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Re-building Trust after Physical Restraint During Involuntary Psychiatric Hospitalization

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ABSTRACT

This study attempted to identify the elements which might best minimize the negative consequences of restriction of inpatients and rebuild therapeutic alliance and trust. Through in depth interviews with 15 psychiatric patients who had experience restrained during the last involuntary psychiatric hospitalization. Analysis of the data revealed three major themes with regard to trust between restrained patient and restraining staff members during restriction of the patient's freedom. Duration of Restriction, Contact with a Staff Member while Restrained, Supportive Interactions and Staff's Response to Restricted Patients' Needs were reported by patients as crucial in determining the way restrained is experienced and its later impact. Physical restraint in psychiatric hospitalizations generates many negative feelings and can even be traumatic. The patients interviewed help us learn how to provide more human and therapeutic interactions even in extreme situations of restrain which can be crucial to rebuild therapeutic alliance and trust.

Literature review

Trust in mental health services

Therapeutic alliance has long been recognized as crucial within the context of interactions between service users and health professionals and is an important element of trust-building (Bordin, 1979; Verhaeghe & Bracke, 2011). A mutual interpersonal relationship based on trust is regarded as vital and one which contributes to effective treatment (Slade, Kuipers, & Priebe, 2002). Trust has been conceptualized as "the belief that service providers will care for service consumers properly" (Verhaeghe & Bracke, 2011). Hence, health professionals must be qualified and trained to attend to the goals and desires of their clients and convey their trust and faith in their efforts and potential progress. Within conditions of uncertainty and vulnerability, trust becomes an even greater necessity. Such conditions may be especially relevant when working with people with serious mental illness (SMI) and supporting their recovery process (Brown, Calnan, Scrivener, & Szmukler, 2009). Naturally the role of trust is even more crucial during extreme situations when restriction of freedom is considered or even activated.

Restricting freedom in mental health services

Restriction of patients freedom by confining them to their room or tying them to a bed occurs in psychiatric hospitals, as a means of controlling challenging behavior typical of certain psychotic states (Whittington, Bowers, Nolan, Simpson, & Lindsay, 2009). People with SMI are more likely than others to experience this type of handling (Happell & Koehn, 2010). These forms of restrain are often in response to violence (Bauer et al., 2007; Whittington et al., 2009) or psychotic symptoms without sings of violence (Keski-Valkama et al., 2009). Severe agitation or disorientation may also be handled by restraint (Bauer et al., 2007; Keski-Valkama et al., 2009). The decision whether or not circumstances justify such extreme measure is complicated, controversial, not always systematically evaluated and often made by physicians (Sailas & Fenton, 2000).

Confinement and restriction, not surprisingly, often have a negative impact on a patient's sense of confidence and trust in their care givers and hinder cooperating with treatment (Jenkins, Bennett, Lancaster, O'Donoghue, & Carillo, 2002) and the system (Cleary, 2003), even when they are strictly used in extreme situations to manage violent and aggressive conduct (Kuosmanen, Hätönen, Jyrkinen, Katajisto, & Välimäki, 2006). Because it entails suspension of basic human rights,

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restriction is usually viewed as negative, harmful and even traumatic (Frueh et al., 2005). It can even be experienced as punishment (Holmes, Kennedy, & Perron, 2004; Keski-Valkama, Koivisto, Eronen, & Kaltiala-Heino, 2010) and is almost inevitably associated with a sense of helplessness, rage, loneliness, confusion and humiliation (Hoekstra, Lendemeijer, & Jansen, 2004). The use of coercion by staff was found to be directly detrimental to the sense of trust (Gilburt, Rose, & Slade, 2008).

In a recent qualitative study in Australia, participants expressed concerns over how restraint resulted in trauma and also how past trauma was sometimes revisited or resonated with the experience of being coerced. The traumatic impact of restraint represents one of the major themes that were apparent across the focus group discussions. Participants identified restraint as nontherapeutic, anti-recovery and an abuse of human rights. The traumatic effects of these practices are long-standing and not limited to an acute or inpatient setting. Participants also recognized specific challenges for Indigenous and culturally and linguistically diverse populations (Prophy, Roper, Hamilton, Juan Jos، Tellez, & McSherry, 2016).

Recent studies seem quite unanimous revealing that restricting freedom is experienced negatively (Larue et al., 2013). For example, in a study by Haw, Stubbs, Bickle, and Stewart (2011), 84% of forensic psychiatry inpatients compared their experience of psychiatric restraint to having been put in a “prison cell,” and believed it was a consequence of disobedience to staff. In another study patients reported feeling the restriction of their freedom was the consequence of bad behavior (Keski-Valkama et al., 2010). It is thus not surprising that inpatients often feel victimized, resentful, and unsure of the reasoning behind the restraint (Ling, Cleverley, & Perivolaris, 2015). In contrast to these negative experiences, A small number of studies and a minority of participants within studies, report less negative and even positive views, such as seclusion providing an opportunity for meditation (Ezeobele, Malecha, Mock, Mackey-Godine, & Hughes, 2014), or that the use of restraint had a calming effect (Wynn, 2004), achieving a sense of being contained, protected and cared for (Brophy, Roper, Hamilton, Tellez, & McSherry, 2016). **Based on the findings of studies, it is recommended that clinicians conduct a verbal interaction with restrictive patients in order to discover the needs of them (Keski-Valkama et al., 2010; Ryan & Happell, 2009).**

In response to the rise of the vision of the recovery and attending to patients subjective experience and protecting their rights, reducing restriction has become a goal of many countries around the world (Chien & Chan, 2005; Frueh et al., 2005; Levinson, 2006; Strout, 2010; Vishnivetsky et al., 2013; Wynn, 2004). In the United States, for example, it has been reported that in Pennsylvania, the phenomenon by 99% (Smith et al., 2005; Smith, Ashbridge, Davis, & Steinmetz, 2015). Similarly, seven other countries, are in the process of formulating plans to reduce or cancel restrictions including Australia, New Zealand, Germany, Ireland, Canada.

In Israel, following a report of a very long-term restriction an inpatient, a lengthy discussion and harsh criticism of the media led to the establishment of a committee to examine the issue of the restriction of psychiatric patients and to recommend ways and programs to reduce physical restrictions (Ministry of Health, 2017). The Committee recommended the construction of an action plan that included two aspects: one aspect relates to conceptual change and a change in the ward climate and the daily interactions between staff and patients. A second aspect relates to determining the inputs required for the system in order to implement the plan. In addition, the committee pointed out a series of complementary strategies that have proven themselves in many Western countries including the provision of good professional alternatives by the teams that will allow access to humane and non-violent channels in challenging situations, while at the same time providing staff members with security.

It is clear from the review of literature that restraint, which has accompanied the mental health system in various forms since its start, usually causes suffering, challenges ones basic dignity, compromises human rights and can be experiences as traumatic. It hurts patient-caregiver relations (Happell & Harrow, 2010; Sailas & Fenton, 2000), particularly damaging the trust a patient in their care provider and the system in large (Slade et al., 2002; Gilburt et al., 2008; Sreenivasan, 1983).

In order to help guide the development of policies and practice reducing restraint it is crucial to explore not only its negative consequences, which have been the primary focus of most studies, but rather also what helps make these situations less negative. To address this, we explored people's retroactive accounts of their experience of restriction with the goal to try to identify factors that influenced the impact of being restrained.

Method

Research design

The qualitative method was chosen for the current study because it encourages an open attitude, unconstrained by rigid theoretical criteria, when identifying the “experience” of patients during involuntary hospitalization (Ungar, 2003). Because little has been written based on the perspective of the patient under restraint, semi-structured interviews were conducted in order to shed light on the themes brought up by study participants as conducive to a sense of confidence in the restraining health professionals during the restraint.

Participants

The sample population comprised of 15 participants. Participants were recruited by convenience sampling in two community mental health clinics providing follow-up services after hospitalization. Inclusion criteria included having experienced restrain during the last involuntary psychiatric hospitalization. After having been informed about the study purpose they signed an informed consent form. All participants were over 18 when interviewed. The average age was 49 (S.D. = 6.9) with a range of 27 to 58 years. The research proposal was reviewed and approved by the ethics committee of Zefat Academic College.

Data collection, method and procedure

An interview guide was developed and used flexibility to assure free expression of the interviewees (Patton, 2002). It included questions about their experience of being restrained and what influenced this experience.

Participants were also encouraged to talk about anything they felt was relevant. The interviews lasted about 90 min and most were recorded and then transcribed and analyzed. Notes were taken in 3 cases when the patients preferred to not be recorded. Analysis was carried out in several stages. First a thorough and careful reading was done so as not to miss any of the nuances of the emotions and perceptions expressed and the attributions to the staff interacting with the patients (Moustakas, 1994). Second, the main themes were identified and later classified in clusters (Shkedi, 2003), and the ties between them examined to form a conceptual model of the world of the participants. In order to check the validity of the study a few techniques were employed – grounding (Lincoln and Guba, 1985) of quotations from the transcribed recordings checked by each of the researchers (Maxwell, 1996); triangulation of onlookers, in order to minimize potential personal biases (Patton, 1980). Two informants, professionals from the psychiatric closed ward who had been interviewed before, were asked to check the analyzed data and give their opinion on its authenticity and validity.