An Ethnomethodological Examination of the Decision-making Process Psychiatric Nurses Use When Deciding Whether to Use Seclusion

by

Bonnie McKay Harmer

A thesis submitted in partial fulfillment of the requirements of the degree of
Master of Science in Nursing
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Abstract

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This replication and expansion of Mason's work on seclusion used an ethnomethodological approach to examine the decision-making process of five Canadian registered nurses. Each nurse read two patient vignettes and then verbally explained whether they would use seclusion and why. The interview data were analyzed in structural, languaging, first-level and second-level analyses. Although all subjects arrived at different decisions, they structured and languaged their responses similarly. The first-level analysis indicated the subjects believed that experience was the most significant factor in their decision-making. However, the second-level analysis implied that a desire to gain positive feedback also significantly influenced the subjects. Commonsense knowledge, attitudes, and reasonings that were shared by the subjects supported an insular work environment that did not promote professional growth or reflective practice. The results of this study implied that a complex interplay of experiential and social factors may affect the nurses' decision-making process regarding seclusion more than the client's symptomology as captured in the vignettes.

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Chapter One

Introduction

Nurses practicing in psychiatric facilities are often required to make decisions whether or not to seclude a client. One may expect that empirical nursing knowledge would provide a substantial foundation for the nurse's decision. However, nursing textbooks devote extremely little (and sometimes no) attention to the concept of seclusion. It appeared to Mason (1993b) that nurses' colleagues and their employer are significant influences who socialize incoming nurses in the use of seclusion. Hence, social factors may be the most crucial factor to consider in relation to the decisions nurses make about seclusion. This indicates that the actual practice of seclusion can be examined from a sociological perspective.

In sociology theory, individuals whose behaviors fall outside the social norm pose a threat to the social order. This typically results in them becoming marginalized and severed from mainstream society. Mentally ill individuals are traditionally among those who are deemed as threats to social norms and social order (Coleman, 1984).

Historically, the locked doors of psychiatric asylums represented society's attempt to isolate mentally ill individuals in order to protect society (Coleman, 1984). Today, mentally ill individuals may continue to be perceived as threats to the social order. They often encounter difficulties achieving full integration into the social community. In hospitals, people experiencing mental illnesses are often cared for in units that are physically segregated from other client care areas. Even within the psychiatric unit, further segregation is possible for individuals who upset the social order of the unit: they may be locked in a seclusion room (Mason, 1997).

The process of seclusion may become routine and commonplace for psychiatric nurses who deal with it on a regular basis. However, to uninitiated viewers, such as nursing students, the practice of seclusion appears harsh and severe. These novices perhaps view the practice of

seclusion more objectively than those already indoctrinated to the social reality and accepted practices of some psychiatric nursing environments (Mason, 1997).

The purpose of this research study is to examine the decision-making processes of psychiatric nurses in relation to their decisions whether or not to seclude patients. This study will closely replicate a British nursing research study done by Tom Mason in 1997.

Mason's (1997) study of the decision-making process of nurses choosing whether or not to implement seclusion examined the seclusion process from an ethnomethodological perspective. This means Mason probed the nurses' underlying knowledge and reasoning patterns which served to maintain a sense of social order in the psychiatric unit. Mason's findings suggested that the nurses' decisions whether or not to seclude were more the result of the interplay of complex cultural and organizational factors than due to the presentation of symptoms by the patient. Mason's examination of the seclusion process from an ethnomethodological framework added a new perspective to the body of literature dealing with the practice of seclusion (Mason, 1997).

Traditionally, nursing research regarding seclusion has been primarily concerned with extracting variables that may be predictive, causal or associated with the implementation of the seclusion process. Nurses have been viewed as individuals who assess the patient, the situation, and the needs of the milieu to arrive at a decision whether or not to implement seclusion. The reasoning process of the nurse is typically seen as logical and a systematic interpretation of the patient and environmental factors of which the nurse is fully cognizant (Mason, 1993a).

Interestingly, despite the recognition and appreciation nurses have for the multitude of complex environmental influences continually affecting the patient, the nursing research does little to demonstrate an awareness of the overt and covert environmental influences affecting nurses' decision-making. That is to say, virtually all of the nursing research dealing with nurses and the seclusion process has tended to study the nurses as discrete entities who are making their decisions independently, and in the absence of a social context. The importance of understanding the effects

of social norms and organizational values within a mental health facility is crucial in truly understanding the complex factors entering into the reasoning and decision-making process of nurses within that unit (Mason, 1997).

Mason (1997) recognized the usefulness of studying the nurses' decision-making process from a social phenomenological perspective. Ethnomethodology, a field of sociology, can uncover the complex hidden reasoning processes of activities that are considered routine, and commonplace. Although ethnomethodology has seldom been used by nursing researchers, this type of research could be very useful to explore nursing practices which are unquestioned and taken for granted by nurses.

Ethnomethodology, in simple terms, deals with the study of everyday meanings, or as the ethnomethodological framework calls it "commonsense knowledge". This commonsense knowledge is derived from one's prior experiences, their unquestioning acceptance of the social realities of their environment, and the reasoning processes which enable individuals to take daily activities for granted or as commonsense. Mason sought to discover the commonsense knowledge and commonsense reasoning patterns used by psychiatric nurses (Mason, 1997).

Through inquiry based on an ethnomethodological framework, a critical evaluation of the underlying assumptions, meanings and values inherent in a particular social situation can be analyzed. This analysis enables the researcher (the observer) to understand the complex reasoning that is occurring in an apparently automatic, commonsense manner. The subject's ability to view their reasoning objectively is difficult due to their own participation in commonsense practices to propagate the social order. This means an observer is required to pull apart the meanings and uncover the processes by which social reality is maintained (Leiter, 1980).

Mason (1997) believed that an ethnomethodological approach to study the decision-making process of nurses regarding seclusion would be the best means to examine the underlying reasoning patterns. He interviewed twenty-five randomly selected volunteer subjects (psychiatric nurses) and

asked them to read two scenarios and then indicate whether or not they would elect to seclude the patients based on the scenarios. The data were reviewed and the themes that emerged were consistent with the principles of commonsense reasoning and commonsense knowledge in ethnomethodology.

The three themes to emerge were mechanistic searching, frame conflict and asylum status (Mason, 1997). Mechanistic search refers to the subject's rapid decision whether to seclude an individual and then the subsequent series of rationalizations produced by the subject to substantiate the validity of the response. Frame conflict refers to the subject's awareness of being judged based on the decision, and therefore balancing benefits and risks in order to arrive at a decision which is least likely to produce criticism from others. Within the theme of frame conflict was the notion of surveillance, whereby the subjects felt any of a number of people were watching and judging their decision (Mason, 1997).

Finally, the theme of asylum status refers to the subject's decision to adopt a decision that places him/her in a position of safety. This meant a moral framework was adopted by the subject to provide justification for their decision (Mason, 1997). Mason's study and the resulting themes will be presented in greater detail in the literature review.

There is a paucity of nursing literature examining the nurse's decision-making process regarding seclusion. There is also a lack of nursing research that has explored nursing phenomena using an ethnomethodological framework of inquiry. This replication and extension of Mason's (1997) research sought to advance the profession's body of knowledge relating to seclusion, and substantiate the usefulness of ethnomethodology as a mode of scholarly nursing inquiry.

Since Mason's (1997) study was done in the United Kingdom at a forensic psychiatric facility, this study examined whether similar findings would apply to a North American, non-forensic psychiatric hospital setting where seclusion is used routinely. This study sought to add to

Mason's work by determining which, if any, of the themes to emerge from his research would be transferable to other mental health nursing settings and their social contexts.

The American Nurses' Association has urged nursing researchers to engage in the replication of prior research to ensure the validity of prior nursing research and to substantiate the scientific foundation for nursing practice. The phenomenon of seclusion and the reasons why nurses implement it has profound implications for nursing practice. It is important to recognize and clarify the complex factors that are embedded in this issue since it plays such an important role in mental health nursing practice. Some Canadian settings practice seclusion routinely and the time has come for nursing research to study the commonsense knowledge of nursing practice critically rather than merely descriptively. This is especially true of the controversial but accepted practice of seclusion. Nurses need not only define what it is we do but also *why* we do what we do. As a maturing profession, we need to enter into an era of reflection and critical analysis of decision-making and practices that are taken for granted.

Chapter Two

Conceptual Framework

Literature Review

The practice of secluding mentally ill patients has been the topic of much scrutiny over the past decade. Seclusion may be regarded as a visible symbol of the starkness of psychiatry and its inability to effectively meet the needs of patients. Randell and Walsh (1994) stated "seclusion is one of the most dangerous and intrusive interventions employed by psychiatric nurses in the inpatient setting . . . there is a need to investigate alternative interventions such as ignoring and limit setting" (p.4). Due to the lack of empirical research that supports the practice of seclusion, as well as the ethical concerns related to limiting another's freedom, Randell and Walsh advocated the abolishment of seclusion as a nursing intervention.

Proponents of seclusion have stated seclusion is a necessary practice due to the lack of other effective means of controlling problematic and dangerous behaviors (Mason, 1997). Wadeson and Carpenter (1976) questioned whether alternatives such as increasing medication dosages to the point where patients are stuporous is really any more humane than seclusion. Steele (1993) concurred that seclusion can be viewed as safer than electroconvulsive therapy, and preferable to medication, with fewer side effects. Other researchers concluded the appropriate use of seclusion may reduce ward violence and improve the morale of the staff (Hafner, Lammersma, Ferris, & Cameron, 1989).

The United States Mental Health Bill of Rights, and the 1982 Supreme Court decision in Youngberg v Romeo, in the United States, have supported the right of nurses to use seclusion when less restrictive measures will not work to control patients who are out-of-control, posing danger to themselves or others or who are severely damaging the therapeutic environment (Haber, Krainovich-Miller, McMahon, & Price-Hoskins, 1997). Similarly, the Nursing Act of 1991 supports the rights of Canadian nurses to use seclusion if it is the least restrictive measure. Nurses

are permitted to initiate seclusion without a physician's order in emergencies when such an intervention would be called reasonable and necessary.

The clinical use of seclusion in Canada has "become standard to the extent that [seclusion is] widely viewed as necessary in a therapeutic milieu" (Steele, 1993, p.23). The actual percentage of patients who are secluded at some point during their hospitalization varies tremendously. Kirkpatrick (1989) noted seclusion rates have varied from 4% to 51% of admissions. This variation has been associated with differences in patient populations and factors in the unit environment.

In an international comparison of the use of seclusion and physical restraint, it was noted that physical restraint is rarely used in Great Britain, and there is a trend toward limiting the use of seclusion in many hospitals. Seven British hospitals reported having non-seclusion policies, "based on the principle that a seriously disturbed patient should not be left alone; although a single room for intensive nursing care was thought essential" (Mason 1994, p.55). Debate regarding the use of seclusion in Britain is centered around its efficacy as a therapeutic tool and the ethical/moral concerns about isolating patients.

Mason's (1994) study of international seclusion practices indicated that physical restraints are used seven times more frequently in Canada than Britain, and frequently for non-psychiatric patients. The use of seclusion is perceived in Canada as having "no therapeutic benefit and is necessary only for the application of other treatments" (p.55). Mason also noted a similarity to Great Britain as the debate about seclusion "emphasizes the moral/ethical debate which foreshadows the legal ramifications [of using seclusion]" (p. 56). Literature pertaining to seclusion in the United State focuses much more on the legal issues associated with the use of seclusion than in other countries (Mason, 1994).

Most nursing research studies have endeavored to isolate the variables in the patient population and the environmental factors that correlate to the use of seclusion. Mason (1993b)

criticized the value of this type of descriptive research relating to variable identification. He pointed out the use of seclusion may indeed be influenced by staffing levels or age ranges, but these variables are unlikely to be major causal factors outside the context in which it is used. Mason (1997) stated there is a need to look beyond the patient and environmental factors which have been the focus of previous researchers in order to explore the social factors relating to the decisions nurses make regarding the use of seclusion.

Literature Relating to Descriptive Variables

Nursing researchers have focused on patient diagnoses (Gerlock & Solomons, 1983; Gutheil, 1978; Plutchik, Karasu, Conte, Siegal, & Jerret, 1978) in relation to seclusion incidents. However, the results have been inconclusive. Gutheil (1978) and Plutchik et al., (1978) found seclusion was most frequently used with psychotic individuals, especially those labeled schizophrenic. Gerlock and Solomon's (1983) research however showed patients with major affective disorders were most often secluded. This contradicted Swett's (1994) findings that indicated seclusion was most frequently used with personality disorder patients. It should be noted that of these researchers, only Gerlock and Solomons are nurses. This could have contributed to the tendency of these researchers to attempt to correlate seclusion occurrences to medical model diagnoses rather than more specific patient behaviors.

Numerous variables have been examined in correlation to seclusion frequencies but these investigations have produced inconclusive or contradictory results. Some of these variables include the age of the patient (Kirkpatrick, 1989; Mason, 1995), the race of the patient (Mason, 1995; Okin, 1985), the staff gender mix (Mason, 1995). Other variables examined which have provided inconclusive findings include days of the week, months, and seasons of the year (Gerlock & Solomons, 1983; Mason, 1995). Also no relationship has been found between barometric pressure changes, precipitation (Gerlock & Solomons, 1983), lunar cycles (Mason, 1995), and the menstrual cycle (Van Heeringen et al., 1995).

Literature Relating to Reasons for Implementing Seclusion

A variety of studies have investigated the beliefs of patients and staff in relation to the reason why seclusion was initiated. Most of these studies showed some discrepancies between the reasons expressed by patients as opposed to staff (Mason, 1995).

The patient behaviors that led to seclusion incidents were studied by Tooke and Brown (1992). Their data indicated that patients and staff held similar views regarding which behaviors were likely to lead to seclusion: destructive behavior, aggressive behavior, and inappropriate sexual behavior. However, patients also believed, to a statistically significant extent, that non-compliant behavior and requests to see a doctor or to sleep in the afternoon would lead to seclusion.

Soloff and Turner (1981) asked nursing staff to select the most important behavioral precipitant to their decision to implement seclusion. Precipitating patient behaviors were grouped into two categories: violent and non-violent behaviors. Non-violent behaviors included such behaviors as refusal to comply with treatment, breaking rules, agitation and disruptive behavior. Violent behaviors included physical aggression toward people, threatening assault, and physical aggression toward property. Their data revealed violent behaviors accounted for 66% of all seclusion with a full 35% of seclusions resulting from "physical attacks on staff".

Kirkpatrick (1989) replicated Soloff and Turner's (1981) study using the same instruments and methodology. Kirkpatrick's data revealed that the majority (79%) of identified patient behaviors prior to seclusion were non-violent. The differences in these findings are notable due to the differences in the severity of precipitating behaviors that led to the decision to seclude. Kirkpatrick's study took place in Canada versus the American sample used by Soloff and Turner. This, or the differences in years for the study, may have influenced the social norms within the practice settings for the nurses within each setting.

Soliday (1985) compared the reason for seclusion as stated by the secluded patients versus the staff who initiated the seclusion. Both the patient and staff groups cited the main reason for implementing seclusion was injury prevention. The staff reported this significantly more frequently than the patients, however. The second and third reasons given by staff for initiating seclusion were "patient's loss of control" and "threats of harm" respectively (p. 285). The patients' beliefs regarding why they were secluded was poorly assessed; the second reason given by patients was labeled as "other" (with no further details available); while the third and fourth reasons were "rule infraction" and "loss of control" (p. 285). Another limitation of this study may be the staff sample. Of the twenty-one staff in the sample nineteen staff were aides and only two staff were registered nurses.

Richardson (1987) interviewed fifty-two patients and then reviewed patient charts to compare the patients' perceptions of their behaviors before, during and after seclusion to the behavior documented in the chart by the staff. With reference to the reason for seclusion, patients answered by describing situations which led up to the point of being secluded. However, the staff documentation did not include the events leading up to the seclusion incident but only listed singular reasons for seclusion. The most frequent reason listed by staff for secluding patients was attacking staff (58%).

A good example of the difference in reporting between staff and patients is seen in the following example related to a patient's refusal to give a radio cassette recorder to the staff.

> The subject explained that the recorder had been a Christmas gift and he had been using it for 2 weeks prior to being asked to give it up by one of the evening shift psychiatric aides. After refusing to give up the recorder, the subject tried to call his father on the pay phone. The father refused to accept the call, which further upset the subject and reinforced his decision not to give up the recorder.

He was secluded for hitting and threatening the staff who tried to take the recorder. (p.236)

Richardson (1987) categorized the patients' reasons for being secluded as, "fighting or acting crazy (23%), using bad or loud language (12%), nurse or staff member did not do something the patient wanted (10%), another patient 'started it all' (10%), the patient embarrassed or tormented the staff (10%), wanting cigarettes (8%), throwing things (5%), refusing to do something the staff requested (3%), reaction to medication (3%), suicidal (3%), and other (13%)" (p. 236).

Although Richardson's (1987) research provides some insight into the reasons for seclusion as perceived by the patients, the fact that the nurses were not interviewed limits the ability of the reader to fully understand the reasons for seclusion from the staff's perspective. The singular reasons listed in the written documentation could be a function of the charting system as opposed to a simplistic and singular reasoning process used by the staff.

Steele (1993) interviewed nurses in four different mental health settings to explore their attitudes relating to various aspects of the seclusion process. Three of the units dealt with children and adolescents while one facility catered to adults and developmentally delayed individuals. The data showed some differences in the attitudes of nurses between facilities in relation to various aspects of the seclusion process. The nurses (6 registered nurses, 3 counselors) at the first facility were asked their chief reasons for implementing seclusion: "Loss of control and dangerous behavior to self or others" was cited by one nurse as the primary reason for secluding (p. 25). Another nurse commented "I don't hesitate to seclude, but I believe [physical] restraint should always be a last resort." The nurses on this unit praised their unit as 'valuing teamwork . . . [having] a highly cohesive staff . . . and being uneasy and concerned when working with inexperienced staff'" (p. 25). Although not specifically addressed in the study's conclusions, there appear to be consistent values and attitudes about the seclusion practice in this setting. The

statement about feeling uneasy working with inexperienced staff may elude to the questions inexperienced nurse places on the social norms and seclusion patterns within the culture of the unit.

The sample of five registered nurses at the second setting in Steele's (1993) study responded to questions about their feelings regarding the use of seclusion in a less unified manner. For example, one nurse commented, "'I like the idea of 1 to 1, but its just not feasible'" while another said "'I'm sure seclusion makes them more aggressive'". A third nurse implied she was uncomfortable about the use of seclusion by some of the staff when she stated "'I would like more audits done to see what the staff did before confining'" (p. 26). Several comments were made by this group of nurses expressing concern for what the patients must think about decisions to use seclusion. This is in keeping with the surveillance theme that Mason (1997) discovered in his ethnomethodological study of nurses' decision-making processes.

No questions relating to seclusion were asked at the third setting since the practice had been discontinued prior to the commencement of Steele's study. The nurses at the fourth facility (2 registered nurses, 2 licensed practical nurses, 2 technicians, 1 counselor) stated they used time out frequently, but did confine patients only if they engaged in actual acts of aggression. One nurse commented "'past history is very important in my opinion to decide how long they stay [secluded] and how quickly you initiate it. I feel justified in secluding [a patient] if other clients say they are anxious or afraid'" (Steele, 1993, p.26).

The response of this nurse also corresponds to themes resulting from Mason's (1997) ethnomethodological research study of nurses' decision-making process. The "mechanistic search" theme included the rapid decision to seclude based on prior experience (referred to as the knowledge at hand in ethnomethodology). Also, the nurse's "asylum status" theme was evident as an attempt was made to provide rationalization for the use of seclusion based upon a moral decision to seclude a patient in order to reduce the other patients' feelings of anxiety or fear.

The Need for Ethnomethodological Study of Seclusion

It is evident in the majority of research studies that very little literature actually pertains to the reasoning and decision-making process nurses use in relation to seclusion. Even when the researcher has asked for the reasons why seclusion occurred, the methodology of the study has not provided a forum for proper analysis of the reasoning process. The great differences expressed by patients and nurses with regard to the precipitants for seclusion episodes underscores the complex and subjective nature of the decision-making process.

The use of questionnaires, surveys and retrospective chart analysis oversimplifies the nature of the nurse's decision-making process and creates an illusion of singularity in the nurse's reasoning. Given this, it is little wonder that a myriad of patient and staff variables have provided inconsistent findings and contributed very little to further our understanding of the phenomenon.

An editorial by Randell and Walsh (1994) denounced the practice of seclusion, but also highlighted the weaknesses of nursing research on the topic:

> The literature on seclusion, based largely on retrospective studies, provides little support for this intervention and at best represents conflicting evidence. Data on secluded patients offer no consistent profile of those likely to require seclusion. In some situations males appear to be secluded more frequently than females but in other situations the reverse is true . . . Race sometimes appears to make a difference . . . and at other times it does not. Diagnosis, legal status, type of institution . . . [also produce] no consistent profile of the patient likely to be secluded. Not only does no consistent profile exist, but the variables identified above are solely descriptive and cannot be altered (p.3).

Since no definitive empirical findings have been achieved using the research techniques employed by nurses and others investigating seclusion, Randell and Walsh (1994) concluded seclusion is unwarranted. This argument actually underscores the inadequacies of the research

methods that have aimed to produce causal variables in an oversimplification of the decision-making process for seclusion. It also highlights the naiveté of some critics who believe nursing practice must be able to be substantiated in singular and absolute terms, even when complex factors are at play.

The benefits of utilizing an ethnomethodological framework to better understand the decision-making process of nurses regarding seclusion seem apparent if one acknowledges the complex factors affecting the nurse at the time the decision is made. According to Mason (1997), the prior research has not explored the state of the decision-maker (the nurse) as he/she coexists with the patient in "a complex interplay of situational dynamics" (p.782). The goal then, of truly understanding the decision-making process for nurses as they choose whether to seclude, is to uncover the inner tensions that arise in the dynamics of the seclusion decision. Mason believed an ethnomethodological approach was the appropriate means to elevate the nursing research pertaining to the seclusion decision.

Ethnomethodology: The Conceptual Perspective

Harold Garfinkel, the sociologist who founded the field of ethnomethodology in the 1950's defined it as "the investigation of the rational properties of indexical expressions and other practical actions as contingent ongoing accomplishments of organized artful practices of everyday life" (Garfinkel 1986, p. 11). This definition is certainly complex and overwhelming to those unfamiliar with the field. Various followers of Garfinkel have attempted to simplify a definition of ethnomethodology that is meaningful and simple. An ethnomethodologist named Livingston (1987) however emphasized the complex, enigmatic nature of ethnomethodology when he stated, "'nothing is as hard, and nothing is as wrong, as offering a definitive answer to the question what is ethnomethodology?'" (cited in Mason 1997, p. 782).

Leiter (1980) described ethnomethodology as the study of commonsense knowledge by means of studying the processes of sense making that people use to construct and maintain the

social world and its factual properties. Put another way, ethnomethodology involves describing how people put together social situations in such a way as to give each other evidence of a social order.

A social situation and its appearance are the product of the participants' ways of perceiving and acting within the given situation rather than something innate to the phenomena (Bowers, 1992a). Therefore, within a nursing context, ethnomethodology addresses the shared meanings and ways of being which are taken as commonsense practices by nurses (Bowers, 1992b). To those who are not participants or actors in this shared social order it may be difficult to understand subtle meanings, valuings and reasonings shared by those within the situation. Therefore, the visible actions and routines that are normative and commonplace to a nurse working in a psychiatric unit can only be understood from within the context of that specific environment at that given time.

Unlike traditional sociological models, ethnomethodology is framed within a phenomenological perspective. This means ethnomethodologists do not seek to explain phenomena in causal relationships and literally defined concepts. When the logical requirements of causality and literal description are applied to social phenomena, they distort the phenomena (Bowers, 1992a). For example, when a psychiatric nurse decides a patient needs to be secluded, the reasoning process which lies beneath the surface cannot be evaluated by merely identifying visible variables which may be incidentally present (Mason, 1997).

Heritage (1984) emphasized that causal models require every event to have an antecedent. Every change must have a cause. However, social events and phenomena are not networks of caused events, nor are they able to be accurately described as such.

Bowers (1992a) emphasized the need to recognize the interactional, interpersonal and environmental context of all nursing actions studied within nursing research. Bowers cautioned against attempting to seek definitive descriptions, valid for all time, within the social order of

nursing activities. He stated that it is impossible to reach an absolute description of a social activity since any attempt to operationalize variables is condemned to failure before it starts. "Any such operationalizing is dependent on descriptions of social actions which have a static sense. The status of nursing research (or sociology) as scientific depends upon this neutral production of valid social facts . . . it cannot lay claim to the status of empirically produced facticity" (Bowers 1992a, p.64).

Ethnomethodology shows that the seeming objective reality of the social world is a result of individuals' showing, displaying and orienting themselves to that reality. This creates the appearance of a stable social order that is evidenced in the methodical, routine ways people go about their daily activities. Instead of the social order being an imminent essence permeating throughout all daily activities, it is accomplished by the organized and ordered social actions that occur daily. Social order is something which is constructed, tested, maintained, altered, validated, questioned, and defined together by individuals separately and yet simultaneously in an odd communion (Bowers 1992a).

Researchers using ethnomethodology often refer to the subjects as the participants or actors. The researcher is the observer, since the researcher is removed from the social world and the meanings it has for those acting within it (Heritage, 1984). The social world that interests ethnomethodologists is the "commonsense world" with its current idealizations as ready-made and meaningful beyond questions for the actors. According to Schutz (1978) there are three phenomena to be considered in commonsense knowledge: the stock knowledge at hand, the natural attitude of everyday life (the sense of social structure), and the practices of commonsense reasoning.

The stock of knowledge at hand. The large body of general knowledge that one has acquired is referred to as the stock of knowledge at hand. This includes the body of knowledge that nurses acquire both through education and through experience. Much of the experiential knowledge is actually received from others who share it with their colleagues (Bowers, 1992a).

The transmission of stock knowledge can be seen in nursing settings as new employees learn "the ropes" from other nurses who are already socialized to the norms. The bits and pieces of stock knowledge can acquire multiple meanings as they are used in different contexts. Thus, such terms a term as "acting out" when used by psychiatric nurses can describe a multitude of behaviors in different contexts. For example, acting out could refer either to a cathartic effort in a psychodrama group, or to a behavior that is considered dangerous and leads to seclusion. Without knowing the context in which the term acting out is used, the situational meaning is removed (Leiter, 1980).

The natural attitude of everyday life. This second phenomenon of commonsense knowledge occurs as individuals experience the social world as a factual environment that they experience in an intersubjective manner (Garfinkel, 1986). They are participants in the world and they have a sense that the world will go on even without them. For this reason, one's existence in the world is taken for granted. Although particular doubts are from time to time entertained, they are never global doubts of the world as a whole (Leiter, 1980). People tend to address the world and its objects pragmatically, dealing only *with* those aspects of the world which are relevant to them at that particular time. Therefore, people are able to negotiate through daily activities in the world knowing that the world remains largely stable and their place within it certain and factual. "The natural attitude of everyday life is treated by ethnomethodologists as a specification of people's sense of social structure" (Leiter 1980, p.9).

Commonsense reasoning. The significance of commonsense reasoning lies in the link it provides between the stock of knowledge at hand and the natural attitude of everyday life. Through commonsense reasoning people are able to create and sustain the sense of social reality as a factual environment. People use their commonsense reasoning in order to pull out appropriate pieces of the stock of knowledge at hand in order to deal with a given situation. This means that commonsense reasoning helps individuals know what pieces of their stock of knowledge to use, and the meaning of that knowledge within a given context (Leiter, 1980).

The Goal of Ethnomethodology in Research

Ethnomethodology strives to understand the social reality of individuals and how it is that this reality is created and sustained. It is not the goal of the researcher to judge the correctness or validity of the social reality, but to understand the underlying practices and meanings that sustain it (Garfinkel, 1986). Therefore, multiple social realities can exist without one being right and the other being wrong. The ethnomethodologist does not critique the validity of one's perceptions of a social reality, but attempts to study how that perception is produced (Leiter, 1980).

In terms of the practice of seclusion, the goal of research using this conceptual framework should be to understand the commonsense knowledge (and commonsense reasoning specifically) that created and maintains social reality by making the decision to seclude or not seclude. The ultimate decision whether or not to seclude is not important in itself: It is the process of making the decision that is the emphasis of the research.

Ethnomethodology in Nursing Literature

The need to incorporate ethnomethodology into nursing research was addressed by Bowers (1992a). However, there are still very few nursing researchers who have used this conceptual framework in order to uncover the underlying norms and reasoning that propagate commonsense nursing practices.

In the realm of psychiatric nursing, Bowers (1992b) studied the socially constructed events that occurred when a nurse (the subject) made a home visit. The study found the subjects (nurses), as visitors in the patient's home, recognized a contextual environmental difference between meeting the patient in the home versus in the hospital. This meant the subjects drew upon their stock of knowledge relevant to guest and host conduct in order to make visible their sense of order in the situation. The dynamics of power were altered as the patient (host) took leadership, and the nurse (guest) only took the lead in matters which both participants saw as medico-psychiatric in nature.

The importance of commonsense knowledge and its impact on nursing practice can therefore be highlighted and clarified through the process of ethnomethodological inquiry (Garfinkel, 1986).

Mason's (1997) Ethnomethodological Analysis of the Use of Seclusion

Mason's (1997) research was the first study to explore the seclusion process from an ethnomethodological perspective. This research study was very important since it signified a potential turning point in the examination of the question -- why do nurses seclude patients? Through the use of this model, Mason was able to verify the complex dynamics of commonsense reasoning which are present in the phenomenon.

Mason's (1997) study was conducted in a forensic psychiatric hospital in Great Britain. According to Mason, seclusion was traditionally used as a last resort at this institution when other interventions had failed. The staff recognized a cultural expectation within the facility to ensure a safe working environment to avoid the risk of harm to staff or other patients (Mason, 1997).

Mason's (1997) sample consisted of twenty-five randomly selected registered nurses in the facility who routinely made decisions whether to seclude patients and who volunteered to participate in the study. Each subject was asked to read two scenarios that portrayed psychiatric patients who "were mentally deteriorating to the extent that they could be perceived as becoming a problem" (Mason 1997, p. 782).

After reading each scenario, subjects were asked for their decision as to whether or not to seclude. Their decision was noted, and they were then asked to explain why they came to that decision. Notes and audiotapes recorded the subjects' comments, which were then analyzed. The subjects reviewed their data by means of the researcher asking them to revisit certain comments they made and to reflect on possible reasons for making these statements. This first-level reasoning analysis done by the subjects demonstrated that they used their past experiences (knowledge at hand) to provide a framework for analyzing the immediate situation. The second-level reasoning analysis in this study was done by the researcher. Since Mason was also an employee at the same

hospital, he was also a socialized agent of the organization and could interpret the subject's responses within the framework of the institution's cultural normative patterns (Mason, 1997).

Mason's (1997) findings were analyzed using an ethnomethodological conceptual framework. In general, a great deal of conflict was evident as the nurses sought to arrive at an appropriate decision. It needs to be reinforced that both the decisions to seclude and not to seclude are reasonable decisions in that they both can be satisfactorily rationalized. Therefore, Mason's published study did not report the actual decision made by the subjects. Three themes emerged from the study: mechanistic search, frame conflict and asylum status.

Mechanistic search. The term mechanistic search referred to the rapid process and decision the nurses used when deciding whether to seclude an individual based on a given scenario. Following the rapid decision, the subjects used their stock of knowledge at hand to pull from their experiences. Past experiences seemed to be an important aspect of the mechanistic search (Mason, 1997). Some examples of comments made by subjects typifying this theme were "'you've got to watch yourself here . . . if he injures himself overnight and you haven't done anything . . . well . . . you're finished' and 'he's done it in the past . . . it's attention seeking . . . ignore him'" (pp.783-784). During the mechanistic search phase, subjects considered the functional role of the institution and paid homage to both the generalized mode of the social reality within the hospital, and also to the ethos of the nursing profession. However, conflict arose when the written policy regarding seclusion did not correspond to the expected, routine working practices. Since the overt and covert operational policies and patterns differed, the subjects were placed in a position of conflict. The rationalizations given by the subjects are a product of a checklisting system (or 'indexes') whereby the subject weighed the pros and cons of each possibility in order to make a decision that lessened the potential for criticism (Mason 1997, p. 786).

Frame conflict. Mason's (1997) term frame conflict referred to the subject's awareness of being judged based on the decision. These subjects attempted to balance the benefits and risks

associated with making a decision. They ultimately made a decision which was least likely to produce criticism from others. This frame conflict worsened when the subjects realized they were in "no win" situations since a decision that pleased one onlooker would bring criticism from another. The subjects therefore decided which external audience they were most concerned to please. The subjects mentioned a diverse range of onlookers who they perceived as scrutinizing their decision. These included the patient, work colleagues, other staff groups, the patient population, relatives, doctors, managers, and Mental Health Act commissioners. Some comments which reflected this frame conflict theme included "'some of your colleagues will think you're soft if . . .'; 'management will remember . . . long memories . . . no promotion'" (Mason 1997, p.784).

Asylum status. The theme of asylum status referred to the subject's tendency to adopt a decision that placed him/her in a position of safety. This meant a moral, professional or legal framework would be adopted to provide justification for the decision. Several examples of subject responses that exemplified this were "'professionally, there may be allegations' . . . 'but as a professional I could justify myself' and 'I think I would ask myself, did I act right?. . . you've got to sleep at night, haven't you?'"(Mason 1997, p.785). Mason (1997) concluded that the research suggested that the decision to use seclusion was based the interplay of cultural and organizational factors

Chapter Three

Methods

Design

This qualitative study used an ethnomethodological research method in order to uncover the decision-making process of nurses as they decided whether or not to implement seclusion. The ethnomethodological approach, originated by the sociologist Garfinkel in the 1950's, was aimed at studying how people in everyday settings reason and formulate their actions (Garfinkel, 1986).

It is an assumption of ethnomethodological inquiry that the everyday, commonsense, actions of people are a means of maintaining a social order (Leiter, 1980). Another important assumption of this approach is that the commonness of everyday actions does not mean that these actions are uncomplicated (Mason, 1997). In fact, it is the recognition of the hidden complexities in reasoning and meanings that underlie people's commonsense actions, that is the focus of ethnomethodology (Bowers, 1992a). Mason stated it is the fact that commonsense actions are reflexive and culturally determined which gives them such a rich interpretive power.

In ethnomethodology, an understanding of the culture being studied, and the commonsense actions being taken, can be both potentially helpful and confining. An awareness of the context of the commonsense action is extremely important in order to understand the meanings embedded within the subject's social world (Bowers, 1992a). Therefore, a researcher who is familiar with the social context in which the commonsense knowledge, attitudes and reasoning occurs is better able to decipher the subject's meanings in context (Mason, 1997).

However, the subjective familiarity of the researcher with the social context can potentially make it difficult to objectively extract pertinent data. A researcher who is keenly acquainted with the subjects' behaviors in their social context must deliberately remain distanced and objective in order to recognize the commonsense actions and the underlying commonsense knowledge (Leiter, 1980).

I made the assumption that the benefits of knowing the subjects and the social context where their decision making occurred were a greater advantage than disadvantage for this investigation since the meaning in context would be enhanced. This ultimately assisted me to uncover the commonsense reasoning that was used by the subjects.

Since the use of seclusion is a sensitive issue for most nurses, and nurses may be concerned about how their decision to seclude or not seclude will be perceived by others (Mason, 1997), the willingness of the subjects to be forthright in their responses depended upon their trust in the researcher. In my opinion, a researcher with whom the subjects were familiar, and who was not associated with the subjects' facility at present, most likely provided a balance between comfort and distance. This in turn, enhanced the likelihood of fully candid responses from the subjects. However, there remained a possibility that the subjects may have altered their responses in some manner due to a concern about how the researcher perceived them and their responses (Leiter, 1980).

Since this study closely replicated Mason's (1997) ethnomethodological analysis of the use of seclusion, the findings from the initial work needed to be recognized and bracketed, so as not to influence my data collection and analysis (Talbot, 1995). If the situations and meaning in context between the current study and Mason's (1997) study were similar, some transferability may have been possible. Thus, it was very important to remain objective and impartial in the data analysis to assure the validity and trustworthiness of this research (Talbot, 1995).

Trustworthiness

An attempt was made to enhance the trustworthiness of the study in several different ways. The subjects already knew me, and vice versa, so it was somewhat easier to establish credibility. Prolonged engagement was established by having several brief contacts with the subjects prior to data collection and then meeting with the subjects on three separate occasions to collect data. The subjects each read the transcriptions of the vignette interviews to ensure the transcripts were

accurate. They also had an opportunity to explain any statements that appeared ambiguous to me from these first interviews. The follow-up interviews provided me with a chance to state my understanding of the subject's interpretation of their decision-making process. The subjects were able to provide feedback to validate the accuracy of my interpretation. In an effort to provide better transferability of the results, the description of the context and the subjects themselves was made as rich as possible.

A research log and an audit trail was maintained. The audit trail reflected the rationale for all decisions made throughout the data analysis and it enhanced the confirmability of the findings. Finally, an experienced researcher, my advisor Dr. Sally Decker, discussed data analysis issues with me and provided guidance and validation for numerous decisions throughout the study.

Setting and Sample

The selection of an appropriate setting and subject sample was an important consideration for this study. Mason's (1993) international comparison study of seclusion revealed that Canadian and British concerns about seclusion focused on the moral/ethical issues related to its use. This was somewhat different than the American literature that demonstrated an emphasis on the legal ramifications of using seclusion in the United States (Mason, 1994). Therefore the underlying values and concerns of psychiatric nurses in Great Britain may have corresponded more similarly with those of Canadian nurses. Also, in my opinion, working in socialized systems of health care perhaps created similarities in the commonsense knowledge and attitudes of nurses practicing within Canada and Great Britain.

The cultural component of the psychiatric unit was a key consideration in the replication of this ethnomethodological study. That is to say, Mason's (1997) findings were more likely to be transferable to situations aimed at maintaining social order based on similar commonsense knowledge. I suspected that Canadian subjects were more likely to have shared similar underlying

values and beliefs as Mason's subjects. For these reasons, a Canadian setting was sought for the current research.

This study took place in a forty-bed inpatient psychiatric unit in an urban general hospital in Southwestern Ontario, Canada. I already knew this facility, and the nursing staff employed there. I had an understanding of the culture of the unit based on first hand experience (as an employee for seven years) and as an outsider (as a nursing faculty who supervised student nurses on the unit for three years). This knowledge of the social order of the unit enhanced my credibility and the likelihood that I was able to provide an accurate interpretation the meaning in context.

Although the selected setting was not a forensic unit, the number of violent patients admitted to the unit has increased since the closing of the region's provincial psychiatric hospital two years ago. The nurses on the unit cared for individuals with a mixture of diagnostic categories including personality, affective and psychotic disorders. The unit was locked during the nighttime hours, but usually unlocked during the daytime. There were four seclusion rooms on the unit. The rate of seclusion varied with the patient population, but typically at least one or two patients were in seclusion at any given time.

During the daytime, the unit was staffed with a charge nurse, six registered nurses functioning as case-managers, and three to six registered nurses who provided direct care to the clients. At night, the unit was staffed with two to four registered nurses. All of the full-time nurses were female diploma graduates with at least ten years of experience working on the unit. None of the full-time registered nurses had nursing degrees or psychiatric nursing certification, nor were any of them in the process of acquiring these credentials.

To a large extent, the nurses learned their psychiatric nursing skills on-the-job and through specific training courses provided to the staff in the form of in-services. Therefore, much of the commonsense knowledge had been passed to new employees through the culture of the unit. Also, since there have been no nurses hired full-time within the past ten years, the nursing staff has been

relatively constant for an extended period of time. However, there have been ongoing lay-offs of nurses, and support staff over the past several years. At the time of the study, the unit had no male psychiatric attendants, but did have access to hospital security personnel who reported to the unit if called. The unit's staffing numbers varied somewhat with the client acuity levels and census.

There was a cultural expectation and policy that the nursing staff ensure a safe, therapeutic, least restrictive milieu for all clients. Seclusion was used to prevent harm to clients or staff, to maintain a therapeutic unit milieu and to prevent the elopement of an involuntary patient who would not willfully remain in the hospital. It was viewed as a means of containing clients until such time as chemotherapeutic agents took effect and the individual was no longer a threat to self or others. Physical restraint was held as a last resort if the seclusion resulted in client behaviors that could be injurious to the secluded client. The secluded individual was checked every fifteen minutes, and assessed at least once a shift to determine whether the seclusion could be discontinued.

There was an implicit expectation that the nursing staff should use seclusion only when necessary, but also that the nursing staff needed to provide a safe, therapeutic environment for the other clients. The nurses did not feel that management provided any direct or indirect cues regarding the use of seclusion: It was accepted as commonplace activity that was not particularly scrutinized by others.

Research Study Proposal

A copy of the research study proposal and consent was submitted to the University and Hospital Institutional Review Boards. The proposal was reviewed and accepted by the S.V.S.U. Review Board with a minor modification in the subject selection process. The Hospital Review Board unconditionally accepted the proposal. The consent form is provided in appendix A.

Subjects

The subjects for this study were purposefully selected to include five registered nurses who were routinely placed in the situation of deciding whether or not to initiate seclusion. Nurses who had worked on the unit for a minimum of ten years were sought since they were believed to have been fully socialized to the unit's social norms and seclusion practices.

The unit's nurse educator compiled a list of registered nurses who met the criteria of having worked at least ten years on the unit, and who routinely made decisions about whether or not to seclude. Fifteen nurses met these criteria. The nurse educator of the unit sent this list to this writer. I sent a letter to each of the fifteen nurses explaining the research study and asking them whether or not they would like to participate. Each of the fifteen letters also explained that each participant would receive a gratuity of $20.00 (Canadian) if they were randomly selected and then participated in the study. Those wishing to participate were requested to return (in an pre-addressed, pre-posted, envelope) a one-page response form indicating their desire to participate. They were also asked to write their preferences regarding location and times for interviews as well as the phone number and address where they wished to be contacted.

Eight nurses returned envelopes indicating their interest in participating. Five names were randomly selected from those nurses who returned a statement of interest. The five subjects were individually notified via a telephone call that their name was randomly selected. They were encouraged to ask any questions they had about the study and again asked whether they wished to participate. Each selected subject was informed that they had the right to withdraw from the study at any time.

The three nurses who were not selected to participate, but who had expressed an interest, were informed via a telephone call that they could choose to remain as back-up participants if one of the randomly selected nurses decided not to participate. Two of the three nurses decided to remain as back-ups. One of the two back-up nurses was randomly selected to participate after one

of the original five subjects withdrew from participation at the time of the initial interview. There were no further withdrawals from the study after the data collection began.

Procedure

The subjects each responded, in writing (in their returned envelopes) and verbally, that they preferred to be interviewed at work, and in their own offices, as opposed to during non-work hours or in a different location. At a mutually agreeable time, the subjects met individually with me and began the vignette portion of the interviews. A semistructured interview was conducted with each subject in either his or her own office or a private office on the unit. An explanation of the purpose of the study and procedure for data collection was reiterated to the subjects. They each signed consent to participate in the study and were informed they had the right to withdraw their consent and participation at any time. However, only those subjects who completed the vignette interviews and the follow-up interviews would receive the $20.00 gratuity.

Prior to having the subjects read the vignettes (included in appendix B), they were reminded that there were no right or wrong answers to the vignettes, and the study was aimed at learning how the nurses arrived at their decision, not what the actual decision was. A tape recorder was turned on as inconspicuously as possible, and the subjects were asked to read the first of two case vignettes. Each vignette depicted a psychiatric client who was seemingly decompensating to the extent that he/she could be perceived as disruptive to the milieu. After reading the vignette, the subjects were asked to describe the decision-making making process that they used to arrive at a decision (whether it was to seclude or not).

A deliberate attempt was made to avoid any demonstration (verbally and non-verbally) of the appropriateness of their responses. The subjects were allowed to continuing speaking until their commentary was exhausted. The responses of the subjects were probed when necessary to prompt the subjects to critically analyze and describe their decision-making process. The same

procedure was repeated using the second case vignette. The interviews for the second vignette occurred within one half hour of the completion of the first vignette interview.

A tape recorder was utilized to capture the subjects' responses while I took brief written notes of any significant non-verbal communication. Mason's (1997) procedure did not include an audiotaped recording of the interviews, but I believed as suggested by Talbot (1995), that the inconspicuous use of a tape recorder enhanced the accuracy of data collected without stifling the subjects' responses. The recorded material was transcribed into type for a comparative analysis of all the subjects' transcripts. The vignette response tapes were erased after the data analysis was completed. I read the vignette interview transcripts numerous times. Any recurrent patterning, including phrases and decision-making factors, in each of the subjects' responses was noted. Both ambiguous and significant statements were highlighted in different colors in the transcriptions.

Another round of interviews, the follow-up interviews that would create the first-level reasoning analysis, was scheduled with all of the subjects. These interviews occurred from six to eight weeks following the initial interviews. Again, the subjects were asked to select a time and location for their individual interview: They all chose to be interviewed at work during work hours.

The purpose and procedure for the follow-up interviews was explained to each subject. These follow-up interviews were also audiotaped and brief field notes were written to document non-verbal communication and incidental notes. Each subject was asked to read the transcripts to confirm the accuracy of the transcriptions from the first round of interviews (responses to case vignettes #1 and #2). After the subjects had read and accepted the vignette transcriptions, I asked them to clarify any statements they made which were unclear to me.

The first-level reasoning analysis began when I asked each subject to reflect upon the reasoning process they used to make their respective decisions. The subjects were asked to elaborate on specific statements from the transcripts that I believed appeared to be significant in

their decision-making process. This probing often took the form of asking the subjects to revisit significant comments they made. I then asked them to reflect upon possible reasons for their statements. The subjects were asked to explain what factors had influenced their decision-making process. The subjects were again permitted to speak until they had exhausted their commentary. Again, I deliberately avoided showing any reaction, positive or negative, to the responses the subjects provided.

The audiotaped recording and field notes were transcribed to a written text. This text constituted the first-level reasoning analysis. When the data analysis was completed, the audiotapes were erased.

Interpretation of Data

The method of accomplishing the first-level reasoning analysis in this study very closely replicated Mason's (1997) approach. Each subject was presented with a typed transcription of his or her responses to the two vignettes. Each subject was cued by the researcher to reflect upon their reasoning process and to attempt to explain their own decision-making process. When I was done probing the subject's first transcript, the same process was used to explore the underlying decision-making process used during the second vignette. The subjects' responses were audiotaped and then transcribed into a typed text labeled as "follow-up interviews". Therefore, the first-level analysis was taken directly from the subjects' own words, as recorded in the follow-up interview transcripts.

Although, it was originally intended that a second-level reasoning analysis would immediately follow the first-level analysis, this did not occur. The first-level reasoning analyses that the subjects provided did not appear initially to have any common threads. A second-level reasoning analysis was not possible until I had a better appreciation of underlying patterns in the subjects' responses. The transcripts of the first-level analysis were reread numerous times, and dwelled upon, for a three-month period. None of the subjects made the same decisions, or used the

same rationale for their decisions. None of the subjects appeared to be particularly insightful as they articulated their decision-making process.

Finally, after doing a sentence-by-sentence comparison of the structural components of the subjects responses, it became apparent that each of the subjects patterned their responses in a highly similar manner. Time was then spent developing and completing a structural analysis for each of the subject's transcriptions for the first and second vignette.

The structural analysis was performed using the following method. Each subject's transcription was read numerous times before I began to identify the underlying structure of the responses. Next, the function of each sentence spoken by the subject was noted and written in the margin. Some of the words used in the margins to describe these functions included; clear decision, supporting reasoning, "what if. . ." statements, reinforcing statements, indecisiveness, other possibles, unfolding and playing out decision, justification and conclusion. This process was done for each of the subjects' transcripts. Similarities in the structuring and organization of the responses became apparent.

The words written in the margin that described the function of the subjects' responses were extracted and labeled as "functional statements". The functional statements consisted of the following terms; instantaneous response, factor identification, hypothetical statements, justification, visualization and summary validation. The sequencing of the functional statements was written down to correspond to each subject's response for each of the two vignettes. This produced ten structural frameworks. The structural frameworks consisted of the functional statements arranged in a specific order to reflect the organization of each subject's response for each vignette.

The structural framework for the first vignette was compared to the second vignette's structural framework for each subject. Then it was compared to the structural framework of the other subjects' responses. This analysis revealed the structure and organization of the responses

was extremely similar between all subjects. The tremendous similarity in response structure was significant especially when considering the actual decisions were extremely different (no two subjects arrived at the same combination of decisions for the two vignettes).

Although the structural analysis provided some insight into a decision-making process that was shared amongst the subjects, it was not very contextual in nature. The difficulty I was having finding a common thread between the responses of the subjects was discussed with my advisor, Dr. Sally Decker. At her suggestion, a languaging analysis was attempted.

The process I used for the languaging analysis included the following stages. From each subject's transcripts the nouns, adjectives, verbs, and phrases were identified: Nouns and adjectives in each transcription were highlighted using a marker, verbs were underlined, and phrases were circled. An adjective, noun, verb and phrase list, labeled as a vocabulary summary, was constructed for each transcription. The vocabulary summaries were examined. This revealed that each subject used many of the same nouns, adjectives, verbs and phrases when responding to each of the two vignettes.

The vocabulary summaries were then compared between subjects. Words and phrases, which were used by more than one subject, were underlined. This enabled me to identify common words and phrases that were used by all of the subjects. Finally, the vocabulary summary was reread numerous times. This enabled me to recognize patterns in the subjects' vocabulary usage that may be reflective of shared commonsense knowledge, attitudes or reasonings. The rereading of the vocabulary summaries also permitted me to identify apparent omissions in the vocabulary selection amongst all of the subjects.

The audiotaped recording of the interviews was replayed, and I listened attentively to the manner in which the subjects spoke during the interviews. The pattern of speech (such as flowing, or fragmented), the intonations, and the flavor of the communication (such as relaxed, guarded or

anxious) was noted. The incidental notes that I made during the interviews (which included notations about non-verbal communication) were compared to the spoken voices on the tapes.

An important notion in ethnomethodology is the limitation of the literal language to communicate actual meaning (Leiter, 1980). This is largely due to the tremendous impact of culture and its norms upon meanings in communication. For this reason, a deliberate attempt was made to consider meaning in context when I was doing the languaging analysis.

Since I was familiar with the social context and cultural norms of the unit, it was possible for me to complete a second-level analysis. The second-level reasoning analysis for this study entailed critically examining the first-level reasoning analysis, the languaging analysis and the structural analysis within the context of the unit's culture.

Since the goal of the second-level analysis was to uncover the hidden relationships, attitudes, beliefs, and social norms that are embedded below the surface of the subjects' responses, a fair bit of time and critical reflection was required. The second-level analysis occurred in three phases. The linkages within the first-level reasoning analysis, and between the first-level reasoning analysis and the structural and languaging analyses were mapped out and highlighted. Secondly, the significance of relationships that the subjects had with other individuals was considered. This was done by reviewing the former analyses, and reflecting on my personal knowledge of the context, in order to establish any linkages. Finally, the attitudes, beliefs and social norms that played a role in sustaining the unit's culture were considered. Long periods of time were spent dwelling on the data before the patterns emerged.

Throughout this process, an ethnomethodological framework was consistently used to assess how social order was maintained through the commonsense knowledge, attitudes and reasonings of the subjects. The findings that emerged from this study were compared to Mason's (1997). Finally, a determination was made regarding whether any transferability of Mason's findings was present.

Chapter Four

Findings

Overview of Data Analyses

As one may recall, Mason's (1997) data analysis consisted of a first-level reasoning analysis and a second-level reasoning analysis. In the first-level reasoning analysis, Mason (1997) cued the subjects to do their own analysis of their reasoning process. The second-level reasoning analysis was his interpretation of the meanings embedded within their first-level reasoning analysis.

In this present research study, the first-level reasoning and second-level reasoning analysis methods that Mason utilized were closely replicated. However, in order to gain a fuller understanding of the nurses' decision-making processes, two additional methods of analyzing the data were used. These additional two methods were aimed at uncovering the process and content of the subjects' responses. The process, or specific stages which the subjects used to respond to the vignettes, was examined in a structural analysis. The ways in which the subjects expressed themselves, verbally and non-verbally, was addressed in the languaging analysis.

The structural and languaging analyses combined with the first-level reasoning analysis provided me with a richer contextual understanding. This enhanced my appreciation for the context and provided me with an excellent framework on which to engage in the culminating method of analysis -- the second-level reasoning analysis. In the second-level reasoning analysis, an effort was made to expose the commonsense knowledge, attitudes, and reasonings embedded in the first-level analysis.

As previously mentioned, the ability of the researcher to view the behavior and responses of the subjects from within the subjects' social culture is one of the greatest strengths of ethnomethodology (Mason, 1997). Therefore, the knowledge that I already had of the people, the environment, and the culture of the unit, was a tremendous asset in the second-level analysis.

Structural Analysis

The decision-making process was analyzed structurally with the intention of deciphering the steps involved in making a seclusion decision. An assumption was made that the verbal responses of the subjects corresponded to their thought processes. Therefore, the verbal discourse and matter of fact responses of the subject were assumed to be representative of their commonsense reasoning processes.

The structural analysis revealed that the decision-making process was comprised of a series of stages. The six stages were labeled instantaneous response, factor identification, hypothetical statements, justification, visualization, and summary validation. All of the subjects incorporated all six of these stages into their responses although there was some variation in the sequencing of some of the stages. However, all subjects began their responses with an instantaneous response, they each ended with summary validation, and they used the other four stages (occasionally in slightly different order) throughout the midcourse of their responses. The following descriptions of each stage reflect the six stages used by the subjects during their decision-making process.

Instantaneous Response

After reading the vignette, all of the subjects responded almost immediately by stating their decision (such as "yes, I would seclude" or "no, I would not seclude"). This response appeared to be stated automatically, almost like a reflex action, and said in a matter-of-fact way. The remaining stages appeared aimed at supporting the instantaneous decision, regardless of what it happened to be.

Factor Identification

Each subject highlighted factors from the vignette that were pertinent to him or her in arriving at their decision. Specific passages from the vignettes that each subject considered to be particularly relevant were usually recited aloud by the subjects. All of the subjects mentioned a

safety or environmental comfort aspect that they believed needed to be considered. Other factors which were discussed by one or more subjects included medication compliance, ability to accept direction, ability to negotiate appropriately, ability to comply with rules, effect on other patients, and legal status of the patient. Subjects identified a prime factor in this stage that was of key importance to them. All of the subjects identified different prime factors. These prime factors will be further discussed later in the first-level reasoning analysis.

Hypothetical Statements

Hypothetical statements were then presented by each of the subjects. The number of hypothetical statements provided by each of the subjects varied, but all subjects provided at least two examples of these "if . . .then . . ." type responses. Again, no two subjects presented the same hypothetical statements in this stage.

In my opinion, the hypothetical statements appeared to have two purposes: they permitted the subjects to consider alternatives and to define conditions or parameters. An example of a subject considering alternatives was evident in the statement "if you just leave him sit there [then] he might settle down on his own." The second purpose, presenting conditions or parameters, was apparent in the statement "if they were in jeopardy [then] I may have to change that reasoning".

Justification

In the justification stage the subjects offered statements to support their initial decision and to refute other possible decisions. These supporting statements were said as matter-of-fact truths, although no literature, nursing theory, or other theory was presented to substantiate the credibility of these statements. It was evident in follow-up questioning that most of the truths stated in this justification stage were the result of the subjects' experiences.

Statements provided in the justification stage were of two types: positive and negative cases. The positive case statements provided commonsense truths to verify the appropriateness of the decision. Negative case statements focused on defeating alternate decisions by providing truths

that would not support that decision. The subjects consistently used more positive case justification than negative case justification.

Positive case justification examples. The following examples of positive case justification were taken from the transcriptions.

"If he's secluded in his room, then he'll take medication better than if he has the freedom of walking around in the halls and in the lounges"

"It may be possible to talk to her - she's not angry- just pestering."

"You're not going to reason with this girl...I'd lock her based on the fact she's not going to listen to you"

"Sometimes they're testing you ...it takes [seclusion] to settle them down..."

"I wouldn't use a lot of words...she doesn't care about all the reasons why or why not you're getting them for her."

Negative case justification examples. The following negative case justifications demonstrated how the subjects defeated a possible alternative decision due to a commonsense truth that did not support an alternative nursing action.

"I would not necessarily lock her because that may just further her angry behavior."

"You try and negotiate with them sometimes, but sometimes that can just feed into their behavior and it gets out of control."

Visualization

The next phase in the reasoning process involved the subjects' visualization of how their initial decision would unfold and be played out. This stage in the reasoning process appeared to allow the subjects an opportunity to mentally play out the consequences of their decisions.

The visualization stage allowed the subjects to validate or modify their decisions. If they visualized the consequences of the decision playing out favorably, then the subject felt satisfied that they had made the best decision. However, if the decision did not play out well, the subject would

have to revisit the decision. The importance of this visualization stage was apparent in the following subject's response.

> "Yeah, I'd leave her alone -- (a 30 second pause; looking at the vignette sheet, the subject appears to be thinking deeply about the situation) "You're not going to reason with this girl" (Another 30 second pause and more thinking) "I start looking at it, you're not going to be able to reason with her, you're not going to -- she's been in and out of people's rooms -- yeah, maybe I would lock her . . ."

This subject changed the initial decision after she decided "you're not going to be able to reason with her". Of note is the choice of words that the subject used to describe her change in thoughts: "I start looking at it . . ." This implied that the subject was visualizing the unfolding of her decision silently during the 30 second pause. When the visualization did not play out satisfactorily, apparently due to the subject's concern that the vignette client would not be able to accept the reasoning given to her, the subject chose to make a different decision. This subject then repeated the visualization stage to determine whether the new decision would unfold satisfactorily. The new decision to lock the client was then played out by the subject. At this point the subject included positive case justification: "Simple as that. I'd lock her based on the fact that she's not going to listen . . . Who knows what rooms she is going into and what kind of problems she could run into in other rooms. She may not be a danger to anybody else, but somebody else could be a danger to her . . . No, this one I'd lock . . ."

Summary Validation

The final stage in the decision-making process was marked by an assuredness and a reaffirmation of the decision. This summary validation only occurred after the subject had successfully visualized how the decision would be played out. An example of summary validation is evident in the above response "No, this one I'd lock". The word "no" seems like a strange prefix for the concluding statement, but it appears to mean there is no question or uncertainty remaining

at this point, despite the subject's uncertainty earlier in her response. The summary responses for other subjects included such statements as "Well, that's what I'd do anyway"; "There again, I can't lock her up just because . . . " and "my preference would be not to lock her . . ."

Languaging Analysis

In the structural analysis, primary attention was given to uncovering the organizational patterns of the response. However, in the languaging analysis, an effort was made to examine the actual words, phrases, intonations, and the ways subjects expressed themselves.

Each subject's pattern of response, and style of communicating was consistent throughout their responses to each vignette. While each subject was cooperative and appeared conscientious in their approach to answering the vignettes, the pattern of communication and the expression of non-verbals was distinctive for each subject.

Subject #1 appeared guarded and tense, subject #2 appeared relaxed and open, subject #3 appeared cautious and controlled, subject #4 appeared uncertain and insecure, and subject #5 appeared casual and open. The two subjects who tended to be tense in their discourse made decisions not to use seclusion, or to use it only as a last resort. The two subjects who appeared more open in their discourse made decisions to use seclusion more frequently. The subject who seemed uncertain eventually decided to lock one vignette client, but remained unsure what to do with the other vignette client.

The language used by each subject, including word and phrase usage, was compared. That comparison revealed a great deal of similarity in several areas of the subjects' languaging. The words and phrases used, and those which were not used, provided some clues into the unit's culture.

Throughout the vignette interviews, and the follow-up interviews, the subjects consistently referred to the vignette clients as "patients". The vignette clients were also referred to as "the first one", "the second one", "guy", "woman", and "girl". Only twice did the subjects identify the

vignette clients by name. None of the subjects ever referred to the vignette characters as "clients" or "individuals".

Throughout the vignette interviews, and the follow-up interviews, the subjects never referred to themselves, or their colleagues, as "nurses". There was never any mention of the nursing profession, or of professional standards, ethics, or accountability. The subjects consistently used the term "staff" to refer to all of the employees who worked on the unit. One subject did identify the importance of a "safety assistant" (an unlicensed aide), and the need to justify her decisions to "the doctor." Otherwise, all of the subjects used the generic term "staff" to identify the nurses and health-care team members.

The subjects never used the words "care" or "caring" or any derivatives of "care" throughout the entire interview process. No mention was ever made of nursing literature, nursing theory, other theory, or unit/hospital policy. None of the subjects referred to collaborating with, or seeking any input from anyone else who was working on the unit, at the time the decision was being made. However, one subject did state she would tell the next shift's "staff" the problems she had been having with one of patients and then let them make their own decision about seclusion.

There were several phrases that appeared frequently in the transcripts. The most common was "needs to be . . ." For example, one subject stated, "she needs to be confronted . . . she needs to be told . . . she needs to be restricted . . . I'd tell her . . . I'd let the doctor know." The change in wording between how this subject addressed the client and how she would address the doctor was noticeable. Other subjects also referred to clients as having needs -- "she needs to be confronted . . . "; "he needs to have less stimulation . . . "; "he needs medication . . . "; "she needs to be made aware that there are consequences."

The subjects tended to interpret the vignette clients' behaviors from a negative, disengaged perspective. The following examples highlight the somewhat negative characterizations and phrasing used by the subjects when describing the vignette clients: "she's being a nuisance . . .

she's bugging the staff, she's bugging the other patients . . . ", "she's only thinking for the moment and she wants some gratification . . . ", "Brandy is disruptive . . . it seems to be behavioral . . . ", "[the patients] they're testing you . . . some of these people can be difficult to deal with -- especially behavioral problem ones", "try and negotiate but . . . that can feed into their behavior and it gets out of control . . ." and "she's not angry, just pestering".

The only subject who appeared to incorporate the client's perspective into the decision-making process was the subject who appeared to have conflicting thoughts and was uncertain what decision she would make. Subject #4 changed her mind several times before deciding what she would do. She was also the only subject to mention the use of open-door seclusion or time-out (although these terms were not used by the subject).

The following excerpt from the transcriptions reveals this subject's concern for the client and consideration of the client's perspective. "If he were just left alone he might do better. But unlocked in seclusion would likely be best if he would do it. Often just getting alone in that space will help: getting away from all the others who are getting on his nerves. I don't think he needs the door locked though, he just needs some space to himself. He may feel like talking after awhile, but I'd just give him space first."

The other subjects had a tendency to view the effects of seclusion from their own perspective. For example, one subject stated she would hesitate to initiate seclusion since that may increase the patient's "agitation and opposition". However, in the follow-up interview, it became apparent that this subject was also considering the effects of "agitation and opposition" upon herself: "I realize that I'm going to have to deal with them [the client] again tomorrow, so if they get angry at me then that may impact on my ability to work with them again . . . part-timers may never see the same patient again so its easier to seclude them and not have to face them again".

The languaging analysis indicated that the subjects used similar words, and phrases in their responses. Also, the subjects generally shared the same beliefs, attitudes and perspectives

regarding the "patients". The languaging analysis was important in developing a better understanding of the commonsense beliefs and attitudes that were present within the social culture of the unit.

First-level Reasoning Analysis

The first-level reasoning analysis, done by the subjects, assisted me to understand the reasoning of the subjects as they described it. The following excerpts from the follow-up interviews transcriptions depict the first-level reasoning analysis provided by each subject.

Subject #1 analyzed the reasoning process used to make a seclusion decision in the following way: "I needed to determine whether these people were safety risks, but they weren't. Unless they are a safety risk seclusion isn't a consideration . . . When I call [the doctor] to notify him that I've secluded somebody I have to be able to justify why that was necessary -- that their safety or someone else's was in jeopardy . . . [The doctor] may want to work toward discharge, especially if this is manipulative . . ." In her responses to the researcher's probing about the influence of experience in making seclusion decisions, the subject responded "I think they [doctors] all have their own preferences. But once you've worked with them for a while, you get to know them, and know what they would want done . . . Considering the doctor's preferences is important when you are building a good relationship with him."

Subject #2 analyzed the reasoning process used to make a decision about seclusion as follows. "First, I look at what their behavior is and whether it is posing a safety risk to anybody. Second, whether they are taking their meds or not. Third, whether they are escalating or able to accept direction . . . if you can talk to them [patients] and they will accept direction, then you likely don't need to lock them. Usually you can try some other things first - like giving a p.r.n . . .". This subject indicated that prior experiences affected her seclusion decisions: "You learn the importance of getting p.r.n.'s into patients before they really escalate! Like the first one didn't take a p.r.n. and wasn't accepting direction - you can see it [the need to use seclusion] coming."

The first-level reasoning analysis for subject #3 included the following statements. "I attempted to determine the possible reasons for their behaviors and the likelihood that I could negotiate an alternative to seclusion. For the first one, I would attempt to engage with him. If that didn't work, then I'd present the consequences to him in that he would either have to take a p.r.n. medication or go into seclusion. In the second situation, I would hesitate to initiate seclusion since that may cause further agitation and opposition. I would inform the oncoming shift of my difficulties with her and let them make their own decision." When asked what role experience plays in the decision-making process, this subject responded "I believe that less experienced staff would find her behavior more threatening, or they would be less inclined to negotiate, and they may choose to seclude her . . . they don't have the relationship with the patients that I have, so if they are busy and don't have the time to deal with her, or she's not willing to work with them, then I can understand their reasoning . . .". With further probing regarding how the subject's relationship with her patients affected her decision-making process, this subject made the following analysis: "It means that I realize that I'm going to have to deal with them again tomorrow, so if they get angry at me then that may impact on my ability to work with them again. The part-timers may never see the same patient again so its easier to seclude them and not have to face them again."

Subject #4's first-level reasoning analysis included the following statements. "He [the first vignette client] could go either way -- seclude or not. If he was just left alone he might do better . . . Often just getting alone in that space will help -- getting away from all the others who are getting on his nerves. I don't think he needs the door locked though -- he just needs some space to himself." However, without knowing the legal status of the first vignette patient, this subject could not be certain what decision she would ultimately make. This subject vacillated in her decision regarding the second vignette client until she realized the client was involuntary. The subject explained her decision for the second vignette: "Her (the patient's) judgment was poor, she wasn't able to listen to reason and she wasn't able to keep out of others' rooms. She could get herself in

real trouble walking into the wrong person's room. She needed to be protected from that. [Being involuntary] means we have the right to hold her here. It sounds like she's likely manicky and her judgment is poor: She needs us to help her stay safe. Stay out of potentially dangerous situations." This subject indicated that experience played an important role in helping her to understand what patients need: "I'm just more aware how people feel being out-of-control and how they need some space sometimes."

Subject #5's analysis of her reasoning process is outlined in the following statements. "I looked at whether or not they were taking direction or whether some limit-setting needs to be done. Like in the first one, he was really causing problems with his inappropriate behavior and he needed to have some firm boundaries laid out. The second one needed to get the message that eloping from the unit would not be tolerated. They needed to see that seclusion is a consequence of their behaviors . . . You try to negotiate with them, but sometimes that can just feed into their behavior and it gets out of control. You have to know where to draw the line. Where to set limits . . . I know a lot of them have been secluded before, so they know what it its. When you tell them that [seclusion] is the consequence sometimes that in itself will work . . . It's a matter of reinforcing the rules and letting them know they are accountable for their actions." When probed regarding how experience influences decision-making, the subject responded "The longer you're around here, the more you see the same situation and people! Over and over! You learn how to become more efficient, to set clear boundaries and limits on behaviors right away. The next time they're in, they remember . . . It [experience] helps you know when they are testing and when you need to provide limits and consequences."

Summary of the First-level Analysis

Several similarities in the first-level analyses were apparent to me. Each of the subjects highlighted factors that they considered to be of prime importance in making their decision. Subjects also acknowledged that experience played a role in their decision-making process. The

following section will summarize the similarities in the first-level analysis presented by the subjects without attempting to interpret or elevate the analysis to the second-level at this point.

Each subject cited factors that were important considerations in their decision-making process. A safety factor to be considered was presented by each of the subjects at some point in either the initial or follow-up interviews. However, most subjects did not explicitly include safety as a consideration when they were urged to analyze their decision-making process in the first-level reasoning analysis. Subject #1 was the clearest in emphasizing the need for safety assessment. She stated in both interviews "Unless they are a safety risk seclusion isn't a consideration". Subject #2 stated in the follow-up interview "I look at what their behavior is and whether it is posing a safety risk to anybody." In the initial interview, subject #3 alluded to considering the client's "awareness of risks"; Subject #4 stated in the initial interview "she may not be a danger to anybody else . . . but somebody else may be a danger to her . . ."; and Subject #5 included "trying to harm a patient or a staff" as one of her criteria for implementing seclusion in response to probing from the researcher.

Prime Factor

For each subject, a single "prime factor" most prominently influenced the subject's decision-making process. Although each subject was influenced by the same prime factor in both vignettes, the prime factor varied amongst the subjects so that no two subjects stated the same prime factor. The prime factors cited by the subjects were safety risk, the patient's willingness to take medication, the patient's ability to negotiate appropriately with the staff, the patient's legal status, and the patient's ability to comply with unit rules.

Key Experience

Each subject indicated that experience played a role in his or her decision-making process. "Key experience" was the label I gave to the experiential event(s) which the subjects believed influenced their current decision-making process. The key experiences, like the prime factors,

varied from subject to subject. The key experience which each subject presented were knowing what the doctor would want done, seeing patients who refused medications begin to escalate, learning how to negotiate with patients, realizing the need to have time to oneself, and knowing when to setting limits on behaviors.

Second-level Reasoning Analysis

The second-level analysis permitted me to interpret the meanings embedded in the subjects' responses from within the context of the unit's culture. This was done by critically analyzing the contextual significance of the subjects' statements to reveal the hidden, social norms and attitudes that were grounded in the subject's responses.

Reasoning Linkages

The researcher examined the first-level analysis that was provided by each of the subjects. The prime factor and key experience were of great importance in the decision-making process used by each of the subjects. In my opinion, the key experience actually influenced the reasoning process of the subjects in two ways: The key experience influenced the factor selection for each subject, and then provided a rationale to support the subject's decision. For example, subject #2 focused on the prime factor of medication compliance. The key experience she cited was the relationship between failure to take medication and rapid decompensation and the need for seclusion. Hence, this key experience pushed the subject toward assessing medication compliance and then justifying seclusion based on her experience with individuals who were not accepting medication. The prime factor and key experience were integrally related and were important in creating and maintaining the "commonsense truths" which each subject used as cornerstones in their decision-making process.

Commonsense Truths

I developed the term "commonsense truths" to label the taken-for-granted, unquestioned beliefs that each subject had. In ethnomethodological terms, these commonsense truths provided

the realities that anchored the subjects' existence, actions and beliefs. They formed the basis for the actions and decisions of the subjects in such a way that actions and decisions were unquestioned by the subjects. Some of the commonsense truths were evident in the statements made by all subjects, while other truths were expressed by only one subject.

All of the subjects' responses revealed a linkage between commonsense truths, key experience, and prime factor. The following response by subject #2 demonstrates this interrelationship. The prime factor selected by the subject was the patient's willingness to accept medication. The selection of this prime factor appeared to be influenced by the subject's key experience. The subject stated that experience has shown her that the need to use seclusion can be foreseen "[when the patient] didn't take a p.r.n. and wasn't accepting direction . . .You learn the importance of getting p.r.n.'s into patients before they really escalate." The subject subsequently stated a commonsense truth regarding enhancing medication acceptance. The subject believed "if he's secluded . . . he'll take medication better . . . he's more likely to take meds when he's in there [seclusion]". Therefore, this subject felt certain that seclusion would be the best decision for the vignette client.

Another example of the linkage between key experience and commonsense truths was evident in the following statements. Subject #5 stated that clients are often trying to "test" the nurse and that seclusion is "what it takes" to settle them down. This commonsense truth was apparently based on this subject's experience with the same clients over a period of time. Key experience had shown this subject that "they remember" during subsequent admissions and she believed the clients were more likely to comply with limits and unit rules in the future.

Commonsense truths appeared to be used to substantiate the appropriateness of the subjects' decisions, but they also appeared to play a role in resolving potential conflicts during the decision-making process. An example of this was when subject #1 (who identified safety as the prime factor) recognized the vignette client may actually become a safety risk if she eloped. The

subject's reasoning became more elaborate as she used a commonsense truth to dismiss the actual elopement risk: "If she was going to elope she would have left some time ago instead of stealing them (money and cigarettes) from other people". Thus, the subject's ability to negate the elopement risk was largely due to her trust in the legitimacy of her commonsense truth regarding the nature of individuals who elope.

A linkage between key experience and commonsense truths was present for all of the subjects. This appeared to make the decision-making process easier for all of the subjects except for subject #4. Subject #4's experiences with seclusion, and the commonsense truths she derived from the experience, possibly made it more difficult for her to arrive at a decision. (This subject had a lived experience in seclusion) It was assumed that both personal experiences and professional experiences of this subject were translated into commonsense truths for this subject.

Subject #4 initially made an instantaneous decision, but when she began playing out the decision and comparing it to alternatives, the process became more difficult for her. She became uncertain. She expressed a concerned that she would "ruin" the research. During the initial interview, subject #4 was noted to frequently stare off at an empty wall in a preoccupied fashion. The subject was given encouragement by the researcher and told that her input was valued and that there were no right or wrong answers to the vignettes. During a follow-up interview, when asked to review the transcripts for accuracy, this subject apologized for being having been "all screwed up" the day of the initial interview. However, the subject presented herself in a similar fashion during the follow-up interviews as well.

No direct mention of the subject's personal experience with seclusion was ever made by the subject or me. When the subject was asked how her experiences affected her decision-making in the vignette, the subject stated she is "more aware how people feel being out-of-control and how they need some space sometimes . . ." The key experience expressed by subject #4 (understanding what it feels like to be out-of-control) was the only time a subject considered the client's

perspective. Understanding the client's perspective by having personal experience with seclusion may have contributed to this subject's awareness that "there's always two sides to consider and sometimes it could go either way . . ."

The subjects appeared to believe that their own commonsense truths were accepted truths for all of the nurses and staff. The following two examples demonstrate how the subjects had different commonsense truths although they were not aware of these differences. Subject #5 stated she believed all of the subjects in this study would use the same criteria for seclusion and that all of the subjects would agree seclusion is appropriate for clients who are "verbally abusive, scaring others, yelling . . ." and so on. However, subject #1 did not accept this belief. Subject #1 emphasized that the only time seclusion is justifiable only if the patient is a safety concern to him/herself or others.

Subject #3 stated the researcher would find a difference between the decision-making of newer, less experienced nurses versus the experienced nurses who were in the study. The commonsense truth underlying this implication was that experienced nurses who've worked on the unit for over ten years would share the same beliefs about seclusion and then make the same decisions. However, as the data later revealed, there were tremendous differences in the responses and decisions made by this group of experienced nurses.

Relations with Others

The nurses in this research study appeared to realize that their decisions would produce an outcome that they believed would be desirable. This meant that the anticipated outcomes from a decision, either to lock or not lock a patient, were perceived by the subjects as having merit that was measurable in terms of the outcomes of that decision. Each subject made some mention of client outcomes. However, probing deeper, using ethnomethodological inquiry, it was possible to understand the hidden outcomes that played a crucial role in the decision-making process.

All subjects made decisions that placed them in a favorable position to receive future benefits in a significant relationship or "core dyad".

Core Dyad

Core dyad is the term I gave to label the most significant relationship influencing the subject during the seclusion decision-making process. While the nurse was one member of the core dyad, the other member of the core dyad varied amongst the subjects. Other dyad members included the doctor, the patient, the researcher and the other patients on the unit. Core dyads will be further explained later in this analysis.

Positive Positioning

"Positive positioning" is a term I created to describe the tendency of the nurses to deal with the matter at hand, namely the seclusion decision, so that the outcomes will be more favorable for the nurse. The specific nature of the positive positioning, and the members of the core dyad, varied with the individual subjects but appeared to reflect an attempt to please the individual(s) who the nurse perceived had the most direct or immediate impact upon the nurse. Thus, while one subject's decision-making was influenced by the need to proceed in a fashion that would gain the doctor's approval, another nurse aimed at seeking the patient's approval. However, the desire to make a decision, which would not produce disapproval at some point in the future, prevailed in the decisions made by these subjects.

Analyses of the Subject's Responses

The following analyses will summarize how the responses the subjects made can be understood from the perspective of core dyads and positive positioning. Additionally, in order to demonstrate the differences between the subject's underlying rationales for seclusion, reference will be made to Gutheil's (1978) rationale for seclusion. The particular rationale that best represents the subject's response will be provided at the conclusion of the following relations focused analyses.

The first subject spoke of a need to be able to "justify" a decision about seclusion to the doctor. This subject appeared to have accepted and implemented rules and commonsense truths pertaining to the use of seclusion: "Unless [a patient] is a safety risk [then] seclusion isn't a consideration". The subject did not appear to experience any inner conflicts while making the decisions, since the decisions were rapidly made according to the subject's safety assessment criteria. When faced with a possible dilemma (an elopement risk), this subject's reasoning became more elaborate -- incorporating the following assumption -- "She is definitely an elopement risk but she isn't threatening to go . . . if she was going to elope she would have left some time ago instead of stealing them [cigarettes] from other people".

Subject #1 made reference numerous times to a need to justify any decision that was made. Upon follow-up questioning, it was discovered that the subject felt a need to be able to justify decisions to the doctor. It appears that the decisions that this subject made were, in the subject's opinion, justifiable to the doctor. The subject's decision was one that would place the nurse in a favorable position with the doctor since the decision was considered "justifiable". This subject also spoke of the importance of experience in terms of learning what the doctor would want done. This nurse indicated that developing and maintaining a good relationship with the doctor was important.

The nurse's actions were aimed primarily at the nurse-doctor dyad with the intentions of preserving a working relationship where the nurse is viewed favorably by the psychiatrist. In terms of Gutheil's (1978) theoretical rationale for seclusion, this subject's decisions relied exclusively on the component of safety.

Subject #2 was concerned the client in the vignette was disturbing the staff and other patients (stated by the subject in that order). Subject #2 stated the client in the vignette was making the environment "uncomfortable." This subject stated the client is "bugging the staff, she's bugging other patients...she's not angry just pestering."

The primary objective of this subject appeared to be to manage the behavior of the vignette clients to establish a quieter, calmer milieu. Seclusion appeared to be a means of quieting the milieu. Seclusion was also portrayed by this subject as a means to achieving medication compliance: "Maybe if you got him locked, then you might be able to get him to take some medication . . . If he's secluded . . . he'll take medication better than if he has the freedom of walking around the halls".

This subject also differentiated between the behaviors of the two vignette patients indicating the second one is "really not presenting as a danger to any of the other patients, she's just loud". The concern for the safety and comfort level of the other patients appeared to be a concern for this subject, and the decisions that the subject made were aimed at producing a favorable outcome to benefit the environment of the non-secluded patients and staff. No mention was made of the environment within seclusion, or the client's perspective.

Therefore, by managing the "disruptive behavior" of the vignette clients, this subject positively positioned herself to be viewed favorably by the other patients and the rest of the staff. The nurse's actions appear to be directed primarily at the nurse-client dyad with the intentions of preserving a non-disturbing environment where the nurse is viewed positively by the staff and other clients. In terms of Gutheil's (1978) theoretical rationale for seclusion, subject #2 was mostly concerned with maintaining a milieu that was therapeutic for the patient population of the unit.

Subject #3 was more willing than the other subjects to bargain with the vignette individuals. This apparent flexibility did produce a positive positioning for the nurse. The decision to attempt to negotiate appeared to be aimed at showing the client that this nurse was actually trying to seek alternatives to avoid seclusion. The subject stated "my preference would be to not lock her if possible". However, in follow-up discussions, the subject readily acknowledged the following shift may "feel the behavior was uncontrollable -- she may be locked". This subject expressed an awareness that some staff members seclude patients much sooner than others: "The

newer staff get scared quicker and would be more likely to lock patients sooner . . . I think you'd find a difference between what the new ones would do versus those of us who've been here a while".

With further probing, it became apparent this subject was supporting the probable decision of the next shift to implement seclusion. Therefore, this subject put herself in a position to maintain a positive relationship and a positive image in the eyes of the patient. The future advantage which would occur for this subject by positioning herself as she did was evident in her statement "I realize that I'm going to have to deal with them again tomorrow, so if they [the individual who may be secluded] get angry at me then that may well impact on my ability to work with them again. The part-timers [nurses on the next shift] may never see the same patient again so its easier to seclude them and not have to face them again". The favorable anticipated outcome for Subject #3 appeared to be a decrease in the likelihood of the patient being angry at the nurse.

The nurse's actions appear to be directed primarily at the nurse-client dyad with the intention of preserving a nurse-client relationship where the client views the nurse favorably. Using Gutheil's (1978) theoretical rationale for seclusion, this subject relied on the principles of containment when an individual's behavior is uncontrollable.

Subject #4 vacillated and had difficulty making a decision for the clients in both vignettes. An immediate decision was made for each vignette, but as the subject verbalized the reasoning process leading to the decision, she became uncertain about the initial decision and wavered. This indecisiveness was pervasive throughout both vignette interviews and the follow-up interview. For example, this nurse stated initially "Yeah, I would put him in seclusion" then modified it to "He needs to go to his room [a seclusion room] but I wouldn't bother locking him" and eventually the subject stated "you could just leave him sit there and he might settle down on his own . . . you could also just try to go for a walk with him - try to find out what he is responding to."

The subject appeared to have conflicted thoughts and feelings that made the decision less clear-cut than the decision-making process of the other subjects. In fact, the subject made several comments about a fear of giving "the wrong answer" and needed reassurance on several occasions that she was a good nurse whose input was respected. For example, after reading the initial interview transcripts to validate them, subject #4 stated "Oh, boy you're not going to want to use this! I'm sorry!" Again reassurances were given that the responses were fine and that there are no 'right' or 'wrong' responses. The subject continued to appear to lack self-confidence throughout the follow-up interview.

In follow-up questioning, this subject indicated that the voluntary or involuntary status of the client was an important consideration since "it means that legally we have the right to hold [the patient] here". The fact that the individual in the second vignette was involuntary was significant to this subject and enabled the subject to finally make a decision. The subject was not clear whether or not the individual in the first vignette was voluntary, and this appeared to make if more difficult for the subject to arrive at a decision in favor of, or against, seclusion. The eventual decision for the first vignette was "it could go either way".

Subject #4 also appeared to use knowledge at hand that evolved from past experiences with seclusion and the mental health system professionally and personally. When asked what role past experience plays in decision-making, the subject responded "I'm just more aware how people feel being out-of-control and how they need space sometimes". This disclosure was followed by the subject staring at the wall for ten seconds, appearing preoccupied with her thoughts, then uncomfortable and uncertain stating "I'm sorry, did I answer that right? Is that what you wanted . . . I hope I didn't ruin this. I hope you can use some of it". The subject appeared genuinely concerned that she may not be providing me with appropriate responses. Reassurances were provided to the subject that there were no right or wrong answers, and that anything she could

disclose would be helpful. The subject's responses left me feeling awkward and this limited the extent of probing during follow-up questioning.

The subject's decision-making appeared to be most directed at providing a response that would be viewed favorably by the researcher. However, since the researcher deliberately avoided any verbal or non-verbal cues that would provide the subject with the feedback and assurance she sought, the subject had a difficult time knowing what response would hypothetically provide positive positioning. This presumably led the subject to change her decision numerous times as she responded. Finally, she decided that the legal status of the vignette client was a safe ground for basing her decisions. Since the first vignette did not specify the legal status of the client, the subject was unable to conclude what she would do and stated "it could go either way".

Therefore, this subject's actions seemed to be directed at the nurse-researcher dyad with the aim of providing responses that would gain positive feedback and the endorsement that the subject is a good nurse. Using Gutheil's (1978) rationale for seclusion, subject #4 viewed seclusion as a respite from the uncomfortable interpersonal confrontations.

Subject #5 made an immediate decision and then provided supporting reasoning to substantiate the validity of the decision. This subject stated numerous times the need to "set some limits" with patients. She indicated that some effort to bargain with the client could be done but she cautioned that the "give-and-take" needs to be controlled so it is "not outlandish".

This subject appeared very open and forthcoming in her comments (she did not know she would be filling in for another nurse until the time of the interview). She admitted "sometimes if you're doing this [making a seclusion decision] at the end of the shift, you and your tolerances are limited and you're thinking more about leaving the shift, but if you're going to be looking after the patient a long time, or even the next day, it's worthwhile to take the extra time [to explain why they are being secluded] . . ." This subject indicated that the client may be "testing you" and that there is a need to use seclusion since "sometimes they're testing you and [seclusion is] what it takes to

settle them down . . . you've got to take charge". In follow-up probing this subject stated "you can try to negotiate with them sometimes, but if they aren't able to do that appropriately, then you have to be firm . . .[and use seclusion] so they understand there are consequences . . .They will come to respect you for being honest with them". This subject indicated that prior experience aided her to recognize the same situations and people over and over. "You learn how to become more efficient, to set clear boundaries and limits on behaviors right away. The next time they're in, they remember."

This subject's activities appeared most directly focused on the nurse-client dyad with the aim of producing a relationship with the client where the client does not challenge the rules of the unit and the nurse is viewed with respect by the client. Using Gutheil's (1978) rationale for seclusion this subject relies on the aspect of confinement. However, this subject also uses seclusion as a means of providing a negative consequence to deter the client from engaging in unwanted behaviors.

Attitudes, Beliefs and Social Norms: Insulated Certainty

The previous analysis focused on the subjects' relations with others during the decision-making process. However, now a change in focus will occur to examine the attitudes, beliefs and social norms that formed the foundation for the subjects' decision-making processes. In order to accomplish this, the first-level analysis, languaging analysis and structural analysis were reviewed critically. As with the previous second-level analysis, my familiarity with the culture of the unit, and of the nurses who work there, permitted a contextual analysis that incorporated my prior knowledge.

Unaffiliated Relations

The subjects in this research study lacked affiliation with others. They did not appear to relate to themselves as members of a team, or even as members of a profession, but rather as individual "staff" who were responsible for the management of their "patients". As previously

identified in the languaging analysis, the subjects never referred to themselves as nurses, or as members of the nursing profession. None of the subjects ever mentioned professional standards, or nursing ethics in their responses. They never referred to any unit or hospital policy, although several subjects did make vague references to ensuring that the vignette client was certified with an involuntary status form prior to using seclusion.

The second vignette alluded to the shift being very close to completion at the time the nurse was to make a decision about whether to use seclusion. Only one subject mentioned the possibility of involving the oncoming shift in a decision. However, during follow-up probing, it was revealed that involving the next shift in the decision would assist the subject to diffuse negative feelings that may arise by initiating seclusion. By relegating the decision to the next shift's nurses, the vignette client would be less inclined to blame the subject for the seclusion. This tendency to consider how decisions would affect the nurse seemed to reflect an overall self-focus which the subjects each had. All of the subjects appeared to make decisions which would be beneficial to them or which they believed were easily defensible.

The lack of interaction between the subjects could be an extension of the attitudes that the nurses shared regarding their roles, and the expectations others have of them. The nurses in the study have all been employed on the unit for at least ten years. However, to my knowledge, the nurses do not maintain social relationships with one another outside of the unit. I would describe the overall essence of the unit as aloof and fearful of change. The familiarity and lack of change appeared to be a comforting niche for the nurses who are employed there. For example, the environment physically has not changed in over twenty-five years. The wallpaper is from the early 1970's when the unit was built: It covers the unit walls with orange and lime-green geometric and concentric shapes. The soiled, cigarette burned, orange cloth chesterfields that line the lounges are also from that era. However, the age and condition of the furnishings appeared to be unnoticed by

those who work there. In fact, it was not until I looked critically at the physical environment that the lack of change (and the level of decay) became apparent.

Routines appeared to have changed little since I first worked on the unit a decade ago. Two of the nurses who were interviewed (subjects #1 and #3) have eaten lunch together from 11:30 until 12:15, in the smoker's cafeteria, virtually every day for fifteen years. The fact that these two nurses need to take their lunch break at that time is unquestioned and is an accepted reality. One of the nurses (subject #4) often eats alone or goes for a walk at lunch. She eats with other staff about half of the time. Subjects #2 and #5 frequently eat together, but also eat with other staff. None of the nurses ever take breaks, except for subjects #1 and #3 who take smoking breaks in the courtyard outside of the unit's lounge.

Despite the fact that several of the subjects spend their lunches together regularly, they do not maintain social relationships outside of work. In fact, the nurses on the unit, have never had a staff party or even dinner out together since the two former units amalgamated into one unit in 1989. Only several members of the staff (attendants, and part-time nurses) ever attended the hospital's annual employee and family picnic. One of the subjects reported that the hospital ceased having picnics three years ago as a cost-cutting measure. This means the hospital no longer sponsors any social activity or dinner for its employees (except for retirees with over twenty-five years service who still receive an afternoon tea in their honor on their last day of employment). Subject #1 receives an invitation and attends annual New Year's Eve parties hosted by the psychiatrist whose caseload she manages. None of the other nurses are invited, and none of the other psychiatrists have ever invited any of the nurses to their parties.

Since the mid 1980's the hospital employees have dealt with annual lay-offs. The nurses in the hospital became unionized five years ago, and this led to complications in the lay-off process. Nurse managers no longer have control over their own budgets and they do not provide input into how they will cut costs. Instead, the sole factor in selecting who will be laid off is seniority.

According to two of the subjects, the budget cuts in 1998 resulted in the lay-off of nurses with eight and nine years of seniority. Future budget cuts will result in the laying-off of nurses who have ten years full-time experience. The union representing the full-time psychiatric attendants who were all declared surplus (and then replaced with full-time minimum wage safety assistants) has litigation pending against the hospital. According to one of the subjects, the nurses on the unit were told not to discuss the situation with anybody.

Although each of the subjects has nursed on the unit for at least a decade, they were concerned they may be given a lay-off notice in the future. In superficial conversations with all of the subjects, each one expressed concern about their future and the future of the unit when the next round of cuts would occur. I ate lunch with two of the subjects the day of the initial interviews. One subject indicated that her husband was at home that day -- he had been declared surplus from the government job he had for eighteen years and this was his first day of unemployment. He apparently was feeling hopeless and frustrated. This subject was concerned whether she and her husband would be able to finance the university education of their two children.

The subjects expressed an awareness that they and the unit culture have changed as a result of the lay-offs. One of the nurses stated "you come in each day and go through the motions -- but its like a part of you has been shut down since this all began". Another subject stated "each year we used to think it (budget cuts) would be over, but now the reality is that it will never be over, there is no such thing as job security . . . We used to have fun times and feel like a part of something - like what we did made a difference. But not anymore . . . Watching good staff be laid off - it was hard at first, now you just think I'm glad its not me!"

Listening to the subjects describe how the work environment has changed over the years, and how they have coped with the changes, led me to speculate that the subjects were operating in a survival mode. They seemed to have minimal emotional connection to their work and also to

their colleagues. Their focus appeared to be more upon themselves and engaging in activities that would provide favorable outcomes for them.

In general, there appeared to be an attitude of inevitability and apathy that permeated the unit's environment. The subjects had minimal interactions with one another and this appeared to accentuate their independent and aloof existence. The subjects reported they are supposed to have staff meetings once a month, but the last one was about 4 or 5 months ago. Two of the subjects were asked whether they were concerned about the lack of staff meetings and the chance to discuss unit issues. One of the nurses stated "No meetings means no changes - and that's good!" The other subject felt the meetings were usually too long and the same information could be shared with a bulletin board directive. She added "This way I don't have to give her (the nurse manager) half an hour to an hour of my [unpaid] time every month!"

In terms of seclusion, the subjects accepted it as part of their job. They did not appear to give its use a great deal of thought. Perhaps, the lack of consideration given to the practice of seclusion could contribute to the lack of review it receives. For example, unlike in Michigan, there is no requirement in Ontario to keep a written record (beyond the client's chart) of seclusion episodes. Therefore, there is no logbook where incidents can be documented and evaluated. Also, there is no expectation that seclusion incidents be debriefed or reviewed by the nurses or staff members.

Four of the nurses were asked if they were ever provided with feedback (and whether they thought it would be useful) from the nurse manager or any colleague for a decision they made about seclusion. They each denied ever receiving any feedback of any type, positive or negative, from the nurse manager, although two nurses reported that evening shift nurses had complained to the primes (day nurses) on several occasions. According to two subjects, several evening shift (part-time) nurses complained they were too busy to initiate seclusion at the beginning of their shift and they preferred the day shift seclude any borderline cases before leaving. None of the subjects

stated they thought there was a need to review seclusion incidents or to work toward increasing or decreasing the number of seclusion incidents occurring on the unit. The attitude of general acceptance regarding seclusion conceivably arose, at least in part, due to the lack of critical review and feedback. The nurses do not appear to believe that there is a need for discussion about seclusion, and they appear satisfied with the practice, as it currently exists.

The subjects' attitudes and beliefs about their peer review appear to extend from a social norm that encourages nurses to practice independently without feedback from others. The nurses do not attempt to collaborate with one another, nor do they typically seek input from outside sources. Therefore, education and professional development are not valued within the nurses' work culture.

Their lack of appreciation for further knowledge was evident in the decisions the subjects have made regarding professional development courses. The only courses any of the nurses have taken are mandatory in-services and annual CPR certification. None of the subjects has enrolled in any college or nursing courses since receiving their nursing diplomas. The social norms and culture of the unit tend to perpetuate this limited commitment for continuous learning activities.

The nurse manager and the nurse educator both earned Bachelor of Health Science degrees on a part-time basis (due to a directive from the management). The nurse manager and nurse educator each have diplomas in nursing. All of the psychiatric attendants (who were laid-off last year) had university degrees in psychology or social work. None of the full-time nurses on the unit have university degrees, although one part-time nurse has a Bachelor of Science in Nursing and two part-time nurses have Bachelor of Education degrees in addition to nursing diplomas.

There appeared to be no cultural expectation that any of the full time staff should earn a degree, however, the nurse educator indicated that she would like to see more nurses attend a conference or seminar outside the hospital at some point (because she had done so and believed it to be worthwhile). The nurse educator indicated that the nurses' responses to the in-services that

she has arranged has been very poor and that staff only attend when it is a mandatory. However, she indicated that making an in-service mandatory irks the staff so she stated that she limits it to only a couple times a year.

Chapter Five

Conclusions

This study examined the decision-making processes psychiatric nurses used when deciding whether or not to use seclusion. An ethnomethodological approach was used to uncover the commonsense knowledge, attitudes and reasoning processes that grounded their decisions. This study closely replicated Mason's (1997) but two additional methods of analysis were incorporated into this current study. These additional analyses, structural and languaging, provided the researcher with the ability to develop a richer understanding of the cultural norms and the social order that was maintained by the subjects' decision-making processes.

The languaging analysis indicated that the subjects shared the same objective realities in relation to how they perceived themselves and seclusion clients. They shared terminology - consistently referring to themselves as "staff" not nurses, and labeling clients as "patients". Patients were characterized as somewhat helpless and needy recipients of "staff" decisions. The nurses had a great deal of power and were comfortable making unilateral decisions that would ultimately provide them with some personal gain.

Social order appeared to be maintained through shared, unquestioned, attitudes about the nurses' roles, the purposes of seclusion, and the nature of patients. In their commonsense world, the subjects created and maintained an idealized existence whereby the nurses functioned within an encapsulated unit where they were isolated from professional growth, and external scrutiny of their actions. In this culture, social order was maintained by a lack of praxis, and an apparent unawareness of nursing's theory and its caring paradigm.

Seclusion, as a nursing intervention, received little scrutiny from the subjects or the management. Subjects indicated they would only use seclusion as a last resort, yet they each had their own set of rules governing its usage. The lack of peer interaction and debriefing regarding

seclusion decisions may have contributed to the illusion the subjects had that their personal use of seclusion was not only sanctioned but exemplary.

The structural analysis demonstrated that although each of the subjects arrived at different decisions regarding the vignettes, they each used the same decision-making stages. All of the subjects initially gave an almost instantaneous response - announcing whether or not they would seclude. This was followed by a series of stages that appeared to be aimed at substantiating the validity of that initial response, whatever it happened to be.

Previous key experiences played an important role in shaping and justifying the decisions the subjects made. The inextricable connection between key experience and prime factor identification was a major factor in the decision-making process for each subject. Subjects each drew from their key experiences with patients and seclusion to identify a prime factor that they considered to be most crucial to assess when making a decision about seclusion. A circular logic was apparent as the key experience and prime factor became focal points in predicting and then supporting each subjects' decision. In other words, each subject's key experience was of paramount importance in determining the prime factor; but then using a corollary logic, the subjects each deduced that their selected prime factor was relevant and justified because they had key experiences to validate its importance. This circular reasoning and justification led the subjects to feel confident and certain that their decision was defensible and correct.

Although each subject selected different prime factors, and each cited different key experiences, there was an internal consistency in the identification of these by each subject. That is to say, each subject indicated they would assess the same prime factor when making a decision whether or not to implement seclusion with either of the vignette clients. As mentioned previously, none of the subjects selected the same key experiences or prime factors. This implies that the subjects responded to seclusion situations in a highly individualized manner whereby the nurse's

key experience was a greater variable than the client's behavior when determining whether seclusion will occur.

The first-level reasoning analysis provided an opportunity for the subjects to analyze their own decision-making processes. The commonplace and routine nature of seclusion decisions appeared to contribute to the matter-of-fact, superficial analyses that the subjects provided. With varying amounts of probing, each subject identified factors and key experiences that they believed were important in their decision-making. None of the subjects incorporated any nursing (or other) theory into their first-level analysis. However, commonsense truths appeared to fill the knowledge void by providing unchallenged facts and trusted realities that gave the subjects a sense of credibility and certainty. The commonsense truths were extremely important in the justification stage of the decision-making process since these truths were capable of sanctioning decisions and negating other possibles. The commonsense truths appeared to be derived from rudimentary attempts to explain key experiences -- especially in the absence of empirical knowledge.

The aim of the second-level reasoning analysis was to expose the underlying commonsense knowledge, commonsense attitudes, and commonsense reasoning inherent in the subjects' decision-making processes. This was done by examining the three previous analyses (structural, languaging, and first-level reasoning) to discover patterns, relationships and linkages that reflected the commonsense life world of the subjects and their decision-making process.

The second-level analysis revealed that the subjects were members of a shared social order or culture. This meant they shared commonsense knowledge, commonsense attitudes and commonsense reasonings. Within this culture, personal rather than collective experiences regarding seclusion appeared to influence the subjects' decision-making most directly. As a culture, the subjects worked very independently and did not seek out assistance, resources or support from others. The lack of interaction between colleagues may be a result of the unit's case

management structure, but nonetheless, the normative behavior was to make seclusion decisions independently, and to avoid critical reflection of nursing practice.

It appeared that the subjects in this study were preoccupied with their job security, and they believed they had endured a great deal of negative changes within the past few years. Some of the subjects implied they were working in an apathetic survival mode and they now dealt with work issues in an emotionally detached manner. Perhaps this contributed to the blasé attitude the subjects had toward professional growth and development. The lack of peer review meant that there was little formalized opportunity to reflect on practice issues and acquire feedback from other nurses.

Comparison of Findings to Mason's (1997) Study

The notion that culture and social norms influence nurses' decision-making processes was supported in both Mason's (1997) work and in this current research study. The commonsense knowledge, attitudes and reasonings that were products of the culture also formed the underlying structure that perpetuated the same culture. In Mason's case, the culture appeared to promote cohesion and a unified frustration, but this current study's culture tended to produce and maintain a culture of individualism and unquestioned nursing practices. As individuals within the culture, the subjects each contributed to the creation and maintenance of the culture: They were both the actors and audience in the life world in which they worked. Their decisions, and the processes they used to arrive at those decisions, perpetuated the culture's ability to maintain social order in both of the studies.

The findings in this study appeared to partially support several specific aspects of Mason's (1997) results. The subjects in Mason's study, and in this current study, responded almost instantaneously to the vignette situations by indicating whether or not they would seclude. It appeared to both Mason and myself that the subjects subsequently attempted to defend that decision which they made so rapidly. Since Mason did not do a structural analysis, the current

study's finding of a six-stage decision-making process could not be supported or refuted by Mason's work. However, both Mason's (1997) study and this current study's findings support the importance of personal experience in influencing decisions regarding seclusion.

The intertwined relationship between key experience, prime factors and commonsense truths was only evident in this current study. Mason did indicate that his subjects did a mechanistic search following their instantaneous decision. This search was a methodical means of justifying their decision, yet specific stages were not uncovered. Possibly, had Mason (1997) done a structural analysis similar to the one done in this study, his findings may have been similar with the findings in this current study.

Benner (1984) indicated that nurses make very rapid, intuitive decisions when they practice at an expert level. Expert practitioners have developed the ability to analyze situations, patterns and significant aspects in a client's presentation very rapidly. They appear to flow effortlessly from the assessment phase into the nursing intervention. It is possible that the subjects in Mason's (1997) were expert nurses and their rapid responses were a function of the automaticity they had acquired. In my opinion, the subjects in this current study did not exemplify the attributes of expert nurses. They were able to make rapid decisions, but they did not appear to recognize all of the contextual elements of the situation. They appeared somewhat rigid and rule oriented at times. These subjects also did not have the professionalism and critical reflection skills that are characteristics of expert nurses.

Mason's (1997) second major finding was a decisional conflict, which he labeled as frame conflict. Mason's subjects agonized over the contradictory messages that they received from the management: Subjects were urged not to use seclusion, but they were criticized when disturbances arose due to a decision not to seclude. In this writer's opinion, the discrepancy between the philosophical ideal and the commonsense reality in the utilization of seclusion led to confusion and frustration for Mason's subjects. This was not the case for the subjects in this current study.

The subjects in this study appeared to have little interaction with the management, and they never alluded to having any explicit or implicit signals sent to them by management, or any external body, indicating a need to reconsider their use of seclusion. This meant that each of the subjects believed their use of seclusion was appropriate. Perhaps, the lack of negative criticism assisted these subjects to rapidly and confidently make decisions about seclusion.

Only one subject in this study appeared to have contrasting thoughts and feelings about what decision to make. This was possibly related to this subject's personal experience in seclusion. In my opinion, the subject's experience in seclusion may have permitted the subject to view seclusion from two conflicting perspectives simultaneously -- that of a nurse working on the unit and that of a secluded client.

In my opinion, experience was the most important influence for all of the subjects in this current study. In fact, the key experience actually appeared to contribute to the doubt and indecision that subject #4 experienced. Therefore, while all of Mason's (1997) subjects experienced a frame conflict, only one subject in this study appeared to have any agonizing conflict regarding what decision should be made. Mason's subjects resolved the 'no-win' situation by positioning themselves in a safe haven position that he labeled as "asylum status."

The theme of asylum status was exemplified in Mason's (1997) study when the subjects sought to avoid the torment of committing to a decision. Rather than being accountable for whatever decision they made, these subjects sought refuge in a legal, theoretical, professional or ethical framework that sanctioned the decision. This enabled the subjects to free themselves from feeling responsible for the outcomes of their decisions since the chosen framework could be used to justify the appropriateness of the decision. The subjects in Mason's study appeared to be making some attempts to avoid negative repercussions for their decisions.

The current study minimally supports Mason's findings of an asylum status theme. One subject, subject #4, the nurse who seemed torn between conflicting personal and professional

feelings, used a legal framework to justify her decision for one of the vignettes. This subject stated she could not make a decision about the other vignette since the vignette client's legal status was unknown. This was the only subject who sought an asylum status in the decision-making process.

As previously mentioned, the subjects in the present study did not feel their decisions were being scrutinized by management and, presumably, did not feel the same need to evade negative consequences. In contrast to Mason's (1997) findings, the subjects in this current study actively sought out positive outcomes for themselves. They appeared to be motivated not by a desire to elude negative feedback, but by a desire to glean positive feedback from the person(s) with whom the subjects had the most immediate or influential relationship.

Hence, from the perspective of positive positioning, the indecisiveness of subject #4 could possibly be attributed to the subject's attempts to receive positive feedback from the researcher rather than an asylum status retreat from accountability. As evident in the transcripts, this subject sought reassurances and affirmation of her abilities frequently from the researcher. However, since I deliberately did not provide any feedback to the subjects regarding their responses, this one subject vacillated back and forth in her decisions. When neither decision appeared to produce positive feedback from the researcher, the subject elected to base the decision on the client's legal status since that could be viewed as an indisputably correct decision which would, in the subject's mind, be received favorably by the researcher.

Overall, the findings in this study show some similarity to Mason's (1997) findings. The subjects in both Mason's study and this current study responded very quickly with a decision and then appeared intent on justifying that decision. The subjects in both studies demonstrated that their own experiences, fears and desires appeared to overshadow the needs and concerns of the clients. The culture and life world of the subjects in both studies appeared to create commonsense knowledge, attitudes and reasonings that perpetuated the decision-making choices the subjects made.

As a researcher who had prior knowledge of the subjects and the unit culture, some preconceived expectations were bracketed before beginning the data collection. However, in reviewing these bracketed notes, it was apparent that the data collection and analysis differed from my expectations.

There was an expectation that the subjects would all make the same decisions and that their reasoning for making the decisions would be largely the same. Several commonsense rules that I had expected to find in the data were not there. For example, there was an expectation the subjects would consider whether the client had been recently secluded (in vignette #1) and the time remaining in the shift (vignette #2) to be pertinent factors influencing their decisions. However, these two factors apparently did not significantly influence the decisions the subjects made -- often the subjects did not even mention these at all.

This writer did not expect the full impact of the commonsense attitudes and truths inherent in the unit culture. I knew the subjects had limited nursing education and professional development, but I had no expectation that the effects of this would be so profound on the subjects' decision-making process. There was an expectation that since these subjects had worked together in the same life world for such a prolonged period of time that they would think and act the same. During the initial round of interviews it was incredibly apparent that this was not the case.

The lack of homogeneity in the subjects' responses was initially baffling. However, it began making sense after the realization came that the cultural norm of the unit did not accommodate peer feedback or critical reflection of nursing practice. The limited professional development also resulted in unexpected revelations in the languaging analysis. For example, the languaging analysis revealed that none of the subjects ever used the words "care" (or any derivative) during any of the interviews. This was completely unexpected.

Ethnomethodology appeared to be the best method of understanding the decision-making process that these subjects used when deciding whether or not to use seclusion. This approach

allowed the commonsense, unquestioned thoughts and attitudes of the subjects to be exposed more fully. Understanding these hidden, underlying structures enabled me to view the decision-making process within the life-world of the subjects. The decisions the subjects made were not simply decisions about whether or not to seclude an individual: they were the commonsense manifestations the unit's culture that contributed to the maintenance of social order.

As Mason (1997) indicated, it is the nurses who create and maintain the commonsense knowledge, attitudes and reasonings that actually create and maintain the cultural norms of a unit. Whereas Mason's subject population appeared to create a culture with social norms that fostered cohesiveness -- this current study did not. The subjects in this study lived in a life world that promoted a culture of individuality and an unquestioning acceptance of nursing practice. Mason's subjects were aware of external political, ethical, legal and professional influences affecting their practice. However, the subjects in this current study shared a life world where they did not appear to feel others scrutinized their decisions – even decisions regarding seclusion.

Further research into the decision-making process nurses use regarding seclusion would be worthwhile since the findings in this study are limited by the small sample size and the particular nature and location of the research setting. It would be interesting to replicate this study in the United States to see how the results differ.

This study brought to light several factors which may influence the decision-making process nurses use when deciding whether to use seclusion. In my opinion, further investigation of these potential variables may be worthwhile.

The subjects in this study alluded to being concerned with their job security. Perhaps, if these nurses felt more secure, they may be more inclined to look beyond their own concerns and be better able to provide care that is client-focused. Perhaps further study of the impact of unit factors such as fears about job security, morale issues, care delivery structure (such as this unit's case management system), could provide the basis for further study.

These subjects had a very limited commitment to professional development. It would be interesting to investigate whether there is any correlation between nursing education or commitment to professional development and the decision-making making process nurses use regarding seclusion.

As previously mentioned, there was no outside monitoring of seclusion incidents in this study although there was in Mason's (1997) study. Further research regarding the effects of more formalized record keeping and documentation of seclusion incidents (as in Michigan) may prove interesting.

Finally, the effect of experience upon decision-making was supported in this study and in Mason's (1997) findings. However, the effect of personal experiences in seclusion upon the decision-making process of nurses remains largely unknown. The one subject in this study who had been secluded appeared to have a different perspective than the others. Further investigation regarding how personal experiences in seclusion affect the decision-making process of nurses would be worthwhile (including pre-planned lived experiences aimed at providing mentally healthy nurses with seclusion exposure).

Chapter Six

Implications

Implications for Practice

In my opinion, several aspects of the findings and conclusions from this research study have implications for nurses in clinical and academic settings. This study indicated that the decision-making process used by the nurses in this study was significantly influenced by a complex array of cultural and experiential factors. The findings also suggest that client presentations are not necessarily the most critical factor in determining whether or not seclusion will ensue. Rather, the nurses' perceptions of their own experiences coupled with the cultural norms of the workplace appear to be instrumental in directing the decisions these subjects made. An attempt will now be made to highlight the implications of this study in relation to the education of nurses.

Decision-making Process

Both Mason (1997) and I noted that the subjects provided an instantaneous response and then appeared to substantiate it through a series of stages that appeared to be aimed at defending the legitimacy of the initial response. The decision-making process that the subjects in Mason's study and this current study used did not indicate the nurses studied the factors or possible options thoroughly prior to announcing their decisions. Even when they did consider possible alternatives, there seemed to be a bias toward maintaining the original decision rather than acknowledging an alternative may have more merit. The reason(s) why the subjects typically did not change their initial decision after reviewing it is not known, but perhaps they were afraid others would not receive the change well or that it would imply an error had been made.

It appears there is a need for educators and clinicians to assist nurses and nursing students to become more attentive to the factors influencing their decision-making process and to discourage hasty, premature decisions about practice issues that have become considered routine. By supporting and assisting others to think more expansively about their options, educators could help

nurses and students to examine all options more thoroughly. There is also a need to reinforce to others that changing an initial decision will not produce negative feedback: it merely demonstrates that the decision-maker is open-minded and making a serious attempt to make the best possible decision.

The subjects in this study seemed to lack insight into their own decision-making process. Prompting and probing by the researcher eventually led to superficial first-level reasoning analyses by the subjects, but it appeared that a discussion about their decision-making process was a new concept to them. Hopefully, discussions about practice decisions and the factors influencing those decisions are not as unconventional to most practicing nurses as it was to these subjects.

Nurses, especially educators, could probe learners to critique their own practice decisions by assisting them to analyze their own decision-making process in a systematic manner. Nurses need to be provided with the skills to critically reflect upon their nursing practice decisions and those made by their colleagues. In my opinion, there needs to be an increased effort to articulate the foundations for decisions in nursing practice rather than simply taking nursing practice decisions for granted in a commonsense manner.

Experiential Factors

The findings in both Mason's (1997) study and this study indicate that subjects' decisions are influenced by their experiences. The relationship between subjects' key experiences and the prime factors they selected to base their decision upon was apparent in this study. The prime factor and key experience appeared to be crucial elements in developing and maintaining commonsense truths. The commonsense truths became honored by the subjects as realities that were beyond question. Benner (1984) stated "the person with limited background knowledge will lack the tools needed to learn from experience" (p.184). The subjects in this study appeared to learn from their experience, but what they learned was often unfounded and untested beyond their own isolated life world. Their limited empirical knowledge appeared to make it easy for everything

they experienced to be understood only within a skewed context that was grounded by the commonsense truths.

Since experience undoubtedly plays a tremendously important role in learning, it is important for nurse educators and mentors to discuss the inferences that a learner extracts from each experience. Benner's (1984) analogy regarding nurses with limited background knowledge lacking the tools required to learn from their experiences (p.184) needs to be clarified somewhat in this writer's opinion. The subjects in this study demonstrated that they learned from their experience, and they even created commonsense truths to explain their learnings. However, their lack of background theoretical knowledge meant that what they learned may not be valid outside of their own life world. Hence, the nurses in this study were equipped with tools for learning, but the tools they had were bent so that the only environment where they could use these tools without the bend being detected was in this culture. Since all of the nurses used bent tools, and there was apparently no standard for comparison, none of the nurses were aware of the inadequacy of their tools. The nurses did not have the caliber of tools needed to move toward nursing practice expertise.

Nurse educators, administrators, and clinicians all have a role in monitoring the quality of tools that assist nurses to learn and develop professionally. They need to be willing to move outside of their own life world to find a standard for comparison. This means they need to objectively evaluate whether nursing practice in their institution relies heavily upon assumptions and commonsense truths. Nurse educators need to examine the learning that students and nurses derive from their experiences in order to determine whether their inferences are well grounded. When there appears to be an over-reliance on commonsense truths to substantiate decisions, nurse educators should carefully examine whether the commonsense truths are filling a theoretical void.

Nurse educators can be a tremendous support for nurses as they attempt to examine their learning process. Creating opportunities for nurses to share their practice experiences, especially

regarding such interventions as seclusion, provides nurses with an opportunity to learn from one another and to recognize each other's interpretations and reasoning processes. Providing nurses with an opportunity to share their thoughts, feelings and attitudes, nurse educators can not only gain insight into the meanings experiences have for learners, but they can also assist the learners to reflect upon the numerous learnings embedded within an experience.

The only subject in this study who was able to consider the client's perspective was the nurse who had an experience in seclusion. This experience appeared to assist the subject to empathize with the circumstances of the vignette clients, and to recognize a potential conflict between personal and professional vantage points.

This implies that opportunities for students and nurses to understand the life world of the client may assist nurses to develop empathy for secluded clients. Experiences such as reading seclusion research, or diaries describing lived experiences in seclusion would be helpful. Whenever possible, discussing seclusion experiences with formerly secluded individuals would assist the nurse/student to more fully understand the perspective of the client. In my opinion, simulated experiences, such as spending time locked in seclusion, would dramatically enhance the nurse's ability to empathize with clients and to analyze their own nursing practice from new perspective.

This study demonstrated that it is possible for nurses to work together for over a decade, and yet work very independently without peer consultation or review. The reasons for the lack of interactions between nurses in this study are not fully known. However, in this writer's opinion, it is possible that the case-management structure, the lack of nursing staff meetings and the lack of expert nursing role models may have contributed. The subjects in this study appeared to lack a nursing identity: they referred to themselves as "staff." In my opinion, the subjects did not feel proud of their profession or even fully affiliated with it.

Nursing leaders should be aware of the importance of providing a forum for nurses to discuss their own practice issues, and professional issues confronting all nurses. By assisting

nurses to realize the similarities between themselves and nurses in other locations, nurses may develop a greater sense of camaraderie and professional identity. They also need to be exposed to expert nurses, and professional role models who could stimulate nurses to build a stronger sense of nursing identity and professionalism. Nurse educators need to be proactive in seeking out resources to support the professional development of all nurses.

The nurses in this study appeared to lack empirical knowledge. As a result, their beliefs and clinical nursing judgment may not have been well founded from a theoretical stance. I suspect this may have contributed to commonsense truths being honored as well grounded, theory-based, realities.

Nurse educators should attempt provide others with readily accessible literature, such as Gutheil's (1978) framework that outlines the theoretical rationales for seclusion. Using this framework as a basis for discussion, educators could assist others to recognize the theoretical principles that may substantiate their practice. In this way nurses may become better able to articulate why they make the decisions they do regarding seclusion. Nursing professionals could also present students and nurses with external, and contrasting sources of knowledge. For example, presenting learners with literature regarding nursing practice in different global cultures could stimulate learners to consider different paradigms. This in turn would possibly stimulate objective critical reflection upon one's own commonsense knowledge, attitudes and reasonings, and perhaps open the door to innovation and change. Hopefully it would create some opportunity to broaden one's perspective.

The majority of nurses working on the unit had worked there for over fifteen years (and many for over twenty-five years). It is assumed by this writer that the long-term employment in this setting may have contributed to the limited influx of new ideas and perspectives. Like a marriage that lost its spark many years ago, the nurses on the unit appeared to take each other for granted as they plodded through their mundane routines.

Nurse administrators, clinicians and educators need to provide stimulation so that peer relationships and nursing care do not become banal manifestations of the nurse's stagnation. Actively recruiting nurses from different backgrounds may be one step toward enriching the social norms of a unit by challenging the status quo. Perhaps nurses could work with management to provide incentives for nurses to transfer to other units to rejuvenate themselves and to rediscover nursing practice beyond the unit walls.

The practice of seclusion appeared to be an accepted, commonplace activity for the nurses in the study. Perhaps, the lack of auditing structures associated with seclusion made the practice seem more innocuous than in other locales. Also, where the study took place, clients who have required seclusion during a previous hospitalization are often assigned to reside in seclusion rooms for their hospital stay (although the door is unlocked and a bed and dresser are wheeled into the room if seclusion is not indicated). This practice makes it very easy to initiate seclusion within minutes and to avoid paperwork and housekeeping issues associated with transferring a client to seclusion. These factors may have made it easier for seclusion to become a commonplace activity for the subjects.

It is important for nurses to monitor the use of seclusion and to educate nurses and all staff members about the significance of seclusion - especially from the client's perspective. Although the government and accrediting bodies did not require a separate logbook to document seclusion incidents, such a book should be developed everywhere in order to track its use. The Canadian practice of assigning clients to seclusion rooms routinely should be examined since it may evoke unnecessarily painful memories for the clients, and it may increase the likelihood that nurses' decisions become distorted by their negative expectations and the ease of initiating seclusion.

Ultimately, there is a tremendous need for nurse educators to assist nurses and students to evaluate the nursing literature and the theoretical basis for seclusion. Nurses should assist one

another to consider the consequences of seclusion upon the client, other clients, family and friends of loved ones who have been secluded, and upon the staff themselves.

Nursing leaders could discuss whether seclusion, as it is currently practiced in this study's setting, is the best way of caring for individuals who are thought to be in need of seclusion from others. Nurse educators and clinicians in clinical settings are in a good position to explore modifications to the practice of seclusion. With innovation and sensitivity to clients' responses to seclusion, perhaps nurses can scrutinize and modify the nursing intervention of seclusion.

The decision-making process that the nurses in this study used provided some insight into the social norms that created and maintain a sense of social order within the subjects' life world. The commonsense knowledge, attitudes, and reasonings that each of the nurses shared supported a culture of individuality and non-reflective practice. The natural attitude of everyday life on this unit differed from that in Mason's (1997) study where the subjects appeared to share more open communication with one another and a greater sense of external influence. Nonetheless, the decision-making process that the nurses used in Mason's and this study served to maintain the culture and social norms inherent in each setting's life worlds. The process of making seclusion decisions that the subjects made were social structures that maintained the culture and the sense of social order.

I believe more research should be undertaken to better understand the phenomenon associated with nurses' decisions regarding seclusion and in regards to the role it plays in maintaining social order. Mason's (1997) study, and this current study, indicate that nurse related factors are perhaps more significant than the client's presentation in determining what decision will be made regarding seclusion. This implies that nursing cultures in each of these settings has developed social norms and commonsense structures that foster a non-client centered focus.

Nursing researchers may discover that further research aimed at uncovering the complex social and cultural factors that influence nurses' decision-making processes may be worthwhile.

Nurse clinicians and administrators may wish to examine the complexity of factors that influence even the routine, commonsense decisions that nurses make daily. Perhaps, evaluating the culture of the unit may give nursing leaders a better understanding of the dynamics that are present and influencing every decision that nurses make within that life world.

More research needs to be done to understand the complexity of decisions regarding seclusion. More effort needs to be directed at articulating why nurses make the decisions that they do. This is especially true of decisions regarding seclusion. Hopefully, in the next century, seclusion decisions in all settings will become consistently client-centered interventions that exemplify a caring nursing culture.

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APPENDICES

Appendix A

Research Study Consent Form

Research Study Consent

I consent to participate in a research study being conducted by Bonnie McKay Harmer of Saginaw Valley State University, University Center, Michigan, which is aimed at analyzing the decision-making process of psychiatric nurses regarding the practice of seclusion. This research will benefit the nursing profession by examining the reasoning processes of highly experienced nurses through an ethnomethodological analysis.

As one of five randomly selected participants chosen form a voluntary subject pool of nurses meeting the criteria for inclusion in this study, I will be asked to respond verbally to two vignettes. This will take approximately ten minutes. Brief written notes may be taken by the researcher, as well as an audiotaped recording, to ensure the accuracy of my comments. The audiotape will be transcribed to a typed transcript and then a brief subsequent interview may be requested by the researcher at a later time to clarify and/or validate the meanings in the transcriptions. I am aware that my identity and my employer's identity will remain anonymous and anything I say will be confidential. Any tape recording or written notes taken by the researcher will be destroyed after the data have been analyzed.

This research study is being conducted independently, with affiliation only to Saginaw Valley State University. Under no circumstance will my responses be shared with any hospital personnel.

I understand that I will receive $20.00 (Cdn.) as compensation for my participation in the study. This money will be paid by the researcher at the end of the study to the five participants who were randomly selected from the subject pool and who completed the interviews. If I do not complete the interviews, I will be awarded $2.00 (Cdn.) for signing up to be in the subject pool. In addition to monetary compensation, a summary of the major findings and implications of the research will be available from the researcher, upon request, at the completion of the study.

My participation in this research study will not have any influence upon my employment and I have the right to withdraw from the study at any time. Any questions or concerns about this research may be addressed to either Bonnie McKay Harmer at [redacted] or Dr. Sally Decker, at Saginaw Valley State University's Nursing Department Office (517)695-5325 Ext. 4145.

Signature of participant _____ Date _____

Signature of witness _____ Date _____

Appendix B

Vignettes

Vignette #1

Assume you are David's nurse. David has been locked in the seclusion room most of the day but the door was unlocked four hours ago. David has been given permission to walk in the hallway and sit in the lounge. For the past hour he has been mumbling frequently to himself and pacing in the hall. You have urged David to take a p.r.n. of his anti-psychotic medication, but David has refused to do so.

David is currently sitting in the lounge, swearing profanities out loud, and tearing pages out of magazines. Other patients have moved away from him, and several patients have left the lounge completely. You have encouraged David to go to his room to settle down, but he has not accepted your direction.

Vignette #2

Assume the shift will change in thirty minutes. You are Brandy's nurse. She is an involuntary patient assigned to seclusion room #25 who has eloped from the unit on two other occasions. Today she is very loud and grandiose in her presentation. Her speech is accelerated and tangential. She has been asking you repeatedly for cigarettes and money. The nursing staff have informed her throughout the day that she has none left, although her family will be bringing some in for her later this evening.

Brandy has continued making pleas to co-patients for cigarettes and money. A patient approaches you and complains Brandy has been going into other patients' rooms when they are not there. When you attempt to talk to Brandy about this, she is uncooperative and swears profanities at you.