Using Restraints and Seclusion to Manage Aggression

I was reading an article about reducing the use of restraints using a trauma-informed approach (Craig & Sanders, 2018), and I had to smile, remembering my first 3 years in the field of psychiatric nursing. There was almost a zero-restraint/seclusion rate where I worked, and there are both good things to learn and cautions to share from my experience.

I started my career in 1976 in a private, 20-bed, open psychiatric unit housed in the “old” part of the hospital, which was separated from the main hospital by a tunnel that was approximately 1/4 mile long. To say that it was not a secure unit would be an understatement. We used the first two floors of an eight-floor building. The unit had an open balcony and open stairwell that went up all eight stories to the unused floors (which were supposed to be locked, but often were not). We had curtain rods and drapes; we served food with actual dishes and real silverware; and every night we served soda in bottles along with other snacks. We could lock the unit doors, but they were rarely locked and did not provide much security as the doors contained glass. We had two seclusion rooms, which were rarely used. I was the charge nurse on the evening shift, and I had one licensed practical nurse, Tina, working under me.

At that time, patients whose aggression could not be managed were committed to the state hospital during the 3 years I worked on that very active unit.

I was fresh out of nursing school and knew little about human behavior and psychiatry, but I had good instincts, I paid close attention, and I had excellent clinical supervision to help mold my instincts into actions. The first thing I learned was that people tended to live up or down to my expectations and that my role in every interaction was the first thing to assess and correct as needed. Patients were not “non-compliant”—I had just not found the right combination of motivation and support they needed or wanted. I also learned that all behavior is functional. People do not behave in ways that do not work—unless they are experiencing psychosis and are not in control, which poses a different set of challenges. However, for most patients on the unit, part of my job was to help make inappropriate behaviors stop and make room for new behaviors.

That was the foundation of my operational paradigm. To make that paradigm work, I learned to “partner” with patients. I learned what mattered to them and used that to help them find motivation for change. I negotiated behavior and rewards. I tapped into universal human needs and taught patients to exchange one reaction for another to “fit in.” I held patients accountable for the agreements we made. Most importantly, I listened and, minus some necessary “bluffing,” I leveled with them.

On the evening shift, there were no therapists, physicians, or support groups; it was just the patients and nursing staff. We spent more time with patients than nurses on any other shift, and as there were only two of us to manage the shift routine as well as unexpected situations, including new admissions, we had to be good at creating a therapeutic milieu to establish and influence boundaries and help patients function within those boundaries.

I had rules for the unit that were designed to create a milieu that would:

- Keep patients and staff safe. That was the number one priority.
- Facilitate self-direction and planned detachment.
- Keep patients moving forward on goals. The evening shift was often the “practice ground” for strategies taught in therapy. Patients could try a behavior or express an issue with other patients, evening shift staff, and, at times, family. I encouraged bad reactions to be seen as “safe practice” and a chance to learn.

We had our fair share of “bad behavior.” Some behavior was simply inappropriate, and some became dangerous. In our open, unprotected ward, that tipping point could come suddenly. We had to be constantly on guard. I learned to operate on instinct. I became good at knowing when someone was ramping up for an outburst, often intervening before it could get that far.

Of course, it was impossible to see and prevent everything. Any time that restraints or seclusion might have been needed I had limited options, which were versions of facilitating patients’ self-control and/or allowing chemical restraint to assist with self-control. In other words, in the environment I worked in with the staffing I had, I
couldn’t “force” patients into seclusion or restraints. I had to entice them.

We did our best with what we had using the milieu to influence patients and provide therapeutic techniques to help patients choose better behaviors than their older, less functional behaviors, offering voluntary seclusion and chemical restraint when necessary. Here are two examples of actual situations where I was able to avoid seclusion/restraint.

**EXAMPLE 1**

A middle-aged woman with major depression was standing at the rail of the balcony threatening to jump. I said:

I’m standing right here, so first you have to get past me, which probably means you’d have to hurt me, and I don’t think you want that. Besides, it’s only one story down. Jumping over that balcony won’t kill you; it will just hurt you. You’ll be in pain, and you’ll make my evening miserable because I’ll have to haul you over to the ER [emergency room] and do paperwork half the night. Why don’t we just go back to your room and talk?

I used this bluff countless times. I, of course, had no idea if patients could kill themselves by jumping over, but I think I was right that it would not be easy. I was 20 years old and did not know what else to do but bluff or use paradoxical interventions long before I even knew what they were.

**EXAMPLE 2**

A 20-year-old man was agitated and pulled a heavy drapery rod off the wall and charged down the hall with it. I said:

You don’t need that to break out. The door is open, and I’m not stopping you. Drop the curtain rod and go. Come back later if you want, but I won’t put up with any threats.

The patient put the curtain rod down. I picked it up and secured it in the nurse’s station. I asked him what was wrong. He said his girlfriend didn’t come for visiting hours and didn’t answer his call from the pay phone in the lobby. He was intent on breaking out and finding her. I got out the Against Medical Advice paperwork (i.e., instructions for patients who were not discharged by their psychiatrist but wanted to leave the unit) and told him his options. I told him that if he threatened me or the patients again, he might as well leave because I’d call the police and have him arrested. I further explained that if he wanted help, and agreed to behave responsibly, that I’d hate to see him go because he clearly had things to work out with his doctor and therapist. He stayed and I don’t recall any subsequent issues.

These examples show situations where my techniques worked to contain aggressive or inappropriate behavior. I found ways to get patients to stop themselves from acting inappropriately, which is preferable to using physical force to contain the behavior. I found that talking about what was happening worked well. I also learned that a substitute was needed; it was never going to work to just say “stop.” Instead, I gave choices, one of which was to tell me what they thought might help if I didn’t suggest anything that resonated with them.

I know that there are times when seclusion/restraint can and should be used safely to manage behavior and protect the patient and other unit patients. I’m not saying they should never be used. I’m simply glad, especially when I read articles on reducing the use of seclusion/restraint, that my training and experience taught me to facilitate patients’ ability to contain their own behavior and not rely on these measures.

**CONCLUSION**

I feel lucky that I entered the field when the environment required me to use my brains to prevent or get out of trouble, rather than have access to an easy means to exert control over patients. That being said, I feel lucky that I didn’t get hurt and that I had great mentoring, which probably helped keep the luck in the right balance. I think all psychiatric units should err on the side of exposing patients to the real world but should not openly tempt fate the way my unit did in 1976. I also think all patients should be taught to make choices to contain their own behavior and not be subjected to external forces unless no other option is available. When seclusion or restraint is used, a complete review of why that option was used needs to be performed to ensure it was the only viable and safe option. It’s far too easy to get scared or turn to the expeditious intervention. In the end, it’s still most important that patients learn to manage their own behavior.

**REFERENCE**


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The author has disclosed no potential conflicts of interest, financial or otherwise.  

doi:10.3928/02793695-20190225-02