RESTRAINTS IN THE TREATMENT OF DISSOCIATIVE DISORDERS: A FOLLOW-UP OF TWENTY PATIENTS

Walter C. Young, M.D.
Linda J. Young, R.N.C., B.S.N.
Kelly Lehl, R.N., B.S.N.

Walter C. Young, M.D., is Medical Director at The National Center for the Treatment of Dissociative Disorders, in Denver, Colorado. Linda J. Young, R.N.C., B.S.N., and Kelly Lehl, R.N., B.S.N., are nurses at The National Center for the Treatment of Dissociative Disorders.

For reprints write Walter C. Young, M.D., The National Center for the Treatment of Dissociative Disorders, 1290 South Potomac, Aurora, Colorado 80012.

ABSTRACT

This paper presents the findings of the use of voluntary restraint in a total of 246 sessions by twenty hospitalized patients with dissociative disorders. The sessions were analyzed both for beneficial effects and for complications arising in the use of restraint. Benefits were obtained in 230 instances, and 117 complications were encountered during forty-five sessions. One patient committed suicide during the course of the study.

The authors conclude that the proper use of restraint, when less restrictive means are not effective, is a safe and viable intervention in the treatment of aggressive or dangerous altered states in patients with dissociative disorders.

INTRODUCTION

To date, no published study has analyzed the relative risks and benefits of voluntary restraint, although abreactions and the emergence of violent and self-destructive alters during the course of treatment of multiple personality disorder have been well documented (Putnam, 1989; Ross, 1989; Young, 1986; Kluft, 1982; Kluft, 1983).

A patient in a dangerous altered state often will respond to hypnotherapeutic interventions (Braun, 1984; Kluft, 1982; Kluft, 1983), and hypnotic restraint is increasingly used with success. On occasion, however, the use of a more tangible and concrete intervention is required. In these instances, the voluntary use of restraints is a viable alternative until a therapeutic alliance can be established with the patient that will allow more conventional forms of treatment to resume. Young (1986), Braun (1986), and Ross (1989) originally described beneficial results in the use of voluntary restraint with multiple personality disordered patients. Inasmuch as the use of voluntary restraint has not been established as a usual and customary procedure, this observational study was undertaken. In this study, twenty patients were evaluated during a total of 246 restraint sessions. Because the majority of patients in the authors' caseloads are female, the feminine gender is used throughout to refer to patients.

TABLE 1
Criteria for the Use of Voluntary Restraint

One or more of the following:

- History of violence in an altered state
- Loss of control in abreactions
- Patient's fear that she will lose control if an alter emerges
- Prior history of a patient's loss of control during treatment sessions
- Actual appearance of out-of-control behavior during dissociative states

METHODS AND CLINICAL PROCEDURES

The sample consisted of twenty hospitalized patients with dissociative states, who were considered to require the use of voluntary restraint when the threat of aggression or self-destructive behavior prevented the safe progression of conventional psychotherapy. All patients were educated extensively about the risks and benefits of the procedure, and gave informed consent. Patients were also informed that this procedure was not an ordinary standard of practice in the community. All patients agreed to the procedure and entered restraints voluntarily. Criteria used to assess the need for voluntary restraint are listed in Table 1. At least one criterion was required before restraint sessions were considered as a treatment modality.

Patients were placed in full leather three-point restraint, with each wrist fastened separately and both ankles fastened together. After experience demonstrated that patients frequently attempted to hit their heads against the mattress, a rest sheet was regularly fastened across the upper body to decrease mobility in the torso and shoulders.

During the course of the study a number of modifications were made in how restraints were applied. This was the outgrowth of recognizing a number of fairly frequent but minor complications, including blistering when patients struggled, and the occasional escape of a patient's limb from the restraints.

The use of a cloth or some other protective device on the wrists prevented blistering. If the cloth were wedged in such a way that the distal end was either rolled or larger, this simple adaptation prevented the patient from being able to pull her hands out of the restraints.

It quickly became clear that a rest sheet across the body was necessary in order to protect patients who became violent or abreactive and struggled during restraint treatment.

It also soon became clear that the patient's wrists could be better controlled if they were held from the top. This minimized scratches to staff.

As the study progressed, the patients who were likely to be difficult to restrain were often identified, and hypnotic techniques were used to suggest that the patient would not pull out of restraints.

Unless the patient demonstrated over repeated sessions that she could utilize the restraint session with only her primary therapist present, the patient was attended by both the therapist and a member of the nursing staff.

Hypnotic suggestions were sometimes used. Effective suggestions invited an internal helping "function" to assist in maintaining safety while restraints were applied and during the session. Ideomotor signals indicated when this function was in place. An internal helping "function" was also invited to aid in helping the patient organize and integrate material. This synthesizing function, which served as an observing ego, gave the patient more cohesive perspectives on the experiences she described.

Some patients were able to transition out of restraint sessions by the hypnotic suggestion that they could work in a structured area without injury to self or others or that their "working space" would be limited to the mattress. In addition, a post-hypnotic suggestion was given in some cases that safety contracts would be maintained, and staff would be notified if the contract was in jeopardy. These contracts were generally effective unless the patient had a prior history of inability to contract for safety in a reliable manner.

Restraint sessions varied in length from forty-five to ninety minutes, with an average time of fifty to sixty minutes. Occasionally a patient was given 100 mg of Nembutal or a mild tranquilizer prior to the session if experience indicated that medication would enhance her ability to work in the session. Patients who were escalated or markedly abreactive during the session were sometimes given post-session medications.

Restraints were not removed during the course of a session until a reliable, helping alter emerged and indicated that the patient could maintain safety. A minimum of five minutes was allowed at the end of each session for the patient to reconstitute and become grounded before the session terminated. While all restraint sessions were done with the voluntary consent of the patient, sessions were not interrupted when alter personality states emerged and demanded to be released prematurely.

RESULTS

The average number of restraint sessions per patient was 12.3. Three-fourths of the patients in the sample underwent 14 or fewer sessions.

The complications that arose during the course of treatment are listed in Table 2. A complication was defined as an unexpected behavioral or emotional event that adversely affected the patient's or the staff's well-being. The most common complications included attempts at self-harm (hitting the head on the mattress, biting, scratching, hitting the bed or bed frame); one or more limbs coming out of restraint; attempts at harm to staff (hitting, scratching).

There were forty-five sessions in which a total of 117 complications were noted. Often more than one method of self-harm was attempted in a single session. In these cases, each method attempted was noted as a separate complication.

TABLE 2
Complications During 246 Voluntary Restraint Sessions

	No. Sessions	Percentage
Sessions in which there were no complications	201	81.71%
Sessions in which there were complications	45	18.29
	246	100.00%
Complications occurring:		
Patient tries to hurt self	80	12.51%
Procedural complications (e.g., limb escapes restraint)	23	3.59
Patient tries to hurt staff or property	10	1.56
Patient hurt as a result of struggling in restraint	3	0.47
Other	1	0.16
TOTALS	**117**	**18.29%**

Complications were recorded by an attending facilitator during or immediately following each restraint session. Recommendations for potential corrective actions were noted.

Nursing staff monitored each patient for 24 hours subsequent to each restraint session and noted on a data sheet as "occurrences" any unusual or extraordinary behaviors. Many of the reactions which occurred during the 24-hour follow-up period were characteristic of the patient's behavior prior to admission or the institution of restraint therapy. Therefore, these behaviors may not have been precipitated by the restraint sessions, but rather may have been continuations of the behavioral patterns which resulted in the original recommendations for restraint therapy.

Occurrences within 24 hours following a restraint session are shown in Table 3. An occurrence was defined as a maladaptive behavioral or emotional event occurring in the 24 hours subsequent to a restraint session, whether or not any relationship to the procedure could be documented. The most common post-session occurrences included attempts at self-harm and voluntary open seclusion and/or restraint to manage affect or abreactions.

The number of patients benefiting from the treatment is listed in Table 4. A benefit was defined as a session in which progress was made toward treatment goals as defined in the individual treatment plan. The most common benefits included managing abreactions; developing a therapeutic alliance with a violent or dangerous alter; connecting with an alter not otherwise accessible; and obtaining information not otherwise available.

A session in which no benefit was obtained was defined as one in which no progress was made in furthering the treatment goals, building alliance, gaining new information, or working through memories. Although a small percentage (6.51%) of individual sessions showed no benefit, each of the twenty patients experienced beneficial sessions during the course of her restraint treatment.

CASE ILLUSTRATIONS

Clinical Vignette #1

A 35-year-old divorced woman with multiple personality disorder was admitted for the treatment of dissociation following an escalation in self-abusive behaviors, including lacerations and cigarette burns, secondary to intrusive and overwhelming images of childhood abuse and incest. The patient's self-destructive behaviors continued after her admission, and she began to experience internal communications from an alter state claiming responsibility for the abusive behavior and threatening to continue unless she maintained silence. After several inpatient suicide attempts, it was decided that it was essential to establish communication with that alter state in order to develop a therapeutic alliance with it. The patient signed an informed consent for voluntary restraint. She utilized restraint sessions three to four times per week over four weeks.

During the restraint sessions, therapeutic contact was made with the aggressive alter state, which indicated that it was punishing the patient for revealing "forbidden" information. As treatment progressed in a non-challenging and accepting manner, the alter state gradually became more amenable to treatment and developed a therapeutic alliance. The self-destructive alter developed an insight that it, too, must struggle with the acceptance of painful experiences and that it held traumatic memories of its own which had been denied through its own perpetration of abuse on other alters. The alter's angry and threatening demeanor diminished as the patient gained awareness and recognition of its positive intention and identified the alter as a part of the overall defense against trauma and pain. This achieved, therapeutic contact could be resumed without need for restraint.

TABLE 3
Occurances in 24-Hour Period Following 246 Voluntary Restraint Sessions

	No.	Percentage
Sessions after which no occurrence was noted	171	69.51%
Sessions after which an occurrence was noted	75	30.49
TOTALS	**246**	**100.00%**
Occurrences:		
Patient tries to hurt self	47	19.10%
Patient requests open seclusion and/or restraint	22	8.94
Patient demonstrates loss of control	4	1.63
Patient tries to hurt staff or property	1	0.41
Patient suicides	1	0.41
TOTALS	**75**	**30.49%**

Clinical Vignette #2

A 32-year-old divorced woman was admitted to the hospital with a history of dangerous behavior towards others. Her diagnosis was multiple personality disorder. She was not fully co-conscious of all of her dissociated states.

In one state for which she was not co-conscious, she became dangerously assaultive after placing herself in high-risk situa-

tions in which she would incite violence by others. This represented a re-enactment of fighting off her perpetrators and was an attempt at mastery over her assault. The patient felt uneasy about allowing this altered state to emerge in the course of treatment, and the use of finger signals indicated that a reliable contract for safety could not be maintained during therapeutic sessions. Voluntary restraint sessions were suggested as a way to make initial contact and assess this patient's dangerousness.

After appropriate informed consent, the patient began voluntary restraint treatment. Initially, this alter struggled violently within restraints and attempted to claw, scratch, and strike out at the interviewers. Within two weeks, however, the dangerous alter made a therapeutic alliance and began to ventilate a great deal of rage. This alter also revealed information crucial to understanding the patient's assaultive behavior, information that put the re-enactments into a comprehensible context. When the destructive behavior was interpreted as an aberrant attempt at adaptation, the patient was able to experience empathy for herself and expressed that she felt more understood.

Shortly thereafter, the patient developed a therapeutic alliance and a willingness to work without restraints. She became able to contract to maintain safety. Subsequently, the patient was able to work in a conventional fashion using safety contracts with increasing control of this alter and its conversion from a hostile, belligerent stance to one in which it appeared to be trying to help the patient develop increasing cohesion and improvement.

DISCUSSION

The number of complications does not reflect the relatively benign nature of almost all of them. Such reactions as attempting to hit one's head on the mattress, kicking the bed or attempting to choke oneself with restraints were easily controlled.

Many of the occurrences subsequent to the restraint session, such as attempted self-mutilation, were not new or different from previous behaviors. It is questionable, therefore, whether these incidents were true complications of the actual restraint sessions. Nonetheless, these behaviors were included as occurrences, and clinical/nursing staffs were advised so that they could be aware that the restraint sessions might precipitate agitation.

In one instance, a patient committed suicide within twenty-four hours of a restraint session. This patient was a high risk for suicide and had made numerous serious attempts prior to the institution of restraint sessions. Her high level of lethality, combined with self-mutilating behaviors and an attempted elopement, were the antecedents for the recommendation of voluntary restraint. Her suicide was included in this study under "occurrences" because it occurred within twenty-four hours of a restraint session.

The average number of restraint therapy sessions was 12.3, although there was a wide variation of numbers of sessions required by individual patients. For patients with whom restraint therapy was used for crisis intervention or to develop a therapeutic alliance with specific alter states, the number of sessions was low. At the other end of the continuum were patients who used restraint sessions as a viable part of the uncovering and working through of highly traumatic issues, or developing alliances with recalcitrant violent alters whose behaviors needed lengthy control.

Many patients abreacted or needed verbal processing to assimilate emerging material in the twenty-four hours following a session. For these reasons, both nursing staff and the patient were made aware that while the patient was processing new information following a restraint session, there might be behavioral escalation, acting out or a flooding of intrusive memories or images.

CONCLUSION

Hypnotic restraint can often obviate the need for voluntary physical restraint, and the authors recommend attempting this and other interventions before resorting to the use of leather restraints. When appropriate, restraint sessions can be a viable, useful method for dealing with dissociative states which are considered self-destructive, dangerous or otherwise difficult to manage in conventional settings when lower-level interventions have been unsuccessful. Voluntary restraint sessions should be utilized only with informed consent of the patient and when there are specific indications for the procedure. The patient should be monitored closely in the ensuing twenty-four hours in the event

TABLE 4
Benefits Obtained in 246 Voluntary Restraint Sessions

	No.	Percentage
Primary benefit obtained from restraint session:		
Therapeutic abreaction	113	45.93%
Therapeutic alliance with violent alter	60	24.39
Connecting with alter not otherwise available	34	13.82
Obtaining information not otherwise available	23	9.35
No benefit obtained from restraint session	16	6.51
TOTALS	**246**	**100.00%**

of an escalation in behavior or a flooding of memories secondary to the material uncovered in the restraint session. An emergence of "forbidden" material may produce an escalation in the patient's impulsive or self-destructive behavior.

The use of voluntary restraint in patients with dissociative disorders should be considered a useful and reasonably safe procedure when lower-level interventions have proven unsuccessful, proper precautions are followed and the facilitator is aware of potential complications. ■

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