Despite the many advances in psychiatry, violence in acute care settings continues and may be increasing. This is particularly problematic, considering the desire of mental health professionals to attain the goal of a restraint-free environment. Respecting the inherent worth, dignity, and autonomy of the patient is necessary if a therapeutic outcome is to be achieved; however, protecting the safety of the patient, other patients, and the caregivers is of no less importance, yet this responsibility also carries with it legal and ethical implications. Balancing these two responsibilities can be realized even in a situation where supportive therapeutic interventions have been ineffective in de-escalation of an aggressive patient. When used with a compassionate, humanistic approach, restraint can achieve a therapeutic outcome for the patient while protecting the safety of others.

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Aggressive behavior among the acute care psychiatric patient population has long been recognized and is well documented in the professional literature (Lanza, Zeiss, & Rierdan, 2006; Slovenko, 2006). Despite the many advances in the field of psychiatry during the past 50 years, such as improved pharmacological therapy, the rate of assault within acute care settings has not decreased. In fact, increases have been reported in the frequency and severity of violent incidents involving the assault of mental health providers (Duxbury & Wittington, 2005; Paterson & Duxbury, 2007; Tucker, 2003). The aggression of psychiatric patients is also, at times, self-directed and can result in serious self-mutilation if not effectively controlled (Karpinski, 2003; Kumar & Geist, 2007). It is the duty of the nurse to provide a safe environment for the patient and to preserve the patient’s dignity (American Nurses Association [ANA], 2005). It is also the nurse’s duty to maintain his or her own safety and that of others (ANA, 2005). Balancing these responsibilities can present the nurse with both legal and ethical dilemmas unless he or she is adequately prepared to intervene in a manner that supports the patient’s dignity and upholds his or her rights while at the same time protecting the safety of others.

In all situations of escalating patient aggression, therapeutic interventions should be the least restrictive supportive approaches required to successfully de-escalate the patient’s behavior. If situational or external causes of aggression are identifiable, they should be ameliorated if possible. All psychiatric staff must be trained to avoid behaviors that might provoke aggressive behavior in patients, such as treating them with disrespect or placing unnecessary demands on them. In most volatile situations, a compassionate, therapeutic approach based on theories of communication and psychiatry will be effective.

However, circumstances arise in acute care psychiatry when even the best attempts to de-escalate a violent situation are ineffective and physical restraint is the only option remaining to protect the patient and others from serious injury. Paterson and Duxbury (2007), in discussing ethical issues related to restraint, stated that restraint should be avoided except “in extremis when the behaviour of service users seriously threatens the welfare of themselves or others” (p. 542). The ANA, in its 2001 position statement, Reduction of Patient Restraint and Seclusion in Health Care Settings, recognized that restraints may be necessary but should only be used when “clinically appropriate” and “adequately justified” (p. 1).

This article describes interventions that can assist nurses in achieving the safety of the patient and others while maintaining the patient’s rights and dignity. Through appropriate assessment of the aggressive behavior and application of the nursing concept presencing in nursing interventions (Zerwekh, 2006), it is possible to achieve both of these desired goals.

**PRIOR TO THE RESTRAINING PROCEDURE**

All staff working in acute care psychiatric settings need intensive orientation to the policies and procedures related to restraint use, as well as training that includes actual practice of the techniques. Nurses need specific education and direction in assessing the appropriate interventions for the different levels of aggression as identified by experts in the field and in previous studies. Learning to identify when physical restraint is the only safe course of action becomes an important skill for nurses in acute care psychiatric settings, because use of physical restraint has significant ethical and legal implications. Use of videos depicting escalation of aggression, which allow nurses to develop this skill in a safe and controlled environment, may be helpful. Periodic ongoing review and training sessions will keep staff current in both procedures and evolving legal issues.

It is important to realize that when violent aggressive behavior erupts on a unit, the emotions of everyone nearby will escalate. In staff and patients alike, emotions such as fear and anger may be engendered. Complete familiarity with the policies and procedures related to patient aggression will help staff respond professionally and appropriately in these circumstances. Other benefits of training programs include increased staff confidence in managing an aggressive situation, decreased severity and number of assaults and injuries, and decreased levels of fear in staff (Lee et al., 2001).

**THE DECISION TO RESTRAIN**

If the decision to restrain is made too early in the progression of aggression—before attempting other less restrictive therapeutic interventions—it is not legally (Lee et al., 2001) or ethically appropriate (ANA, 2005). If the decision to restrain is made too late, assault and injury may result in accompanying legal consequences. Slovenko (2006) reported that “a hospital (or staff member) may be held liable for malpractice for failure to exercise due care in preventing assault upon a patient” (p. 255). Simon and Shuman (2007), in the *Clinical Manual of Psychiatry*...
and Law, devote a chapter to discussing case law related to seclusion and restraint. They report that under federal regulation and individual state statutes, physical restraints can be used “to prevent harm to the patient or others when control by other means is ineffective or inappropriate” (p. 104). If legal standards are not met, malpractice may result. However, these authors also state that failure to restrain when the patient causes harm may result in a negligence claim.

To engage in effective clinical judgment related to the decision to restrain an aggressive patient, nurses must acquire the complex and comprehensive skills necessary for making an accurate assessment of a patient’s potential for being an immediate danger. It is therefore important that the progression of aggression be understood. Professional literature sources from the disciplines of medicine and psychology have described and reported research related to this phenomenon. The classic study conducted by Kay, Wolkenfeld, and Murrill (1988) demonstrated that aggression in psychiatric patients most often, although not always, follows a systematic pattern, and that the point at which violence occurs is predictable. These findings are congruent with the escalation of behaviors described in the Overt Aggression Scale (Silver & Yudofsky, 1987), which is still in use today.

Maier (1996) described the same escalation of aggression as reported above but categorized it into five stages of arousal. For each stage, the author described the patient’s behavior and his or her associated feelings. In stage one, the patient begins to show minor motor changes in the jaw and fists and feels a sense of frustration. In stage two, hostility is evident and is accompanied by verbal threats or abuse. This is followed by stage three, evident anger with increased major motor activity. In the fourth stage, feelings of rage are expressed as physical aggression. Following the acting out of aggression is the fifth and final stage, a state of exhaustion.

More recent data related specifically to observable behavior in the progression of aggression are lacking. In their qualitative study, Johnson and Delaney (2007) found that different kinds of escalation exist and that not all will progress to aggression in a predictable trajectory; in some cases, aggression may erupt suddenly. However, these authors did identify situations in which interventions were unsuccessful and the trajectory of escalation continued until the situation was out of control.

Least restrictive measures are always indicated when immediate danger is not present. In cases in which nurses decide to use physical restraints early in the escalation of aggression, before supportive interventions are attempted, the patient is unnecessarily deprived of his or her autonomy and perception of control. This situation can destroy the potential for the development of a therapeutic, trusting relationship between the patient and the nurse. In addition, there exists a violation of the patient’s legal rights as well as an abrogation of ethical standards related to respecting the dignity of the patient. Supportive measures would be appropriate interventions in the first, second, and early third stages described above by Maier (1996).

However, waiting too late in the progression of aggression can also have devastating effects. If a patient progresses to rage and physical violence as described in Maier’s (1996) fourth stage, serious harm may result. Assault, injury, and death of patients, staff, and others have been reported in the literature (Bowers et al., 2006; Slovenko, 2006). For these reasons, it is most important that nurses who work in acute care psychiatry receive intensive preparation to effectively make decisions concerning patient interventions in relation to patient aggression. When supportive interventions have not been successful in de-escalating aggression, seclusion may be an option, but it is not appropriate if safety cannot be achieved. Behaviors such as forceful head banging or attempting serious self-mutilation require more restrictive measures.

It is necessary for nurses to recognize that situations exist in which even the most expert interventions may not be effective
in de-escalating the aggression. The literature identifies cases in which a violent action occurs without warning (Owen, Tarantello, Jones, & Tennant, 1998). Winship (2006) described situations where there is “little time to think” and action is required “beyond pondering” (p. 58). When this occurs, physical restraint may be the only intervention that will prevent serious harm to the patient, the caregivers, or others.

THE RESTRAINING PROCEDURE

When physical restraint of a patient is indicated, two major goals must be met if the intervention is considered to be successful. The first is that the physical safety of the aggressive patient, other patients in the vicinity, and the health care providers is maintained. The second goal is that the patient’s dignity, humanity, and comfort are actively supported throughout the entire procedure of restraint application and maintenance. Each of these aspects is discussed below.

Maintenance of Physical Safety

To ensure the physical safety of all involved, a written policy with specific instructions based on evidence from past studies and history needs to be developed. Models of specific restraint procedures already exist. Keltner, Schwecke, and Bostrom (2007) recommend that staff participating in the restraining procedure provide support for the patients’ limbs, chest, and head. During the procedure, no pressure may be applied to vital organs or ribs. After the initial restraining process has been accomplished, nurses need to provide compassionate and intensive care for the patient related to vital sign assessment and preservation of circulation, skin integrity, hydration, and elimination. Provision of privacy is also necessary.

In most institutions, the monitoring of the restrained patient’s physical status and requirements such as physician’s orders for restraints and length of time in restraints are set by policies that reflect legal and professional standards. The care of the restrained patient is included in most psychiatric nursing textbooks, but generally, physical interventions are emphasized (Winship, 2006). In most textbooks used in academic nursing programs, discussion of restraints is limited to a few paragraphs. Although these texts may mention supportive care and comfort measures, there is very little discussion of related theory or specific interventions aimed at achieving a therapeutic effect, which can be perceived as such by the patient. This consideration leads to the second goal identified above, the preservation of dignity, the unconditional positive regard and valuing of the patient as a fellow human being.

Maintenance of the Patient’s Psychosocial Integrity

It is not difficult to identify the tremendous emotional stress a patient is experiencing that brings him or her to the point of total loss of control resulting in unbridled aggression. There are a variety of potential predisposing factors for violence related to the specific patient’s psychopathology. Among these are paranoid delusions, effects of psychoactive substances (Duxbury & Wittington, 2005) such as amphetamine or steroid abuse, mania, lack of impulse control, or frightening hallucinations (Fagan-Pryor et al., 2003). The patient may also be frightened by his or her own feelings of being out of control; on the basis of my own experience as well as that of my colleagues, it is not uncommon for patients to verbalize this after an aggressive episode. Therefore, it is of utmost importance that the nurse approach the restraining situation with extreme sensitivity, providing a caring and compassionate presence. Only in this way can such a traumatic event result in a therapeutic outcome for the patient.

To achieve these desired therapeutic outcomes, nurses need not only training related to the mechanical aspects of restraining but also in-depth preparation and education concerning the affective components of the procedure. This can be best achieved by applying the concept of presencing as it has recently been discussed in the nursing literature. According to
Zerwekh (2006), “The practice of a caring presence can be defined as the intentional authen-
tic responsiveness of the nurse to another human being. The nurse is sincere and expresses genuine
caring feelings” (p. 125). Patricia Benner, a noted nurse theorist, has written widely about this aspect of nursing in both classic (Benner & Wrubel, 1989) and current works (Benner, 2004). She describes how presencing is more than being present and that the nurse’s actions, including body language, touch, tone of voice, and showing that the patient has really been listened to, have a major therapeutic effect. In educating nurses about presencing in restraining situations, all phases of the procedure need to be addressed.

The concept of presencing is supported by the philosophy of Martin Buber (Birnbaum, 1998; Buber, 1958), who first explained the relationship between individuals when an imbalance of power may exist. Buber’s work was groundbreaking in its potential for its application to social and human sciences. This philosophy addresses the primacy of the I–Thou relationship instead of the I–It relationship and the implications this had for the disciplines of psychology, sociology, and education. Buber, in discussing the I–Thou relationship, stated “and so he can be effective, helping, healing educating, raising up” (Herberg, 1956, p. 48).

This primacy of the I–Thou relationship takes on even more importance in nursing situations where patients can be highly vulnerable and where empathy on the part of the nurse is necessary if a therapeutic effect is to be achieved. It is evident that Buber’s concepts are the basis for presencing, bringing an awareness of the shared humanity between the caregiver and the care receiver in which the nurse is able to achieve a therapeutic use of self. This awareness of shared humanity is of utmost importance when it is necessary to use physical restraint as a last resort for the maintenance of safety in the clinical setting.

During restraint placement, the nurse should supervise the actions of the team, making sure no excessive force is used and the procedure is followed correctly. There should not be unnecessary discussion or comments by the team members, and the nurse should, in a calm and even voice, assure the patient of his or her safety. The nurse’s words and body language should convey that this is not a punishment.

When the patient is secured, the nurse should assure the patient that he or she will remain with him or her. The nurse should convey concern in both words and actions for the patient’s physical and emotional well-being. The restraining process is physically rigorous for the patient; therefore, he or she should be offered a sponging with a cool washcloth. Gentle massage of extremities can also be calming if the patient is accepting. Offering frequent sips or drinks of fluids also may have a calming effect. Allowing the patient a choice of fluids and the option to have mellow music playing in the room can provide the patient a small sense of control.

The patient should be informed honestly and matter of factly what behavioral standards he or she will have to meet to be released from restraints. The patient should be told that the length of time he or she will need to be maintained in restraints depends on his or her response and that the staff will be glad to help the patient in any way they can to return to regular activities. These caring interventions will demonstrate the nurse’s concern and respect for the patient and that the nurse is truly present to the patient in their shared humanity.

**ETHICAL IMPLICATIONS**

The subject of physical restraint in acute care psychiatry is indeed a controversial one. Some professionals in this field question whether restraints can ever be therapeutic (Huckshorn, 2004) or if there is ever a legitimate reason for their use (Gordon, Hindley, Marsden, & Shivayogi, 1999). As an advanced practice nurse, researcher, and academic with more than 20 years in the field of acute care psychiatry, I am in complete opposition to the idea that restraint can never be ethically indicated or that a therapeutic effect cannot be achieved. When a humanistic approach is taken, the safety of the patient and others can be maintained while still providing dignity and respect for the patient, resulting in a safe and therapeutic outcome.

Aggression by patients in acute care psychiatric settings may be manifested in various ways. In some cases, patients engage in self-directed harm and actions of self-mutilation as serious as enucleation (Karpinski, 2003; Kumar & Geist, 2007). Suicides by psychiatric patients have also been reported (Bowers et al., 2006). Patients may also assault others in the vicinity. In an ongoing study by this author, which received Institutional Review Board approval for meeting ethical standards in all participating institutions, more than 60% of the nurse participants have been assaulted. Reported injuries include bone fractures and permanent disability. In a prior study (Moylan, 1996), 68% of the 104 psychiatric nurse participants had been assaulted by aggressive patients, 66% of whom required medical treatment. From these reports in the literature and research findings, it is evident that restraint may be necessary—when
1. It is nurses’ legal and ethical responsibility to maintain safety on a psychiatric unit.

2. A physical restraint intervention should only be used as a last resort when no other less restrictive intervention is effective in maintaining safety.

3. By using a compassionate, humanistic response grounded in presencing, a therapeutic effect may be achieved from a restraint intervention.

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all less restrictive therapeutic interventions have been ineffective—to protect the patient or others. Restraint, as a last resort, is congruent with the requirements of the ANA’s (2005) *Code of Ethics for Nurses*, which requires that the nurse protect the patient from harm as well as maintain his or her own safety.

**ACHIEVING A THERAPEUTIC OUTCOME**

The idea that restraint can never be therapeutic also requires further examination. The literature identifies positive perceptions of restraint by patients when they have felt completely out of control and needed protection. In a study conducted by Wynn (2004), some patients described negative perceptions of restraint while others voiced positive feelings. Positive feelings included a perception of a calming effect and a belief that the “use of restraint did protect them from hurting themselves or others” (p. 136). In a research study by Chien, Chan, Lam, and Kam (2005), 30 psychiatric patients in a Hong Kong hospital were questioned 2 days after a physical restraining experience. Although negative perceptions of the restraining event were reported, two thirds of the respondents reported positive feelings of the restraining intervention, relating to achieving a sense of protection and to the caring attitudes and caring behaviors of the staff. This qualitative study identified themes of safety and trust, caring and concern of staff, explanation and frequent interaction by staff, and being respected by staff. Negative effects reported by patients in this study related to staff who were not empathetic, did not seem concerned, did not actively listen to the patients, or did not give information about the restraint during or after its use. This finding provides support for the therapeutic effect of presencing.

In a study of 69 psychiatric patients in a hospital affiliated with Massachusetts General Hospital, Feldberg (1995) also found positive perceptions of patients who had been physically restrained or secluded. Fifty-seven of these patients had been placed in four-point restraint. Although a majority reported some negative perceptions, 49.7% reported feeling helped by the restraining event. Positive perceptions included feelings of safety, protection, and control of impulses. In my own clinical experience, I have found that patients have reported experiencing fear and, at times, terror in relation to their out-of-control behavior. At these times, restraint can be the most therapeutic intervention, provided the nurse engages in this intervention in a safe and truly caring manner in which the patient’s physical safety and emotional well-being are protected and supported.

The protection of nurses and other health care providers is also of great importance. Just as aggressive psychiatric patients are deserving of a safe, secure environment and ethical treatment, so too are the caregivers. Those who strive to provide compassionate care to the most vulnerable in society are also worthy of respect and a safe work environment. Yet the data related to assault of nurses and other health care providers demonstrate that this often is not the case.

In addition, nurses should not be made to feel that they are a failure if, after attempting less restrictive interventions, restraint is required to prevent serious...
harm. The goal of a restraint-free environment is an ideal worth pursuing but it may not be realistic in all situations, considering the nature of acute care psychiatry. A phenomenological study conducted by Bigwood and Crowe (2008) reported that nurses were uncomfortable with the responsibility of restraining but recognized its necessity in some circumstances. This study concluded that the practice of restraint needed to be approached with as much care and humanity as possible for the good of both the patient and the nurse.

In an effort to meet the needs of both patients and health care providers, rigorous intensive education and training related to the safe, appropriate, and therapeutic use of physical restraining procedures must be instituted in acute care psychiatric settings. In this way, safe, compassionate care can be provided to a vulnerable patient population without compromising the safety of patients, nurses, and other health care providers.

REFERENCES


