

Justifying Restraint-Use in Psychiatric Care

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ABSTRACT

Critics offer a number of objections against the use of physical restraints in psychiatric care. The objections typically cite the difficulty in reconciling this treatment with trends towards increasing respect for patient autonomy and dignity. Critics also question whether the efficacy of such treatments have been adequately studied, risks have been properly identified, and so on. Although we should take these concerns seriously, they must be set against the sometimes ambiguous nature of the caregiver's obligations, as well as the perceived sophistication of alternative treatments. Restraint-use necessarily involves medical paternalism, and there are institutional safeguards should continually be reexamined in light of what we learn about patient care. Still, were we to deny caregivers the authority to restrain their patients we might create ethical problems at least as great as those that restraint-use is said to create.

Key Words: autonomy; dignity; physical restraints; paternalism.

The Need for Reconciliation

It is not easy to say how one should defend the use of physical restraints in psychiatry, but it is natural that some critics would think that we should try to. If, that is, we take principles like beneficence or respect for autonomy to be important in healthcare, we might wonder how a decision to forcibly strap a struggling patient to a bed could ever be appropriate.¹ Likewise, if we welcome the increased interest in patient empowerment, we ought to ask if it is really possible to restrain patients without depriving them of their dignity (Colaizzi 2005). It might matter less that caregivers sometimes raise such concerns, even if they seem well-placed to identify the moral liabilities involved (Lai 2007). The concerns about restraint-use probably merit our attention regardless of where they originate.

What it would mean to justify restraint-use, however, in a way that convinces the critics, is itself a complex philosophical question. For instance, there is something to the idea that “the moral resonance that surrounds discussions of restraint is very much tied to larger

issues of therapeutic identity, purpose, and possibility” (Belkin 2002, p. 663; see also Tumeinkski 2005). But should this holistic view lead us to give up on reconciling this treatment with our conventional beliefs about medical ethics? Coming at things from a slightly different direction, we might agree that restraint-use is an imposed treatment, one used on or against patients who are expected to resist it. Knowing that, it might seem that reconciliation would need to start against the backdrop of the rules that, under ordinary conditions, are supposed to carve a protective, quasi-political, space around each patient (Sandman & Munthe 2009). Those rules work as they do because they specify things like how much information caregivers must provide patients or how much influence the caregivers should have on decisions that patients make about a treatment. The rules provide a check on the caregiver's authority, and establish a baseline of respect for patient autonomy. But conditions in the relationships where restraints might be used can change quickly. Even the best rules can then seem less helpful, especially if we think that the caregiver's obligations should mirror those changes.

We might want obligations like the need to respect autonomy to extend only as far as the threshold of caregivers' other obligations, such as the duty to protect the patients from themselves and others (DeMarco 2002). Yet disputes over where those thresholds should be set can give rise to the uneasiness about restraint-use. It seems that the cluster of responsibilities that caregivers take on would not only need to adapt to the varying interests that each patient might have. We could then want the obligations to reflect the patients' ability to understand which interests or preferences should count (Sjostrand & Helgesson 2008, esp. p. 115).

There are good reasons to build this kind of adaptability into the healing relationship. For one thing, it allows that respect for autonomy can sometimes give way to principles that support restraining some patients, in the interest of preventing harm (Dawkins 1998). Secondly, it helps explain how a duty to prevent harm could sanction the use of a treatment like restraints or even forced seclusion. For that, something seems needed beyond an appeal to the sheer practicality of restraint-use, or the claim that restraints are simply useful when patients do not respond to information in a way that suggests that they have self-control.

The flexibility in our reasoning about the caregiver-patient relationship is particularly important where critics warn that patients who are forcibly restrained pay the price for their caregiver's lack of clinical imagination. The fear there is that caregivers who

use restraints will be taking the easy way out once things take a turn for the worse in the relationship. But how widely this warning can apply is unclear. Likewise, just how “the use of seclusion and restraint can be eliminated when other beliefs and principles are practiced” (Ashcraft & Anthony 2008, p. 1199) remains to be seen. It might be more fair to place some of the burden on the critics of restraint-use. Perhaps they should explain, for instance, how caregivers are supposed to show respect for the autonomy that they cannot, at the time, observe in their patients. The critic might also be asked to explain what is to be done when, however rich the clinical imagination, the patient’s behavior appears to stem from influences that she has no understanding of or control over. If nothing else, we might say that it is strange to insist that caregivers in that context would want to frame their relationships with patients in terms of a shared conception of *healing*.

The sensible course might seem to be one that bases the defense of restraint-use on the caregivers’ perception of the risks that the patients face. In short, we would look closely at what the patients stand to gain or lose. Where critics can again turn skeptical is on the issue of what these caregivers should consider as they formulate that ledger of risks and benefits. It is tempting to believe that a fairly simple analogy will carry the day. We could think of the authority involved when other caregivers treat patients who cannot consent. They routinely treat accident victims, anorexic patients near death are forcibly fed, and young children are lined up for needle-and-syringe inoculations (Matthews 2000). What “consent” there might be for such treatments is presumed or provided through proxy. In these cases, it is impossible or impractical to consult with such patients about their preferences.

The conventional view is that caregivers who administer treatments like these, under such extraordinary conditions, will need to assume that their patients would, if they could deliberate, trade the imposition and any unpleasantness for the benefits promised. But for a number of reasons, that is a questionable assumption. For one thing, it signals that the caregivers will have decided to do without the usual negotiation that results in the judgments of appropriateness and effectiveness. A judgment of effectiveness will normally be based on shared opinions about the comparison between intentions and outcomes. What did the patient want, and what would the patient like to have? A judgment of appropriateness would normally be arrived at through dialogue as well, since it has to do with the actual decision to use a treatment, to continue it, or to change directions entirely. The key is that none of this seems possible in the example scenarios.

That has traditionally been a problem, since there are clearly risks in abandoning the idea that treatment decisions must ultimately meet a test of the patient’s own standards. With something like an emergency surgery, the judgment of appropriateness might not, after the fact, reflect shared beliefs about the perceived value of the various treatment decisions. Since in most any situation we can find ourselves unsure of what we should want, the idea that someone else might claim to know better is bound to be controversial. Wherever there is this departure from the usual progression that has caregivers and their patients agreeing on the terms of effectiveness and appropriateness, the check on the caregiver’s authority is weakened.

Typically, an appeal to the fact that the caregiver had to work

under extreme circumstances is enough to warrant the unilateral decision. Still, any treatment decision that is said to be taken in the interest of the patient who cannot validate it invites the usual concerns about medical paternalism (Tannsjö 2004). Those concerns seem particularly striking where restraint-use is the outcome. The problem is not simply that caregivers might not have sufficient knowledge of the availability of resources in the institution, the patient’s history, or anticipated risks and benefits (Khadivi, et al 2004). Of more concern is the likelihood that the decision to restrain will make some reference to the patients’ limited rationality. What seems to matter is what we add to that judgment about the patient’s ability to make reasonable choices.

One might reply that references to rationality will be made in the other examples. But there are two differences. First, with the inoculation of children, for instance, caregivers can in theory say how the patient’s symptoms relate to the anticipated balance of risks and benefits. They can defend the imposed medical care as a method of treating a clearly defined set of symptoms, not to control the patient’s behavior. It may not be as easy to explain the causal connections at work with restraint-use; there have been regrettably few attempts to try (Busch and Shore 2000; Dodds 1996). And critics might allege that if we are honest, we will have to look on the restraints as being something of an experimental treatment, or even as medical apparatus rather than a treatment per se.

As an aside, it might be worth pointing out that this view has some obvious flaws. It becomes hard to understand what a change of language would give us when we try to justify restraint-use. Patients might just as well be restrained by the brute force of the caregivers themselves, not devices or apparatus, and that would not eliminate the underlying moral concern. Also, the potential use of pharmaceuticals poses a challenge to this revised image of restraint-use. That is, caregivers might achieve the same result with either treatment, and both might be given without consent having been obtained. (Interestingly, the medication might even have the advantage of being geared towards the influences on the patient’s behavior, instead of the behavior itself.)

To return to the original point, the second reason that the case against restraint-use can look weak is that we seem to presume that the patients in the “extreme circumstances” examples might someday be able to understand the intervention and judge it to have been worthwhile. While they clearly won’t make informed choices at the time, the patients’ cognitive state might improve through recovery or even maturity. Children can grow up and reflect on their parents’ good judgment for having forced them to endure the needle stick. Once whole again, the accident victim, might later appreciate the causal connections that his caregivers made between the symptoms (or the symptoms to be prevented) and the imposition of the treatment. It is easy to think that he too could someday understand the decision to impose treatment. The determination of appropriateness in such cases would be delayed, not substituted. Such patients might even thank their caregivers someday. That outcome seems less likely with patients who are restrained in the psychiatric institution (e.g., Chien et al, 2005; Johansson, et al, 2002). The evidence from such patients, the relative few who are able to communicate with their former caregivers, does not show them being very grateful for having been restrained (Olsen, 2003).

It might seem that this is too narrow a scope. Why not also poll the other patients, those who benefit from having the unruly patients around them restrained? We could try that, but if we have problems enough convincing the critic that the paternalism was justified, we will only dig ourselves deeper in if we seem to appeal to the idea that some patients can be restrained because of the benefits that this provides for those around them. From the critic's viewpoint, it is going to be hard to see where that line of reasoning might stop. Any justification of paternalism is going to be forward-looking. The task here is to explain how we might accommodate the prospect that a patient who is restrained might never possess the cognitive or communication skills to understand, much less validate, her caregiver's decision.

In light of these concerns, we seem to have to give up some of our ideas about paternalism, or lower our expectations with regard to how important autonomy and patient interests should be in the first place. The latter possibility seems more promising. We could seek compromise in an expanded comparison, which could include the class of patients who are comatose and not expected to return to normal function. They are entitled to care and protection (Burns, 2008, esp. p. 195), yet the final word on the appropriateness of their treatments has to remain in a moral and clinical limbo. There are also some grounds for thinking that we should not associate paternalism with such patients, as caregivers might not know their preferences one way or another, and therefore not know when a treatment would be contrary to the patients' wishes. This seems as much a problem with the comatose patient as with the patient who needs to be restrained, since neither seem to have the necessary abilities to communicate or control themselves.

Paternalism and Dignity

Whether or not one finds restraint-use a permissible treatment, or considers it a treatment at all, will possibly come down to this: are we comfortable with saying that restraint-use might be effective (if only because one rarely hears of a patient breaking free from straps), but never proven to be appropriate? That we might ask this does not mean that we must deny that when a patient turns violent or unresponsive, a decision must be made about how protect that patient and others. The caregiver's obligations are not nullified by such conditions; their responsibilities increase in significance. But it might be that as much as we want a caregiver's decision to restrain to meet a test of appropriateness, in some exceptional cases the most we can hope for will be a simple determination of effectiveness. We might even want to let caregivers revise the criteria for appropriateness, and re-conceptualize their patient's lack of autonomy as though it was the "symptom" to be treated. The use of physical restraints could then be one method among several to help caregivers bring their patients in line with the standards of behavior that they want to uphold in the institution.

None of this would amount to our trying to paper-over the paternalistic nature of restraint-use. Rather, we would see the decision to restrain as part of a progression where caregivers impose their preferences on patients for their own good. The caregivers would fall back on what might seem like little more than their own professional judgment, but as odd as that might sound, such a defense of restraint-use would have much in common with

the justification for something like a rule which allows caregivers to compel their patients to take part in therapeutic recreation activities (Shoenfeld et al. 2008). Denying caregivers this ability to protect patients could create ethical issues that are at least as troubling as the political implications of excessive medical authority (Minas & Diatri 2008).

The critic might concede that caregivers will need this kind of discretion, but still question whether restraint-use can ever be compatible with patient dignity or self-respect (Gastmans & Milisen 2006, p. 149). That concern is often heard alongside claims that the restraints are barbaric, or that they deprive patients of moral personhood (Gallagher 2004). It is a concern worth taking seriously, as on an empirical level, it seems obvious that there are ways of treating patients that can afford them more dignity than other ways might. But we can stipulate that patients are candidates for restraint-use only where their ability to recognize and respond to information is in question. This is not a novel view; what is not often noted, however, is how unclear it is whether those patients have much dignity left to lose.

The idea, in other words, would be that a patient who appears to have no control over her behavior, and cannot evaluate the consequences of her actions, may already have lost what we might think of as personhood. As we have seen, the justification of restraint-use presupposes that the patient's actions appear, to the caregiver, to spring not from autonomous decision-making, but from symptoms that caregivers can treat. It is that condition which generates the obligation to intervene, when caregivers feel that they can prevent the further loss of dignity, among other things. This would follow from a common-sense interpretation of dignity, which theorizes that there is a close link between the person's capacity for autonomous behavior and the sense of self-worth or respect that person is aware of (Van der Graaf & Van Delden 2009). Those determinants come together in a criterion that denotes diminished or possibly excludes personhood.

Earlier, the claim was that caregivers might believe that their restrained patients would not, if they were able to deliberate, want to pose a threat to themselves or their fellow patients. To that we can now add that a decision to interfere might reflect a sense of what level of protection someone in the patient's condition is entitled to. We rely on reasoning like this, involving judgments about personhood and moral entitlement, outside of healing relationships. We so when we try to, for instance, prevent a drunk friend from driving. We would not typically think that our friend could maintain his dignity while posing a threat to others, if that was a threat that we believe he would not want to cause. As before, the obligation to protect can develop out of a judgment that the person's symptoms are leaving him vulnerable. And, as a safeguard, we would usually want to insist that efforts made to protect would function as a prosthetic sense of self-control, not punishment, whether for the friend or the patient.

Objections

Logic or language that departs from the everyday experiences that caregivers have will benefit no one. It is hard to pretend that dignity is enhanced when patients are restrained. Nor is it easy to dismiss historical references to the days when patients were

simply chained to the floor and left with no real care to speak of. The critic is right to stress the need to explore less invasive or drastic treatments that would allow for the highest possible level of dignity (Bigwood & Crowe 2008, esp. p. 221). This is especially so if we think that such treatments might achieve the desired level of protection, and possibly even help the patient move towards self-control again (Korr 2005).

Nevertheless, the unfortunate fact is that caregivers who had access to alternative treatments might still need the power to stop a patient from acting a certain way if the risks from not being able to seemed great enough. What is to be done when even the most progressive treatments fail to achieve the necessary level of safety? By the same token, we do not clarify the moral or medical dilemma if we simply describe all methods of restraint as barbaric. Some of those methods are consistent with the “everyday human interaction in nursing” (Winship, 2006 p. 55). We often protect patients, with paternalistic intent or not, by using restraints like bed-rails, and that is in turn consistent with how we protect passengers in cars with devices like seatbelts (Colgrove 2005). This reinforces the idea that we can give high priority to autonomy while allowing that there must be some type of control over those who would threaten the well-being of themselves or others. It seems equally plain that a certain level of security is going to be central to the ability that patients will have to govern their own lives.

We also do not seem to have the option of shying away from drawing distinctions, such as that between the strapping of a child into a car seat and the subduing of a potentially dangerous patient. Regardless of how hard it is to assign a moral value to such distinctions, we leave too much unsaid if we simply advocate for alternative treatments, or characterize the treatment as a necessary evil. Both pronouncements can hint that restraint-use does not lend itself to the usual style of moral and clinical analysis, and that seems untrue. What to do about the underlying concern about giving caregivers this power to decide which beliefs their patients ought to act on is of course harder to say.

One might object that the justification of restraint-use can easily begin to sound circular. The caregivers might contend that the rules governing restraint-use must be sufficiently elastic to permit the treatment, even though it involves actions that would in other circumstances be considered inappropriate, if not illegal. But in that respect, all we might have proven is that a particular interpretation of rule-following will leave latitude for the application of some rules to match the caregiver’s equally specific interpretation of extreme circumstances. In effect, the objection is that we will have shown that, in simple terms, caregivers can never restrain their patients unless they feel that the patients need to be restrained.

For any treatment, it will usually be a matter of preference and tradition, not necessity, how we order clinical details (e.g. “what effect can we anticipate from treatment X?”) with ethical ones (e.g., “what entitles this patient to treatment X?”). What remains constant is the way that the process of testing our value claims must end somewhere. A natural place to locate that end point in this case would be where we claim that the use of restraints is permissible because of certain conditions and impermissible under others. That does not mean that, if caregivers have a flexible rule, we do little more than arm them with rhetorical tactics that they need to make restraint-use sound less problematic. Caregivers who ponder

the rules that might apply to restraint-use do confront a rhetorical problem, to be sure, but there is a more important consideration. Restraint-use is something imposed on the patient, and again, this holds true whether we consider the method a *treatment* or not.

We might demand that this imposition be justified, and in the medical setting we would usually want proof that the caregiver has acted appropriately. Still, as we have seen, it is hardly enough for us to claim that the caregiver’s actions have been effective, and then to conclude the discussion before someone asks how we define effective. The suggestion that seems to make the most sense would therefore be to grant the force of the critic’s objection. We may not be able to do much more than show that restraint-use is effective, and even doing that might be a tall order in some cases.

This is because restraint-use exists in a category of clinical procedures that can come close to being justified as appropriate, but may never quite reach that horizon. As we have seen, this is due to the difficulty in proving that restraint use will be, for any particular patient, in his or her best interests, or that it will be something which the patient might retrospectively approve of. Things would be simpler if we could appeal to the usual rules governing consent, for instance. Yet to do that, we would have to take considerable liberty with our interpretation of those rules.

This leaves the caregivers as well as their patients in a precarious moral position. Yet because the insistence on supporting reasons must stop somewhere, a reasonable course is to qualify the caregiver’s authority using a host of considerations that ought to come into play before the decision to use restraints is made. Those considerations would include some awareness on the caregiver’s part of the history of restraint-use, the social and political context of the patient’s relationship to the healthcare system, and the practical limitations that caregivers must work within, which would include such things as personnel and equipment. Most importantly, the use of restraints would have to take into account the instances where, in- and outside of the medical context, difficult choices must be made about paternalistically imposing our will on another person.

In the end, if the charge is that the justification of restraint-use is incomplete, one response is that a degree of finality is not likely to be found anywhere else, and that caregivers have no choice but to attempt to come as close as possible to that. Once we build this allowance for ambiguity into the justification of restraint-use, we can see how misleading it is to object that caregivers should, for instance, err on the side of caution, and suspend the use of restraints until alternative methods are developed. It would be no easier to justify the risks that such an approach would pose to the patients, including those who were placed in danger by the patient who needed to be restrained. A circumscribed power to restrain patients would be in keeping with conventional views about human well-being in psychiatry, which has never been neutral about which future states are preferable for patients, or which conditions are favorable to dignity. On the contrary, caregivers have always had to enforce boundaries between permissible and prohibited behavior. It is within that traditional domain of moral judgment and authority that we might locate a permissible use of restraints, as a response that is as imperfect as it is in some cases necessary.

Notes:

1. There are a variety of ways that patients might be restrained, not all of which are equally forceful or threatening to the patient. A patient might be wrapped tightly in sheets, for example. The relevant ethical issues arise, however, where the treatments of this sort are imposed against a struggling, or non-compliant patient.

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