CURTAILING THE USE OF RESTRAINT IN PSYCHIATRIC SETTINGS

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Summary

This article explains past and current theory and practice regarding the use of coercion with persons targeted for psychiatric treatment and outlines the benefits of reducing the use of force in psychiatric settings for consumers, staff, and the wider society. Resources are described for building explicitly noncoercive norms in a therapeutic community by establishing a coherent humanistic theoretical basis, with special attention to trauma theory. The article analyzes the causes of human aggression and the impact of violence on the healing process and describes case examples of nonviolent clinical settings. Appendices offer tips for practical application.

Keywords: *nonviolence; psychiatric; restraint; therapeutic; milieu.*

Let it be indeed a Refuge from distress; an Asylum, not in name, but in deed and in truth—a place where the sufferer may be shielded from injury and insult—where his feelings may not be uselessly wounded, nor his innocent wishes wantonly thwarted. Here let him repose until the

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> light begin to dawn on his benighted mind, and he confess with heartfelt joy and gratitude, that the day he entered a Lunatic Asylum was indeed a blessed day.
>
> Hill (1838/1976, p. 55)

INTRODUCTION

When a psychiatric consumer behaves dangerously and staff members believe they cannot protect the consumer, themselves, or other consumers by any other means, the consumer may be forcibly restrained and/or separated from the rest of the community. This seems only sensible to the person administering the restraint. But the use of force has countertherapeutic implications. Restraint rationales focus on consumer pathology divorced from the context of interpersonal relating. If a staff member's fear and helplessness impart the "right" to exert control, consumers have as much right to restrain staff. If the rationale is a faith in violence as redemptive, it should be recognized that, in many cases, it is structural and personal violence that makes people sick—to replicate the violence of the wider milieu within the hospital destroys the safety that allows healing. Humanistic psychology emphasizes human choice, creativity, and self-realization (Hergenhahn, 1999, p. 509) in the context of freedom. Humans develop into the exceptional individuals they can be (Davison & Neale, 2001, p. 37) guided by their own propensity to self-actualize (Rogers, as cited in Davison & Neale, 2001, p. 36). To control their behavior, especially with force and without a context of coaching self-awareness and self-mastery, implies a willingness to debase that principle. Psychiatry/psychology is not officially meant to be one of the institutions in our society that metes out punishment. Restraint in psychiatric settings ostensibly heals. Yet patterns of blame and vengeance that permeate wider society also affect responses to consumers. Often staff members act like police and deny that this is what they are in fact doing (Bassman, 2001, p. 22). Whatever the justification for it, violence precludes therapy, and the use of restraint and seclusion often constitutes violence.

DESCRIPTION AND DILEMMAS

Restraint is used when a consumer demonstrates agitation, hallucinations, refusal to cooperate or comply, unwanted or disruptive conduct, the start of a habitual cycle of escalation, suicide attempts and self-harm, or violence or threats of violence against nonhuman targets, staff, or consumers (Fisher, 1994, p. 1587; Goren & Curtis, 1996, p. 4). Ideally, a staff member is able to verbally diffuse threatening or agitated behavior and persuasively gain the consumer's cooperation. But a sudden exception of trust and rapport in an overall context of coercion and fear may not be possible, or the consumer may be unable to respond to calming cues. A prearranged team response, using physical holds, is the next resort under clear guidelines and with nonpunitive motives. This may involve a "take-down," followed by isolation in an empty room, perhaps tied to a mattress at the wrists and ankles. Very often, the consumer is chemically sedated as well, with a shot of psychotropics. Periodic assessment for release and physician evaluation and reevaluation within a specified time are usually mandated (Felthous, 1984, p. 1225). After the consumer is calm, follow-up processing is held in which the consumer can experience concern and express feelings and staff can process the event in a nonpunitive atmosphere (Blumenreich & Lewis, 1993, p. 50).

This is the ideal execution[1] of a less-than-ideal procedure. Needless to say, often response to consumers is not completed according to these guidelines. The Boston *Courant* reports that an estimated 50 to 150 consumers die each year as a result of being restrained (Weiss, Altimari, Blint, & Megan, 1998). Even when the guidelines prevail, restraint can be severely traumatizing to the consumer. In response to violence against consumers, and in parallel with wider social trends from nursing homes to parenting to criminal sentencing, a call to reduce and regulate restraint within psychiatric settings competes with the pressures and difficulties that make for 'snake pit' conditions on psychiatric units (Weiss, 1998). These difficulties and oppressions affect not only consumers. Critics of staff machismo or inhumanity are simply relocating pathology. The following analysis avoids blaming in favor of theoretical frames for understanding aggression, descriptions of success stories, and practical alternatives.

NECESSARY? DETRIMENTAL?

Restraint of personal liberty to preserve public safety certainly predates the institution of psychiatric facilities. Recall the biblical story of the man who so disturbed people that they chained him in a graveyard. He repeatedly broke his bonds and cut himself with shards (*The Holy Bible*, 1978). Or witness our extensive and growing prison industry, for centuries based in part on a public safety premise. Concern about the ethics of restraint reaches back a long way as well. In 1838, Hill wrote, "In a properly constructed building, with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of Lunacy whatever" (Hill, 1838/1976, p. 21). However, most psychiatric staff (rarely a "suitable number of attendants") have been taught that seclusion is necessary to prevent injury, calm the consumer, and reduce sensory overload (Gutheil, as cited in Fisher, 1994, p. 1584); that using it can help consumers feel more safe (Cotton, as cited in Fisher, 1994, p. 1585); and that consumers "need limits." One author described its use as a re-parenting technique in which self-control is achieved through internalizing the parental "no." (Gair, as cited in Fisher, 1994, p. 1585).

But others dismiss this as delusional self-justification: "Ask any person who has been subjected to the interventions . . . they will tell you it was one of the most terrifying, depersonalizing experiences of their lives" (J. Silbert, personal communication, October 12, 1998). Most authors believe restraint impacts the consumer negatively. Robbing a human of essential freedom has serious adverse consequences; it does not allow healing (Bassman, 2001, p. 21). Opponents of restraint cite prevention of harm to self or others as the only justification for it. This might encompass special cases such as protection of the fetus during pregnancy, prevention of harm during administration of medical treatment for comorbid conditions, or protection for a counselor during a therapy hour with a multiple-personality-disordered consumer (Fisher, 1994, p. 1586).

Critics point out that restraint could be used as a treatment substitute, as punishment, or for staff convenience (Fisher, 1994, p. 1586). Sometimes staff are judged on the quietness of their ward "without consideration for methods used to induce the subdued milieu" (Goren & Curtis, 1996, p. 5). And restraint always poses a health risk to consumers, who often experience it as a physical trauma

(Blumenreich & Lewis, 1993, p. 106). Also, for certain consumers, even punitive attention can be positive reinforcement for violence (Fisher, 1994, p. 1586). Chemical restraints may appear more humane but can be used just as vengefully and with equally adverse consequences for consumer freedom and power (Kupfersmid & Monkman, 1988, p. 15). Informed consumer consent for administration of potentially damaging drugs is seldom obtained, even outside the context of restraint and response to crisis (Cohen & Jacobs, 2000, p. 59). Using force to take away autonomy and dignity may be necessary in extreme circumstances, but it does not heal. Furthermore, often the consumer does not create such circumstances.

SWINGING THE SPOTLIGHT OVER

Discussions of restraint cannot focus only on the consumer—restraint happens in the context of a relationship. Resistance and noncompliance are normal; escalation into aggression requires staff participation (Goren, Abraham, & Doyle, 1996, p. 8). It has been proven for at least 40 years that staff norms and behavior affect consumer violence (Stanton & Schwartz, 1954, as cited in Goren et al., 1996, p. 1). That research was required to establish this indicates the extent to which we see psychiatric consumers as "other" and attribute our failings to their pathology. Might the pathology lie with those who want to control and diagnose (Siebert, 2000, p. 43)? Unless actively hallucinating, the consumer usually has a reason for violence.

Consumer violence often relies on staff participation in a number of unrecognized ways. First, consumers attempt to cast staff in abusive roles based on the traumatic scripts of their past, an often irresistible phenomena we will examine later. Second, consumers largely depend on staff for needs satisfaction, so that staff hold power over them. Frustration arising from the thwarting of consumer desires can result in violence, as can aversive stimuli provided by staff. Third, the extent to which staff and consumers are polarized hierarchically with few opportunities for warm interaction significantly affects consumer violence. Finally, staff beliefs about the role of restraint and their prejudices about a consumer can create self-fulfilling prophecies in the form of negative expectations and rejection. Related to this is the projection of personal

conflicts and fears or the communication of intra-staff tension into the consumer population.

Frustration and Aversion

Only a minority of consumers behave aggressively in the absence of aversive stimuli, such as preventing or denying the consumer, making an activity demand, insulting or criticizing the consumer, or approaching or touching the consumer (Whittington & Wykes, 1996, pp. 11-14). Seemingly unprovoked aggression may in fact be a delayed response to aversive stimuli (Whittington & Wykes, 1996, p. 16).

Boettcher (1983, p. 57) identified nine commonly frustrated needs of psychiatric consumers: territoriality, communication, self-esteem, safety/security, autonomy, personal identity, to move on their own time, to be physically comfortable, and to understand accurately what is going on around them. A consumer may have a distorted perception of her or his needs or a different perception from a staff member's. Staff often assumes upset stems from pathology. They may suspect a visitor of triggering an outburst but "never a member of staff or the structure of the hospital" (Rosenhan, as cited in Whittington & Wykes, 1996, p. 12).

Structure

A restraint-prone hospital structure might mean a wide social divide between the people in charge and "their" consumers. Polarized power relations ensure that restraint will be experienced as controlling or provocative by consumers (Felthous, 1984, p. 1223). Structure can also mean the tone of a physical setting. Cold, chaotic, or boring settings, unclear staff roles, and unpredictable schedules are predictive (Blumenreich & Lewis, 1993, p. 38; Kupfersmid & Monkman, 1988, p. 12). A security motif or poor provision for privacy sends a message of distrust and lack of respect as its subtext. Strumpf and Evans (1994) found in a study of nursing home consumers that those hospitals with fewer completed interactions and fewer personal furnishings had more restraint in spite of corresponding levels of nurse belief in the necessity of restraint. Improved services, not culpability, are at issue here, including better physical settings and reduced aversive stimuli from staff.

Staff Beliefs

Professional ideology regarding specific diagnoses and hospital-wide philosophy impact rates of restraint more than consumer behavior or characteristics (Gaidemark, 1985; Weiss, 1998). Not even factors such as per diem cost, staff to consumer ratio, or university affiliation make as much difference. When staff members cite a higher range of justifiable reasons for restraint or evince an aggressive attitude, restraint is higher (Fisher, 1994, p. 1587; Megan, Blint, & Altimari, 1998).

Staff beliefs about individual consumers, including cultural biases, also contribute (Fisher, 1994, p. 1590). When dormant class, racial, or other prejudices evoke perceived threat, dire staff fantasies produce anxiety, anger, rage, or despair, resulting in repressive, and thus provocative, behavior toward the consumer (Dubin, 1989, p. 1281). Children seem to be the most consistently at-risk group (Fisher, 1994, p. 1586). Fear is intrinsically contagious—consumer and staff fears escalate each other and mutual aggression is often the result (Blumenreich & Lewis, 1993, p. 15; Dubin, 1989, p. 1280; Felthous, 1984, p. 1223; Lion, 1972, p. 49).

Countertransference and Projection

Seclusion and restraint can be easily misused as a punishment because of the anger inevitably aroused in staff by an unreasonable or threatening consumer attitude. But such anger is often also a result of "countertransference," which is a response to unresolved feelings toward someone in the past, or of "projection," a ready, and often inaccurate, identification in others of disliked and disowned parts of the self. (Sometimes "countertransference" is mistakenly used to refer to all the feelings that staff members have toward consumers, even when those feelings are not unconscious distortions of the past.)

Consumer advocates often fail to recognize the dilemmas of providing therapeutic care. Staff may feel caught in a double-bind between addressing their own safety concerns and answering to the censure of supervisors. They may be unjustly compromised through injury or emotional arousal, be it anger or even unwanted sexual arousal during contact with a consumer (Fisher, 1994, p.

1588). The Boston *Courant* sympathizes: "Staffers can suddenly find themselves the target of a thrown chair, a punch, a bite from an HIV-positive consumer" (Weiss et al., 1998). The temptation to abuse authority when faced with an abusive, yelling, accusing, or resistant person looms large, particularly when restraint will put an immediate end to the aggravation (Bloom, 1997, p. 151).

But the responsibility for identifying and dealing wisely with the emotional aspects of an interaction lies with the caretaker and requires high self-awareness in identifying countertransference. Punitive motives may be disguised by using terms like "limit setting," "behavior modification," and "reality orientation" for practices that actually increase a consumer's feelings of helplessness and lower self-esteem (Dubin, 1989, p.1281).

Intra-Staff Tensions

Restraint rates can increase because of an unseen form of communication between staff and consumers, called the Stanton-Schwartz effect, whereby order on the ward disintegrates when staff does not resolve conflicts with one another. Perhaps subtle changes in staff responses to consumers occur. Perhaps staff members who feel abused by supervisors act out on consumers (Kupfersmid & Monkman, 1988, p. 18). Perhaps consumers sense emotional shifts with remarkable sensitivity. For whatever reason, consumers accurately mirror and enact staff tensions (Felthous, 1984, p. 1225; Fisher, 1994, p. 1587; Kupfersmid & Monkman, 1988). Bloom (1997) described how the Stanton-Schwartz effect worked on her ward, as follows:

> Until the conflict surfaced, the life of the community would rapidly deteriorate, with the most vulnerable consumers erupting into agitation, excitement, and even violence. The problem could be rapidly solved by simply surfacing the conflict . . . Without such ongoing communication, nonverbal acting-out communication fills the gap. (p. 121)

Constant education and review can inculcate a set of values that will help neutralize the staff's own psychological conflicts and reduce the likelihood of tipping ward situations toward violence (Dubin, 1989, p. 1283). Regular meetings commit valuable time, in

recognition of the impact of intra-staff relationships on ward life, and help build a culture of conflict resolution.

THE LENS OF POWER RELATIONS

It should by now be clearly established that restraint and seclusion often harm consumers and are usually unwelcome (Fisher, 1994, p. 1588; Goren & Curtis, 1996, p. 3; Strumpf & Evans, 1994). Restraint reinforces negative behavior and disrupts the therapeutic milieu. It can restimulate feelings surrounding past episodes of rape or abuse, common in consumer populations, and be equated with the "solitary confinement" of the penal system (Megan et al., 1998). It is frequently countertherapeutic; it is not possible for consumers to deal with inner conflicts while they are frightened of being assaulted (Felthous, 1984, p. 1224).

Psychiatric consumers often arrive on the ward from the bottom rung of society, with impaired ability or inadequate resources to make their stories known (Honberg, as cited in Weiss et al., 1998). The power to determine "deviance" lies with others (Bloom, 1997, p. 87). In addressing the question of power contrast for the field of conflict resolution, Kraybill (1996) wrote that a holistic peacemaking praxis seeks "to view reality through the experience of those who are weak and vulnerable rather than those who are powerful and dominant" (p. 139). Humanistic psychology asserts that people can be understood only from the vantage point of their own perceptions and feelings (Rogers, as cited in Davison & Neale, 2001, p. 36). We too often restrain and punish (whether it be consumers, children, or criminals) before we have taken the time to understand the "cause" of behavior we don't like; its meaning in the world of the actor.

This is not to imply that either one or the other—consumers or staff—must surrender their rights to safety and understanding. On the contrary, their interests coalesce; both benefit from a safe and well-regimented environment. Nor are staff members to be burdened with falsely attributed omnipotence. They often feel helpless and afraid. Regardless of the need to expose abuses, a judgmental approach cannot resolve the dilemmas of restraint constructively (Wade, as cited in Weiss et al., 1998). Without

emphasizing denunciation, a humanistic philosophy of restraint nonetheless follows the substance of Kraybill's (1996) perspective and the trauma lens, discussed below, which ask us to view reality through the eyes of the less powerful.

THEORIES OF VIOLENCE

Students of aggression present a number of interlacing and mutually reinforcing explanations for its causes to help us understand the experience. Strictly biological explanations are rapidly achieving hegemony (Blumenreich & Lewis, 1993, p. 30). In this view, aggression is a natural product of the functioning animal brain. Physical factors like heat, odor, and crowded conditions can trigger aggression, as can brain lesions, drugs, and environmental stress (Blumenreich & Lewis, 1993, p. 21). Adrenaline "rush" reinforces aggressive response.

In the frustration explanation, aggression results when the desires surrounding basic survival drives are denied (Blumenreich & Lewis, 1993, p. 30) or when there is a conflict between what is seen to exist and what the person thinks should exist (Kupfersmid & Monkman, 1988, p. 29). Another type of hostility is sadism as "an expression of desperate meaninglessness" (Kupfersmid & Monkman, 1988, p. 29). The sadist feels pleasantly confirmed in this nihilism each time he or she recreates this internal reality by causing harm.

The social learning model ascribes aggression to experience, reinforcement, and modeling (Blumenreich & Lewis, 1993, p. 21). Humans learn how to behave by watching and imitating those around them, and hostility may be encouraged by the endorsement of cultural norms. Our culturally and socially constructed assumptions then determine our expectations, which are likely to be frustrated at some point in the course of events. They also teach us the appropriate response to frustration.

Socialization continues throughout life, but at key developmental phases its imprint can sink more deeply. Developmental theorists ascribe propensity toward violent behavior as a function of developmental insults sustained in childhood, for example, by the deprivation intrinsic to an emotionally distant or disorganized family (Blumenreich & Lewis, 1993, p. 30). This does not contradict the biological perspectives—experiences with attachment in early

life shape the neural pathways in the mind related to hostile response. But developmental theory provides more social meaning and points in the direction of social preventions rather than chemical treatments.

The psychological/psychoanalytic model (Blumenreich & Lewis, 1993, p. 30) describes the emotional and cognitive events around aggression. An "injured" person experiences high levels of anxiety in subsequent years, with aggression as an instinctive response to anxiety. Shame theorists such as James Gilligan (1996) and John Braithwaite (1989; see also Braithwaite & Daly, 1994) see violence as a misguided attempt at justice. They hint that even apparently sadistic and gratuitous harm is predicated on the perception of prior injury (Gilligan, 1996). This story will be a difficult sell in our cultural context, despite a growing body of supportive analysis. Lion (1972) described aggressive behavior as a "mechanism by which the individual deals with an unbearable sense of fragility and helplessness" (p. vii). He proposed that "violent patients are frightened of their own hostile urges and desperately seek help in preventing loss of control" (p. vii).

TO UNDERSTAND VIOLENCE, UNDERSTAND TRAUMA

Why the concern with causes of violent behavior? Simply, if we wish to avoid stigmatizing containment and "other"-management, if we wish to consider the needs of the consumer more than our own convenience, then we need an explanation that comprehends those needs. Trauma theory sees inborn or biological factors as interactive with experiences like cultural learning, modeling, reinforcement, and the anxieties caused by injuries and developmental insults. It can be our guide for a humanistic response to aggression.

Consider the following. The autonomic nervous system responds involuntarily to danger with a "fight or flight" response of hyperarousal in which complex thought closes down until the danger passes. An inborn sequence of physical, emotional, and cognitive responses follows. If this response is triggered too frequently, as it is in children exposed to too much danger and too little protection, even minor events may later trigger this chain reaction. (Bloom, 1997, p. 72).

In trauma, the coping mind's ability to contain the terror evoked by horrifying events is overwhelmed. The physiology of the brain is permanently modified, leading to a variety of mental and physical problems (Bloom, 1998a, p. 11) and creating persistent learning and concentration deficits (Bloom, 1998a p. 10). The mind also loses the capacity to order reality, make meaning, and create the illusion of a safe universe necessary to human functioning (Bloom, 1997, p. 70). "Because in a just world terrible things do not happen to good people, traumatized people frequently blame and hate themselves" (Bloom, 1997, p. 111).

Often, a recursive loop of inner experience forms in which the past is experienced as the present and the body believes it must continue to fight for its life (Bloom, 1997, p. 40). In other words, the experience lives on in a sealed-off chamber of the mind, to be accessed whenever details associated with the experience recur or to emerge repetitively in physical symptoms, unbearable nightmares, intrusive flashbacks, panic attacks, or other behavioral signals from the unconscious, such as reenactment or self-harm.

The memory of trauma is not only separate, it is also qualitatively different from normal memory because it is in a more primitive part of the brain having to do with sensation and emotion, not meaning and language (Bloom, 1997, p. 30). In preverbal abused children especially, there is no channel through which to integrate the intense, incomprehensible "memories" imprinted through trauma.

As adults, our moods influence each other. But, particularly as children, we depend on others for regulation of our internal biological systems (Bloom, 1997, p. 75). Even normal experience, in the absence of secure attachments, traumatically shapes neural circuitry.

When the trauma is being caused by a caregiver, the result is even more complicated, because danger automatically strengthens social bonding (Bloom, 1997, p. 49). With abused children and torture victims, the more danger an abuser creates, the deeper the attachment becomes. The nature of social learning insures that this dynamic will be recreated in future relationships, a phenomenon known as "reenactment," unless trauma is resolved (Bloom, 1997, p. 149). "People who have been maltreated," Bloom (personal communication, November 2, 1998) wrote, "will often compel a psychiatric staff to abuse them again" or repeatedly expose themselves deliberately and unconsciously to danger (Bloom, 1997, p. 57),

because they cannot help but do so. As Bloom (1997) stated, "we are bound to tell the story of our unresolved past through our behavior in current relationships" (p. 149). Freud first termed this "repetition compulsion" (as cited in Bloom, 1997, p. 57).

Dissociation, multiple personalities, learned helplessness, addiction to danger, and painful "body memories" (frequently misdiagnosed by a strictly medical model) are a few faces of posttraumatic stress disorder that cannot be addressed at length here (for a complete outline contrasting trauma theory with traditional medical theory, see Bills & Bloom, 1998). First recorded (and later denied) by Freud, the aftereffects of exposure to severe abuse were rediscovered and legitimized in studies of "shell-shocked" war veterans. Recent neurological findings, along with repeatedly confirmed evidence of the ubiquity of child abuse, clear a path for interpreting the behavior and understanding the needs of psychiatric consumers in a new way.

Bloom (1997, p. 151) wrote that prior to understanding traumatic reenactment, she and her staff would react to hostility with hostile retaliation, albeit disguised as an appropriate treatment for such a "sick" consumer. Understanding the staff-consumer relationship in the context of attachment and reenactment has important implications for restraint and seclusion.

RESTRAINT AS SANCTUARY TRAUMA

Abuse has been a factor in mental disorder in perhaps as many as 80% of all cases (Jacobson & Richardson, 1987, as cited in Bloom, 1997, p. 109). Restraint (or watching others be restrained) can easily be restimulating, although "really psychotic consumers do need restraint, as opposed to having five people on top of them every few minutes" (A. Selew, personal communication, August 20, 1998). Like Vietnam veterans who expected a haven from war and instead found hatred, many consumers enter hospitals at the most vulnerable times in their lives (Breeding, 2000, p. 67). They expect comfort and instead find "rigid rules, humiliating procedures, conflicting and often disempowering methods, and inconsistent, confusing, and judgmental explanatory systems" (Bloom, 1997, p. 10). Diagnostic categories, presented not as tentative interpretation open to revision but as scientific classification, invalidate consumer self-perception and hope for change (Honos-Webb & Leitner,

2001, p. 53). Restraint communicates that "you are not worth understanding" or "your rights don't matter." One ex-patient wrote,

> My belief in fairness was severely damaged during my first few months of confinement. Foolishly, I continued to demand rights that I believed I had, only to discover that I would pay dearly for my ignorance at playing the hospital game. (Bassman, 2001, p. 13)

Can hospitals provide true sanctuary? Looking at those making serious and effective efforts to use restraints and seclusion ethically and with studious care demonstrates that reducing restraint is feasible, if not easy.

HEARTENING EXAMPLES

Training in understanding consumer attitudes reduced restraint in one case from 360 hours per month to 30 hours per month. In another it was reduced by 64%, with a decrease in average duration of 54%, despite staffing decreases (Fisher, 1994, p. 1589). There is a philosophical shift attendant to reducing restraint. For example, the director of a state hospital in New York City described how restraint rates were brought to the lowest in the region for state hospitals by changing the culture of the institution: "We have redefined seclusion and/or restraint as a therapeutic failure. This means: therapeutic effect implies that the individual has (has been given) strengths or resources for self-mastery" (J. Silbert, personal communication, October 12, 1998). It becomes evident in examining the three hospitals below that such reframing and ideological modifications are key to reducing restraint.

Virginia Treatment Center for Children

Goren's public hospital is a classic example: The Virginia Treatment Center for Children had "a good reputation, a history of surviving major changes [such as transition from long-term to short-term care], a staff proud of delivering state-of-the-art care, and an institutional memory" (Goren et al., 1996, p. 2). Staff at the hospital believed restraint and seclusion were necessary, effective, therapeutic, and a result of consumer pathology, not of interaction. But a task force halved the seclusion rate and brought medication use

down through "education, improving intra-staff communication, persuasion, policy revision, and engaging consumers' families in care" (Goren et al., 1996, p. 1). Their project focused both on reducing coercive staff response and reducing conflict among staff, which included behaviors such as lack of cooperation, territoriality, and scapegoating (Goren et al., 1996, p. 4).

To focus on the goal, the task force made clear ground rules at the outset that demanded "regular attendance, parity, and surrender of territoriality" and forbade undermining of change efforts (Goren et al., 1996, p. 5). They stated their philosophy as valuing differences, being supportive, resolving conflict among themselves, and achieving safety through teamwork and professionalism. Goren and colleagues (1996) claimed that focus on the agency-wide environment was crucial in sidestepping "objections of those who rationalized their coercive behavior with reference to their greater power in the consumer-staff relationship and those who were resistant to change" (p. 4).

The resulting process in fact increased the administration's willingness to follow the task force's recommendations and improved coordination and communication throughout the hierarchy. Now, nurses are trained in prevention of aggressive behavior and de-escalating power struggles (Goren et al., 1996, p. 6). Staff members solve problems without blaming, mealtimes are relaxed to be more pleasant, and policies about managing consumer behavior are standardized (Goren et al., 1996, p. 6). Before, children were "fined" inconsistently, with no possibility of correcting negative balances. This actually encouraged negative behavior. The physical environment of the hospital was improved and a better staff/consumer ratio put in place (Goren et al., 1996, pp. 5-6).

Goren and colleagues (1996, p. 1) concluded from this experience that violence within institutions is context-based, involving consumers, staff, and the institutional climate, and confirmed that traditions and assumptions, not clinical imperatives, determine the use of coercion.

The Divine Spark—Philhaven

Philhaven, a private psychiatric facility in Pennsylvania, holds an institutional belief in the sacredness of "all God's children." In the Mennonite subculture in which Philhaven is nested, religious expression of principles predominates. A philosophy of fundamen-

tal equality lends highest priority to the dignity and worth of consumers, even when they attack. "Unless you remember that," says Ken Yoder, a trainer for new personnel, "you cannot be therapeutic. You can't humiliate or punish. Your first priority is to provide safety" (personal communication, September 22, 1998).[2] The orientation toward consumer safety, emotional as well as physical, results in a particular training emphasis. Yoder teaches being in command of oneself, because, he says, influencing an incident begins long before intervention and crisis. "It's not what you do, it's who you are," he tells incoming staff. "Use of force is an encouragement to aggressive behavior and a hindrance to treatment."

Before teaching holds, then, Yoder teaches a regimen of self-discipline: how to continuously gauge personal limits, keep expectations realistic, develop concrete self-control strategies for remaining relaxed, replenish the self, and seek supervision. Yoder believes caregivers should operate as though they carry 80% of the responsibility for what happens with consumers. It is therefore important for staff to know themselves, recognizing "problems at home that may be affecting job performance, people or events that push your buttons, personal issues at work, anxiety level from minute to minute, or interpersonal dynamics with particular consumers." The bulk of training focuses on preventive measures revolving around self-awareness to communicate that prevention is indeed viable and expected. The theme of self-awareness continues even into crisis-management training. Many of Yoder's specific recommendations can be found in the Appendices.

Philhaven enjoys a high level of professionalism, attractive amenities, and adequate funding. Yet its underlying rationale contributes at least as much to low levels of restraint. The "divine spark in every person" story provides a powerful reason for staff to accept the rigorous level of responsibility they are expected to own.

Sanctuary Out of Chaos

Lyndra Bills describes the ward she was asked to take over several years ago as "a chronic, extremely violent women's unit in a state hospital in a rural, mid-Atlantic region." Over a period of 6 months, Bills was able to turn the unit into a safe setting that did not tolerate violence, including self-harm and threats, by taking trauma theory seriously and focusing on change at the level of community. Bills wrote,

> The level of reported violence, particularly self-harming behavior, that was an endemic part of this environment convinced me that there must be a high level of previously unrecognized and unresolved traumatic experience in the backgrounds of these consumers, a finding that has been recognized in previous research. (Bills & Bloom, 1998, p. 1)

This insight gave her hope.

Bills entered the system in the midst of rapid downsizing. Because the unit had a history of culpability in consumer deaths, staff members were hesitant to establish any rules out of fear of consumer advocates. Because consumers were not considered safe enough for group therapies, effort focused entirely on heavy staff presence to prevent incessant self-harming behavior. Bills described one consumer with known history of sexual abuse, as follows:

> She repeatedly cut herself so severely that the wounds required plastic surgery. She also had frequent gynecological problems. Five times in 1 day she placed objects into her vagina—the top of an aluminum soda can, a large square earring, broken glass, a pencil, and batteries. Neither she nor any of the staff appreciated this behavior as a symbolic reenactment of her incest. (Bills & Bloom, 1998, p. 4)

Bills herself developed symptoms of secondary victimization as she became hypervigilant and plagued by nightmares after close encounters with the violence on the ward. "It was as if Violence was an active entity that ran the unit," she wrote (Bills & Bloom, 1998, p. 4).

Her first step was to evaluate each case and rediagnose many of the consumers according to the insights of trauma theory. Bills then sought data and counsel about the changes that she wanted to see. She discovered that the changes

> did not require fancy techniques or expensive equipment but rather a change at the level of system norms—a change in the way the treatment team approached the consumer, understood and explained problems, and altered their expectations of behavior for themselves and their consumers. (Bills & Bloom, 1998, p. 7)

She decided to base her strategy on trauma theory. At staff meetings, she regularly spoke about violence and introduced the community-wide focus of centuries-old "milieu therapy," in which the

community itself is the catalyst for treatment (Bills & Bloom, 1998, p. 11). Bills made consumers responsible for their own treatment and for helping other consumers. She sought voluntary and psychological methods over physical and chemical persuasion. "I had come to recognize that violence was not only condoned but encouraged by the normative structure of the unit and by the lack of an alternative model," Bills wrote. "And I was going to guarantee that there was, in fact, an alternative option" (Bills & Bloom, 1998, p. 11).

Accepting that "progress in treatment can only be expected if safety has been established," Bills took every violent episode as an opportunity to restate the new norm of nonviolence. Gradually, consumers and staff became adept at identifying the reenactment content of incidents. Bills found that "once it is understood as perpetration against the self, an internalized form of identification with the aggressor, the behavior becomes more accessible to treatment" (Bills & Bloom, 1998, p. 12). As consumers and staff began to communicate and interact in new ways, it was possible to adopt new policies that deprived consumers of attention for self-harming behavior and granted positive attention for healthy behavior.

Bills dealt with the consumer advocates with similar openness. The advocates had developed a style of interrogating staff in a threatening tone about their "wrong" treatment of consumers. "To me," Bills wrote, "this was the same problem at a different level. The staff were not safe" (Bills & Bloom, 1998, p. 13). Because her policies required consequences for violent behavior, advocates were initially critical, but Bills persisted.

When the violence had been reduced, individual and group therapies were initiated and changes in the consumers began to be noted. There had been 24 women on the unit, all involuntarily committed. One quarter of them had been hospitalized for 6 months to 4 years, and another quarter had been in the hospital for more than 10 years (p. 6). By 1996, 2 years after Bills left the hospital, one of the original consumers had died, but only two others remained in the hospital. All the rest had been discharged (Bills & Bloom, 1998, p. 14).

The ingredients for this change were not related to funding or breakthrough technology but to "leadership, commitment, vision, and desire": Bills gives the credit to "the time-proven tenets of the therapeutic milieu and the newer insights of the trauma field" (Bills & Bloom, 1998, p. 14). The striking example of the "chronic, extremely violent, women's unit" dramatically demonstrates the

importance of interactional factors, reenactment, and the value of nonviolence. To restate, (a) restraint occurs within a context of interpersonal relating, influenced by all the factors that bear on such interactions, including *but not limited to* an individual consumer's pathology; (b) hurt people hurt people; and (c) healing cannot occur in the presence of violence.

HUMANISTIC VISION FOR CHANGE AT EVERY LEVEL

The guidelines regarding appropriate use of restraint and seclusion delineated in this article are widely accepted in theory. If there is a new idea here, it is that the professions have failed to live up to these ideals because of inadequate underlying constructs. Trauma theory provides the conceptual power necessary to invoke change.

In sum, much violence is an encoded message about the injury of past victimization. As such, violence represents a failure of the group, not the individual (Bloom, 1998). Our readiness to blame and punish only adds momentum to this failure. Howard Barker has written, "We are reviving a medieval social theology in which human nature is deemed incurably corrupt to reconcile the poor with poverty, the sick with sickness, and the whole race with extermination" (as cited in Bloom, 1997, p. 240). Cases of true organic dysfunction and genetically based vulnerability should not be cited to avoid the implications of injury-based dysfunction. To deny the latter often means removing both individual rights to safety and individual responsibility for actions. Bloom has written that "the present focus on genetics as an absolute is simply a way to avoid the socioeconomic and political implications of the alternative viewpoints" (personal communications, November 2, 1998).

These implications bring into focus the epidemic proportions of violence. As Bloom (1998a) scrupulously documents, research from a wide variety of sources is pointing to physical abuse as a strong determinant in public health issues such as substance abuse, crime, family decay, teenage pregnancy, "as well as the development of deviant patterns of processing social information which may mediate the development of aggressive behaviour" (Bloom, 1998b, p. 9). The trauma lens not only provides a context for reframing restraint and seclusion in the micro, it also links to the macro in uncomfortable ways. If healing requires safety and vio-

lence causes illness, the prevalence of illness is a message we seem to be ignoring. By labeling the messenger "sick," we avoid the implicit indictment of the pervasive violence of our culture. Reform within psychiatry and psychology is not enough and cannot succeed for long without reform of the wider milieu.

In 1953, in his book about the therapeutic community, Maxwell Jones wrote, "In the field of mental health, most attention has been given to psychotherapy; some to mental hygiene, but very little as yet to the design of a whole culture which will foster healthy personalities" (Bloom, 1997, p. 1). Attempts to change the use of seclusion and restraint in psychiatric settings press against more than simple force of habit in a handful of staff. Psychiatry is fundamentally coercive (Breeding, 2000, p. 66), and it rests in a society in which violence is accepted, justified, and celebrated—at least when it is perpetrated by powerful people.

After extensive documentation of the public health consequences of violence, Bloom (1998a) wrote compellingly that

> all of our cultural systems for making meaning are infiltrated with this lethal virus, contaminated in a such a way that we now mistake the "virus" for normal "cells," for normal human feeling, acting, believing, and being. In fact, human culture has become trauma-organised, organised around the unrecognised, unmetabolized, and untransformed thoughts, feelings, and behaviours of a posttraumatic response. (p. 31)

We learn this system through the millions of social messages we begin absorbing from infancy and perpetuate it with reenactment and silence as adults. The loop seems unbreakable.

> If you violently oppose the sick system, you become part of the sickness. If you do not oppose the system, you collude with it. The dilemma is apparently unsolvable and therefore members of the system must enter a kind of group trance in which they agree together silently and unconsciously not to see the inherent sickness in the system, not to discuss or critique its underlying assumptions and never to comment on its contradictions. (Bloom, 1998b, p. 4)

The starting point is to "turn our attention away from our exclusive preoccupation with the pathology of the victim and the pathology of the perpetrator and begin planning how to heal the pathology of the bystander" (Bloom, 1997, p. 245).

Reform within psychiatric institutions, if sustainable, will reverberate. Those who undertake violence reduction should know that it is difficult to take on a piece of a violent system without tripping far-reaching forces of resistance.

> Think of it as an energy flow that has to keep circulating for the entire system to stay "lit up." But within our present paradigm, there is always one of more blocks to the flow of energy, and without that sustenance, people—and systems—burn out. (Bloom, 1997, p. 188)

This broad context, while overwhelming, nevertheless provides potential reformers the power of a compelling story. We can assume that as the spirit of an institution changes, it affects the institutions around it. The new story finds its way into the larger culture. Supportive networks across disciplines compose the filaments of an invisible grid. An antidote for the epidemic of violence that fills our wards, prisons, schools, homes, and minds exists. The medicine we need to ingest is the humanistic story of trauma theory—hurt people hurt people, violence creates violence, and the *whole group together* bears the responsibility to create safe, healthy environments.

APPENDIX A
Practical Ways to Reduce Restraint: Understanding Consumers' Reality

- Defuse escalating behavior *based on your knowledge of the consumer*—knowledge obtained from the consumer during verbal de-escalation about what made or makes them angry (Dubin, 1984, p. 2). (Be careful that this is not reinforcement or consumers will act out when they need attention.)
- Examine environment for unmet expectation or agitator on the periphery (K. Yoder, personal communication, 1998).
- Convey safety through calm, in-control manner (Dubin, 1984, p. 2). Most consumers are terrified of losing control and welcome reduction of severe anxiety (Blumenreich & Lewis, 1993, pp. 41, 51).
- Understand violence as a message and don't get defensive. Bad behavior is a code when normal communication isn't working well. "Crisis management is identifying underlying reasons and providing understanding. The more you take things personally, the less in control of yourself you are" (K. Yoder, personal communication, September 22, 1998).

- Establish connection and limits from first contact. Use sincere praise, provide chances for physical outlet, notice and take interest, be nearby as appropriate, touch (i.e., high fives), model courtesy, set limits (as distinct from provocation)—preferably, limits arrived at together—state personal limits. "Consumers will know if a staff member is having a bad day, but they need to know that *the staff member knows*" (K. Yoder, personal communication, September 22, 1998).
- Provide opportunities for extensive practice in verbal de-escalation throughout, even if restraint is used. Eighty-five to ninety percent of consumers will respond to verbal intervention that conveys genuine willingness to help (Blumenreich & Lewis, 1993, p. 51).
- Verbal de-escalation is listening. Decode and feedback what you sense. One way to discern driving emotions is to notice your own. If you are beginning to feel fear in a consumer's presence, this is a clue that the consumer is afraid. Give him or her words to help name these unmanageable feelings.
- Use silence, use their name (with older adults, their last name).
- Communicate respect.
- Redirect energy.
- Offer choices.
- If they refuse direct speech and are inflamed by you addressing them, cross-talk praise for them to someone else.
- Show empathy and admiration, especially in the face of criticism; disarm by finding some truth to agree with; empathize with words and feelings by paraphrasing and acknowledging; inquire gently to learn; use "I feel" statements and sincere praise (K. Yoder, personal communication, September 22, 1998).
- Sometimes acknowledgement of a person's angry feelings and the right to experience them can defuse a situation.
- Know some predictors of violence-proneness: weapons, substances, recent loss, grudges, history of deprivation, addiction, head trauma, child abuse, perpetration of cruelty to animals, truancy, arson, military experience, jail and police records, appearance of face/body/speech/affect/mood that indicates upset, delusions, disorientation, and impaired judgment [i.e., drugs, etc.] (Blumenreich & Lewis, 1993, p. 37).
- Notice any change in a consumer's norms (of posture, speech, and motor activity) and plan appropriate intervention (Hatfield, Kutsche, Fox, & Cable, 1982, p. 17).

APPENDIX B
Training Staff

Training should emphasize values and principles, not just reproducible information (Fisher, 1994, p. 1589). Adequate training in prediction and methods has been seen to reduce incidence (9.4%), consumer (12%) and staff (10.4%) injuries, and lost time (31%). In another study, consumer-related accidents decreased by 32%. In a third, 1 out of 31 trained staff was assaulted, whereas 24 of 65 of untrained staff were assaulted—perhaps because 86% felt more relaxed on the ward after training (Fisher, 1994, p. 1589). Teach these humanistic principles: Consumer will be treated humanely; intervention will not cause injury or pain; staff stays in control by anticipating.

And the goal is to assist the consumer in regaining self-control (K. Yoder, personal communication, September 22, 1998).

- Prevent violence with behavior management strategies, social skills training, and a system of reinforcements (not listed here).
- "Chemical restraint should be made voluntary as often as possible to reduce the sense of being overpowered and out of control" (Hatfield, 1982, p. 19).
- Be self-aware. HALT—Are you hungry, angry, lonely, tired (Dubin, 1989, p. 1281)?
- Be aware of the signals you send. Watch your posture, facial expression, and tone of voice; approach from the side without sudden movement; and do not touch the consumer or stare (Blumenreich & Lewis, 1993, p. 45). Do not threaten or imply punishment (Blumenreich & Lewis, 1993, p. 48). "Force should never be presented to the consumer as a challenge to a male consumer's masculinity" (Dubin, 1984, p. 3).
- Crisis may begin with questions. The consumer needs information and support; don't blow them off.
- Refusal should not be met by "oh yes, you will" but with listening to find out why and with explanation and negotiation. Issue authoritative commands rather than authoritarian responses that strip the consumer of dignity.
- Verbal barrage also needs recognition of the feelings but is best met with silence and a holding environment. Back off during the intimidation phase of a crisis. Remain calm and avoid provocative triggers (K. Yoder, personal communication, September 22, 1998).

APPENDIX C
Creating Therapeutic Milieu

Norms of hospital culture can have either "facilitory or inhibitory influences on a consumer's potential for assault" (Felthous, 1984, p. 1223). Norms grow out of shared values that can be inculcated through training. "Both staff and consumers must be trained in community norms of nonviolence if in-hospital violence is to be reduced" (Fisher, 1994, p. 1589).

- Reiterate that the whole unit is responsible for all unit problems, of staff or of consumers (Jones, 1952, p. 159). Consumers have a duty to exercise vis-à-vis one another's treatment, which boosts self-esteem and nurtures the capacity of role reversal. Jones (1976) focused on frequent group interaction and discussion as well as on trust, leadership, shared decision making, confrontation, learning through working through problems together, buy-in, and consensus.
- Always remember there is a hidden but strong underlying need for affection and warmth for everyone on the ward (Kupfersmid & Monkman, 1988, p. 8). Don't be afraid to use the "L" word (love) (K. Yoder, personal communication, September 22, 1998).
- Don't neglect professionalism, a good example of which was listed more than 100 years ago: "vigilant and unceasing attendance by day and by night, kindness, occupation, and attention to health, cleanliness, and comfort, and the total absence . . . of other occupation of the attendants" (Hill, 1838/1976, p. 37).
- Create unity and solidarity with both staff and consumers. Avoid demonizing or glorifying either role.
- Promulgate antiviolence norms with consumer orientation manuals, treatment meetings, staff contacts with individual consumers, and repetition (Felthous, 1984, p. 1223).
- Involve consumers through discussion and joint development of manuals and policies.
- Make all feelings acceptable. The norm of nonviolence can't be taken to the extreme of outlawing anger or discriminating against consumers with a violent history (Felthous, 1984, p. 1224).
- Insure adequate programming and structured activity (Kupfersmid & Monkman, 1988, p. 15).
- Bring in consumers' support networks to widen the impact of intervention (Kupfersmid & Monkman, 1988, p. 20).
- Provide opportunities to link with healthy external communities. This provides something to live up to (Kupfersmid & Monkman, 1988, p. 21).

- Humor cannot change organic illness, but it can decrease aggression and create community, and it offers a way of being sane in an insane place. (Kuhlman, 1988, pp. 1085-1086).
- Gather frequently to tell, hear, and mirror back each other's stories. Playback theater adaptations are an excellent form for this.
- Openly address violent incidents with group debriefing for both staff and consumers (Lion, 1972, p. 50) to understand what happened and why it happened (Felthous, 1984, p. 1224). Allow ventilation (Dubin, 1989, p. 1282). But base decisions for change on consumer interests, not countertransference (Felthous, 1984, p. 1226) or a "we can, so we will" attitude (Strumpf & Evans, 1994).
- Try to maintain permanent staff who function as a team with prearranged signals (Blumenreich & Lewis, 1993, p. 3).
- Sometimes companionship and diversion are simple alternatives to restraint.

NOTES

1. Restraint can also mean a simpler limitation of range of motion for limbs or, most commonly for the elderly, netting and rails to prevent falls. In rare cases, consumers may be limited in their range of motion but allowed to participate freely in ward activities as a less restrictive alternative to seclusion and as a consumer-supported part of treatment (Troutman, Myers, Borchardt, Kowalski, & Bubrick, 1998, p. 1). In this article, restraint refers to crisis-driven restraint.

2. The information and quotations in this section were provided by Ken Yoder at an orientation session on verbal de-escalation at Philhaven Psychiatric Facility, Lancaster, PA, September 22, 1998.

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