RECOGNIZING REAL-LIFE RERAINT USE

To the Editor:

Restrainment and seclusion. Ask someone who doesn’t actually work in a psychiatric or forensic setting, and they probably conjure up horrifying images of crying little old ladies tied to their wheelchairs or terrified patients strapped to a bed by unfeeling orderlies. Like most assumptions without the benefit of actual knowledge, it would be hard to depict a scenario further from the truth.

I work as a staff nurse in a locked psychiatric unit. I am fairly used to people coming in paranoid and afraid and matter-of-factly sure that they are being persecuted. To quite a few of these folks, a glance or a chance comment is pretty routinely misheard as a threat of imminent violence, to which they respond in a way that is logical to their perceptions: They attack back. I phrase it that way because that is how the patients experience it.

I really appreciated the thoughtfulness of the recent article on seclusion and restraint use in children and adults by Allen, de Nesnera, Moreau, and Barretnet (2014). I think there is a great deal of misperception and misunderstanding about when and how it is appropriate and safe to use restraints and seclusion. I have a favorite story about the real-life use of restraint and seclusion. Identifying details are obscured for reasons of privacy and confidentiality.

On the day in question, a particular patient was back in the psychiatric intensive care (PICU). I say “back” because he had been discharged the week prior with court-ordered instructions to continue taking his medications. There are many reasons that make sense to a patient why a needed medication might be stopped abruptly. Perhaps a family member insisted he was now cured and didn’t need them. Perhaps a friend told him that only weaklings needed medication, and the patient felt it necessary to throw out the medication to save face. Or maybe when he refilled the prescription it was a generic from a different supplier, and because the pills were a different shape or a different color he thought the pharmacy was trying to hurt him. Unfortunately, stopping such medication abruptly hurts the patient. There is a rebound effect where the symptoms the medication was being used to address come back. In spades.

So this patient had been brought back into the hospital after the police found him yelling and threatening and generally scaring the heck out of some people he didn’t know—throwing things and escalating. He needed to be stopped before he hurt someone. Once back in the PICU, he recognized a few of the staff on the unit. He agreed to take his scheduled medications, partly because he knew us, and he was willing to trust that they would be helpful. Today the medications weren’t enough.

That rebound of fear and paranoia that had ambushed him when he stopped taking his medication still gripped him. He was still hearing people talking softly as threats. He was still experiencing people looking at him as the first part of an assault. So he took a swing at a depressed fellow patient, and instead of calming down, he escalated to the point where the depressed fellow patient who started weeping in the lounge and certain that people really are trying to kill him, can struggle enough to flip over a standard hospital bed. This patient was swearing and promising to “take out” the gang member who had assaulted him. In actuality, the depressed fellow patient who started weeping in the lounge and had been so badly misinterpreted had no idea of how his distress was being misperceived.

The misperceiving patient was not willing to accept the additional medications that would help his perceptions be more accurate and help him calm down. So the nurse gave him the two psychiatrist-prescribed injections that had been ordered.

While this was going on, one particular staff member was speaking very calmly to him, telling him that right now, because the patient wasn’t capable of making sure he was safe, the staff members were doing it for him. That our plan was to get him out of these restraints, out of this room, as soon as possible. That we were
there trying to help him, and that we understood he was in an unpleasant state of mind at the moment.

One may think that a patient who has been strapped down and given injections would be upset. And he was, and most patients in these scenarios are, and that makes perfect sense. That’s only part of the story. The medications did their job. His thoughts cleared. He was able to calm down and realize that no one was trying to attack him. He was able to realize where he was, and to remember that if he did feel attacked or even disrespected by a fellow patient, that the staff really were there to help.

Within a couple of hours he was calm enough and in control enough to join his fellow patients and some of the staff in the lounge. One of the first things he did was walk over to that staff member who had been explaining things to him during the application of the restraints. He extended a hand, and the two slapped palms. The patient nodded to the staff member. “Thanks for helping me out, man.”

What makes this story my favorite is that it happens often. At least two or three times a week someone needs more help—medication-and-restraint wise—than they would like. It’s given with explanations—and with respect—per medically accepted practice and per the law. Sometimes the patient can recover in hours. Sometimes it takes days. The whole time, we are there for such patients, answering questions and doing the things that seem scary to them, and often to the family, but need to be done. Checking in with the patients. Asking them how they are doing, what they are hearing, what they are seeing. Making sure that everyone is safe. Sometimes the patient stays angry and doesn’t understand. Often the patient does.

It’s nice to be able to slap that patient’s hand back, and say to him, “You’re welcome. I’m glad you’re feeling better.”

REFERENCE

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The author has disclosed no potential conflicts of interest, financial or otherwise.
doi:10.3928/02793695-20140401-89