

Original Article

Patients' Perspectives on and Nurses' Attitudes toward the Use of Restraint/Seclusion in a Turkish Population

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Abstract

Purpose: This study was carried to determine patients' perspectives and nurses' attitudes to the use of restraint/seclusion in psychiatry clinics.

Methods: The participants included patients who had been previously restrained/secluded and nurses working at the Elazig Psychiatric Hospital. Data were collected for 64 nurses and 80 patients who had been restrained, agreed to participate in the research, and were capable of answering the questions, without any sample selection. To collect data, questionnaire form was used.

Results: Looking at the knowledge and attitudes toward the use of restraint/seclusion, many nurses did not want restraint/seclusion to be prohibited. They were upset when a patient was restrained and regarded patients' aggressive behavior (against themselves, personnel, furniture) as the cause of the restraint. Patients stated that they were upset and felt punished when they were restrained. They thought the reason for the restraint/seclusion was aggressive behavior against other patients or personnel. The patients stated that their needs (nutrition, excretion, etc.) were not met during the restraint/seclusion period.

Discussion: Most of the patients had negative attitudes toward restraint/seclusion and did not consider it therapeutic. As a recommendation, in-service training for reducing the frequency of restraining practice can be given to staff who work in psychiatric services.

Keywords: Nurse, Restraint, Seclusion, Psychiatry, Attitude

Introduction

Restrictive methods such as restraint/seclusion are implemented in psychiatric clinics to prevent inpatients from injuring themselves, other patients, or hospital staff (Whittington, Baskind, & Paterson, 2006). The confinement of patients in an area without their consent to prevent them from leaving their present location is defined as "seclusion" (Happell & Harrow, 2010). Mechanical or physical interventions that restrict patients' movement and bring their behavior under control in an isolation environment are called "restraint" (Busch & Shore, 2000). In the

literature, various definitions indicate that restraint/seclusion is a punitive intervention, a therapeutic attempt, a method for managing patients, and a demonstration of the staff's power (Beck, Durrett, & Stinson, 2008; Boumans, Egger, Souren, Mann-Poll, & Hutschemaekers, 2012; Kontio, Joffe, & Putkonen, 2012).

Nurses in psychiatric clinics often face aggressive patients. The extent of violence in psychiatric clinics is higher than in other clinics (Petit, 2005). Restraint/Seclusion has been a powerful method for ensuring restriction and safety when staff are faced with the difficulty of

managing behaviors that pose a danger to nurses, other patients, or the institution (Presley & Robinson, 2002)). Although the efficacy and ethics of restraint/seclusion are debated, it is still widely used to manage patients and serves as a routine part of daily psychiatric practice (Sailas & Fenton, 2000; Whittington et al., 2006). Restraint/seclusion was found in many studies conducted abroad that nurses support the use of restraint and perform restraint to manage patients' aggression and violence (Duxbury, 2002; Meehan, Bergen, & Fjeldsoe 2004). Restraint/seclusion is regarded by health care workers as an effective method for patients to calm down and feel better, whereas to patients, restraint represents power assertion and punishment. Cangas found that restraint/seclusion was used because of overcrowded services, inadequate patient privacy, and the presence of too many restless and noisy patients in the service at the time (Cangas, 1993). The most common cause found by Usok and et al. and Tunde-Ayinmode and Little has been identified as harm to oneself or others (Tunde-Ayinmode & Little, 2004; Usok, Kora K. et al. 1996). Studies report that nurses support the use of restraint/seclusion (Duxbury, 2002; Meehan et al., 2004; Terpstra, Pettee & M., 2001). In a study conducted by Alty with 64 nurses, the majority argued that restraint is a valuable intervention method and should continue to be used (Alty, 1997). In a study conducted in the United States, there was a positive correlation between the perceptions of nurses and patients, and both groups found these methods safe and beneficial for the patients (Petti, Mohr, & Somers, 2001).

In the literature, the most common indications for the use of restraint/seclusion were posing a risk to others, posing a risk to themselves, and the risk of escaping. Patients feel abandoned and angry after restraint and remember the traumatic events that they had before (Bonner, Lowe, & Rawcliffe, 2002; Gaskin, Elsom, & Happell, 2007). However, patients believed that restraint/seclusion was applied because they refused to take drugs or to participate in treatment programs, but often patients did not know the cause of punishment (Holmes, Kennedy, & Perron, 2004; Mayers, Keet, Winkler, & Flisher, 2010). In a study by Valkama et al. 66.3% of the patients assessed restraint as a punitive method that takes their

freedom away (Valkama et al., 2010). Questioning the restraint experience of patients, patients argued that their basic needs are not met, the staff does not communicate with them, and the follow-up after restraint is insufficient. Patients also argued that they have felt punished when they are restrained and were not informed about the restraint, and there should be alternative methods other than restraint/seclusion (Larue et al., 2013). Looking at the attitudes of previously restrained patients toward restraint/seclusion, they felt alone, rejected, and abandoned. Some patients did not want to talk about this issue and changed the subject; in addition, they expressed that their basic needs (hunger) and security were not met (the lights were off), and the nurse did not communicate with them (Holmes, Kennedy, & Perron, 2004). This reveals that restraint is not a therapeutic intervention but a punitive method, and acts as a catalyst for negative emotions. The excessive use of restraint to reduce disruptive behavior in closed treatment environments reduces the likelihood patients will develop daily life skills necessary to manage the challenges experienced by individuals with psychological disorders outside these environments (Donat, 2005). A study conducted in the Bakirkoy Psychiatric Hospital in Turkey on patients' files reported that 194 of the 810 admitted patients (23.9%) were restrained during 1 month, the average restraint duration was 3.25 hours, and the number and duration of the restraint were moderate compared to those found worldwide. The risk of restraint/seclusion and prolonged restraint increases depending on the female gender, advanced age, and severity of psychotic symptoms. Night and weekend shifts are more risky because of the longer duration of the restraint (Bilici, Sercan, & Tufan, 2013). Debates on restraint practice continue, and restraint/seclusion serves as a routine part of daily psychiatric practice, despite international recommendations (Sailas & Wahlbeck, 2005). Most nurse and patient injuries in hospitals occur during the seclusion and restraint process (Mohr, Petti, & Mohr, 2003). It is necessary to understand nurses and patients' experiences of, and attitudes towards, restraint and seclusion because not only can they influence adoption of these practices, they need to be taken into consideration when devising strategies to reduce or eliminate these measures (Möhler & Meyer,

2014). A limited number of related studies on the subject have been conducted in Turkey, and no study on the restraint experience and attitudes of patients in the study region was found. The data collected during this study should lead to similar studies in the future.

The aims of the present study was to determine patients' perspectives on seclusion/restraint and nurses' attitudes to the use of seclusion/restraint in psychiatric clinics.

Methods

Participants and procedure

Population of this study constituted previously restrained/secluded patients and nurses who work at the Elazig Psychiatric Hospital. This hospital is one of the two hospitals opened January 12, 1925, in Turkey and serves the eastern region of Turkey. Located on 66 acres, the hospital serves 18 provinces in the east and southeast Anatolia Regions with 12 different services, 1,000 beds, and approximately 250 staff (106 registered nurses, 13 physicians, 50 caregiving nurses, and 81 cleaning staff). All nurses were enrolled without a specific sampling method and patients who met the study inclusion criteria. The final study sample comprised 64 nurses and 80 patients who had been restrained who met the study's inclusion criteria and agreed to participate in the study. The inclusion criteria for patients were open to communication and cooperation, diagnosed with mental disorders according to the DSM-V diagnosis criteria, between 18 and 60 years old, and had been restrained 7–30 days before the interview. Exclusion criteria for patients included having other and/or additional axis I mental disorders (drug or alcohol addiction) and organic brain syndrome or mental retardation.

Instruments

The study was conducted as a descriptive study. As a data collection tool was used questionnaire form was first created in accordance with the opinion scanned literature specialist (Duxbury, 2002; Meehan et al., 2004; Terpstra et al., 2001; Beck, Durrett, & Stinson, 2008; Boumans, Egger, Souren, Mann-Poll, & Hutschemaekers, 2012; Kontio, Joffe, & Putkonen, 2012).

The questionnaire included question for eliciting information on the descriptive characteristics of the patients and of the nurses.

A pilot testing of the open ended questions was applied to 3 patients and 3 nurses with interview and minor revisions were made.

The final questions used was: "What did you feel when you have been restrained/secluded?", "What was the reason for your restraint/seclusion?", "What would you suggest as an alternative method for restraint/seclusion?", "What happened during restraint/seclusion?", "What do you feel when patients have been restrained/seclusion?", "What do you think about restrain/seclusion?" The open-ended questions were grouped in accordance with the answers given by the patients.

Data Analysis

Qualitative data were analysed by using content analysis and interpreted in terms of the categories and codes. For the quantitative data descriptive statistics were used.

Ethical Considerations

Before the study began, written consent was obtained from the study hospital, and approval was obtained from the Erzurum Ataturk University, Institute of Health Sciences Ethics Committee.

The research data were collected by the researcher through face-to-face interviews, after informing the patient and nurses about the research, for 20–25 min in an interview room at the clinic. The patients were informed about the fact that their information would be kept confidential and not be used in any other place, and they have the right to withdraw from the study at anytime. Patient was obtained that they voluntarily agreed to participate in the study.

Since the use of human fact in the study requires protection of individual rights, "Informed Consent Principle", "Voluntary Basis" and "Protection of Confidentiality Principle" which are relevant ethical principles were realised.

Results

Of the patients, 72.5% were male, 67.5% were single, and 56.3% were primary school graduates; 77.5% of the patients was diagnosed with psychotic disorders. Of the nurses, 64.1% were female, 81.3% were married, and 59.4% had worked at the hospital for 0 to 5 years.

Table 1: Frequency of patients' perspectives according to the category and code

Categories	Codes	n	%
What did you feel when you have been restrained/seclusioned?	I wanted to hit my head on the wall	10	12.5
		38	47.5
	I was so sorry, I felt punished	12	15.0
	I felt they would kill me	20	25.0
	I wanted to commit suicide		
What was the reason for your restraint/seclusion?	Aggressive behavior against other patients, furniture or employees	70	87.5
	Refusal of treatment	10	12.5
What would you suggest as an alternative method for restraint/seclusion?	Drug Therapy	24	30.0
	Communication	38	47.5
	There is no alternative method	18	22.5
What happened during restraint/seclusion?	Our needs(eating, drinking, toilet etc.) were not met	60	75.0
	Nobody visited	20	25.0
	Nobody explained anything aboutrestrain/seclusion	60	75.0

Table 2: Frequency of nurses' attitudes according to the category and code

Categories	Codes	n	%
What do you feel when patients have been restrained/seclusion?	I am very sorry	42	65.6
	I'm not impressed	22	34.4
What was the reason for restrain/seclusion?	Aggressive behavior against other patients, furniture or employees	40	62.5
	Refusal of treatment	20	31.3
	Attempted escape	4	6.2
What do you think about restrain/seclusion?	Restrain should be forbidden	11	17.2
	Restrain is necessary	53	82.8

Discussion

In this study, many of the patients stated that they were upset and felt punished when they had been restrained/secluded. Negative feelings because of perceived lack of interaction with the staff before, during, and after seclusion/restraint are common (Meehan et al., 2004; Valkama et al., 2010). A study conducted in Australia determined that restraint/seclusion led to a feeling of punishment in patients, patients preferred drugs to restraint, and restraint/seclusion was not considered therapeutic (Schreiner, Crafton, & Sevin, 2004). Seclusion/restraint-related negative emotions often mentioned by patients are anger, helplessness, powerlessness, confusion, loneliness, desolation, and humiliation (Hoekstra, Lendemeijer, & Jansen, 2004). Studies have shown that patients feel abandoned and angry after restraint, and remember the traumatic events that they had before (Forquer, Earle, & Way, 1996). In a study by Walkana et al. many of patients assessed the restraint as a punitive method that takes their freedom away (Valkama et al., 2010). The findings in this study are in line with these findings.

In the current study, many of the patients stated that they thought the reason for the restraint/seclusion was aggressive behavior against another patient or staff and nobody explained anything about restraint/seclusion (75.0%). Studies have reported that patients were mostly not informed about the reason for such practice, and patients often did not know the cause of punishment; however, they believed that restraint was applied because they refused to take drugs or participate in treatment programs (Meehan et al., 2004; Mohr et al., 2003). Donat found in his study that 70% of patients complains about the lack of information and disclosure related to the restraint (Donat, 2005). Patients has stated that communicate may be an alternative method to the restraint/seclusion. In a study conducted abroad the majority of patients has emphasized that there was no alternative method other than restraint/seclusion, and only minority of them has proposed drug therapy (Larue, Dumais, & Drapeau, 2010). The results of our study show that patients do not want to be restrained and prefer communication as an alternative. The restrained patients' experience and the meaning ascribed to the restraint probably affected the communication proposal.

In this study, many of patients stated that their needs (eating, excretion, etc.) were not met during restraint/seclusion. The relatively high number of patients that talk about this issue indicates a finding to be considered since it highlights the importance of the procedure performed during restraint/seclusion. In a study conducted abroad on the attitudes of previous restrained patients towards restraint, it was found that they felt alone, rejected and abandoned, and even some patients didn't want to talk about this issue and changed the subject; and also they have expressed that their basic needs (hunger) and security were not met (the lights were off), and the staff didn't communicate with them (Holmes et al., 2004). Debates on the restraint/seclusion practice continue, and restraint/seclusion serves as a routine part of daily psychiatric practice and will continue to serve, despite international recommendations. It is very important to meet the needs of patients appropriately during restraint/seclusion.

Looking at nurses' attitudes regarding the use of restraint/seclusion, 65.6% stated that they were upset when they restrained or decided to restrain a patient. Restraint/seclusion has significant and harmful physical and psychological impacts on both patients and staff (Fisher, 2003); 62.5% of nurses regarded the patients' aggressive behavior as the cause of the restraint/seclusion. In several studies conducted abroad, restraint was mostly used in cases of harm to self or others, threats of violence, and agitation (Mayers et al., 2010; Meehan et al., 2004; Tunde-Ayinmode & Little, 2004). In addition, it has been pointed out that restraint/seclusion is an important tool at the time of crisis, and hospitals would be more dangerous and unsafe unless they are used (Boumans et al., 2012). 62.5% of the health personnel regarded the aggressive behavior of patients (against themselves, personnel, furniture) as the cause of the restraint/seclusion in this study. It was suggested in a study by Meehan et al. (2004) that nurses apply restraint when patients had an aggressive, violent behavior against staff and themselves. In a study conducted in Australia, the most common restraint indications were reported as posing a risk to others (74%), posing risk to self, and the risk of escaping (Tunde-Ayinmode & Little, 2004).

The most common cause found in the studies by Ucock et al. (1996) and Mohr et al. (2003) has been identified as the harm to self or others.

In this study, 82.8% of the nurses did not want restraint/seclusion prohibited. Studies have reported that nurses support the use of restraint/seclusion (Duxbury, 2002; Meehan et al., 2004; Terpstra et al., 2001). In a study conducted by Alty (1997) with 64 nurses, the majority of nurses has argued that restraint is a valuable intervention method, and needs to continue to be used. Nurses argued that the restraint/seclusion is necessary, not punitive and this procedure is effective for the patients to feel better and calm. In a study conducted by Petti et al. (2001), it has been argued that the patients would be more insecure and dangerous without restraining. In a study by Wynaden et al. the majority of nurses regarded the restraint as a necessary and acceptable strategy in psychiatric services (Wynaden, Chapman, McGowan, Holmes, & Ash, 2001).

Although restraint/seclusion has many negative physical and psychological effects in patients and nurses, it continues to be part of daily psychiatric practice. It is important to inform the patient, apply the restraint as briefly as possible, check on the patient at specified intervals, meet his or her physical needs during restraint/seclusion, and get feedback from the patient after restraint. In addition, comprehensive studies are needed to reveal restraint/seclusion related profile in Turkey.

References

- Alty A. (1997). Nurses' learning experience and expressed opinions regarding seclusion practice within one NHS trust. *Journal of Advanced Nursing*, 25(4), 786-793.
- Beck NC., Durrett C., Stinson, JVA. (2008). Trajectories Of Seclusion And Restraint Use At A State Psychiatric Hospital. *Psychiatric Services*, 59(1027-1032).
- Bilici R., Sercan M., Tufan E. (2013). Psikiyatri Kliniklerinde Yalıtım Ve Bağlama Uygulamaları / Using Of Seclusion And Restraint In Psychiatry Clinics. *Dusunen Adam: The Journal of Psychiatry and Neurological Sciences*.
- Bonner G., Lowe T., Rawliff DVA. (2002). Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK. *Journal of Psychiatric and Mental Health Nursing*, 9, 465-473.
- Boumans CE., Egger JI., Souren PM., Mann-Poll PS., & Hutschemaekers G.J. (2012). Nurses' decision on seclusion: patient characteristics, contextual factors and reflexivity in teams. *J Psychiatr Ment Health Nurs*, 19(3), 264-270.
- Busch AB., Shore, MF. (2000). Seclusion and restraint: A review of recent literature. *Harvard Rev Psychiatry*, 8, 261-270.
- Cangas JP. (1993). Nursing staff and unit characteristics: do they affect the use of seclusion. *Perspect Psychiatr Care*, 29, 15- 22.
- Donat DC. (2005). Special section on seclusion and restraint: encouraging alternatives to seclusion, restraint, and reliance on PRN drugs in a public psychiatric hospital. *Psychiatric Services*, 56 (1105-1108.).
- Duxbury J. (2002). An Evaluation Of Staff And Patient Views Of And Strategies Employed To Manage Inpatient Aggression And Violence On One Mental Health Unit: A Pluralistic Design. *Journal of Psychiatric and Mental Health Nursing* 9 (3), 325-337.
- Fisher JA. (2003). Curtailing The use of restraint in psychiatric settings. *Journal of Humanistic Psychology*, 43(2), 69-95.
- Forquer SL., Earle KA., & Way BVA.(1996). Predictors Of The Use Of Restraint And Seclusion In Public Psychiatric Hospitals. *Administration and Policy in Mental Health*, 23 (6), 527-532.
- Gaskin CJ., Elsom SJ., Happell B. (2007). Interventions for reducing the use of seclusion in psychiatric facilities: review of the literature. *Br J Psychiatry*, 191, 298-303.
- Happell B., Harrow, A. (2010). Nurses' attitudes to the use of seclusion: a review of the literature. *Int J Ment Health Nurs*, 19(3), 162-168.
- Hoekstra T., Lendemeijer H., Jansen M. (2004). Seclusion: the inside story. *J Psychiatr Ment Health Nurs*, 11(3), 276-283.
- Holmes D., Kennedy S., Perron A. (2004). The mentally ill and social exclusion: a critical examination of the use of seclusion from the patient's perspective. *Issues Ment Health Nurs* (25), 559-578. .
- Kontio R., Joffe G., Putkonen HVA(2012). Seclusion and restraint in psychiatry: Patients' experiences and practical suggestions on how to improve practices and use alternatives. *Perspectives in Psychiatric Care*, 48(1), 16-24.
- Larue C., Dumais A., Boyer R., Goulet MH., Bonin JP., & Baba, N. (2013). The experience of seclusion and restraint in psychiatric settings: perspectives of patients. *Issues Ment Health Nurs*, 34(5), 317-324.
- Larue C., Dumais A., Drapeau AVA.(2010). Nursing practices recorded in reports of episodes of seclusion. *Issues Ment Health Nurs*, 31(12), 785-792. .
- Mayers P., Keet N., Winkler G., Flisher AJ. (2010). Mental health service users' perceptions and experiences of sedation, seclusion and restraint. *Int J Soc Psychiatry*, 56(1), 60-73.

- Meehan T., Bergen H., Fjeldsoe K. (2004). Staff and patient perceptions of seclusion: has anything changed? *Journal of Advanced Nursing*, 47(1), 33-38.
- Mohr WK., Petti TA, Mohr BD. (2003). Adverse effects associated with physical restraint. *Can J Psychiatry*, 48:, 330-337.
- Mohler R., Meyer G. (2014). Attitudes of nurses towards the use of physical restraints in geriatric care: A systematic review of qualitative and quantitative studies. *International journal of nursing studies*, 51(2), 274-288.
- Petit J. (2005). Management of the Acutely Violent Patient. *Psychiatr Clin N*, 28, 701-711.
- Petti TA, Mohr WK., Somers JW (2001). Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. *Jul-Sep;14(3):*, 115-127.
- Presley D., Robinson, G. (2002)). Violence in the emergency department: nurses contend with prevention in the healthcare arena. *Nurs Clin NorthAm.*, 37:, 161-169.
- Sailas E., & Fenton M. (2000). Seclusion and restraint for people with serious mental illnesses. *Cochrane Database Syst Rev CD001163*. .
- Sailas E., & Wahlbeck, K. (2005). Restraint and seclusion in psychiatric inpatient wards. *Curr Opin Psychiatry.*, 1(4), 255-259.
- Schreiner GM., Crafton CG., Sevin JA. (2004). Decreasing The Use Of Mechanical Re-straints And Locked Seclusion. *Adm Policy Ment Health*, 31, 449-463.
- Terpstra TL, Pettee EJ., HunterM. (2001). Nursing Staff's Attitude Toward Seclusion, *Journal of Psychosocial. Nursing*, Vol. (2001). Nursing staff's attitudes toward seclusion and restraint. *Journal of Psychosocial Nursing and Mental Health Services*, 9 (5), 20-28.
- Tunde-Ayinmode M., Little J. (2004). Use Of Seclusion In A Psychiatric Acute Inpatient Unit. *Australas Psychiatry*, 2:, 347-351.
- Usok A, Kora K, Bostanci F. (1995) Seclusion in closed psychiatric wards in Turkey. *European Journal of Psychiatry*; 10:149-154.
- Valkama A., Sailas E., Eronen M., Koivisto AM., Lonnqvist J., & Kaltiala-Heino, R. (2010). The reasons for using restraint and seclusion in psychiatric inpatient care: A nationwide 15-year study. *Nord J Psychiatry*, 64(2), 136-144.
- Whittington R., Baskind E., Paterson B. (2006). Coercive Measures In The Management Of Imminent Violence Restraint, Seclusion And Enhanced Observation. In: D. Richter & R. Whittington (Eds). *Violence in Mental Health Settings: Causes Consequences, Management*. New York: Springer Science & Business Media., pp. 145- 169.
- Wynaden D., Chapman R., McGowan S., Holmes CA., Ash PBA.(2001). Through the eye of the beholder: to seclude or not to seclude. . *International Journal of Mental Health Nursing*, 11, , 260-268.