Physical Restraints and the Geropsychiatric Patient

Until the elderly have become one of the greatest cries against inhumane treatment of patients since Pinel released the mentally ill from their chains. The recent focus in this country on freeing elderly patients from restraints in nonpsychiatric settings (long-term care institutions, acute care hospitals, and rehabilitation units) has brought attention to the use of physical restraints on older adults in psychiatric hospitals. Even though psychiatric institutions report the lowest incidence of physically restraining older adults, there is little indication that these settings have a better understanding of aged persons or the deleterious effects of physical restraints. Rather, psychiatric hospitals have had more legal regulations and guidelines for restraint and seclusion use, whereas other health-care institutions have not. This policy may account for the low reported use of physical restraint in psychiatric hospitals. On the other hand, behavior problems are often manifestations of the psychiatric illness for which older adults are admitted to geropsychiatric units, and are thus amenable to psychoactive drugs alone.

Furthermore, some psychiatric hospitals do not include soft cloth restraints and geri-chairs in their reports of restraint use; most report the number of hours that patients are placed in leather restraints or seclusion. Large stuffed chairs or bean bag chairs are sometimes used on the units to restrain older adults who cannot get out of the chairs on their own volition. These chairs should also be considered mechanical restraints.

Stilwell defines physical restraints as those devices, materials, and equipment that are attached to or are adjacent to the patient's body; prevent free body movement to a position of choice (standing, walking, lying, turning, or sitting); and cannot be controlled or easily removed by the patient. Physical restraints in and of themselves are not therapeutic but are a time-limited means of controlling patient activity or movement to carry out essential health care. In the past, however, some forms of restraints were viewed as therapeutic.

Benjamin Rush, the father of humanitarian psychiatric treatment in America, invented the tranquilizing chair in which patients were strapped in a sitting position for long periods. He also designed the gyration board, where persons were bound upside down on a slanted rotating board. These restraining devices were used because it was believed that they would cure certain mental illnesses. Today we look back on that period with disdain, yet we still restrict patient movement by using the geri-chair. The geri-chair, no matter how well designed, remains a mechanical restraint that has potentially adverse effects on patient well-being.

Physical restraints are instituted for a variety of reasons ranging from management of behavior problems to carrying out medical regimens. Restraints are used to prevent assaultive behavior, wandering, falls, and exhaustion. Unfortunately, they may also be used when there is a lack of staff available for safe monitoring for the geropsychiatric patient and for involving elders in activities.

Mion and colleagues, in a study of nurses on an acute medical unit, found that more than one reason was given for restraining 46% of the restrained patients. Some reasons given were to maintain therapies, prevent disruption of tubes and dressings, manage violent behavior, and maintain sitting balance. Strome discusses several major reasons for restraining older adults. These include behavior that is violent or assaultive, or when patients with aggressive behavior are sensitive to psychotropic drugs or are not amenable to alternative measures, such as interpersonal techniques or environmental manipulation. For patients energized by self-destructive psychotic thoughts, even a 1:1 nursing assignment may not prevent the patient from acting on those thoughts.

Whether or not one agrees with the argument surrounding the use of physical restraints or strives to provide care in the least restrictive manner, it is sometimes necessary to use physical restraints with the geropsychiatric patient. More importantly, in the event that restraints are necessary, because of both physical and psychological consequences, the patient requires intensive nursing care, continuous observation, and psychosocial support.

More research is needed not only to determine alternatives to physical restraint use with older adults, but also to determine appropriate nursing care outcomes. Nurses are being challenged to find the least restrictive and most therapeutic ways to ensure autonomous and safe treatment for geropsychiatric patients.

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REFERENCES