a set of semi-structured interview questions geared toward the experience itself, what was learned during the R&S episode, and any insights on how he might have avoided R&S.

There are several approaches available for obtaining information from children but most literature suggests that drawings and the stories told about them by a child participant are the most appropriate approach because this method reveals more accurately the perspective of a child and causes little if any emotional burden during the interview process (Malchiodi, 1989; Machover, 1949). It is important to gather data directly from the children who have been in R&S so they can describe their feelings and the meaning of this lived experience in their own words. Heidegger (1962) believed that peoples' realities are influenced by the world in which they live. This approach helps the researcher understand more about the perceptions of children in R&S. Wynn (2004) noted that patients who have been restrained are the only ones who can really provide

authentic information about the R&S experiences and perceptions. These data can complement observational data as to why R&S is used, whether it could have been avoided, and its outcome. Docherty and Sandelowski (1999) argued that children are able to give accurate accounts of their experiences if interviewed in a proper manner congruent with their level of development. However, they also noted that children may have difficulty discussing topics that are sensitive, taboo, or emotionally charged, and that children may be unable or unwilling to talk about traumatic events. Poster (2005) found that children easily use drawings to maintain communication with the treatment team, especially at times when relationships are strained by anger, withdrawal, fatigue, or feelings too emotionally charged to be expressed with words. Drawing, often referred to as the universal language of childhood, can serve as a valuable tool that enables children to express their experiences (Rubin, 1984).

Reflexivity is an important part of qualitative research. Technically, it is the reflecting on the process of one's research and trying to understand how one's own values and views may influence findings. Reflexivity adds credibility to the research and should be part of any method of qualitative inquiry (Jootun & McGhee, 2009). As I thought about my study and reflected upon the barriers to data gathering, I reassessed procedures, and attempts to make the process better. I determined that using case study guided by critical theory would best assist in helping understand the perspective of a child who had undergone the intervention called R&S and the social context in which it occurred.

Contributing knowledge gained from this study will give nursing science some insight into whether or not R&S is a helpful or harmful intervention within the context of the environment. It will allow nurses to determine how they wish to view patient care and

their implementation of interventions by looking at our social structures and ideologies which are historically bound and may oppress our way of being in the world. More effective interventions, theory, and policy may be developed to guide nursing practice after considerations of the child who has actually experienced R&S.

CHAPTER TWO

Literature Review

Despite the fact that the *Hartford Courant* exposed the dangers of R&S between 1988 and 1998, and new legal and regulatory mandates have been imposed, the practice of R&S with children is still commonly in use, and research about its efficacy remains sparse. What little research about the experiences of patients in R&S there is has focused primarily on adults. Evans and Strumph (1989) clarified that most attention on the use and misuse of R&S has focused on the geriatric population. The majority of R&S interventions used in psychiatric hospitals today have been tested on adults, not children.

It is difficult to know exactly how many children are restrained or secluded in the United States; the prevalence and use of R&S are not monitored nor are they reported to any oversight agency (Mohr, Petti, and Mohr, 2003). Agencies are required to report patient deaths while in R&S to federal agencies though it is difficult to know how many of these deaths are actually reported. As Kennedy (2001) noted, the actual incidence and use may be higher than indicated since the incidence and prevalence of restraint use is not monitored, nor are these statistics collected.

Characteristics of children most likely to be restrained include being male, having a previous psychiatric history, a longer psychiatric inpatient length of stay, a history of

suicidal behavior, and a history of significant physical abuse and out-of-home placements (Delaney & Fogg 2005). Lipschitz, Winegar, Hartnick, Foote, and Southnick (1999)

found trauma histories (such as sexual and physical abuse, neglect, or unstable and chaotic living environment) in 93% of inpatient youth, 32% of whom met criteria for post-traumatic stress disorder. Delaney and Fogg (2005) reported that no US studies analyzing rates, patterns, and causes of R&S use in youth were done from 1995 to 2005. In order to fully understand the phenomenon of R&S as well as important gaps in the literature, this review includes literature from other allied health science disciplines as well as nursing. Searching the literature was done using CINAHL plus, Health Source; Nursing Academic Edition; Medline Plus; PsychArticles; PsychINFO; ERIC; and Google Scholar. Studies published between 1940 and the present were reviewed. These dates reflect the time since R&S was identified, defined, and implemented almost 60 years ago. Keywords used for literature searching were *restraint, seclusion, child psych units, R&S on psych units, legal issues in child psychiatry, children's experiences, children's experiences in R&S, R&S in psychiatric nursing, experiences of inpatient psychiatry, adult patient experiences, phenomenology, case study, and critical theory*.

Very few studies examine the direct experiences the patient had regarding R&S. Only three studies have been published exploring specifically children's experiences about R&S and four studies about specific adult experiences of R&S. Most published R&S studies present sparse and inconsistent research results that include (a) demographic information about those who have been in R&S, (b) information about the type of health care facilities that use R&S, (c) how to implement R&S interventions, (d) the dangers of R&S, (e) arguments that R&S may be useful in preventing injury in violent patients, (f) new regulations regarding R&S, and (g) opinion papers and anecdotal information from patients and providers about R&S. Some research reports the nurses' experiences or a

comparison of nurse and patient perceptions. Because of the paucity of information about the direct experiences of patients in R&S, adult and child studies are also included here.

Historical issues with R&S. When one examines the use of R&S throughout history, it becomes clear that some of the same issues that clinicians grappled with decades ago are still problems for our present day. The use of R&S throughout history has a unique ebb and flow, not a progressive and directional trend. There are distinct periods of severe inhumanity in which psychiatric patients were essentially tortured followed by times when it was unpopular to even “therapeutically” restrain a patient. Then, interestingly, a more inhumane time would re-emerge without much explanation. There is a long gap in reported restraint use or any type of psychiatric treatment between approximately 200 BCE until 1200 ACE and not much mention of youth treatment in any reference until the early 20th century. It is difficult to determine at which point in history R&S was first used with children.

During ancient times (approximately 2000 BCE to 1000 ACE), patients were tied to cots so that a Shaman or Voodoo doctor could apply herbs, precious stones, and ointments to rid the evil spirits (Antai-Otong, 1995). The first mental hospital, Hospital of St. Mary of Bethlehem, built in 14th century London, became known as “Old Bedlam” in which custodial care was introduced. Whipping, chaining, and years of unjust imprisonment were the standard of care (Antai-Otong, 1995). Drs. Tuke, Pinel, and Chiarugi fought for and won the abolishment of the worst forms of R&S during the years from 1793-1795 (Zilboorg & Henry, 1941). They argued that isolation of patients is contradictory to the goal of treatment, which is social integration.

Types of mechanical restraint used during those times included metal manacles, leather wristlets, and composing chairs to which patients were tied for the majority of their day (Colaizzi, 2005). Colaizzi (2005) describes the absence of regulations in the use of these instruments; therefore, many patients suffered for days or even weeks while uncomfortably tied down. An interesting dichotomy existed in the historical writings of R&S that reflect much the same issues we face today and are being studied here; essentially people over centuries have struggled as to how to help a violent patient, how to prevent harm to all, and how to treat the underlying illness. The literature suggests that clinicians practiced with no input from the patient or guidance from legal regulations and research.

Psychiatric treatment for children was not seen as a community need until the late 1800's, so there is very little written about children before then (Murray, 1991). In the early 1900s it is clear that adolescent psychiatric hospitals used seclusion but not restraint. Between 1920 and 1960, the Menninger Clinic, Bellevue Hospital, Southard School Children's Hospital, and the Bethlem Royal Hospital were frequently written about as having high standards for the psychiatric inpatient treatment of children and adolescents (Levy, 1969). Restraint was not used in these hospitals as it was considered not helpful (Levy, 1969). Locked room seclusion was used as a last resort for dangerous and violent acting out. Psychoanalytic, social, and occupational therapies were the focus of treatment. Other methods used to treat violence were placing the patient in pajamas rather than clothes, removing privileges, or giving a consequence to the acting out child's entire peer group. By the 1970s the surge in admissions of youth to psychiatric hospitals

was a national problem. Conduct disorders, chemical dependency, and psychotic disorders were on the increase requiring a need for better ways to treat violence (Crespi, 1990). During the 1980s and 1990s inpatient psychiatric admissions for every age group were in decline except youth admissions which were escalating (Crespi, 1990).

Federal and regulatory influences. Both clinicians and the lay public have questioned R&S practice and in some cases have brought suit against hospitals and treating professionals. The Omnibus Budget Reconciliation Act of 1987 regulated the use of R&S in U.S. nursing homes for the elderly. For the first time, in July 1999, HCFA (now Centers for Medicare and Medicaid Services {CMS}), issued regulations governing the use of R&S in hospitals (HCFA, 1999). The US General Accounting Office, the Department of Health and Human Services, the Surgeon General, the Joint Commission, the CMS, and the Office of the Inspector General have all investigated R&S use. In addition, nurses, educators, physicians, and Congress have asked for more research about R&S in order to determine its effectiveness, and how, if at all, it should be used.

Sourander et al. (2002) observed that the use of restraints potentially poses a conflict between a patient's clinical needs and legal rights. Consequently, this issue has not only been debated by clinicians but has also been debated in our nation's highest courts. Cases about violations to the Eighth and Fourteenth Amendments to the United States Constitution have been documented. The Eight Amendment prevents excessive bail and fines and prevents cruel and unusual punishment. The Fourteenth Amendment, ratified in 1868 and initially intended to protect the rights of former slaves, was first known as the Reconstruction Amendment. It requires states to provide equal protection under the law. In 1982 the mother of a youngster who was injured after confinement in a

state psychiatric facility during R&S brought suit against the state of Pennsylvania. The case was eventually heard by the U.S. Supreme Court which declined to extend the Eight Amendment protection against cruel and unusual punishment to residents of hospitals and psychiatric facilities though it ruled that even minors retain Fourteenth Amendment liberty interests in freedom of movement and personal security (*Youngberg v. Romeo*, 1982). In 1999 a U.S. Congressional committee headed by Sen. Arlen Specter commented that restraints are cruelly over-used and we must consider imposing negligence charges for those situations (Manos 1999). The report also noted that laws do not mandate reporting of deaths caused by R&S. Obviously, then, the number of actual injuries and deaths due to R&S is probably under-reported. The Joint Commission does collect voluntary disclosures.

In 1999, Congress passed the Children's Health Act (P.L.106-310) setting out rules for the protection of young patients' rights and requiring that patients be free from restraints used for discipline or convenience. Opponents of R&S, though, reported that convenience, lack of staff education, transference issues, and personal opinion are often what guides the nurse to use R&S rather than sound empirical evidence (NAMI, 1999). The law governing the use of R&S is ambiguous, but it is evolving, and certain trends are evident (Kennedy, 2001). Court decisions support a clear trend against the employment of restraints.

Relevant adult research. Binder and McCoy (1983) studied 13 men and 11 women (total N=24) patients' experiences of seclusion on an acute adult psychiatric unit over an eight month period. The 24 participants ranged in age from 18 to 67 with a mean age of 33. Semi-structured interviews were used; the questions themselves or who developed

them was not reported. The interviews were conducted within one week of the seclusion incident, but the location of the interviews and whether they were individual or group format was not reported. Eleven patients were schizophrenic. Patients' responses indicated that most did not know why they were secluded and that nothing good came of the seclusion. Four of the 24 patients reported appreciation of the therapeutic effect e.g., it provided external controls. Most experienced negative reactions to seclusion and felt anxiety levels rise during the incident. Most patients felt that even though the seclusion experience was negative, there were other parts of the hospitalization that were helpful. These findings are similar to other studies of adult experiences of R&S.

Bonner et al. (2002) conducted a pilot study exploring the experiences of six hospitalized British adults who had been in R&S; a secondary aim was to determine whether or not semi-structured questions were an appropriate method of data gathering in this type of study. Semi-structured interviews lasting 30 minutes were conducted on the patient's unit as soon as possible after the R&S incident. Patients were asked to briefly describe what had happened during the R&S process, precipitants to the incident, all emotions felt prior to the incident, and helpful coping skills used during R&S. Three members of the research team analyzed transcripts using one of the seven methods described by Miles and Huberman (1984). Three independent examiners reviewed individual incidents to establish themes, and then the entire set of transcripts was analyzed as a whole to establish an overview of these data. The three different evaluators then compared their coding and interpretations and agreed on a consensus.

All six patients reported some degree of feeling embarrassed, misunderstood and ignored during the R&S process. Three of the six patients reported that R&S brought

back memories of past abuse and violence. Examples of the descriptions of *antecedents* of the R&S incident were: “I got angry because they wouldn’t listen to what I was trying to tell them. I didn’t feel like a human being.” “I felt I was just a number and I thought they were going to kill me.” Examples referring to the *aftermath* of the R&S incident were: “I was still angry and distressed. Disgusted that I had stooped so low.”

“Embarrassed and forlorn at having reached that point.” “Low, anxious, scared. I was in a side room and they shut the door.” Although the sample size was small, the verbatim transcripts provide some evidence regarding the specific feelings and experiences of this group of British psychiatric adult inpatients.

Holmes et al. (2004) reported that few studies take interest in the actual patients’ experience of seclusion. They used a phenomenological approach to study the experiences of six adults who were interviewed within seven days after their R&S event. A semi-structured, non-directive, individual interview revealed themes of loneliness, isolation, punishment, and humiliation. Interestingly, these are themes that the patients reported as feeling in their own private lives outside the hospital. “I was bad that’s why they put me there. Then they didn’t come to see me. Nobody comes to see me. I don’t have any friends or sisters or brothers who come to see me.” No information was given about the script of the semi-structured interviews. The researchers used Colaizzi’s steps (1978) to analyze data; i.e., they read interview transcripts several times to absorb them, identified sentences or parts of sentences that directly dealt with the object of study, summarized the meaning of sentences, categorized similar sentences, developed themes from categories, and then described the essence of the patients’ experiences in rich text. The process of planning, implementing and analyzing the study was clear. The

researchers argued that although the number of participants (six) was small, they believed they observed the principle of saturation and stopped interviewing when no new data emerged.

Meehan, Vermeer, and Windsor (2000) performed a qualitative study on 12 adult males from 18-52 years of age in Queensland, Australia, within seven days of their seclusion experience. The participants were interviewed by a member of the research team who was familiar with the patient. Interviews were analyzed using a “meaning categorization” method that helped move data beyond simple description to themes and general statements that reflected the experiences of patients. The researchers discovered five recurrent themes that have implications for nursing practice: patients felt seclusion was overused; seclusion was used to keep patients safe though it caused negative emotional impact; sensory deprivation caused patients to feel they were going mad and losing their minds; patients felt a lack of control over the environment though some were able to conjure coping skills to help themselves; and staff/patient communication was poor both prior to and after the seclusion procedure. “Fear,” “punishment,” “isolation” and “depression” were words used by a majority of the patients to describe their seclusion experience. The authors concluded that the lack of previous studies in an Australian context led to an inability to draw analytical conclusions.

These empirical studies on the experiences of adults in R&S are sparse, yet they suggest that although a minority of psychiatric inpatients reported some positive effects of R&S, for the majority, R&S was a very negative experience that led to patients feeling disempowered, isolated, and misunderstood.

Relevant children's research. Research findings on children's experiences of R&S on inpatient psychiatric units are similar to those reported for adults. From 1985 to 1991 Mohr et al. (1998) interviewed 19 children and examined 4,321 charts related to the R&S experience in psychiatric hospitals owned by the same corporation. The researchers did not provide information on the children's ages or length of time between the R&S experience and the interviews. Interviews were done individually using unstructured questions directed at the child though no reference was made as to how the questions were developed or whether they had been previously used with children. After coding and analyzing, results revealed three types of "traumatic experiences" voiced by the children. These were vicarious trauma, direct trauma and alienation from staff.

Martinez, Grimm, and Anderson (1999) used focus groups and written surveys to learn about the feelings, thoughts, or beliefs of 15 children, 9 who had been secluded, and 6 who witnessed other children being secluded in a public sector psychiatric hospital. The written survey included questions using the semantic differential scale and open and closed ended questions, which the authors admitted may have been too complicated for a child to give accurate responses to. Focus group analyses included verbal responses only. No mention was made as to whether the issue of developmental level was included when deciding on the interview technique. Results showed that children had more negative than positive emotions about the seclusion experience. The children who were secluded reported they knew seclusion was used to keep everyone safe though it was used too often and for periods of time that were too long. They described feeling "bored," "agitated," "punished" and wished they could have had play dough, soft music or a punching bag to help them deal with their feelings. Non-secluded children witnessing

others being secluded also said the time lengths of seclusion were too long. The non-secluded witnesses felt safer (83%) than the secluded patients (22%). Seventy five percent of children felt that the hospital would have been better off without seclusion. Those that felt seclusion was helpful said they felt the staff was keeping them safe at a time when they knew they were out of control.

The researchers acknowledged the data collection methods were a methodological weakness and that the survey questionnaire may have used words or concepts that were too complex for children. Findings included combined adult and child responses making it difficult to interpret the results. Despite the methodological weaknesses, this study shared data and strategies that seemed appropriate for use with children who are hospitalized in psychiatric facilities.

Miller (1986) studied 40 emotionally disturbed children, ages 5 to 13, living in a residential treatment center by asking them to draw a picture of the seclusion room. The older children were also requested to write what they thought seclusion or time out meant. The results yielded 43 pictures that the staff claim “baffled them” and indicated very different staff versus child perceptions. Of the 43 pictures, only 14 drawings contained people, and of those 14, only one contained a member of the staff. Analyses of both drawings and writings showed that the predominant theme was that patients felt seclusion was for punishment and similar to being in jail. Many of the drawings focused on bars, concrete bricks, locks and feelings of isolation. The researchers noted that most R&S studies of children do not report the impact of the procedure on the child but simply define “success” as a decrease in problem behaviors following R&S.

Miller's work lacked any theoretical framework or a model for the analysis of the drawings and description of the study process/procedures. It did, however, provide staff perceptions regarding how the R&S procedure was affecting the patients.

Mohr (1998) evaluated nine types of experiences in a descriptive account of children admitted to a psychiatric inpatient unit in Texas. One of those nine was the experiences of the children who were restrained and/or secluded in the institution. Nineteen children were interviewed after discharge using semi-structured in-depth interviews mostly taking place at the child's home. These children were asked "what was your experience of the psychiatric hospitalization as you understand it" and "how are you doing now?" Colaizzi's analytic strategies were used to understand the data. Archival data were also used. The duration of the interviews lasted 3 to 6 hours because the subject matter caused many of the children to cry and then take time to compose themselves for further interviewing. Symptoms/conditions reported to Mohr (1998) as a result of R&S and/or hospitalization in general were recurring intrusive negative thoughts, flashbacks, increased arousal, and the unhealthy use of avoidant behaviors. According to Mohr (1998) herself, there were limitations to the study. First, medical records do not often reflect exactly what happens on the unit but are worded toward the procurement of reimbursement. It is difficult to know if chart entries are accurate when the staff entering data have payment in mind. Secondly is that most of the children and parents interviewed were angry about the need for hospitalization. Had these patients been more accepting of the hospitalization, results may have been different. Overall, the final evaluation revealed the need to decrease a child's experiences of R&S.

These studies on hospitalized children's experience of R&S reported similar findings; feelings of isolation and of being punished. Only the Martinez et. al (1999) study reported some of the children felt safe knowing someone was watching them. None of the studies investigated what the children learned from the R&S experience or how the R&S episode could have been avoided.

In the studies reported above, similar methodologies were used and they reported similar findings, both for the psychiatrically hospitalized adults and children. All of the studies concluded that there is simply no empirical evidence that R&S is beneficial to psychiatrically hospitalized adults or children. Unfortunately, all of the sample sizes were exceedingly small, and one must rely on the researchers' interpretation that saturation was reached. None of these studies included both projective drawing techniques as well as interviews. All varied on the time frame following R&S for the collection of data. Only two examined chart data. Interview techniques did not always seem to be appropriate for children. Most reported only experiences of secluded rather than secluded and restrained patients. Most of these data were gathered on adults and may not be at all representative of children.

Conducting Research with Children

Interviewing children: Practical and developmental considerations. Alderson (2000) argues that the best method of understanding a child's experience is to ask him or her. Until recently, it was thought that children were unable to accurately recall events and had difficulty distinguishing fantasy from reality (Priestly & Pipe, 1997). In their study of how props such as dolls, photos, or sand play facilitate children's accounts of personal events, they found that, in fact, children were able to accurately recall events

even over quite long time periods. They are also able to describe their experiences in rational and critical ways if researchers apply developmentally sensitive and age-appropriate methods. (McAuley, 1996). The shift towards the child as an active participant in research was reflected internationally in a 1989 United Nations Convention. At that meeting, it was reported in Article 12 of the Rights of a Child that children should be consulted on issues that affect them. Now, the onus is placed on researchers to incorporate children's perspectives. It is very important to investigate the child's world and this world has been studied quite inadequately from the point of view of nursing (Kortesluoma, Hentinen, & Nikkonen 2003). A variety of considerations should inform conduct of qualitative research with children in order to obtain rich, accurate information. These include: (a) understanding children's growth and developmental stages, (b) developing a rapport with children in order to help ease anxiety, (c) creating a pleasant atmosphere, and (d) proper organization of the environment used for the interview. These topics represent the majority of the literature written about how to obtain data from children.

Interactive strategies to establish rapport. Clark (1999) reminded us that traditional verbal interviews may be methodologically problematic because they rely on linguistic communication, and for young children verbal language limits the issues and questions that researchers can explore. Also, they may not have the cognitive or emotional capacity of an adult. Faux, Walsh, and Deatrick, J. (1988) claimed researchers must modify their interviewing techniques and questions to make them compatible with the individual linguistic and cognitive stage of development of each child. When talking about their lives and experiences, children usually use verbs denoting action, and using

those kinds of words will make it easier for children to answer (Stern, 1992). Rich (1968) recommended that before and during the interview, children need to be assured there are no right or wrong answers. It is important to use concrete words and “here and now” situations rather than abstraction.

The feasibility of interviewing children as a method of data collection depends especially on the interviewers’ ability to gain children’s confidence and to get involved in the interaction between themselves and the children (Kortesslouma et al. 2003). Some authors suggest playing with the child prior to the interview to help the child relax. Others recommend providing child size furniture, child friendly art work, or toys in the interview room. Overall, the researcher must possess a genuine interest in the wellbeing of children, an attitude of acceptance, and the belief that their opinions are valuable.

Developmental considerations and theoretical underpinnings. A psychoanalytic perspective is used to interpret drawings. In humanistic psychology, children are thought to be individuals developing meanings out of their experiences and interactions (Grieg & Taylor, 1999). Freud and Erikson described personality and emotional development as a series of predictable stages respectively. Understanding developmental stages helps the researcher better know what is normal and what is reasonable to expect of the child’s abilities. The perspectives of Freud and Erikson informed the interpretation of the children’s drawings and stories. Freud was interested in the interconnections among art, symbols, and personality and believed that art expression could be a route to understanding the inner world of the human psyche (Malchiodi, 1998). Erik Erikson built on Freud’s work through the development of the Epigenetic theory. This theory explained eight stages of emotional development during encounters

with the environment throughout the entire human life (Murray and Huelskoetter, 1983). Each stage of development sets the groundwork for the next stage and describes the order and sequence of human development and the conditions necessary to accomplish these. Epigenetic theory specifically refers to Erikson's thought that even though human development, beginning at conception, passes through identifiable phases determined genetically, the social environment does have a significant effect on the success with which the child will master the stage (Thomas, 2000). Erikson's stage of development relevant to this study is the school age stage of "Industry vs. Inferiority." During this stage children want to get busy with activities and at the successful completion of the stage will feel competent. Adults may aid the child in successful attainment of competence by guiding them with tasks that they can accomplish while feeling a sense of worth. A child feels competent when he can use his skills and intelligence to complete tasks. Knowing the best way to assist a child with his aggression or violence (such as the situation of R&S on the psychiatric unit) will increase feelings of worth and competency. According to Ericson, the child who masters these developmental skills tends to be a more mature, healthy adult. Depending on how he/she handles the child's aggression, the nurse is able to influence his or her development in a healthful way.

Use of projective drawings in research with children. The interview is the most widely used method of gathering data in qualitative research, and there are many types of interviews (Nunkoosing, 2005). Children may have difficulty verbally expressing their feelings regarding issues that may be affecting them emotionally (Lukash, 2002). Thoughtful construction of questions to use during an interview with children is

necessary, and the use of projective measures or drawings may be used to supplement the amount of information received (Jick, 1979).

The basis of projective drawing tests is that children's drawings reflect personality, perceptions, how they see themselves, and attitudes so that valuable information may be obtained in a non-threatening manner (Malchiodi, 1998). Projective assessment techniques are often used to help children express emotions in the hospital setting, and drawings are the simplest of these methods (Johnson, 1990). For more than one hundred years, there has been an attraction to connecting art expressions with the personalities of their creators (Malchiodi, 1998). In 1885 Ricci published his observations on the drawings of Italian children, possibly the earliest collection of children's drawings on record, which at that time were used as an adjunct in classroom education. Goodenough (1926) used the Draw-A-Person test to help determine intelligence level. Around 1940 projective drawing techniques emerged and were used on the accepted belief that drawings represent the inner psychological realities and subjective experiences of the person who created the image. At this point, Machover (1949) began to study symbols in children's art in order to help gain an understanding of their inner feelings. While a single drawing should not be used to formalize a diagnostic impression, it can be a non-threatening means of discovering information about the child's sense of self, cognitive development, emotional difficulties and interpersonal problems.

Using art as a process to help children externalize complex feelings during an interview can add another layer of assessment and increase the amount of information gathered in the clinical setting (Looman, 2006). Looman's (2006) research into the experiences of children displaced by Hurricane Katrina revealed that one must apply a

developmental lens in order to tailor the assessment process and discussion during the drawing. She also encouraged researchers to ask the children to describe their drawing in order to understand it as fully as possible. Drawings sometimes contain objects that are not recognizable. By asking the child to describe his drawing, the researcher will gain much more information than simply looking at the drawing and assuming what it represents.

Gross and Haynes (1998) conducted a series of studies to explore whether drawing facilitated verbal reports in children, supporting the premise that drawing does indeed appear to enhance children's communication of feelings and perceptions. In two separate investigations they compared two groups of children: one group who talked about experiences while they drew pictures and a second group who were simply asked to tell about their experiences. Children in both studies who were allowed to draw while talking provided more information leading to three assumptions about why drawings are helpful adjuncts to increasing children's verbal reports: a) drawings may reduce anxiety and help the child feel more comfortable with the researcher, b) drawing may increase memory retrieval, and c) drawing may help children organize their narratives. Welsh, Instone, and Stein reported that drawing a picture may help lessen the stress of the visit to the pediatrician's office and can also assess fine motor skills and visual-perceptual abilities (Dixon & Stein, 2006). They found drawings also provide useful information about the child's sense of self, developmental status, family relationships and adaptation to stress so that talking about the drawing and may open up a resourceful and therapeutic discussion among parents, child and clinician. Using projective drawings to elicit

information from children in this study is therefore a developmentally appropriate way to understand their experience.

Introduction to specific techniques. Draw-a-Person, House-Tree-Person, Draw-a-Family, Drawn Stories Technique and Kinetic Family Drawings are some of the projective techniques available to a researcher to elicit information from children. Many other less structured techniques are also available. While there is no hard and fast rule about which test to use for which situation, there is some literature to guide the decision. Because the aim of this study was to obtain information about children's experience with R&S, the domains of communication, self-image, and emotional tone relative to this experience were important to elicit. When Machover (1949) used the DAP test with children and adults, she wrote,

The human figure drawn by an individual who is directed "to draw a person" relates intimately to the impulses, anxieties, conflicts, and compensation characteristics of that individual. In some sense the figure drawn is the person and the paper corresponds to the environment. (p. 35)

This technique provides information about self-image and emotional tone. A freehand drawing of the actual R&S experience enhances that information revealing details in the communication domain of the R&S itself and the extent to which the child feels isolated or connected to his environment. This information allows the researcher to better understand how R&S directly affected them, what they learned, and whether or not R&S is a useful intervention.

There are critics of using art and projective drawing in research. In 2000 Lilienfeld, Wood, and Garb studied three projective techniques often used in literature and most frequently used in clinical practice. Their findings, presented in a monograph, imply that projective techniques are susceptible to faking, are routinely used for purposes in which they are invalid or poorly supported by research, and have no norms for projective techniques. They propose that the Rorschach Inkblot Test, Human Figure Drawing, and TAT (Thematic Apperception Test) do not have adequate reliability, meaning that there is considerable subjective meaning and error in the scores from one clinician to the next. Human Figure Drawings have been criticized by Handler and Habernicht (1994) who suggest that projective techniques are biased against North American minority groups and that there are substantial differences in characteristics of human figure drawings across ethnic and cultural groups. Given that there are no valid and reliable instruments to measure the phenomenon of interest, projective drawings remain a developmentally appropriate way to elicit the children's perspective and gain insight into their experiences. Drawings are also one of the least threatening methods to gather information from children who may be too fearful to talk about topics that are taboo or highly emotionally charged. Threats to validity can be mitigated by using the standardized interpretive guidelines developed over a 15-year period by Machover (1949) in her study of children's drawings. To improve reliability, a second and sometimes third interpretation by qualified reviewers blinded to the original investigator's analysis is suggested.

Conclusion and rationale for this study. The most obvious gap in literature is the lack of well-designed studies directly exploring the perceptions and experiences of

children who have been restrained or secluded. Effects of this intervention on children, alternative methods for combating violence or providing care within the complexities of a psychiatric facility have not been adequately investigated. Nurses often choose to use R&S based upon personal preference or age-old protocol and lack evidenced based research to guide care. This study will provide information to help examine how a child perceives R&S, whether or not it was helpful as well as how the identification of ineffective policy may remove the barriers to further research and expert patient care.

CHAPTER THREE

Settings, Methods, Procedures and Participants

My study was conducted at the inpatient unit of a community psychiatric treatment center in the western United States using a descriptive case study method. The research design was inspired primarily by Yin's methodology for conducting case studies. The decision to use a case study approach was driven by my need to understand R&S within the context of the psychiatric hospital, its staff, its policies, and the social and historical components where children are restrained or secluded.

The case is a participant's drawings and interviews that were done and interpreted using a psychoanalytic perspective along with Colaizzi's seven step analysis method. Colaizzi has influenced and assisted many qualitative researchers in data analysis including several authors' articles reviewed here in this dissertation. Coward (1990) described Colaizzi's steps and how to use them in her analysis of the experiences of women with breast cancer. That article lists the steps as follows; (a) read all the participant's descriptions (b) extract significant statements (c) create formulated meanings (d) aggregate formulated meanings into clusters of themes (e) write an exhaustive description (f) identify the fundamental structure of the concept (g) return to the participant for validation. This design served to enrich the analysis and better illuminate the case (Baxter & Jack, 2008). Creswell (2003) recommends building a case by declaring its boundaries. Defining time and place, similar to stating inclusion and

exclusion criteria, are part of building the case, which helps keep the data manageable and the analysis consistent with the research questions initially asked. The following paragraphs provide the information with which this case was built including inclusion/exclusion criteria, how information was obtained for study, recruitment, techniques on working with the clinic staff, the interview process, data analysis, ethical considerations, HIPPA regulations and rigor.

Children were to be included if they were between the ages of 7-12, had been restrained or secluded in an inpatient psychiatric hospital, and were able to give consent along with their parents or guardians. Children should be given full information about what the research and interview entail and should be given an opportunity to reflect on these before making a decision to participate (Hill, Laybourn, & Borland, 1996). Age limits were determined due to hospital policy in the facility where the interviews took place; the maximum age for a child patient on the unit is 12, and by policy no children under 9 are placed into restraint. All children, though, are allowed to be secluded.

Children were excluded for three reasons in this study. First, they were excluded if their legal custody status was uncertain or if they were in the custody of the county courts. The experience of these patients would have been valuable, but obtaining consent from court appointed guardians would have required more time than was feasible for this study. Second, children were excluded if they were physically unable to hold a pencil or sit comfortably in a chair. The third exclusionary criterion was an inability to speak English. Appendix A summarizes the demographic data to be collected. These included the child's age, sex, ethnicity, year in school, date of hospital admission and interval since placed in R&S, and reason for admission.

Recruitment and Informing of staff

Medical, nursing, and ancillary staff was informed of the study prior to beginning. I attended staff meetings in the youth services department to introduce the study objectives and my methods of data gathering. An all-house email went out after IRB approval was granted to inform staff of the exact date for beginning the study. The staff were informed that my pager number and cell phone number would be available 24 hours a day in case of adverse patient reaction or questions from the staff.

Recruitment was done in several ways. I posted flyers describing the study around the lobby and group rooms in the inpatient and outpatient program areas. Each therapist was given flyers to hand out in private sessions with children and their families. These same flyers were posted in each staff unit lounge and in other visible but patient-free areas to remind staff of the study. I was present at the beginning of each treatment day to speak with interested families and answer any questions about the study. I notified the attending psychiatrists of the study and requested they hand my flyer to any interested patient who met the criteria. These physicians, who were all familiar to me and with whom I had worked for many years, agreed to notify me and were excited about the possibilities this study would provide.

This study complied with all HIPPA standards imposed by the IRB and the psychiatric facility where the study was conducted. HIPPA, The Health Insurance and Portability and Accountability Act of 1996, enacted legislation to facilitate electronic billing, improve privacy protections, and promote continuity of health insurance coverage (Burman & Daum, 2009). Current use of electronic medical records, faxing, emailing and scanning allows relative ease for intruding into a private medical record. The

purpose of HIPPA regulations are to help health care facilities become acutely aware of how important it is to provide privacy to a person's health care record and be held to standards and consequence if not provided that privacy.

Actual Interview Process.

The child in this study was interviewed using the Draw-a-Person (DAP) test administered according to instruction by Machover (1949) and a "freehand" drawing specifically about the R&S experience. The actual interview took place at the local public library close to this child's home. The library allowed us to use a quiet and private room for the interview. Careful observation of the child was conducted during the interview in order to make sure the child felt comfortable and safe. A table with children's sized chairs, white paper, colored pencils and plain pencils with erasers were used. Care was taken to use a room with restrooms close by. I engaged the child in small talk and simple play in order to put him at ease. He was asked to make three drawings: a male person, a female person, and a picture of the seclusion room. Anything said in conversation by the child during drawing was noted on paper as exactly and inconspicuously as possible. After he completed the drawings, I asked him to tell me a story about them to clarify content and gather additional information.

Though there may not be a uniform way of asking these questions, an interview guide was used and may be found in Appendix B. A worksheet was used to organize these findings (Appendix C). Exact order of drawing and interview tasks may be different for each child. The following is how this process went: (a) The child was situated comfortably in a chair at the table making sure there was plenty of room to draw, and then the reason for the study was reintroduced in child-friendly language, (b) He was

given a piece of blank, white, 8 1/2x11 paper, sharp colored pencils and erasers, (c) He was asked to “draw a person” according to Machover’s (1949) instructions. A phrase was added (at Machover’s suggestion) “This has nothing to do with how well you draw; I am interested in how you try to make a person.” (d) The sex drawn first was noted and on the second drawing he was asked to draw the sex opposite of what he had just drawn, (e) It was noted if an essential body part was left out and he was encouraged to finish the drawing, (g) Observation was made of affect and mood of the child, the way in which he used the art materials provided, conversation offered by the child, and the overall behavior of the child. These items are part of a comprehensive psychosocial evaluation and are important in understanding the child. Then the child drew a picture of the seclusion room based on the procedures by Miller (1986) and Machover (1949).

The term “quiet room” or “blue room” was used as these are the informal terms used on most child units to refer to the seclusion room. Friendly conversation and encouragement were also used. An example of this is “If you knew a person who was in R&S, what would they draw”? No specific instructions were given to the child about what to include in his/her seclusion room drawing. During the drawing time the researcher made simple conversation when needed. Assurance was given that there was no right or wrong answer to any question or conversation. Continuous assessment of the child was made for signs that the interview/drawing must be stopped. These signs included but were not limited to absolute refusals despite encouragement or any request to stop the interview and distress as evidenced by distraction, loss of interest, hostility/anger, or excessive crying. If he had been removed from the interview, reassurance would have been given that no harm would come to him for not completing

the task. A call would have been placed to the chief psychiatrist to determine whether additional care was needed or not. The parent would have been notified of the situation (whether the child completed or did not complete the interview) and if any further treatment must be administered. The participant received a toy from the “toy bag,” and a thank you note was sent to their home at the completion of the drawings and interview.

Data Analysis

Sources of data in this study included drawings, demographic information, and my notes about behavioral observations of this child and his mother during the research encounter, verbal conversation of the child and his mother, and general observations of the staff in the facility. Analysis of the drawings was based upon the interpretation of the individual drawings primarily using Machover’s (1949) guidelines including such items as figure size, use of background effects, whether the figure is drawn in profile or front view, proportions, erasures, incompleteness, symbols, action, and postural tone. Machover never developed a numerical scoring system for analysis of drawings as other researchers later did. Her focus first was global; on each body part in terms of properties, behavior during drawing, the tendency toward incompleteness and the amount and placement of detail. She then paid certain attention to particular aspects of a drawing based on principles of personality analysis. Evaluation of action(s), style, and symbols in each drawing helped determine the domains of emotional tone, communication (sense of feeling connected or isolated from others), and self-image that together represent the inner world of the child’s experience (Burns & Kaufman, 1972). The research and writings of Malchiodi, (1998), Knoff and Prout (1985), and DiLeo (1983) were also used to assist in drawing analysis. Colaizzi’s method was used to discover the “voice of the

child” through qualitative analysis of his drawings and stories. Appendix C is an example of the worksheet that was used to organize the content of the child’s drawing and allowed me to interpret his emotional tone, communication, and self-image related to his R& S experience. Appendix D contains a guide used to explain how these interpretations are made of various components of each drawing. Machover (1949) explains that one may directly interpret any obviously literal aspect of the graphic product, though, must also include the projective meaning behind the content of the images. The drawings were evaluated individually and collectively to determine common themes. A second evaluation of the drawings was conducted by an experienced psychiatric clinical nurse specialist and art therapist in private practice to increase the validity of this analysis. Individually the stories told by the child about the drawings augmented the meaning of the drawings and helped me to further my understanding of his experience with R&S. Stories about each drawing were then analyzed collectively to again note common themes. The stories were read several times to fully absorb them. They were summarized, coded, categorized to find meaning and determine themes. Descriptive text was developed to translate the essence of the patient’s experience.

Ethical Considerations

In addition to the basic, humane standard of protecting the participant, principles of the Nuremburg Code, the Declaration of Helsinki (DoH) and the Belmont Report guided me. These ethical standards applied at every point along the way, including during the choice of criteria measures, how data were analyzed, how graphics are portrayed, what generalizations are made and what conclusions and inferences were (Meltzoff, 1998). The Nuremburg Code and the DoH are universally accepted guidelines, while the

Belmont Report is a document written in the United States to ensure Institutional Review Boards are involved in deciding whether a study is ethical or not. Whether or not a study is ethical must be determined before the study is begun not after the results are available (Beecher 1966).

The well-known Nuremberg Code was written after the discovery of the actions of Nazi doctors and focused on three items; (a) the demand for voluntary, informed consent, (b) that there must be favorable risk-benefit analysis, and (c) that the participant will have the right to withdraw from the study without repercussion (Rice 2008). In 1964 the DoH built upon those principles adding that there must be an advanced review of research projects by an independent group and that publishers must have proof that the researcher followed DoH principles prior to publishing any results.

The Belmont Report demands respect for persons, beneficence, and justice. In this study those principles were carried out by providing informed consent, providing confidentiality, and not excluding a potential participant if the study may benefit them. Also, the study was conducted based on the mindset that minimum harm and maximum benefit is sought rather than using participants for a better societal good. Institutional Review Boards of the University of San Diego and the psychiatric hospital where data was gathered reviewed this study and gave permission for it to be carried out. Any adverse event was to be reported as soon as it was discovered and appropriate care and compensation given to the participant.

During the consent/assent process, the child's biological mother was in attendance as I read the entire consent to them and answered any questions. The consent and assent were obtained in writing prior to any interview questions or drawing began. Child friendly

wording was used. When both parent and child agreed to participate they were each given a signed copy of the consent /assent. Any questions asked by either the parent or child were kindly answered throughout the entire consent and research encounter. The child was told he could change his mind about participating and drop out at any time without repercussion from the researcher or psychiatric facility. This reassurance was also given to the parent if they chose not to allow their child to participate. Prior to the start of the interview a plan was set up with the facility's chief psychiatrist to provide care needed as a result of harm caused by the research process. There was no subject harmed during this study nor was the psychiatrist needed for any situation. The following is now a presentation of the case in this dissertation.

CHAPTER FOUR

Interpretation of Findings

Analysis in this study began not at the end when data had been completely gathered, but almost at the very beginning, for two reasons. First, simply because rich qualitative research done with rigor demands that the analysis phase be considered during the early phases of work on the study. And second, I began “another” analysis after two or three weeks into recruitment when I encountered my first of several barriers to enrolling participants. I observed, looked for meaning behind behaviors and policies, and began to understand that more was going on that I needed to explore. More was happening than simply my need to gather participants, analyze data and find answers to my questions. As Stake (1995) says analysis should not be seen as separate from everlasting efforts to make sense of things. The goal now was to understand the essence the child’s experiences within its context in order to see the issues in totality and to bring clarity to my research endeavor. I was now considering the social, political and philosophical elements within the facility where I data gathered.

Organization of the findings

This study used an overarching qualitative approach to describe the experiences of a 12 year-old child who was restrained and secluded during a psychiatric hospitalization within the social context of the event. Data and analysis of the child participant, his drawings and stories, and barriers to the research project will now be presented.

An innovative approach, using three drawings done by the child participant and the stories he told about them, guided the interview process to elicit information from the child. A psychoanalytic framework focusing on style, symbols and action was used to guide interpretation and to identify common themes that represent this child's perceptions in terms of communication, self-image and emotional tone.

There were four stages of analysis: (a) interpretation of each projective drawing using Machover's analytic approach, (b) thematic analysis of the child's narrative about each drawing, (c) thematic analysis of all of the drawings and narratives as a whole using Colaizzi's methods, (d) a final analysis of data considering the child's perspective, contextual issues according to the methods proposed by Yin (2003), and a critical evaluation of the environment itself including the socialization of staff, and the philosophical guidelines under which the facility operated. Yin's method consists of examining, categorizing, tabulating, or otherwise recombining the data to address the initial research questions of the study, which were: (a) what was the perception of a child in restraint and seclusion? (b) does R&S help children learn to better manage their violent behaviors? (c) how could the child have avoided R&S. Chapter five revisits these questions for discussion and analysis, and how nursing science might benefit from such an understanding.

The Child Participant (see Appendix A)

The child participant in this study was a 12 year-old right handed Caucasian boy currently in the 7th grade. His admission to the inpatient psychiatric hospital was 5 months and 23 days prior to this interview. He had been expelled or suspended from school several times in the past two years prompting the inpatient admission. His anger,

to not be in the room when the interview/drawing was taking place. Immediately the boy looked startled and said “no I want my mom to stay.” His mother did stay during the entire research encounter. She was helpful and supportive and the process went very smoothly. The relationship between mother and child appeared healthy, trusting and mature. She did not at any time try to lead the child, get him to change his answers or interfere. When she spoke it was in a supportive way describing her child’s struggles with psychiatric illness.

The following drawing encounter used Machover’s (1949) guidelines. Beginning with drawing one, I asked the child to draw a picture of a person. As is typical for age, the child chose to draw the male first asking for no clarification about the directions given. (This is in contrast to when directions were given to draw the seclusion room experience, explained below.) Despite the availability of many colored pencils on the desk he drew it very quickly in complete black and white then said “ok here it is.” I was worried the research activity might be boring or unpleasant for him. I asked him to “add anything you’d like, there is plenty of time, I’d like to see more of how you draw.” He chose to not add anything and we went on to the next drawing.

When looking specifically at clothing, stance and body parts in drawing one, though the body parts are proportionate without distortion, what stands out is there is relatively no color and all the features are very small. Overall, there is a noticeable floating appearance to the figure. Almost all projective drawing literature concurs that the size of a human figure is highly significant, most relating this to a sense of poor self-esteem or inadequacy, low energy and those who may use repression as a primary defense mechanism (Malchiodi, 1998). He is face front with a very slight gaze to the right. Though the feet

to not be in the room when the interview/drawing was taking place. Immediately the boy looked startled and said “no I want my mom to stay.” His mother did stay during the entire research encounter. She was helpful and supportive and the process went very smoothly. The relationship between mother and child appeared healthy, trusting and mature. She did not at any time try to lead the child, get him to change his answers or interfere. When she spoke it was in a supportive way describing her child’s struggles with psychiatric illness.

The following drawing encounter used Machover’s (1949) guidelines. Beginning with drawing one, I asked the child to draw a picture of a person. As is typical for age, the child chose to draw the male first asking for no clarification about the directions given. (This is in contrast to when directions were given to draw the seclusion room experience, explained below.) Despite the availability of many colored pencils on the desk he drew it very quickly in complete black and white then said “ok here it is.” I was worried the research activity might be boring or unpleasant for him. I asked him to “add anything you’d like, there is plenty of time, I’d like to see more of how you draw.” He chose to not add anything and we went on to the next drawing.

When looking specifically at clothing, stance and body parts in drawing one, though the body parts are proportionate without distortion, what stands out is there is relatively no color and all the features are very small. Overall, there is a noticeable floating appearance to the figure. Almost all projective drawing literature concurs that the size of a human figure is highly significant, most relating this to a sense of poor self-esteem or inadequacy, low energy and those who may use repression as a primary defense mechanism (Malchiodi, 1998). He is face front with a very slight gaze to the right. Though the feet

are solid and stable there is shading and cross-hatching apparent. This combination of shading and floating may suggest anxiety, and literally feeling like he has no sure footing in life. He is placed against a pure white background with no objects or personal items around. There is no action in the picture; perhaps he is not sure what action to take or has low mood and low energy. No symbols, decorations or accessories are present and he is drawn very small, almost dead center in the middle of the page. Center-placed drawings may indicate healthy adjustment. There are signs that this boy is presently stable and by his mother's report he is doing better overall. There are, though, there are several elements in the drawing that will refute healthy adjustment particularly for this child's age.

The figure looks frightened and uncertain as evidenced by the large eyes and unsure footing. The drawn figure actually looked like the child himself, not only in physical attributes but the mood, the timid stance and the somewhat fearful expression on his face. His demeanor suggested that he may have felt frightened and unsure of himself. When asked what the boy in the drawing is doing, the child at first had no answer. It took him several minutes to say, "Well I guess he could be walking home from school and forgot his backpack." When asked about what mood the figure was in he said, "he is happy because he's out of school and most kids don't like school." There were seven erasures on the male figure. His erasures were intense and done with more than enough pressure placed on the paper. At one point he erased the same place over and over despite there being no pencil markings left. The manner in which the figure was drawn was almost in one dark solid outline then much shading over and over in between erasures. Again, anxiety is often shown by erasures and shading (Machover, 1949). The solid lines may show a feeling of isolation from peers, family or society and an ambivalent self-concept

(Knoff & Prout, 1985). A feeling of needing to avoid society and misunderstanding social cues may be the reason his lines outlining the figure are so solid, unbroken and dark. This “barrier” is important to help protect him from the world which he perceives is a hostile or inaccessible (Machover, 1949). The large eyes with dark outline show a need for hypervigilance in a world that may be threatening or painful to him (Machover, 1949). The figure is not engaged in any activity; he is stiff, standing alone with hands in pockets and arms pressed firmly against the body. This style may suggest that he is literally trying to hold himself together. The hands in pocket reveal evasiveness and tension, not understanding how to reach out to the world to engage and enjoy people or (Machover, 1949). Again, this is how he presented in actual life, shy, timid and unsure. His mood during the encounter was stable but his drawing suggests that he might have been unhappy and not sure how to engage in the world around him. The child really had very little to say about the figure; despite my encouragements to explain or elaborate he kept very quiet. He did become progressively talkative while drawing figures two and three. Perhaps it took him a while to feel comfortable with me or he is generally a timid person.

Specific items in a drawing gain validity when referred to the drawing as a whole (DiLeo 1983). Overall, when attempting to understand this child by looking at this whole drawing, several themes are evident; anxiety, uncertainty, insecurity, timidness, and possible depression. It is as if he has provided a barrier of protection around himself with the dark lines and in the blank white space. The size of the figure shows poor self-image or a more subtle feeling of insignificance. Burkitt, Barnett and Davis (2003) state when a child draws him/herself small they may feel unimportant as opposed to the child who feels

the person or subject is important they will draw it a proportionate size or larger than usual.

At this point I thought I was beginning to understand this child as a whole and wondered why restraint and seclusion were chosen for him as an intervention. Even the most ardent anti-restraint advocates do admit when extreme violence is present in a person who has no capacity to understand common language (maybe due to acute psychosis or drug ingestion) there are times when restraint or seclusion is necessary for short intervals. However, that did not seem to be the case here. He was intelligent, able to understand and converse well. He followed instruction and was able to create rapport. A manic person may in fact have unlimited energy during the manic phase which looks intimidating to a staff nurse leading him or her to consider R&S. But this was a child small in stature, not a hulking, strong, intimidating, raging adult male. He was a small boy possibly anxious about himself and with adequate reality testing. Literature does give options to the psychiatric nurse on how to manage the violent, non-psychotic, verbally proficient child who has a manageable size and is not under the influence of mind altering drugs.

The female he drew in his second drawing is very similar to the male figure but the child's behavior and the process of the drawing were quite different. This change in behavior, primarily becoming more anxious and unsure, became more pronounced as the interview went along. Since the child chose to draw the male figure first he was next asked to draw a female figure. I used the word "female" in my directions to him. He did not question me but proceeded to draw. While looking at the blank white drawing paper he said "ok this is going to be my girl picture." He then picked up a black pencil. Interestingly, before beginning to draw, he left the girl picture and went back to continue

coloring in the boy's blue pants. He erased the boy's pants several times before declaring it was complete. This back and forth drawing between the two pictures happened at least four times. After his declaration of completion he never went back to the boy picture but finished the girl. A psychoanalytic theory may interpret this behavior as conflict with sexual identification (Machover, 1949) but this child's history reveals no sexual abuse, sexual role confusion behaviors or domestic violence. Knoff and Prout (1985) says this could mean indecision, anxiety and insecurity or perfectionistic traits and that the child may be threatened by the first drawing so he redraws. These themes of emotional tone are probably more accurate here as they are also seen in the boy drawing. He states, "I really don't know how to draw girls too much I guess I could draw a group of girls talking. I usually draw them with pigtails." He did not, though, draw the figure with pigtails or in a group. He drew the female figure with the same solid, dark outlining as in the boy drawing. He mumbled, almost rambling to himself during the female drawing saying "hmmm, ok here we go, that's better, I think I'll have them wear both shirt and jeans, there that's a good design, let's make them a little taller." During this mumbling he stopped suddenly to say to me, "nobody will see these pictures right?" I assured him no one except my teachers in the university would see them. He was satisfied with that but then quickly and fearfully asked "what are you writing down?" I showed him my notebook and said I was writing down the things he said so they would be correct when I told my teachers about it. He was also satisfied with this answer. I asked him if he now wanted me to turn on the tape recorder instead of writing. He said no. I asked him if he wanted to take a break to which he also replied no.

There is a marked increase in anxiety shown here while drawing the girl as opposed to drawing the boy. I am not sure if this represents a generalized anxiety and insecurity or if he was showing some anxious anticipation of drawing the seclusion room. He then began the mumbling again saying “oh yea there we go, there now she’s tan, wait wait.” He was suddenly “done” and put the pencil down with firmness (not anger or irritation) making a slight slamming noise on the table. He was smiling. The female figure, as detailed in drawing one and appendix C is strikingly similar to the male figure. The manner in which he drew this figure was with much more concentration and intensity than when drawing the boy. He had to “stop and think” several times, and asked mom twice “if this is ok?” The position on the page, stance, absence of decoration, absence of action, coloring, solid, dark lines, shading, tiny features, wide-eyed uncertainty and many erasures (12 to be exact) are present in the female as well as the male. There is the same floating, white space surrounding the female figure indicating anxiety and an unsure footing in life (Machover, 1949). Seeing this same style drawing on two separate documents gives more credence to interpretation. Granted, these drawings are done in the same sitting, though, the sameness may indicate we are able to rest a bit more assuredly on the conclusions drawn. The small size may mean unimportance or poor self-esteem. Again themes of anxiety, timidity, insecurity and possible fear are present. My thoughts about the picture closely resembling real life for this child were unchanged after seeing the female drawing. This drawing added validity to my interpretations of his first drawing, both suggesting his inner feelings and thoughts, and relationship to the world and how he saw himself in it.

Drawing one.

11-1-11

Drawing 2

1
1
1
1
1

Thus far the interview encounter was going very well. The child and his mother were engaged; the child did not appear to be harmed from the process and denied needing anything to make him more comfortable. At this time, as he knew would happen, I asked him to “draw a picture of the seclusion room.” He immediately answered “which one do you want me to draw about?” I asked him if he had been in more than one seclusion room to which he answered “oh yea.” His mother confirmed he had been in seclusion both with and without restraint “many” times. Before I could explain directions further he said “I know which one to draw, the one that traumatized me the most.” This was probably my most surprising moment during the entire research encounter. I could not remember using the word “traumatize” at any time in his presence and was not sure where he had heard the word. As he continued to draw and describe his experiences, though, it was clear why he chose it.

The child was very hesitant as he began the drawing, a very different approach than when drawing the male and female figures in which he got started right away on the task. He needed much encouragement to keep drawing. Again I use the word striking to describe this child’s drawing. As one can see in drawing three there is no sign that this is a seclusion room; the child never got to the point of drawing a bed and the usual objects and people seen in a seclusion room during a restraint intervention. When the drawing was completed I asked him if there was anything else he wanted to add and led him a bit giving examples of “other people, windows, a bed, medicine or carpet.” He stated “no that doesn’t matter, only Molly matters. She was the restraint nurse and was mean to me and bad at her job.” The floating placement of the figure on the page and the dark solid lines are similar to the male and female drawings again indicating anxiety and perhaps even a

literal feeling of not knowing where to put his feet or where on earth to feel safe and stable. In the seclusion drawing there is no color and the proportions of the figure are less accurate. Even though the child describes this as a person, in fact specifically “his nurse”, it more resembles a monster than a human showing unrecognizable body parts and hoof type feet rather than shoes or human looking feet (he later describes this as elephant legs). He began by drawing only the head. With encouragement he continued to draw the body then the arms which he describes as “a snake arm.” He said “The devil carries it around and oh yea a pitchfork. Now there is a demon head and a big fat body with elephant legs.” His mother confirmed that the nurse this child was referring to was overweight. She was very supportive of the child as he was drawing and said “yes she was mean to him.” His mother was obviously upset for her son but it did not appear to influence the interview process. The child again became intense, mumbling “there now this is that elephant Molly, oh wait, that’s right.” He then erased and redrew the pitchfork “arm” which comes from the right side of the body. He suddenly said “mom where is the kidney?” His mother pointed anatomically where the kidney is. The child said “hey how’s the kidney” with a mocking sympathetic tone. He then drew the small dark area on the left side of the body indicating “this is a kidney and no I did not get stabbed I’m just trying to show you how I feel about her.” By now this child is visibly sad. His speech quality vacillated between angry and quivering. He at one point looked as though he was holding back tears. He persisted though, and gave no signal that this was too unpleasant or that he wanted to stop the process. He then began to erase. After approximately two minutes of him silently erasing and redrawing he said “I’m done and that’s all.” I thanked him for “helping me

understand how he felt and for giving me these drawings.” I asked if we could talk about the drawing and he said yes.

Drawing three.

11.11.11

in life overall as I described above, he was willing to engage with me and participate fully in this research experience.

I wondered about this child's color choices from the beginning when noticing he chose only the blue and black despite many colors of pencil available. Burkett, Barnett and Davis (2003) investigated color choices in children's therapeutic drawing. Their conclusions suggested that children are able to alter their use of color systematically and symbolically during drawing tasks and they respond differently with color to affective topics. That study, though, focused on interpreting emotion based upon drawing showing a wide array of color used. It gave no clues on how to interpret the use of essentially no color as we see here. The child here used black shading, black outlining and some blue. No literature known to me explains these color choices. Based on general psychoanalytic theory, I think it is safe to say these colors may show anxiety and poor self-image. This child has stated that no one asked him how they could help while he was out of control; that he was not listened to and his ideas were not valued.

Summary of the interpretation of the drawings. Interviewing this 12 year-old boy was a valuable and pleasant experience for me and I felt he had given me the gift of understanding his experiences. He was willing, cooperative, insightful and informative.

Using projective techniques when interviewing children can help bring out information about the child that words alone could not do (Malchiodi, 1998). Machover (1949) encourages clinicians who are interpreting children's drawings to look at the whole picture and interpret directly and literally that which has striking realness. Interpreting the style, symbols and action in this boy's drawings while at the same time looking at the drawings as a whole gives us insight into his perspective about his view of

himself (self-image), the extent to which he feels isolated or supported by others (communication) and his emotional response (emotional tone) to having been in R&S.

Self-Image. Poor self-esteem and a devalued self-image is shown here in the smallness of his male and female figure, the floating position of the figures, the timid, frightened affect, and the lack of color. He stated “no one would listen to me, I am bad and mad.” He did not feel supported by his nurse, and did not feel valued. At first glance it appears there is no style at all in these drawings. When looking deeper though there is a sparse, non-imaginative, and vacant “style” that may represent inner feelings of someone who doesn’t have much to offer; a non-imaginative little boy without vision or direction and a poor self-image.

Emotional Tone. The heavy dark lines and many erasures are two typical elements of style present in these drawings indicating anxiety, insecurity, and indecision are described by Burns and Kaufman (1972); Knoff and Prout (1985); and Machover (1949). This child also showed anxiety and uncertainty in his behavior during the drawing encounter. He also showed anger and voiced “hurt.” The seclusion room drawing indicates the same heavy dark lines and the explanations he gave describe the hurt he has now and the anger and non-therapeutic relationship he had then with his nurse. He described feeling “like he had been stabbed” and he “hates” his nurse Molly. These are powerful emotions. The snake arm and pitchfork in drawing number three are the only apparent symbols in all three drawings. Most literature across many disciplines says the snake has sexual meaning whether it is normal or pathological. I refute that due to this boy’s direct statement about why he drew the snake. He very clearly describes this nurse involved in his R&S as having a “snake arm” like the devil. He then decided to draw a pitchfork to emphasize the

about R&S and his nursing staff. He may always have some degree of difficulty with anxiety and in his relationships with nurses due to this unpleasant R&S experience.

Thematic summary and the meaning behind projection. All three pictures seemed to have a unique quality and consistent theme about how he viewed his R&S experience. The drawings are not distant and isolated from him as a person; when considering his behavior and conversation during the drawing they appear to be quite representative of his inner world, his emotions and his experiences as he described them to me. At the point in time of the research encounter it appears R&S may have made this child's condition worse. He had anxiety, bad dreams about the R&S experience, and thoughts of hatred toward the nursing staff. It is clear the child was angry at the nurse who restrained and secluded him and he was not able to develop any kind of therapeutic relationship with her. What does his future hold if he needs further inpatient psychiatric care but has anger, anxiety, hate, and feelings of uncertainty related to a nursing encounter? He himself stated he felt uncertain and hurt. He looks fearful in his drawings as evidenced by the large eyes. He stated he "was not stabbed but just wanted you to know how I felt about her" while drawing a grotesque picture of a "nurse" that does not even look human. His feelings of being hurt by this nurse cause to him "feel like being stabbed." Instead of building a trusting therapeutic relationship with his nurse, he felt stabbed, hurt and hate. While no certain generalizability is possible, this R&S experience for this child was not helpful or positive. He did not learn how to be healthier or how to avoid R&S in the future as a result of this experience.

His drawings and behavior display a host of unhealthy feelings yet his narrative suggests some maturity and resolve. He is content with his drawings and even though on

the surface he wants to please by having a “drawing that is right” he does not apologize for anything and presents his drawings at the end of the session with confidence. He was calm and willing to give me any information he could. He was likable, polite and had remained in therapy at the time of this research interview.

The concept of projection is based on a psychoanalytic framework and refers to an unconscious externalization of aspects of one’s personality such as feelings, thoughts, needs, conflicts and attitudes (Poster, 1989). Overall, the child participant in this study describes feeling uncertain and hurt, fearful, and having no healthy nurse-patient relationship. He though shows the beginnings of having overcome some of his obstacles and moving toward health. He was able to describe his experiences in R&S while remaining emotionally intact. He, knowing I was a nurse, was able to be honest with me and participate in research. Taken as a whole, these data provide insight into his experience with R&S, which may be characterized by themes of (a) uncertainty (b) fear (c) a non-therapeutic relationship with nursing (d) hurt and (e) overcoming.

Contextual Barriers to the Research Process

Most research projects are affected by unexpected barriers. Managing and overcoming them are a natural part of the encounter and hopefully can be used to enhance learning. The barriers encountered here were discovered at different times during the recruitment and data gathering phases leading me to reconsider the R&S intervention; I now saw the need to investigate this participant’s experiences of R&S within the social, historical, philosophical, and political background of the site. These data will be presented in time-line fashion in order to help make sense of the research project as a whole since two years

understand how to go about contacting a parent for research participation. They were not familiar with terminology or the questions that parents ask. At least two participants were lost due to the fact that the nurses were frightened to approach the parent about this research opportunity. It seemed no matter how supportive I was of them they were apprehensive about the topic. New staff was a particular challenge; it became very time consuming to identify and notify each new staff of their duties helping me recruit participants. I wondered if it was fair to place this amount of research oriented burden on them. In many facilities it is not uncommon for staff personnel to assist with research projects of many kinds. This responsibility, though, clearly was not easy for them nor had they had experience with the duties I was asking of them.

Lack of staff participation. At the beginning of my research project the staff at both inpatient and outpatient sites were excited and offered to help me at any point along the way. I secured a verbal contract with the psychiatrists to present my flyer to potential participants and their parents during office visits in their private practices. They were all willing to phone call me to notify about potential participants. The therapy staff at the outpatient services verbally contracted with me for the same involvement. At in-services I gave to nursing, physician, and ancillary staff they seemed very willing to support my endeavor. I repeatedly made appearances at their offices and team meetings to remind them of the study and ask if they knew of a potential participant. As time went along, though, and for reasons largely unknown, these staff were less and less able to support me. Though I did get a few participant “leads” from them, their interest dwindled despite me offering gift card rewards. I tried to be at the facility as often as I could to support them and actually be present when a parent was there; it was difficult to actually meet with a

parent on inpatient because they are not on campus often; there are only two hours per day of visiting allowed. Often the parents were not able to come for visits at all. Even if I was onsite when a child was restrained or secluded I had to wait until the nurses had time to contact the parent at home. On the outpatient campus parents often dropped off their children for program and left. During the times I was able to meet and mingle with outpatient parents, no available participant meeting inclusion criteria was identified.

Imprecise information available. There were times when staff from inpatient and outpatient sites approached me with information about a possible participant. As I attempted to contact and enroll these patients, I found much of the information provided to me was inaccurate. For example, parents were not aware that their child had been in R&S, there was no documentation of the event, and incorrect names were given to me. This happened more often in the outpatient setting than the inpatient site. These problems further complicated my recruitment efforts. It is not certain exactly where in the patient care continuum these inaccuracies happened. I spoke with two parents who were upset, not with me for calling, but calling with “information” that their child had been in either restraint or seclusion. They were simply asked by staff if their child could participate in research but not given the topic of investigation. When I told them it was a project exploring R&S with children they were upset that either their child was in R&S without them being told or that they were sure their child had never been in R&S and were upset it was on their chart in error. The end result were minimal enrollment opportunities even after two years of recruitment efforts.

Summary A qualitative approach using case study methodology including a list of barriers to data gathering have been presented. The 12 year-old participant graciously

shared his perspective of the R&S intervention via drawings and an interview. A psychoanalytic theory guided analysis of the drawings and themes were developed to help better understand his experience. Despite efforts to recruit other children into the study over a two-year period, significant barriers were encountered. In chapter five these data will be discussed further and include recommendations for nursing science, nursing practice, nursing education, research and health policy.

CHAPTER FIVE

Discussion

Children, psychiatric nursing care and policy regulation. This entire research encounter illuminates the perspective on R&S of one 12 year-old male child and findings related to contextual barriers at the research site. An analysis of common themes for the child in this study at the time of the interview showed he probably did not benefit from the R&S procedure. He had bad dreams of the experience, he learned to hate his nurses, and he may not have learned any healthy skills to combat his tendency toward violence. Violence is a symptom of his mental illness and the reason he was admitted to the facility. Stabilization of mood and learning about coping skills for future episodes is minimal care a patient may expect to receive when hospitalized. This patient did not appear to receive this basic care. These findings are consistent with other literature that questions the use of R&S. More research is needed to identify those factors specifically responsible and to help nursing science understand whether R&S is an effective treatment.

Through my research I had hoped to interview many children about their R&S experiences but accessing them was difficult. Considering the paucity of research about children in R&S coupled with the apparent adverse effect it had on my study participant, it is troubling that access to these unique patients is so limited. Today, much the same conclusions are being drawn about R&S with children as were written about 20 years ago. Nothing much in the literature has changed and it is now very difficult to even obtain access to the patient to study this questionable intervention. Marc et.al (2011) examined

studies published over the past 10 years that showed still relatively high rates of R&S use in the U.S.. These authors explain that R&S has been shown to lead to severe psychological and physiologic consequences and that more research is needed to determine its effectiveness. Studies by Mohr, Noone, and Mahon (1998), Delaney (2006), Sourander, Elila, Valimake, and Piha (2002) among others report essentially the same findings; little is known about this procedure of R&S with children and it may even be a harmful intervention. My study was developed to investigate these children's perspectives in order to learn if it was a helpful or a harmful procedure.

Children and critical theory. The findings of this study are situated within a critical theory paradigm in order to make sense of the power relationships and political context within which the study was conducted. Critical theory aims to bring self-knowledge and self-reflection to individuals whose perceptions of situations are clouded by values imposed upon them by the society in which they live and is concerned with careful clarification of what *is* in order to ultimately liberate us from what *has been* (Holt, 1995).

According to Roberts (1983) oppressed groups are controlled by outside forces with greater prestige, power and status. The study of children and childhood has historically been accorded a marginal place in the health, human, and social sciences in part due to the fact that children are a disenfranchised group whose perspectives have not seemed important (Berman, 2003). Much of what we know about children has come from their parents or teachers reporting it to us. Using tenets of critical theory to guide this research I have attempted to listen directly to children and give them a voice, allow them to discuss

children about their perspective about R&S and which elicited the information in a child friendly and scientific manner. The attention now drawn to this subject is valuable for nurses, research clinicians and of course the patient themselves. We are long overdue in exploring the R&S practice especially in light of the many requests in literature to further study this topic. Actually going to the children themselves is crucial in order to really know what they think and how they feel about a procedure.

Another strength was my ability to identify barriers to this study during the research process. With the help of my advisor I did not continue down a frustrating path of no participant recruitment after two years of trying, but took a look at what was really going on in this facility. Perhaps other facilities are struggling with the same complex issues. Understanding the social culture is crucial to then knowing how to proceed in discovering ways to provide healthier and more honest care to patients. As a long time respected employee of the research site I had an insider's advantage, but still had difficulty accessing participants. Other strengths include a sound theory base from which to work, following a reliable and valid guide to the interview process and interpretation of drawings, eliciting data from the participant via drawings and narrative rather than using only verbal language, and employing a specialist in child art therapy to review the findings.

The principal limitation of this study is I could not overcome the apparent barriers in this setting in order to recruit more children into this study. I also did not anticipate the immense burden staff would have in helping me recruit participants. If administrators of this psychiatric facility had known exactly how much access I wanted to the patients we

children about their perspective about R&S and which elicited the information in a child friendly and scientific manner. The attention now drawn to this subject is valuable for nurses, research clinicians and of course the patient themselves. We are long overdue in exploring the R&S practice especially in light of the many requests in literature to further study this topic. Actually going to the children themselves is crucial in order to really know what they think and how they feel about a procedure.

Another strength was my ability to identify barriers to this study during the research process. With the help of my advisor I did not continue down a frustrating path of no participant recruitment after two years of trying, but took a look at what was really going on in this facility. Perhaps other facilities are struggling with the same complex issues. Understanding the social culture is crucial to then knowing how to proceed in discovering ways to provide healthier and more honest care to patients. As a long time respected employee of the research site I had an insider's advantage, but still had difficulty accessing participants. Other strengths include a sound theory base from which to work, following a reliable and valid guide to the interview process and interpretation of drawings, eliciting data from the participant via drawings and narrative rather than using only verbal language, and employing a specialist in child art therapy to review the findings.

The principal limitation of this study is I could not overcome the apparent barriers in this setting in order to recruit more children into this study. I also did not anticipate the immense burden staff would have in helping me recruit participants. If administrators of this psychiatric facility had known exactly how much access I wanted to the patients we

may have been able to come to a better understanding of what I could be allowed to do from the beginning. This may have allowed me to obtain more participants and have a smoother course during the research process.

Another limitation is that I only accomplished six of the seven steps of Colaizzi's analysis. Colaizzi's analysis method was used to understand data from the child participant and requires seven steps. Step seven states that after analysis and the final conclusions are drawn the researcher will return to the participant to ensure these conclusions are correct. I can only hope my conclusions are drawn correctly but recognize this may cause some readers to doubt results.

Lessons learned

In planning the design for this study it would have helped to obtain permission for data gathering at multiple sites to increase participant availability. Training a research assistant may have helped provide more time to the staff to help them with questions or apprehension. Prior to launching a study like mine, exploring the child's perceptions, it may have helped to conduct a chart review across several sites learning about incidences of R&S, precipitating factors, and parental notification. Arming oneself as a researcher with this information may have helped design a study without the barriers faced here.

Implications for Nursing Research

Recommendations for future research fall into three categories: how organizational power affects nursing practice, how nurses decide which intervention to use with a violent child on an inpatient psychiatric unit, and a continued attempt to understand the child who has been in R&S. I propose that children on psychiatric units are marginalized

crucial. Understanding how nurses view the violent child and how they determine which interventions to use and at which times will enable us to know how to further educate and assist them to use best practices. Intervention studies are beginning to look at ways to avoid R&S with children by early assessment prior to the violent phase, redesigning staffing patterns, and better assessment of the child and his/her coping patterns.

Continuing to investigate these topics will be helpful.

Research to help understand these complexities may best be done within a critical theory framework because as Morrow (1994) stated, critical methodology will help us ultimately liberate ourselves from what has been. If nurses can become enlightened and be able to question the legitimacy of their current practice then newer and more beneficial ideas and practices might be developed.

Implications for Nursing Education and Practice

As an educator I have already begun to assist baccalaureate students on effectively questioning current standards of care, how to begin the change process in a health care facility and how to evaluate appropriate implementation of psychiatric nursing care. Nursing students at the graduate level must be able to begin questioning and redesigning policy standards for care. They must question philosophy of care and the mission of a particular facility, then delve deeper to assist in understanding and helping to improve actual standards for practice. Providing students with conflict resolution and policy writing skills will then enable them to identify misguided or ineffective practice, work diplomatically with staff to find healthier ways and actually put that into written practice.

crucial. Understanding how nurses view the violent child and how they determine which interventions to use and at which times will enable us to know how to further educate and assist them to use best practices. Intervention studies are beginning to look at ways to avoid R&S with children by early assessment prior to the violent phase, redesigning staffing patterns, and better assessment of the child and his/her coping patterns.

Continuing to investigate these topics will be helpful.

Research to help understand these complexities may best be done within a critical theory framework because as Morrow (1994) stated, critical methodology will help us ultimately liberate ourselves from what has been. If nurses can become enlightened and be able to question the legitimacy of their current practice then newer and more beneficial ideas and practices might be developed.

Implications for Nursing Education and Practice

As an educator I have already begun to assist baccalaureate students on effectively questioning current standards of care, how to begin the change process in a health care facility and how to evaluate appropriate implementation of psychiatric nursing care. Nursing students at the graduate level must be able to begin questioning and redesigning policy standards for care. They must question philosophy of care and the mission of a particular facility, then delve deeper to assist in understanding and helping to improve actual standards for practice. Providing students with conflict resolution and policy writing skills will then enable them to identify misguided or ineffective practice, work diplomatically with staff to find healthier ways and actually put that into written practice.

other interventions (or both), it would be helpful to determine best practices and place those into policy. Teams composed of experts, patients themselves and policy makers would be able to challenge this topic and hopefully develop standards of care.

Helping researchers access participants more effectively and successfully is important. An exploration of how policy is able to protect patients while still reasonably allowing the study of psychiatric nursing practices may help administration and researcher come to a more practical method for data gathering. Considering how policy about research was written and from which historical and political context it came may allow more effective methods of running a hospital while allowing research practice. At state and federal levels, educating stakeholders about the importance of access to participants for research may open dialogue capable of improving the relationship between researcher and the public. In turn, this will hopefully lead to a more effective way to improve quality of care.

Summary and Personal Notes

Literature confirms there are some possible negative effects to restraining and/or secluding a child. Best practices when providing nursing care to a violent, mentally ill child must, at a minimum, include a healthy nurse-patient relationship and be sure that no harm is caused to the patient. Perhaps my most frustrating and disappointing finding in this entire research process was that this child did not develop any therapeutic nurse patient relationship during his violent behavior episode(s) while an inpatient on a psychiatric unit. In fact he has decided to hate nurses.

A patient in today's healthcare system is placed inpatient only in the most extreme circumstances; when they are violent toward self and others. They are there to learn healthy coping skills and how to manage triggers to their stresses in life. The nurse-patient relationship is the very essence of psychiatric nursing and helps the patient realize stability and improvement in mood (Peplau, 1952). How can a patient learn helpful healthy ways to a meaningful and enhanced life if there is hatred between him and the nursing staff?

Writing this dissertation has generously provided me with insights into a child's journey through psychiatric treatment, organizational structure in a psychiatric facility, and about me. I have learned so much. Hopefully the insights and education provided me here will only help to advance the practice of psychiatric nursing through well designed research, continued practice and an ability to convey an honest and rich appreciation for ill children and for those staff working with me.

References

- Alderson, P. (2002). Children as researchers: The effects of participation rights on research methodology. In P. Christensen & A. James (Eds.), *Research with children: Perspectives and Practices* (pp. 241-257). London: Falmer Press.
- American Heritage Dictionary, The. (1994). Houghton Mifflin Company.
- Anderson, R. (2005). *Case Study Research; The view from complexity science*. Qualitative Health Research, May (15) 5, 669-685.
- Antai-Otong, D. (1995). *Psychiatric nursing biologic and behavioral health concepts*. W.B. Saunders Co. Philadelphia.
- Baxter, P., & Jack, S. (2008). Qualitative Case Study Methodology: Study design and Implementation for novice Researchers. *The Qualitative Report*, 13(4), 544-559.
- Becker, H. S. (1956). Interviewing medical students. *American Journal of Sociology*, 62, (2), 199-201
- Berman, H. (2003). Getting Critical with Children. Empowering Approaches with a Disempowered Group. *Advances in Nursing Science*, 26 (2), 102-113.
- Binder, R., & McCoy, S. (1983). A study of patients' attitudes toward placement in seclusion. *Hospital and Community Psychiatry*, 34(11), 1052-1054.
- Bonner, G., Lowe, T., Rawcliffe, D., & Wellman, N. (2002). Trauma for all: A pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9, 465-473.
- Bower, F. L., McCullough, C. S., & Wellman, N. (2003). A synthesis of what we know about the use of physical restraint and seclusion with patients in psychiatric and acute

care settings: 2003 update. *Online Journal of Knowledge Synthesis for Nursing*, 10, document 1.

Bowers, L., vanderWerf, B., Vokkolainen, A., Muir-Cochrane, E., Allan, T., & Alexander, J. (2007). International variation in containment measures for disturbed psychiatric inpatients: A comparative questionnaire survey. [Special Issue] *International Journal of Nursing Studies*, 44(3), 357-364.

Burkett, E., Barnett, M., & Davis, A. (2003). Children's colour choices for completing Drawings of affectively characterized topics. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, 44(3), 445-455.

Burman, W., & Daum, R. (2009). Grinding to a halt: The effects of the increasing regulatory burden on research and quality improvements. *Clinical Infectious Diseases*, 49, 328-335.

Burns, R., & Kaufman, S. (1972). *Actions, styles and symbols in Kinetic Family Drawings (K-F-D). An Interpretive Manual*. New York: Brunner/Mazel.

Busch, A., & Shore, M. (2000). Seclusion and restraint: A review of recent literature. *Harvard Review of Psychiatry*, 8, 261-270.

Colaizzi, J. (2005). Seclusion and restraint. A historical perspective. *Journal of Psychosocial Nursing* 43 (2), 31-37.

Coward, D. (1990). The Lived Experience of Self-Transcendence in Women with Advanced Breast Cancer. *Nursing Science Quarterly* No. 3, 162-169.

Crespi, T. D. (1990) Restraint and seclusion with institutionalized adolescents. *Adolescence*, 25(100), 825-830.

- Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage.
- Cusack, K., Freuh, C., Hiers, T., Suffoletta-Maierl, S., & Bennett, S. (2003). Trauma within the psychiatric setting: A preliminary empirical report. *Administration and Policy in Mental Health*, 30(5), 453-460.
- Day, D. M. (2000). A review of the literature on restraints and seclusion with children and youth: Toward the development of a perspective in practice. For *The Intersectoral/Interministerial Steering Committee on Behavior Management Interventions for Children and Youth in Residential and Hospital Settings*. Toronto, ON.
- Delaney, K. (2001). Developing a restraint-reduction program for child/adolescent Inpatient treatment. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 128-140.
- Delaney, K. (2006). Evidence base for practice: Reduction of restraint and seclusion use During child and adolescent psychiatric inpatient treatment. *Worldviews on Evidence-Based Nursing*, 3(1), 19-30.
- Delaney, K., & Fogg, L. (2005). Patient characteristics and setting variables related to use Of restraint on four inpatient psychiatric units for youth. *Psychiatric Services*, 58, 186-192.
- DeLoache, J., & Marzolf, D. (1995). The use of dolls to interview young children: Issues Of symbolic representation. *Journal of Experimental Child Psychology*, 60, 155-173.
- DiLeo, J. (1983). *Interpreting children's drawings*. New York: Brunner/Mazel.

- Dixon, S., & Stein, M. (2006). *Encounters with children: Pediatric behavior and Development* (4th ed.). Philadelphia: Mosby.
- Docherty, S., & Sandelowski, M. (1999). Focus on qualitative methods: Interviewing children. *Research in Nursing and Health*, 22(2), 177-185.
- Donat, D. (2005). Special section on seclusion and restraint: Encouraging alternatives to seclusion, restraint, and reliance on PRN drugs in a public psychiatric hospital. *Psychiatric Services*, 56, 1105-1108.
- Duxbury, J. (2002). An evaluation of staff and patient views of and strategies employed to manage inpatient aggression and violence on one mental health unit: A pluralistic design. *Journal of Psychiatric and Mental Health Nursing*, 9, 325-337.
- Evans, L. K., & Strumph, N. E. (1989). Tying down the elderly: A review of the literature On physical restraint. *Journal of the American Geriatric Society*, 37(1), 65-74.
- Ewing, G., Rogers, M., Barclay, S., McCabe, J., Martin, A., & Todd, C. (2004). Recruiting patients into a primary care based study of palliative care: Why is it so difficult? *Palliative Medicine*, 18, 452-459.
- Falconer, D. J., & Mackay, D. R. (1999, December). The key to the mixed method dilemma. In *Proceedings of the 10th Australasian Conference on Information Systems* (pp. 1-3).
- Faux, S. A., Walsh, M., & Deatrick, J. (1988). Intensive interviewing with children and adolescents. *Western Journal of Nursing Research*, 10, 180-194.
- Feagin, J., Orum, A., & Sjoberg, G. (Eds.). (1991). *A case for case study*. Chapel Hill, NC: University of North Carolina Press.

- Field, P. A., & Morse, J. M. (1985). *Nursing research: The application of qualitative approaches*. London: Croom Helm.
- Frueh, C. (2005). Special section on seclusion and restraint: Patients' reports of traumatic or harmful experiences within the psychiatric setting. *Psychiatric Services*, 56, 1123-1133.
- Gerring, J. (2007). *Case study research: Principles and practices*. New York: Cambridge University Press.
- Goethals, S., Dierckx de Casterale, B., & Gastmans, C. (2012). Nurses' decision-making in cases of physical restraint: A synthesis of qualitative evidence. *Journal of Advanced Nursing*, 68(6), 1198-1210.
- Gomm, R. (2000). *Case study method: Key issues, key texts*. London: Sage.
- Goodenough, F. (1926). *Measurement of intelligence by drawing*. New York: Harcourt, Brace.
- Gostin, L., & Nass, S. (2009). Reforming the HIPPA Privacy Rule. Safeguarding Privacy and Promoting Research. *Journal of the American Medical Association*, 301 (13), 1373-1375.
- Greig, A., & Taylor, J. (1999). *Doing research with children*. London: Sage.
- Gross, J., & Hayne, H. (1998). Drawing facilitates children's verbal reports of emotionally laden events. *Journal of Experimental Psychology*, 4, 163-179.
- Gullick, K., McDermott, B., Stone, P., & Gibbon, P. (2005). Seclusion of children and adolescents: Psychopathological and family factors. *International Journal of Mental Health Nursing*, 14, 37-43.

- Health Care Financing Administration. (1999). Hospital condition of participation in Medicare and Medicaid. *Federal Register*, 64, 127, Friday, July 2nd, 36089.
- Hill, M., Laybourn, A., & Borland, M. (1996). Engaging with primary aged children about their emotions and well-being: Methodological considerations. *Children and Society*, 10(2), 129-144.
- Kennedy, S. & Mohr, W. (2001). A Prolegomenon on Restraint of Children: Implicating Constitutional Rights. *American Journal of Orthopsychiatry*, 71(1), 26-37.
- Hoekstra, T., Lendemeijer, H., & Jansen, M. (2004). Seclusion: The inside story. *Journal of Psychiatric and Mental Health Nursing*, 11, 276-283.
- Holmes, D., Kennedy, S., & Perron, A. (2004). The mentally ill and social exclusion: A Critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing*, 25, 559-578.
- Holter, I. M. (1987). *Critical theory: An introduction and an exploration of its usefulness as a philosophical foundation for developing nursing theories and for guiding nursing practice and administration*. Unpublished master's thesis, University of Rhode Island Providence, Rhode Island, USA.
- Howard, J. D., & Reay, D. T. (1997). Positional Asphyxia. *Annals of Emergency Medicine*, 32(1), 116-118.
- Huckshorn, K. (2006) Re-Designing State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33, No. 4
- International Society of Psychiatric-Mental Health Nurses. (2001). Position Statement on

- the Use of Restraint and Seclusion. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 100-102.
- Jick, T. D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. *Administrative Science Quarterly*, 24, 365-367.
- Kortesluoma, R., Hentinen, M., & Nikkonen, M. (2003). Conducting a qualitative child interview: Methodological considerations. *Journal of Advanced Nursing*, 42(5), 434-441.
- Krumboltz, J. D., & Krumboltz, H. B. (1972). *Changing children's behavior*. Englewood Cliffs, NJ: Prentice-Hall Inc.
- Levy, E. (1969). Long-term follow-up of former inpatients at the Children's Hospital of The Menninger Clinic. *American Journal of Psychiatry*, 125 (12), 1633-1639
- Lilienfeld, S. O., Wood, J. M., & Garb, H. N. (2000). The scientific status of projective techniques. *Psychological science in the public interest*, 1(2), 27-66.
- Lipschitz, D. S., Winegar, R. K., Hartnick E., Foote, B., & Southwick, S. M. (1999). Post-traumatic stress disorder in hospitalized adolescents: Psychiatric comorbidity and clinical correlates. *Journal of American Academy of Child and Adolescent Psychiatry*, 38, 385-392.
- Lofland, J., & Lofland, J. H. (1984). *Analyzing social settings: A guide to qualitative observations and analysis* (2nd ed.). Belmont, CA: Wadsworth.
- Looman, W. (2006). A developmental approach to understanding drawings and narratives from children displaced by Hurricane Katrina. *Journal of Pediatric Health Care*, 20(3), 158-166.

Lukash, F. N. (2002). Children's art as an index of anxiety. *Plastic and Reconstructive Surgery*, 109(6), 1777-1786.

Luna, J. (2001). *Limiting the use of restraint and seclusion in psychiatric residential Treatment facilities for patients under 21*. Health Law Perspectives. Unpublished Juris Doctorate Thesis, University of Houston Law Center.

Machover, K. (1949). *Personality projection in the drawing of the human figure*. Springfield, IL: Charles C. Thomas Publisher.

Malchiodi, C. (1998). *Understanding children's drawings*. New York: The Guilford Press.

Manos, D. (1999). Congress looks at hospital use of patient restraints. *AHA News*, 35(15), 1-3.

Marc, H., Nele, D., Hella, D., & Correll, C. (2011). Prevalence and correlates of seclusion and restraint use in children and adolescents: A systematic review. *European Child and Adolescent Psychiatry*, 20(5), 221-230.

Martinez, R., Grimm, M., & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing and Mental Health Services*, 37, 13-22.

McAuley, C. (1996). Children's perceptions on long-term foster care. In M. Hill & J. Aldgate (Eds). *Child Welfare Services: Developments in Law, Policy, Practice, and Research*. Jessica Kingsley Publishers Limited. London, England

Meehan, T., Bergen, H., & Fjeldsoe, K. (2004). Staff and patient perception of seclusion: Has anything changed? *Journal of Advanced Nursing*, 47(1), 33-38.

- Meehan, T., Vermeer, C., & Windsor, C. (2000). Inpatients had mostly negative experiences of seclusion during short term treatment in a mental health facility. *Journal of Advanced Nursing*, 31, 370-377.
- Meehan, T., Vermeer, C., & Windsor, C. (2000). Patients' perception of seclusion: A qualitative investigation. *Journal of Advanced Nursing*, 31 (2), 370-377.
- Merleau-Ponty, M. (1964). *The primacy of perception*. Northwestern University Press. Translation by James Edie. Evanston, Ill.
- Miles, M., & Huberman, M. (1984). *Qualitative data analysis: Sourcebook of new methods*. Thousand Oaks, California: Sage.
- Miller, D. (1986). The management of misbehavior by seclusion. *Residential Treatment For Children and Youth*, 4(1), 63-72.
- Mohr, W. (1998). Experiences of patients hospitalized during the Texas Mental Health Scandal. *Perspectives in Psychiatric Care*, 34(4), 5-17.
- Mohr, W., Mahon, M., & Noone, M. (1998). A restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing*, 12(2), 95-106.
- Mohr, W. K., & Pumariega, A. J. (2001). Post restraint sequelae five years out: Concerns And policy implications. *Paper presented at the Annual American Psychiatric Association*. May 9th, 2001. New Orleans, LA.
- Mohr, W. K., Petti, T. A., & Mohr, B. D. (2003). Adverse effects associated with Physical restraint. *Canadian Journal of Psychiatry*, 48, 330-337.
- Morrison, E. F. (1993). Toward a better understanding of violence in psychiatric settings:

Debunking the myths. *Archives of Psychiatric Nursing*, 7(6), 328-335.

Munhall, P., & Oiler, C. (1986). *Nursing research. A qualitative perspective*. Norwalk, CT: Appleton-Century-Crofts.

Murray, R. B., & Huelskoetter, M. M. (1983). *Psychiatric/mental health nursing: Giving emotional care*. (3rd ed.). Englewood Cliffs, NJ: Prentice-Hall.

National Alliance for the Mentally Ill. (1999). Cries of anguish: Reports of restraint and seclusion abuse received since the October 1998 investigation by The Hartford Courant. [Electronic Version]. Available: <http://www.nami.org/update/hartford.html>.

Nelstrop, L., Chandler-Oatts, J., Bingley, W., Bleetman, T., Corr, F., Cronin-Davis, J., & Tsuchiya, A. (2006). A Systematic Review of the Safety and Effectiveness of Restraint and Seclusion as Interventions for the Short-Term Management of Violence in Adult Psychiatric Inpatient Settings and Emergency Departments. *Worldviews on Evidence - Based Nursing*, 3(1), 8-18.

Norman, E., & Parker, J. (1992). Coping with coping assessment: A critical review. *European Journal of Personality*, 6(5), 321-344.

Nunkoosing, K. (2005). The problems with interviews. *Qualitative Health Research*, 15(5), 698-706.

Opalinski, A. (2006). Pouring Rights contracts and childhood overweight: A critical theory perspective. *Journal for Specialists in Pediatric Nursing*, 11(4), 234-244.

Outlaw, H., & Lowrey, B. (1994). An attributional study of seclusion and restraint of Psychiatric patients. *Archives of Psychiatric Nursing*, 2, 69-77.

Peplau, H. (1952). *Interpersonal relations in nursing*. New York: G. P. Putnam.

- Petti, T., Mohr, W., Somers, J., & Sims, L. (2001). Perceptions of seclusion and restraint By patients and staff in an intermediate-term care facility. *Journal of Child and Adolescent Psychiatric Nursing*, 14(3), 115-127.
- Poster, E. (1989). The use of projective assessment techniques in pediatric research. *Journal of Pediatric Nursing*, 4(1), [page numbers].
- Price, B. (2008). Case study research with children and their families. *Paediatric Nursing*, 20(6), 39-45.
- Priestley, G., & Pipe, M. (1997). Using toys and models in interviews with young children. *Applied Cognitive Psychology*, 11, 69-87.
- Ray, N. K., Myers, K. J., & Rappaport, M. E. (1996). Patient perspectives on restraint and seclusion experiences: A survey of former patients of New York State psychiatric facilities. *Psychiatric Rehabilitation Journal*, 20(1), 11-18
- Rubin, J. (1984). *Child art therapy*. New York: Van Nostrand Reinhold.
- Roberts, S. J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 5(4), 21-30.
- Sanders, C. (2003). Application of Colaizzi's method: an auditable decision trail by a Novice researcher. *Contemporary Nurse*. 14, 292-302.
- Schimmelmann, B. G. (2011). Seclusion and restraints: A neglected area of research in child and adolescent psychiatry? *European Child and Adolescent Psychiatry*, 20, 219-220.
- Schutz, A. (1962). *Collected papers I: The problem of social reality*. Boston: Martinus Nijhoff.

- Silas, E., & Fenton, M. (2003). Seclusion and restraint as a method of treatment for people with serious mental illness. *The Cochrane Review*.
- Silas, E., & Wahlbeck, K. (2005). Restraint and seclusion in inpatient psychiatric wards. *Current Opinion in Psychiatry*, 18(5), 555-559.
- Snowden, M., & Roy-Byrne, P. (1998). Mental illness and nursing home reform: OBRA-87 ten years later. *Psychiatric Services*, 49, 229-243.
- Solomon, J. L. (1987). *From Hegel to Existentialism*. New York: Oxford University Press.
- Sourander, A., Ellila, H., Valimaki, M., & Piha, J. (2002). Use of holding, restraints, seclusion and time-out in child and adolescent psychiatric in-patient treatment. *European Child and Adolescent Psychiatry*, 11, 162-167.
- Spradley, J. (1979). *The Ethnographic Interview*. New York: Holt, Rinehart, & Winston.
- Sreenivasan, U. (2006). Position Paper presented at the Professional Standards and Practice Council. July 1982.
- Stubblefield, C., & Murray, R. (2002). A phenomenological framework for psychiatric Nursing research. *Archives of Psychiatric Nursing*, 16(4), 149-155.
- Thomas, R. M. (2000). *Comparing theories of child development*. (5th ed.). Stamford, CT: Wadsworth/Thompson Learning
- United Nations. (1989). *Convention on the Rights of the Child*. Geneva: United Nations.
- Vandenberg, H., & Hall, W. (2011) Critical ethnography: extending attention to bias and reinforcement of dominant power. *Nurse Researcher*. 18 (3), 25-30
- Wynn, R. (2004). Psychiatric inpatients' experiences with restraint. *Journal of Forensic*

Psychiatry and Psychology, 1(1), 124-144.

Yin, R. (2003). *Case study research: Design and methods* (3rd ed.) Thousand Oaks, CA:

Sage

Youngberg v. Romeo, 457 U.S. 307 (1982).

Zilboorg, G., & Henry, G. W. (1941). *A history of medical psychology*. New York: WW

Norton.

Appendix A

Demographics

1. Date of inpatient admission_____.
2. Time since discharge_____.
3. Reason for admission and Axis I diagnosis if
known_____.
4. Age_____ sex_____ ethnicity_____.
5. Year in school_____.

Appendix B

Interview Guide for Drawings

Though there is no way to write an exact script of what to say with every child. Here is an example of how the interview might go:

Part one

1. Hello bobby, thank you for agreeing to help me learn about you and make some drawings for me. Please sit down and I'll show you what we're going to do. I really like that race car on your shirt!
2. Here are some pencils and paper. This is what you will use to make your drawing. You may stop anytime you'd like and if you want to say anything while we are here just let me know.
3. This is a tape recorder. Have you ever seen one of these before? Would you like to touch it or push one of the buttons? Oh you have one of these at home, good so you know what it is.
4. Are you comfortable? Is there anything I can get you?
5. Ok so now if you could make me a drawing of a person please. Go ahead you are doing well. I don't care if you are good at drawing I just want to know about you and what you thought about being in the blue room. Making this drawing of the person will help me know that. Thanks so much you are doing fine.
6. Ok great! I see you made the picture of a girl person. Now could you please draw me a boy person?

7. Thanks so much Bobby you are really doing well. Now if you could draw me a picture of the blue room and anything you remember about being in there that time. No you will not get into any trouble. Anything you draw or say here is confidential. Have you ever heard that word confidential? Well it means I don't tell anybody what you draw or say. Take your time and ask me if you have any questions.
8. Yes I do understand you were mad that day it happened. I am not going to get you in trouble for being mad and I'm not going to give you any time outs right now. You may draw whatever you'd like. I really would like to know everything about how you felt and what you thought while you were in the blue room.
9. Wow Bobby this is a great drawing of the blue room. Thank you so much for helping me. Now let's talk about the drawing.

Part two

1. Tell me about your drawing. Who is in the picture? What is everyone doing? What is everyone thinking? Feeling?
2. Who would you like to have with you in this place? Is anyone missing? Did you learn anything from being in this room? Is this a room that would help other people your age?
3. Where is this R&S room?
4. Who is in charge of the room?
5. What did you do while in R&S?

6. Tell me about this _____. (refer to different objects that may be in the picture). How many stories does it have? What does this _____ need most?
7. I wonder why you are in this room. Where is everyone else? What did you think about while you were in this room? What happened before? I wonder what will happen next.
8. Will you ever go back to this room? If not, how do you plan to stay out of it at another time? This is great Bobby. You are go good at answering my questions. Now let's get mom back in here and all talk together for just a minute.
9. Mom, the session is completed now and Bobby did really well. Bobby I would like to

give you a gift. Here, why don't you look into this toy bag and pick out one thing you would like. Yes take it home with you and keep it forever.
10. Bye Bobby, bye mom. Thanks again.

Appendix C

Organizational Worksheet for drawing 1: male figure

Each child will have a worksheet in which notes about the drawing encounter as well as interpretation of content will be written. The work sheet will be filled out both while observing the child draw and after the drawing during the interview about the drawing.

1. Behavior during encounter: the pt is calm, “comfortable,” has a relaxed affect that is congruent and full range with conversation. At no time during the interview did the pt become a behavior problem or have uncontrollable emotion. He followed instruction well and appeared to function at his stated age and school grade. He drew strength from his mother who was there for the entire drawing though he never looked to her for answers. He was insightful and polite.
2. When asked to draw a person he chose to draw the male figure first.
3. Overall impression of the drawing, relative size and placement of objects and figures, are objects/people grounded, floating, colors, objects absent or present, activity, barriers present: small, non-active, floating in the middle of the page. It looks vacant, lonesome. There is nothing drawn on the page except the male figure. The body itself is proportionate except perhaps the eyes which are bigger and look almost in shock or similar to someone who is very uncertain. The figure is wearing a black short sleeved shirt, bright blue pants, white socks, black shoes without laces or fasteners, black hair. Hands are in front pockets. Dark lines may represent barriers to the “outside.”

drawn in as blue and the boy's pants are blue (same blue color/same actual colored pencil. The girl is also floating and floating in the same position on the paper as the male figure is, no other objects or people in the picture, no activity, the same dark lining around the picture maybe representing the barriers.

4. Body parts present or absent, facial mood/expression, profile/front/back view, anything bizarre or obviously out of the ordinary, anything vulgar or sinister. Body parts are all present but very small. Exactly the same as the male drawing. Hair is longer on the girl. Front facing, gazing to her right side. Mouth a straight line and tiny round circle for a nose. Standing straight, feet facing outward. May be that these are his drawing skills or perhaps he has trouble differentiating himself from others.

Organizational Worksheet for drawing 3

1. Behavior during encounter: pt.'s behavior became more intense and irritable. He was never in distress or out of control but he moved around and fidgeted much more than during the other two drawings. His speech became louder and sharper. He could state that drawing the seclusion room caused him "anger."
2. Overall impression of the drawing, relative size and placement of objects and figures,
are objects/people grounded, floating, colors, objects absent or present, activity, barriers present

Body parts present or absent, facial mood/expression, profile/front/back
view, anything bizarre or obviously out of the ordinary, anything vulgar or
sinister:

Appendix D

Guide to Interpretation of drawings

This guideline to understanding meaning behind drawings will be used in conjunction with the worksheet (appendix C). Specific meanings about personality that are revealed in the drawing will be discussed in the results chapter.

1. How does the child behave during the drawing encounter? For example does he talk a lot or a little, does he appear independent or need encouragement, a little or a lot of encouragement, does he erase often, does he cry, is he able to focus. Does he draw with a logical progression or with confusion and scatter? Does he return to one aspect of the drawing over and over?
2. Overall impression of the drawing: for example; is the drawer energetic, sad, angry, likeable, tense, dull, chaotic, excessively small or large, passive, or strong? Are there obvious strikingly real-life symbols such as guns, blood, storms, items representing fear or happiness? What is the amount of content in the drawing?
3. Relative size of the figure and where it is placed on the paper. Whether people or objects are grounded or floating. Whether they are in obviously incorrect places in relation to the entire drawing.
4. Placement of body parts and their relative proportion.
5. Use of background.
6. Use of color.
7. Whether the figure is drawn profile or front view.
8. Mood or expression in the face. Stance of the person.

9. Missing body parts.
10. Heavily or lightly drawing of lines and shading.
11. The presence of barriers. For example does the drawer place a large object between him and the nurse? Does the drawer place himself in a box or other symbol that shows he feels isolated?
12. Is there activity or lack thereof in the drawing?
13. Presence or absence of clothing, buttons, pockets, shoes and hats.

Behavior, order in which they draw, the relative size and placement of objects and figures.

Describe: _____

Overall Impression of drawing. Describe:

People and objects grounded? Y N

Describe: _____

Body parts: present or absent, facial mood/expression, profile or front view, bizarre.

- Head

- Eyes
- Mouth, ears, neck
- Trunk
- Arms
- Fingers
- Hands
- Legs
- Knees
- Feet
- Toes

Notes: _____