Mechanical restraints in acute and emergency psychiatric settings: Understanding patients’ perspective

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Abstract

The objective of this presentation is to present the results of a qualitative research on the lived experience of patients regarding the use of mechanical restraints in psychiatry. This research project was designed to provide a critical ethical understanding of the use of mechanical restraints in mental health care. As extreme sites where bodies are sequestered, the study drew on the phenomenological experience of psychiatric patients placed under mechanical restraints and the nurses who care for them on two very specific units: psychiatric emergency room (PER) and regular psychiatric unit (RPU). We turned to phenomenology in an effort to understand the lived experience of both patients and nurses. The purpose of this study was to shift the terms of ethical discourse in a manner that would be more commensurable with the lived experience of patients and with nursing staff who care for them. We believe that such an examination could help nurses to consider the emotional impacts of mechanical restraints on patients and on themselves, and encourage them not only to better understand the experience of patients but also to actively find alternatives to this controversial intervention.
Introduction

As extreme practices where bodies are trapped, our study privileges the phenomenological experience of psychiatric patients placed in mechanical restraints. We turn to phenomenology in an effort to understand the experience of the trapped-body in bioethics. We propose a distinctly ethics-oriented application of the methodology known as Interpretive Phenomenological Analysis (IPA), that is, the interpretive dimension of the research will focus on ethical practice in mental health care. While IPA has become increasingly popular with qualitative researchers, to date very little research has addressed the subjective dimensions of body and place in the study of ethical practice, particularly concerning mechanical restraints in psychiatric settings (Strout, 2010). As clinical health sciences become increasingly technological, the body tends to be conceived in static and objective terms—bodies are probed quantitatively at the chemical and molecular levels, through genomics; bodies are understood statistically, epidemiologically, pharmacologically, through risk-factors and biometrics. Our research project appears to be in opposition with this trend. In effect, this paper presents a summary of the results of a research project funded by the Canadian Institutes of Health Research (Holmes and Jacob, CIHR: 2013-2015) looking at the lived-experience of both patients and nurses with regard to the use of mechanical restraints. In this paper, only the lived experience of patients hospitalized in a psychiatric setting (psychiatric emergency unit or acute psychiatric care unit) will be presented and discussed.

Research Problem and Objectives

Nurses are regularly confronted with the use and effects of restrictive measures such as mechanical restraints, and are forced to navigate between care and control. Following an important review of the literature on the experience of being restrained, Strout (2010) reports that the “division between beliefs about the therapeutic benefit of physical restraint and the actual perceptions and experiences of our patients points to a serious gap in our understanding about the potentially harmful effects of this common intervention” (p.425). Therefore, clinicians are often unaware of how patients feel when they are being restrained. Apart from a few reports of positive restraint experiences from patients, the body of literature consulted generally points to generalized negative experiences. Unfortunately, nurses and other health care professionals have been found to support the continued use of mechanical restraints despite little evidence of its safety and effectiveness (Moss & La Puma, 1991; Nelstrop et al., 2006; Strout, 2010), believing it to be therapeutic (Evans, Woods & Lambert, 2003; Gerolamo, 2006; Johnson, 1998; Moylan, 2009; Sailas & Fenton, 2000). In fact, current literature seems to indicate quite the opposite: restraint use has been associated with complications rather than benefits for patients (Strout, 2010).

The stated objectives were [1] to gain access to the bodily phenomenon of being placed in mechanical restraints; [2] to “give voice to” (Larkin, Watts, & Clifton, 2006) the intimate experiential understanding and elaboration of this experience through words and bodily gestures; and [3] through phenomenological interpretation, to understand the subjective processes and meaning-making of this experience, a feature that is underdeveloped in the literature (Brocki & Wearden, 2006; Larkin, Watts, & Clifton, 2006)—and is not discussed at all in the context of ethics. Following a literature review using several databases, we believe that these reasons are...
used to justify the use of mechanical restraints: [1] therapeutic purposes (for example to help the patient gain control over a particular situation); [2] safety issues (to prevent a patient from engaging in acts that are dangerous to him-/herself or others); and [3] punitive purposes (such as behavior modification). Published works suggest that patients often perceive the use of mechanical restraints as a punitive/coercive intervention deployed when rules are not respected (Evans, Woods & Lambert, 2003; Gerolamo, 2006; Johnson, 1998; Sailas & Fenton, 2000; Wynn, 2004).

Methodological Approach

The study took place at a large university-affiliated general hospital and patients were recruited from two psychiatric units: acute inpatient unit as well as a locked emergency psychiatric unit. Data collection included [1] in-depth, semi-structured interviews conducted by the lead researchers and graduate student assistants; [2] gathering and analysis of institutional documents related to the policies and procedures surrounding seclusion and restraint. A total of 19 participants were recruited. Data saturation was achieved after 15 participants but data collection continued until 19 in case new information would arise. All participants have had direct experience with mechanical restraints, remembered that experience (current or past hospitalization), and were able and willing to share their experiences.

Results

Three main themes emerged following our data analysis; these themes are: experiencing mechanical restraints, patient’s needs, and finding alternatives. These themes are further delineated into categories and sub-categories. Please see Figure 1 for a complete overview.
1) Experiencing mechanical restraints

The first of three main themes emerging from the interviews relate to patients’ personal experience of mechanical restraints. Herein, two categories were delineated: patient’s perceptions, and patient’s reactions. The patient’s perceptions category was further divided into two sub-categories: environmental and material elements, and quality of care. Similarly, the patient’s reactions category was divided into three sub-categories: emotional reactions, physical reactions, and trauma. In the following text, patients position themselves in relation to various personal and contextual factors at play during the mechanical restraint experience. The statements were multifarious, however, they generally portrayed a negative impression of mechanical restraints.

[Sample quotes will be presented at the conference]

Patient’s perceptions (environmental and material elements)

It has been noted that the environment in which one finds him-/herself can have direct and indirect consequences on one’s mental health (Evans, 2003). This insight is pertinent for patients on a mental health unit. Unhealthy psychiatric environments will undoubtedly have negative repercussions on a person’s mental health (the reverse may also be true). Thus, the physical environment and materials used for care are instrumental when applying mechanical restraints.

[Sample quotes will be presented at the conference]

Patient’s perceptions (quality of care)

In general, patients perceived their mechanical restraint experience as antipathetic. At times, this is due to their perception of nursing care received during their time in mechanical restraint. Subsequently, mechanical restraints may have deterred patients’ mental health.

[Sample quotes will be presented at the conference]

Interestingly, despite resenting the actual procedure, some participants did report positive experiences in regard to the care received during the time spent in mechanical restraints. As is the case with other participants, having one staff member present with the patient during the intervention was conducive to therapeutic rapport.

[Sample quotes will be presented at the conference]

Patient’s reactions (emotional)

In majority, participants expressed a negative emotional reaction to mechanical restraints. One participant states that mechanical restraints worsened his mental state. Further, experiencing mechanical restraints for patients is resoundingly unsettling for the nurse-patient relationship. The interviews reveal a certain apprehensiveness on behalf of the patient when contemplating their relationship with the healthcare staff after regaining freedom from the restraints. Reconciling this relationship proves to be an important task so as to provide quality mental health care.
Contrarily to the majority’s position, some felt that mechanical restraints had a positive impact on their mental health and general well-being. The interviews show that staff and patient safety appeared to be a positive outcome of mechanical restraints.

**Patient’s reactions (physical)**

Another point of importance that emerged from the interviews is when participants state that the mechanical restraints were adjusted too tightly. This caused distress and pain for some of the participants. Additionally, having all four limbs (and torso) bound to a stretcher with straps and buckles is in no way natural for any individual. This restriction on one’s freedom and autonomy occasioned participants’ physical resistance to the intervention.

**Trauma**

Invasive interventions that directly target the body (e.g., restraining a person, inserting an intravenous catheter, surgical procedures) may cause the advent of a negative health outcome (e.g., bruises, infiltration, paralysis). In the case of mechanical restraint, physical as well as psychological trauma may ensue; especially if the restrained patient is physically resisting the intervention.

2) Patient’s needs

The second main theme of the study revolves around the mechanically restrained patient’s needs. To the same degree that intensive care patients have specific care needs, so do mechanically restrained patients. In general, a mental health patient has varied physical and psychological needs that need to be met prior to a situation that ‘requires’ invasive interventions. Therefore, it is important for all those involved in the patient’s care to be conscious of and meet patients’ needs in order to avoid the use of mechanical restraints.

**Physical needs**

Mechanical restraints fully restrict a person’s physical autonomy – contradicting the nursing deontological principle of autonomy. In doing so, the patient is unable to attend to their needs. One of those needs, while in mechanical restraints, might be to properly adjust their ankle and wrist restraint to allow adequate comfort. In the following excerpt, the participant illustrates his or her experience when asking staff to increase comfort.

**Psychological needs**
Moreover, with patients who experienced mechanical restraints, the interviews elucidated varied psychological needs that depend on the patients’ reactions to the intervention. During this intervention, patients may experience fear, anger, confusion, apprehension, frustration, irritability, sadness, abandonment, powerlessness, anxiety, guilt, humiliation and psychological pain. A recurring notion was that patients’ desire for staff to help them deescalate from their agitated state (deescalation is a means by which the nurse-patient dyad achieves a mutual agreement or compromise in order to secure a violent or agitated situation in hopes of avoiding severe physical prejudice to the integrity of the patients, co-patients, or staffs’ physical and mental well-being). As one participant states, staff members’ verbal and non-verbal communication embodied frustration thus aggravating the emergency situation.

[Sample quotes will be presented at the conference]

3) Finding alternatives

Last in the sequence of our main themes, some of the alternatives proposed by the participants are presented here. Theoretically, mechanical restraints are meant to be used as a last resort intervention after all means of deescalation have been implemented. Sometimes, in a real-time clinical setting, this is impractical. For example, in the case of an excessively agitated psychotic patient whereby applying methods of deescalation would be futile, mechanical restraints are at times used preemptively for safety reasons. Participants shared their need for options in regard to their care, distraction tools and techniques, ‘as needed’ oral medication, deescalation and calming rooms or seclusion room.

[Sample quotes will be presented at the conference]

Discussion Points

The use of mechanical restraints in psychiatry exists as a last resort intervention, equivalent to an intensive care situation. Within such situations there are multiple contextual elements (i.e., the physical environment, the quality of the patient-staff relationship, and the attendance to patients’ needs) that can potentially alter, for better or worse, patients’ health outcomes. Each person, whether they are directly or indirectly involved in the mechanical restraint intervention, in virtue of having diverse needs, is entitled to have their voices heard and accounted for in the scientific literature and healthcare policy-making arena. In so doing, this article attempts to actuate nursing care that is ethical, trauma-informed and pertinent to patients’ intensive care needs.

1. Evidenced in the extant literature, patients’ perceptions are incongruent with that of nurses when it comes to the uses of mechanical restraints. The latter often rationalize this clinical intervention as therapeutic for patients, or as a method for maintaining safety. The former often judges its use as punitive. The negative perception and understanding that patients have in regard to mechanical restraints amounts to an unpleasant overall experience; this is made explicit in the patients’ verbatim. Given that the nurse-patient
relationship is the foundation of quality psychiatric nursing care, disagreement between patient and nurse vis-à-vis any and all interventions may lead to deleterious effects on the outcomes of care. Hence, is it at all possible to reconcile these incompatible views of mechanical restraints? Can the patient be persuaded to see mechanical restraints as therapeutic? Would this be a laudable pursuit? Or rather, should nurses concede that mechanical restraints are ultimately harmful to their patients as well as the therapeutic relationship? In light of our results, it would also be important to explore how mechanical restraints can be conceptualized on a continuum of care considering that patients advocate for alternative forms of control measures that are less invasive (ex. seclusion).

2. Ethically speaking, is it possible to rationalize the use of mechanical restraints as one that restores autonomy to a patient (autonomy ostensibly being restored at the end of the intervention when the patient is no longer agitated, aggressive, or violent)? In this study, the results illustrate multiple negative emotional reactions such as fear, frustration, anger, and pain. Moreover, patients report feeling “trapped” and “controlled.” Therefore, based on the accounts of participants, the process of restraining patients is purportedly an infringement of patients’ autonomy. Again, we are faced with the problem that, in majority, patients’ perceptions are at odds with the perceptions of the healthcare team. To return to our initial question, how is nursing’s ethical practice impacted by the results presented in this research study? Are the means (processes) put in place to regain “autonomy” justified by its ends or are there other ways to frame practice and avoid (or diminish) the use of control measures.

3. Generally, psychiatric milieus constrain patients’ freedom – especially if they are prohibited from leaving the unit. Therefore, we can empathize with the frustration that our patients feel when confined to an enclosed space. For instance, this frustration can often lead to agitation and violent behaviour. The manner in which nurses effectively deal with these situations is a reflection of the resources available on the unit. The first and foremost important method nurses have at their disposition for such situations is deescalation; this englobes a vast array of methods and technologies used to assist a patient independently regain control over their behaviour (listening to music, using a comfort room, exercising, using prn medication, etc.). As last resort, nurses at times use mechanical restraints for severe situations. Bearing this in mind, what type of hospital constraints can influence the way nurses are able to provide care to agitated, aggressive or violent patients and what does this mean for patients’ health outcomes?
References


