**Argumentative Paper: Physical Restraint**

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**Abstract**

The issues presented in this paper underscore conclusions in that this area is one that begs for research into alternative methods of assessment, care giving, and treatment planning. It is one that requires caregivers to be educated in the attendant dangers of restraints use and alternatives to their use.

Alternatives that can be considered include: time out, constant observations, counseling (verbal interaction), de-escalation, medication, offering positive reinforcement for improved behavior, food and drinks, decreased stimulation, punch bags, exercise and relaxation techniques. And recently, the clinical application of interventions grounded in behavioral science and technology, which seem promising in reducing aggressive behavior, thus reducing the use of restraints.

**Key words:** Bioethics, physical restraint, mental illness, aggression, violence

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**Introduction**

Aggressive behavior is defined as any behavior that produces lagging cognitive skills in the domains of flexibility, frustration tolerance, and problem solving (Greene, Ablon, & Martin, 2006). Furthermore, it is cited as a significant problem that faces nurses in psychiatric hospitals (Chrzescijanski et al. 2007). In addition, it is linked with negative consequences for nurses such as stress, burnout, absenteeism, turnover and decrease of quality of care. Moreover aggressive behavior compromises nurse’s safety in the workplace (Mayhew & Chappell, 2002) and increased use of physical restraint for these patients (Mohr, 2010).

On the other hand, physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily and which restricts freedom of movement or normal access to one’s body (Allen, 2010). Heino, Korkeila, Tuohimäki, Tuori, and Lehtinen (2000) found that in 1,543 admissions to the psychiatric clinics evaluated by the retrospective study, physical restraints were applied to 32% of the patients. Mechanical restraints were used on 10% of the patients.

The unfortunate requirement of professional nursing that nurses often find troubling. Nurses report that they prefer to use other means to manage aggressive behavior, that they are not in general comfortable with restraint use, and that the process is as painful for them as for their patients (McCain & Kornegay, 2005; Bigwood & Crowe, 2008).

Recent studies have questioned their therapeutic necessity and effect. Furthermore, many concerns have arisen about the immorality of the use of such measures, including the potential for physical and
psychological injury to patients, and the violation of the patients' civil rights (Barloon, 2003). Therefore, many studies reviewed the dilemmas of using physical restraints with aggressive psychiatric patients. Many authors advocated against their use in modern psychiatric care, while others consider them as a necessary intervention to manage these aggressive behaviors.

Psychiatric nurses are often faced with legal, ethical and moral dilemmas over physical restraint with aggressive psychiatric patients. There are many questions surrounding the use of restraints among these patients such as:

Should the physical restraints be used during the care of aggressive psychiatric patients? And if yes, in which situation, and based on what strategy, and procedure? Does the restraint inflict harm and contradict patient's rights of freedom, autonomy and respect? Is the physical restraint harmful? Are there any alternatives?

In my opinion, physical restraints should be eliminated as an intervention with aggressive psychiatric patients. Physical restraints may lead to many negative outcomes such as, worsen the therapeutic relationship, and may increase the occurrence of violent episodes and physical injury. Moreover, health care professionals need to develop alternative strategies to reduce or replace physical restraint, such as educational programs and cooperation from other institutes to address their responsibilities to reduce or replace physical restraint with aggressive psychiatric patients.

The purpose of this argumentative paper is to solve the conflict related to use of physical restraint during the care of aggressive patients, by answering the previously mentioned questions which are: Should physical restraints be used during the care of aggressive psychiatric patients? And if yes, in which situation, and based on what strategy, and procedure? Does the restraint inflict harm and contradict patient's rights of freedom, autonomy and respect? Is the physical restraint harmful? Are there any alternatives?

To conduct the answer of these questions, deep, and intensive search was done in many databases. The criteria of the chosen papers in this review were centered on the use of physical restraint in aggressive psychiatric patients in published papers in CINHAL database, ScienceDirect database, and PubMed database. However, no specific article handled these questions adequately, which led me to having a general literature review.

**Literature Review**

Mental illnesses can affect an individual's cognitive, behavioral, emotional, and social functioning; their impact may compromise patients’ ability to fully participate with the treatment team in their care (Mohr, 2010). Furthermore, Zimbardo (2007) stated that organizational realities and ecological factors raise concerns as to the pressures that health team members face and how these factors can seriously impact ethical practice.

Patients and their families trust that professionals will practice competently and ethically. Trust is a vital component of and a basis for relationships between clinicians and patients (Mohr, 2010). These interpersonal trust relationships have moral content fidelity, to trust is morally worthy; infidelity of trust is morally blameworthy. The need for trust and reliance on trust are especially important in health care because of patients’ acute vulnerability to suffering, lost opportunity, and lack of power (Goold, 2001). In so far as patients under professional care in mental health facilities die because of that care, begs us to ask whether the restraint use is consistent with the spirit of the principles set forth in professionals’ codes of ethics (Mohr, 2010).

Many studies reviewed the dilemmas of using physical restraints with aggressive psychiatric patients. Many authors advocated against their use in modern psychiatric care, while others consider them as a necessary intervention to manage these aggressive behaviors.

**For Physical Restraint for Aggressive Psychiatric Patients**

There were many studies that addressed the use of physical restraints with aggressive psychiatric patients. These studies focused on the reasons for indications for them. Migon, Coutinho, Huf, Adams, and Allen (2008) described that there are a limited number of ways to control situations and ensure that everyone is safe when talking to an aggressive ill person. However, physical restraint in some cases is used to prevent injury and reduce patient’s agitation (Kolanowski, Litaker, & Buettner, 2005).

Furthermore, psychiatric patients with aggressive behaviors are at high risk of being restrained due to the chance of harming themselves or others, and they cannot be controlled by means of verbal interventions, voluntarily medications or other interventions (Wynn, 2002). Moreover, other studies have reported preventing harm to self or others as the primary indication for physical restraint, and it is an effective way of preventing injury and reducing agitation (Fisher, 1994).

**Against Physical Restraint for Aggressive Psychiatric Patients**

Despite the evidence supporting the positive outcomes of the use of physical restraint with aggressive psychiatric patients, several agencies and health care quality groups recently have advised to reduce physical restraints in psychiatric hospitals and nursing homes (Valerie, 2005). Nurses should eliminate using it as an intervention in aggressive psychiatric patients because their use constitutes an infringement on patient's autonomy, worsens the therapeutic relationship, and may increase the occurrence of violent episodes and physical injury (Wynn, 2002). In addition the use of restraints poses a conflict between patient’s needs and ethical rights (Sourander, Ellila, Valimaki, & Piha, 2002; Dennis & Donat , 2005; Stolker, Nijman, & Zwanikken, 2006).
Many complications include problems of elimination, aspiration pneumonia, circulatory obstruction, cardiac stress, skin breakdown, poor appetite, dehydration, decreased peripheral circulation, muscle atrophy, pressure ulcers, infections, agitation, social isolation, psychiatric morbidity, functional decline, serious injuries, depression, post traumatic stress, anxiety, delirium, and death (Valerie, 2007; Lois & Valerie, 2008). Moreover, financial implications of physical containment include costs incurred because of these staff injuries, nursing time prearranged to monitor restrained patients, and tort liability (O’Halloran & Frank, 2000).

Kennard (2006) proposed that physical restraints have been reported to be associated with many social effects in residents, such as, cognitive problems, fear, unhappiness, frustration, loss of dignity, behavioral symptoms such as increased agitation, skill loss, and from the ethical and legal view, since physical restraint could be seen as a type of battery, assault, or false imprisonment, and also constitutes a breach of the patient’s freedom and autonomy. Therefore, many researchers have proposed a number of alternatives to reduce or replace the use of physical restraint with aggressive patients in psychiatric units to reduce negative consequences (Lee et al, 2001; Paterson & Leadbetter, 2004; National Institute for Mental Health in England (NIMHE), 2004; National Institute for Clinical Excellence (NICE), 2005).

Discussion
As the author said before, physical restraints should be eliminated as an intervention with aggressive psychiatric patients. Physical restraints may lead to many negative outcomes such as, worsen the therapeutic relationship, and may increase the occurrence of violent episodes and physical injury. Moreover, health care professionals need to develop alternative strategies to reduce or replace physical restraints, such as educational programs and cooperation from other institutes to address their responsibilities to reduce or replace physical restraint with aggressive psychiatric patients. So, now I will defend arguments in the discussion part which includes two parts; ethical argument, and legal argument.

Ethical Argument
The nurses face ethical dilemmas over using physical restraints with aggressive patients. They struggle with conflict between right to personal freedom and dignity, and feeling of obligation to protect others and patients. From an ethical point of view, there are many ethical principles such as autonomy, beneficence and non-maleficence that rationalizes use or not of physical restraint with aggressive psychiatric patients.

Autonomy
The autonomy principle represents that the patients are freed to act independently with patient’s desire and capacity for self-determination (Guido, 2010). Moreover, the respect for autonomy is a reflection of this morality and in the United States, is based on the right to privacy and self-determination (Mohr, 2010).

Two fundamental components of autonomy are liberty, the right to self-determination without interference or controlling influence from others, and agency, the capacity to make decisions and intentionally act upon them (Mohr, 2010). Liberty generally requires that the patient be able to make a decision without being coerced or manipulated (Mohr, 2010).

Physical restraints are incompatible with the principle of autonomy by restricting patients or limiting their freedom in some way against their will (Mental Health Commission of Scotland, 2006). Moreover, a unilateral decision made by caregivers that a patient is unmanageable and in need of external control made on behalf of patients and against their will has the potential to become paternalistic (Mohr, 2010).

Autonomy is often under assault in clinical settings (Cheung & Yam, 2005). The authors concluded that authoritarian attitudes toward patient behavior, violation of autonomy, and compliance become particularly significant in mental health settings because some mental health workers are not highly skilled staff, such as psychiatric nurses, who traditionally have been the direct caregivers in such settings. In the context of staffing with the least educated individuals to care for the most vulnerable, the issue of inequality raises grave concerns about giving them power over virtually all of the daily activities of such patients. When given such power, persons who may have little economic or social power may be tempted to become tyrants (Mohr, 2010). In addition, the author concluded that the relationship of psychiatric patient and nurses is one that is inherently unequal. Therefore, it is incumbent upon professional caregivers to strive to create environments that foster patients’ autonomy.

The idea of compliance as an expectation from patients strengthens and underscores inequality. The expectation of compliance, as opposed to patient engagement in treatment, is the contrast of respecting individual autonomy, and the use of coercive power to achieve compliance overtly violates the principle of autonomy. From what has been discussed, it can be concluded that the evidence argues strongly against the use of restraints as a therapeutic modality. Their use can violate the principle of autonomy.

In some instances, the use of restraints is the only alternative available to staff members who are charged with patient safety. Moreover, the staff members themselves have a right to expect to be safe and to have the tools at their disposal to assure that they and their charges are protected against bodily harm. Thus, in the absence of less coercive tools, they are forced to breach patient autonomy at times when it is unavoidable.

Beneficence and Non-maleficence
The principle of beneficence discusses a moral obligation on psychiatric nurses to act for the
benefit of their patients (Mohr, 2010). Nurses are rarely able to produce benefits without creating additional risks or incurring some costs. As a result, to act with beneficence, they must act only when the benefits warrant the risks and costs associated with a procedure or action. However, beneficence must be constrained by autonomy to prevent the rights of individuals from being subjugated to their medical needs or the medical needs of others.

A patient’s ability to exercise autonomy or self determination may conflict with a clinician’s ethical duty of beneficence. Psychiatric nurses want to provide the care that they believe is best for patients but must also acknowledge patient preference. This dilemma raises the interesting question of whether a nurse’s primary obligation is to act for the patient’s medical benefit or to promote his or her autonomous decision making.

Nevertheless, the principle of beneficence is deeply rooted in both ethics codes of professional conduct and general practice of all care giving professionals. Beneficence can be viewed on a continuum from preventing or removing harm to facilitating good or promoting a person’s welfare. It is based on one human being’s duty to assist another in need. Beneficence usually requires specific action on the part of the health care provider, which includes weighing all available options to facilitate maximal benefit to the patient. With respect to those actions, they should be therapeutic and promote well-being; otherwise, patients would be in no need of health care providers. They could become well on their own and heal themselves (Guido, 2010). The Child Welfare League of America (CWLA) (2004) concluded that there is little in the research literature which can inform the practice of restraints use or their therapeutic benefit with children and youth. Also, Day (2002) conducted thorough reviews concluding that the theoretical paradigms in support of restraint use are outdated. Moreover, there is very limited empirical evidence to support the therapeutic utility of restrictive measures or research that could be used to inform practice (Day, 2002, Martin, 2002; Sailas & Fenton 2000). In addition, recent studies actually suggest that restraints can serve as positive reinforcers for aggression (Kahng, Leak, Vu & Mishler, 2008).

As there is no evidence that restraints are therapeutic of mental health professionals, it is important to ask whether they violate the principle of non-maleficence. Non-maleficence simply means “do not harm, prevent harm, remove harm, and facilitate good”. To harm someone means to act in such a way as to negatively impact or to disadvantage him or her in some way (Beauchamp & Childress, 2001).

Patients can experience a range of negative consequences during and after using physical restraints such as discomfort, injury, pain, panic, fear, frustration, isolation, shame, sadness, and even death (Fish & Culshaw, 2005; Lois & Valerie, 2008; Valerie, 2007). Furthermore, Fish and Culshaw (2005) reported that physical restraint also effects on nurses who implement it; they can experience a range of negative consequences like physical injury, sadness, frustration, shock, anger and self doubt and conclude that the only way to reduce the risks associated with use of physical restraints is to stop using them.

From what has been discussed, it can be concluded that the evidence argues strongly against the use of restraints as a therapeutic modality. Their use can cause serious patient and staff injury and they have resulted in many deaths (National Executive Training Institute, 2005). The principle of beneficence to a patient is rarely absolute in maintenance of patient and staff safety, and it is unclear, based on present literature, whether any benefit (good) accrues to the patient from the use of restraints that entails anything other than safety. Instances such as imminent danger illustrate the principle of beneficence coming into conflict with the principle of autonomy in so far as beneficence is applicable to the public, as well as to the patient who comes in contact with that public. However, other than in those instances where safety is truly a legitimate concern, restraint use would seem to violate the principles of beneficence and non-maleficence.

Legal Argument
Physical restraint for aggressive psychiatric patients is considered a battery, because battery is considered as intentionally unpleasant contact with another person, any unwanted touching, or touch without consent (Guido, 2010). Moreover, use of physical restraint lays the foundation for false imprisonment (Cherry & Jacob, 2008).

There is no policy or any law that oversees physical restraints in Jordan. There must be an objective reason for the restraint in order to prevent harm. Moreover, the restraint must be “proportionate”, that is, the need for the restraint must be sufficiently serious to justify such a serious response, and if less intrusive ways of dealing with the situation can be found, these should be preferred. This argumentative paper negates the use of physical restraint for aggressive psychiatric patients and recommends alternatives rather than using physical restraint.

Recommendations
The first recommendation to the Mental Health Department is that research in the area of safe alternatives to restraints is an urgent moral imperative. This imperative has been stressed in position statements and practice parameters (American Psychiatric Nurses Association, 2007; American Academy of Child and Adolescent Psychiatry, 2002). Other examples of research that is vitally needed are those which compare the use of various de-escalation techniques and differentiate the characteristics of patients with whom each type of technique is most effective. In addition to well-documented effective best practices that reduce violent episodes and restraint use should be evaluated (Huckshorn, 2006; Lebel et al., 2004; Witte, 2008).
The second recommendation is that information about the dangers of restraint use must be discussed more widely in the professional literature and in educational programs. Well over a decade ago, Stillwell (1991) conducted a study that determined that more than half of nurses (51.8%) whom she surveyed reported having no instruction in the use of restraints and their effect on children. In that same study, only 8% reported knowing that restraint use could be dangerous.

A third recommendation is to use the tools that we already have which have proven effectiveness. The functional analysis of behavior is a tool that has been available to inform treatment planning for many years. A functional behavioral assessment or analysis is a process which seeks to identify the problem behavior a patient may exhibit to determine the function or purpose of the behavior and to develop interventions to teach acceptable alternatives to the behavior (Virtues-Ortega & Haynes, 2005). Finally, in view of the dangers associated with restraint use, these dangers must be clearly communicated and spelled out to patients and their families and to professionals.

Conclusions

A traditional bioethics analysis of the use of physical restraint suggests that their use as part of the toolkit available to clinicians in clinical settings is a complex and multifaceted issue. It points out potential limits to the codes of ethics and the principles underpinning them in the face of what nurses may encounter in psychiatric settings. They may be inadequate to take into account dangerous situations that may result in patient and staff morbidity or mortality. The relative relevance of autonomy in instances where it must conflict with beneficence is not one that lends itself to easy solutions.

The issues presented in this paper underscore other conclusions in that this area is one that begs for research into alternative methods of assessment, care giving, and treatment planning. It is one that requires caregivers to be educated in the attendant dangers of restraint use and alternatives to their use.

Alternatives that can be considered include: time out, constant observation, counseling (verbal interaction), de-escalation, medication, offering positive reinforcement for improved behavior, food and drinks, decreased stimulation, punch bags, exercise and relaxation techniques, and recently, the clinical application of interventions grounded in behavioral science and technology, which seem promising in reducing the aggressive behavior, thus reducing the use of restraints.

When these interventions are applied, the following considerations should be taken into account. Respect the dignity of the patient, and constant evaluation of the patient once the restraint is initiated. Objective documentation that supports the need for these measures and those alternatives were considered.

The question that remains is what can be applied in Jordan?

1. Increase the awareness of staff, knowledge, and training of physical restraints by educating the staff of, what are the other alternatives that can be used first, when to apply them, how to apply them in an appropriate manner to cause least harm for both staff and patients. This must be a mandatory course in the orientation. In addition, it should be tested at least once a year.

2. Staff should be trained on how to apply alternatives and to recognize early warning signs to avoid escalation and crisis. The protocol provides a clear structure for the four phases of early recognition: First are the introduction of the method to the patient(s) and an explanation of what is expected of the patient and the nurse. Second, the nurse, patient, and members of the patient’s social network are asked to list the main warning signs for the patient in question and to describe these within the early detection plan (which is a relapse prevention plan based on early signs). Third, patients learn to monitor their behavior to recognize early warning signs. Fourth, preventive actions are outlined, and the patient is encouraged to carry out these actions when early warning signs are detected (Fluttert et al., 2008).

3. Objective documentation of the incidents should be reported, for both legal and ethical consideration, and for identification and therapeutic purposes.

4. For design purposes, it is necessary to create wards with sufficient single-bed rooms for patients to reduce patients being overcrowded and stimulated. However, patients who are at high risk of committing self-harm are excluded.

Finally, it is also one that demands open communication between families and caregivers to meet the best interests of patients. Moreover, the best practice is the one that supports the patients safely, with high quality to improve the patient’s quality of life and quality of care, without interference with the other rights, which mainly follow fixed applicable policy and standards of care.

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