Nursing Staff's Attitudes Toward Seclusion

Seclusion and restraint use in a variety of health care settings has received increased attention in recent years (Canatsey & Roper, 1997; Dawkins, 1998; Dewey & Brill, 2000; Holzworth & Wills, 1999; Ray, Myers, & Rappaport, 1996). Nurses are often on the front line, interacting with patients who may be violent or who display disruptive behaviors, and choosing to use seclusion and restraint as interventions. However, with the growth of the psychiatric consumer movement, society has demanded that people with mental illnesses be treated with the least restrictive methods possible (American Hospital Association & National Association of Psychiatric Health Systems, 1999; Klinge, 1994). In addition, the
Restraint

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growing public emphasis on patients’ rights recently has prompted the Health Care Financing Administration (HCFA) to establish the Patients’ Rights Conditions of Participation (CoP) and has led the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to revise its standards in the area of seclusion and restraint (Kozub & Skidmore, 2001b).

Although there is a large body of literature on the use of seclusion and restraint, only a few studies have focused on the attitudes of staff toward their use (Klinge, 1994; Quinn, Moody, & Maas, 1993; Steele, 1993). Amid the controversy about the use of these interventions and the apparent lack of consistent guidelines for their use, nursing staff often are caught in the middle, needing to care for people who are disturbed or violent in a safe and therapeutic manner, while assuring the safety of the patient, other patients, the environment, other staff, and themselves.

**LITERATURE REVIEW**

Much of the research and literature on seclusion and restraint use with people with mental illnesses has focused on:

- Patient and milieu characteristics that correlate with the use of seclusion and restraint (Canatsey & Roper, 1997; Swett, 1994).
- Incidence and duration of use (Brown & Tooke, 1992; Ray & Rappaport, 1995).
- Reasons provided by staff for using seclusion and restraint (Betemps, Somoza, & Buncher, 1993; Outlaw & Lowery, 1994).
- Safe use and application (American Psychiatric Nurses Association, 2000).
- Patient responses to seclusion and restraint use (Johnson, 1998; Ray et al., 1996).

Staff attitudes toward the use of locked-door seclusion rooms or physical restraints (i.e., leather cuff and belt) also have been studied. Among physicians and therapists, attitudes have polarized over time. Some health care professionals defend that seclusion and restraint should be considered emergency interventions aimed at protecting patients in danger of harming themselves or others, and that they should be used as infrequently as possible. The American Psychiatric Nurses Association (APNA) (2000), in its position statement on the use of seclusion and restraint, emphasized the reduction of seclusion and restraint use and prevention of violent or destructive behavior. The Seclusion and Restraint Standards of Practice (APNA, 2000) gave specific guidance for minimizing seclusion and restraint use, while maintaining a safe environment for patients and staff.

Not all health care professionals consider seclusion and restraint desirable or efficacious. Objections to seclusion and restraint use have been based on ethical grounds, with the use of these interventions being viewed as punitive and as a violation of patients’ basic rights of freedom and dignity. Others contend that seclusion and restraint may be countertherapeutic and induce dependency on staff, produce symptoms such as hallucinations through sensory deprivation, and cause feelings of abandonment (Brown & Tooke, 1992).

From 1990 to 1992, the National Institute of Mental Health (NIMH) sponsored a series of round-table talks, which included providers, consumers and their family members, and administrators. Discussion focused on alternatives to involuntary treatment (including seclusion and restraint use). Two consensus opinions resulting from these meetings were that patients nearly always perceive involuntary seclusion and restraint as

![Nursing staff often are caught in the middle, needing to care for people who are disturbed or violent in a safe and therapeutic manner, while assuring the safety of the patient, other patients, the environment, other staff, and themselves.](image)
aversive and that these interventions should not be considered treatments (Fisher, 1994). In addition, Johnson (1998) found that patients who had been restrained reported feelings of powerless and harm from the experience.

Some studies focused specifically on the attitudes and perceptions of clinical staff toward seclusion and restraint use. These studies were of particular interest to the authors of this article because staff members’ perceptions and attitudes can serve as the basis for selecting one intervention instead of another when working with patients. Steele (1993) surveyed 28 employees in four inpatient psychiatric facilities to determine their attitudes and opinions about confinement. Although 60% of the subjects saw the use of seclusion or restraint as therapeutic, many also were hesitant and anxious about participating in the physical control of patients. Subjects reported concerns about potential abuse of rights, loss of dignity, and control over persons who are at a power disadvantage. Quinn et al. (1993) described nurses feeling conflicted between the patients’ right to self-determination and the nurses’ responsibility to provide the best care to patients.

Klinge (1994) sought opinions about seclusion and restraint use from 109 staff members who cared for acutely psychotic psychiatric patients in a forensic hospital. Results indicated that staff chose to treat patients as they themselves would want to be treated. In addition, staff with higher levels of education (including psychologists and social workers) believed restraint, seclusion, and medication were overused, and that staff other than physicians should have the authority to write seclusion and restraint orders.

### Table 1
**DEMOGRAPHIC DATA**

<table>
<thead>
<tr>
<th>Item</th>
<th>Result</th>
</tr>
</thead>
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<tr>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
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</tr>
<tr>
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</tr>
<tr>
<td>Average time on ward</td>
<td>10.3 years</td>
</tr>
<tr>
<td>Mean number of seclusion episodes involved in during employment at hospital</td>
<td>19.3 episodes</td>
</tr>
<tr>
<td>Mean number of restraint episodes involved in during employment at hospital</td>
<td>33 episodes</td>
</tr>
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### PROBLEM

Seclusion and restraint are controversial interventions for disruptive and violent behavior in psychiatric-mental health settings. Research has shown that wide variance exists in the frequency with which these interventions are used from one health care setting to another. One significant factor in this variance may be the attitudes of staff toward their use. Staff’s attitudes toward seclusion and restraint use have received limited study. Attitudes toward the use of these interventions are important because, according to King (1981), attitudes are among the components of the self. The perceptions and attitudes of nursing staff will influence not only their interactions with patients but also their choice of interventions when responding to an identified need or problem. Therefore, this study sought to answer the following questions:

- What attitudes or opinions do nursing staff have toward seclusion and restraint use?
• What reasons do nursing staff give for choosing one intervention over another?
• Do staff view the use of seclusion and restraint as an opportunity to provide more intensive therapeutic interventions?

METHOD
Design and Sample
The study had a descriptive correlational design. The setting was a 376-bed neuropsychiatric hospital in the midwestern United States. The convenience sample for this study consisted of licensed nurses, including both RNs and licensed practical nurses (LPNs), as well as nursing assistants (NAs) who worked on acute and chronic psychiatric wards. All levels of nursing staff were included in the sample because all levels of nursing staff, regardless of decision-making authority, may be involved in placing patients in seclusion or restraint. The survey was distributed to 64 RNs, 15 LPNs, and 65 NAs from all acute and chronic psychiatric wards. The acute and chronic psychiatric wards were selected because seclusion and restraint use was more likely to occur on these wards, rather than in acute medicine or the nursing home care unit.

All questionnaires were distributed by the authors to the nursing staff on the wards selected as study sites. This distribution occurred during morning and afternoon report times, in person on the wards or via mailboxes, if personal contact was not possible. Each questionnaire included a cover letter explaining the purpose and potential benefits of the study, an assurance of anonymity, and an attached return envelope addressed to the authors, with no identifying factors. Responses were encouraged by e-mail reminders. In addition, the authors attached a tea, coffee, or hot cocoa bag to each questionnaire with a slogan, “Take a Break With Me.” Appropriate ethical standards regarding research activities were followed.

The definitions for the terms used in this study were obtained from the Medical Center’s policy guiding seclusion and restraint use and are as follows:
• Seclusion was defined as setting a patient apart from all others and/or the ward environment to restrict movement to a specifically designated, confined environment of one room behind a locked door.
• Restraint was defined as using locked leather cuffs and belts for the purpose of restricting the activity of a patient to prevent a patient from physically harming himself or herself, from physically harming others, or from causing substantial property damage.

Instrument
Klinge (1994) developed a tool designed to examine staff’s attitudes and opinions about seclusion and restraint use. Permission to use an adapted version of the tool was obtained from Klinge for use in this study. Klinge’s (1994) version included 23 forced-choice items about attitudes and opinions and 7 open-ended items asking respondents to use short sentences to elaborate on their choice of responses. The remaining 10 items sought demographic information from subjects.

For the purpose of this study, the sequence of two questions was changed to accommodate block instructions and enhance flow. Three additional forced-choice items with corresponding open-ended items seeking explanations were added. Two of these added items asked about the influence of staff mix and numbers on staff’s attitudes and opinions about seclusion and restraint use. The third item asked whether or not staff viewed the time a patient spent in restraint or seclusion as an opportunity to provide intensive therapeutic interventions. This item was a source of disagreement in the literature, and the opinions of this sample on the issue were sought. Demographic items were altered to match the multilevel nursing staff sample, rather than Klinge’s (1994) multidisciplinary sample.

FINDINGS
Questionnaires were distributed to 144 staff members, with a return rate of 45% (n = 65). Demographic data describing the sample are summarized in Table 1. The sample included 33 (51%) RNs, 6 (9%) LPNs, and 22 (34%) NAs. Four respondents did not identify their nursing staff level. Educational levels are summarized in Table 2.

The length of time a staff member had worked in the psychiatric program was positively
and significantly correlated with the mean number of restraint episodes in which he or she had been involved ($r = .43, p = .01$). However, in contrast, the length of time a staff member had worked in the psychiatric program did not correlate significantly with the mean number of seclusion episodes in which he or she had been involved ($r = .22, p = .09$).

The first consideration was examining respondents’ choice in using medication versus seclusion and restraint to manage an out-of-control patient. When asked to put themselves in the role of an out-of-control patient, the majority of respondents (85%) preferred the use of medication to physical restraint. Similarly, 92% would choose to calm patients using medication. The relationship between the responses to these two items was tested. Some staff chose to treat patients as they themselves would want to be treated ($r = .33, p = .007$).

Regarding why staff would prefer medication to seclusion and restraint, staff gave three primary explanations:

- It is less restrictive.
- It has a calming effect on patients.
- It allows the patient to have more control.

Similar information was sought from respondents who preferred to use seclusion or restraint rather than medication. The most frequent reason given for use of seclusion and restraint was that these two interventions were more likely to result in immediate control of violent behavior. The next two most frequent responses were that greater safety for staff and other patients could be achieved with seclusion and restraint and that medication sometimes could worsen a patient’s condition.

Next, respondents’ preferences for seclusion or restraint when they put themselves in the role of an out-of-control patient were examined. Fifty-eight percent replied that seclusion would be more effective in calming them down than restraint, and 40% felt restraint would be a more successful approach than seclusion. The remaining 2% did not respond. When asked which approach they felt was more effective in helping a patient calm down, 48% preferred seclusion, while 45% chose restraint. Seven percent did not respond. There were no relationships between staff who preferred the use of seclusion or restraint for themselves and staff who preferred the use of seclusion or restraint for patients.

Reasons for choosing either seclusion or restraint then were sought. When respondents who preferred seclusion were asked for the rationale, the most frequent reply was that this intervention allows the patient more freedom of movement. The next two most frequent responses were that seclusion decreases external stimuli and allows the patient to have more control. The most frequent response by staff who felt restraint was more effective was that restraint...

<table>
<thead>
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</thead>
<tbody>
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<tr>
<td>Associate degree</td>
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<tr>
<td>Baccalaureate degree</td>
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<td>5 (15)</td>
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<tr>
<td>Other degrees</td>
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</tr>
</tbody>
</table>

* Eight respondents (12%) did not provide their educational levels.
KEY POINTS

1. Staff preferred to treat patients as they themselves wanted to be treated.
2. More than one third of respondents did not view seclusion and restraint use as a time for a therapeutic intervention.
3. If staff are practicing from their belief patterns, they will choose interventions to avoid use of seclusion and restraint.
4. The majority of respondents preferred using medication to treat out-of-control behavior because they considered it less restrictive.

reduced physical injury to all involved. In addition, restraint allows staff greater control over violent behavior, provides physically reassuring contact by staff, and provides patients with immediate feedback about the dangerousness of their behavior.

Eighty-three percent of staff felt that patients received more staff attention when in restraint than seclusion. When asked how they thought patients viewed the quality of attention they received when in restraint or seclusion, 65% said it made the patient feel better, 28% said the attention made the patient feel worse, and 7% did not respond.

The majority of staff (71%) felt that other patients on the unit paid more attention to a peer who was in restraints than a peer who was placed in seclusion. Fifty-four percent of respondents felt the attention patients in restraints or seclusion received from others made the patient feel worse, but 28% felt this attention was positive or rewarding. Seventeen percent of the sample did not respond to this question, and one participant (1%) wrote in “neither” in response to this question.

Staff also were asked how frequently they felt a patient in seclusion or restraint should be checked. Thirty-two respondents (49%) indicated that monitoring the patient every 15 minutes was acceptable. Twenty-three (35%) felt continuous observation was necessary. The remaining participants either did not respond or wrote in other time frequencies. There was no correlation found between level of education and how often staff felt the patient should be monitored.

One questionnaire item asked whether staff would agree with a patient’s choice about whether to be placed in seclusion or restraint. The majority (62%) reported they generally would agree with the patient’s choice. Thirty-seven percent of respondents indicated they would decide for themselves what was best for the patient. One percent did not respond.

Staff were asked whether only physicians should have the authority to write seclusion and restraint orders. The majority of respondents indicated that only physicians should have this authority (66%). There was no correlation between level of education and belief that only physicians should be able to write seclusion and restraint orders. In addition, when asked if they viewed the patient’s time in seclusion or restraint as an opportunity for intensive therapeutic intervention, 54% of the respondents viewed it as such. However, 38% did not. Eight percent did not respond.

Thirty-three respondents (51%) indicated that staff mix on the ward influenced decisions to place a patient in seclusion or restraint, while 24 (37%) reported that it did not. Respondents who believed staff mix was important ranked staff skill levels in coping with behaviorally disturbed patients as the number one reason. Other reasons influencing treatment decisions included the number of male staff present, team cohesion at the time of an incident, and control issues between staff members.

Number of staff present was another factor influencing treatment choices for 31 respondents (48%), but it was not important for 28 respondents (43%). Those who answered that number of staff present was important indicated that fewer staff increases staff fear when approaching difficult patients. However, although there would be fewer staff present for a show of force, more staff meant there would be more
personality and styles of leadership with which to cope.

Finally, staff members were asked whether medication and restraint were used appropriately, too much, or too little. Forty-eight percent of respondents felt that seclusion was used appropriately, 41% viewed it as underused, and 5% thought it was overused. Six percent did not respond to this question. In the case of medication, 49% of respondents felt this intervention was used appropriately, 42% viewed it as underused, and 8% thought it was overused. One percent did not respond. Regarding restraint use, the majority of respondents (72%) felt physical restraint devices were used appropriately. Results indicated that education level of staff was not related to beliefs regarding appropriate use of seclusion, restraint, and medication.

DISCUSSION AND CONCLUSIONS

First, in managing unacceptable behaviors, respondents in this study chose to treat patients in ways they themselves would want to be treated. Eighty-five percent of respondents preferred medication as the approach of choice because they thought it was less restrictive. These results are very similar to those of Klinge (1994). This is important in relation to the current focus on restraint reduction. If staff are practicing from their belief patterns, they will choose interventions to avoid seclusion and restraint use. This has implications for staff development programs, which would need to focus on a wide range of restraint alternatives, including the judicious use of medication.

Second, findings indicated that 38% of respondents did not view seclusion and restraint use as a time for therapeutic intervention. These results are comparable to Steele (1993) and corroborate the controversy in the literature regarding the therapeutic value of these interventions. Seclusion and restraint are resource-intensive interventions, and their use must be scrutinized in light of these results. This also has implications for staff development programs, which would need to educate staff on the advantages and disadvantages of these interventions when selecting them for use with individual patients.

Third, the majority of respondents felt patients received more staff attention when in restraint, rather than in seclusion. While 65% said this made the patient feel better, 28% said it made the patient feel worse. Few respondents felt the attention patients in seclusion or restraint received from other patients was positive or rewarding. These results emphasize the importance of determining the therapeutic benefit and relative reinforcement value of the three modalities discussed in this study (i.e., seclusion, restraint, medication). This study did not question patients about their beliefs, but this would be an important subject for future research.

Finally, unlike Klinge (1994), this study found no relationship between staff education level and the belief that only physicians should have the authority to write seclusion and restraint orders. This result may be explained in part by the difference in education levels between respondents in Klinge’s (1994) study and this study. Klinge’s (1994) respondents were psychiatrists, psychologists, social workers, and rehabilitation therapists, as well as nursing staff. This study’s sample included licensed and unlicensed nursing staff only.

These findings can be applied directly within health care facilities. Staff must be educated about the therapeutic value of seclusion and restraint as well as alternatives. Kozub and Skidmore (2001a) discussed a variety of least restrictive approaches that can be taught to staff. These approaches include interaction and redirection, setting limits, using time outs, and safe physical escort techniques. Use of seclusion and restraint within a facility must be monitored continually, and each incident should be reviewed as part of the overall individual treatment plan. Such monitoring is an important part of the staff’s role in maintaining the least restrictive environment for patients in psychiatric settings.

REFERENCES


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