

Restraint Use: Attitudes, Safety & Best Practices

Authored by
mohammed loot

November 23, 2025

RECOMMENDED CITATION

mohammed loot (2025). *Restraint Use: Attitudes, Safety & Best Practices*. Psychepedia.
Retrieved from <https://psychepedia.arabpsychology.com/?p=26282>

Historical and Conceptual Foundations of Restraint Use

The application of physical or pharmacological restraints in clinical settings, particularly psychiatry and acute care, possesses a long and often controversial history. Historically, restraints were frequently viewed as necessary instruments for maintaining order, ensuring the safety of highly agitated patients, and protecting staff from potential harm. This traditional perspective often prioritized immediate safety and control over patient autonomy or therapeutic alliance. Early conceptualizations of mental illness, which sometimes involved notions of **dangerousness** or unpredictability, reinforced the belief that strong measures, including physical containment, were essential tools in managing acute behavioral crises. Consequently, professional attitudes during these eras often normalized restraint use as an unavoidable, albeit regrettable, component of patient management, leading to high rates of application across various institutional settings.

However, the latter half of the 20th century witnessed a significant paradigm shift, driven by advances in psychiatric treatment, human rights movements, and growing scrutiny regarding institutional practices. This shift challenged the historical acceptance of restraints, prompting critical examination of their psychological impact, potential for harm, and overall efficacy. The prevailing attitude began to transition from acceptance to a model emphasizing **reduction** and, ideally, elimination. This change was underpinned by the realization that restraints, while providing temporary physical control, often exacerbated patient distress, contributed to trauma, and undermined therapeutic goals. This evolution necessitates a deeper understanding of the complex interplay between historical practice, evolving ethical standards, and contemporary clinical judgment when assessing professional attitudes toward restriction.

The conceptual framework surrounding restraint use now differentiates clearly between necessary emergency intervention and routine management. A favorable attitude toward restraint use today is generally defined not by the willingness to apply them, but by a commitment to rigorous assessment, adherence to **least restrictive environment** principles, and comprehensive documentation following application. This modern perspective requires clinicians to view restraints as a measure of last resort, utilized only when all less restrictive interventions have failed and an immediate, substantial risk remains. Therefore, understanding attitudes toward restraint is intrinsically linked to understanding adherence to contemporary standards of care, which mandate a proactive, preventative approach focused on de-escalation rather than reactive physical control.

Ethical and Legal Dimensions Shaping Attitudes

The ethical dilemmas inherent in restraint application significantly influence the attitudes held by healthcare professionals. The core conflict lies between the duty to protect the patient (beneficence) and the duty to respect the patient's freedom and autonomy (nonmaleficence and autonomy). When a professional holds an attitude that overly prioritizes safety and control, they

may inadvertently violate the patient's right to **self-determination**, potentially leading to overuse or premature application of restrictive measures. Conversely, an attitude that excessively prioritizes autonomy in the face of imminent danger can compromise the safety of the patient or others. Navigating this complex ethical terrain requires a balanced professional attitude rooted in careful, situation-specific risk assessment and ethical deliberation informed by established institutional guidelines.

Legally, the use of restraints is heavily regulated, and these regulations impose strict constraints on professional practice, thereby shaping attitudes toward their necessity and appropriateness. Jurisdictions typically require detailed protocols regarding initiation, duration, monitoring, and termination of restraints, often mandated by accreditation bodies. The legal imperative is to ensure that restraints are used only as a last resort and for the shortest possible duration. Staff attitudes must reflect an understanding that failure to adhere to these legal mandates--such as inadequate documentation, lack of physician review, or failure to utilize less intrusive alternatives--can result in institutional liability and professional sanctions. Therefore, a positive professional attitude in this context means viewing documentation and procedural compliance not as bureaucratic burdens, but as essential **safeguards** protecting both the patient's rights and the institution's legal standing.

Furthermore, the concept of the least restrictive environment is a fundamental legal and ethical principle that profoundly impacts attitudes. If staff view restraints as a routine management tool, they are less likely to invest time and resources in developing and utilizing alternatives, thereby violating this core principle. A shift toward a restraint-reduction culture requires professionals to internalize the principle that freedom from restraint is a fundamental patient right, requiring rigorous justification for any deviation. This necessary attitudinal change involves proactively seeking environmental modifications, individualized care plans, and specialized training in de-escalation techniques, moving away from a reliance on physical intervention. The legal framework thus serves as a powerful external force compelling healthcare professionals to adopt more cautious and **conservative attitudes** toward restraint use, demanding constant justification for their application.

Clinical Rationales and Professional Perspectives

Clinical rationales for restraint use typically center on preventing immediate, serious harm. The primary justifications include preventing self-injury (e.g., head banging, attempting suicide), preventing injury to others (e.g., assault on staff or peers), or preventing the disruption of critical life-sustaining treatment (e.g., pulling out intravenous lines or endotracheal tubes in acute medical settings). Professional attitudes often diverge significantly based on the specific clinical environment. For example, emergency department staff facing high-acuity, unknown patients may hold attitudes that favor quick, decisive intervention due to the rapid turnover and high risk, while psychiatric unit staff, focused on long-term therapeutic relationships, may prioritize verbal de-

escalation and rapport building, viewing restraint as detrimental to the therapeutic process.

Physicians, nurses, and allied health professionals often exhibit distinct professional perspectives influenced by their training and scope of practice. Nurses, who are typically responsible for the direct application and continuous monitoring of restraints, often feel the greatest burden and **moral distress** associated with their use. Their attitudes are shaped by the immediate safety concerns of the unit, the emotional toll of restraining a patient, and the procedural demands of monitoring. Physicians, who authorize the restraint, base their attitudes on diagnostic criteria, risk assessment, and legal liability, often perceiving the decision as primarily a risk management one. A positive professional attitude across disciplines involves shared decision-making, clear communication regarding the necessity of the intervention, and a unified commitment to evidence-based termination criteria.

A major factor influencing professional attitudes is the perception of control and competence. Staff who feel inadequately trained in managing aggression or who work in understaffed environments may develop attitudes that perceive restraints as the most reliable, if not the only, method for regaining control during a crisis, thereby relying on them defensively. This reliance can become cyclical, where lack of confidence in de-escalation skills reinforces the attitude that physical control is necessary. Conversely, comprehensive training in crisis prevention and intervention significantly alters professional attitudes, fostering a sense of **competence** and self-efficacy in managing agitated behavior without resorting to restrictive practices. The belief that one possesses the skills to manage a crisis effectively is a critical precursor to adopting a restraint-averse stance.

Patient and Family Experiences: The Lived Reality

Patient attitudes toward restraint use are overwhelmingly negative, often characterized by feelings of fear, humiliation, rage, and profound loss of control. Studies consistently show that the experience of being restrained can be highly traumatic, contributing to the development or exacerbation of **post-traumatic stress symptoms**. For many patients, particularly those with a history of abuse or previous institutionalization, the experience of being physically overpowered and confined recreates historical trauma, severely damaging the therapeutic alliance essential for recovery. Staff attitudes that minimize the patient's subjective experience--viewing the restraint merely as a necessary procedure rather than a potentially damaging event--can further alienate the patient and undermine future cooperation and trust.

The perspective of family members also plays a crucial role in shaping the broader societal and institutional attitudes toward restraint use. When families learn that their loved one has been restrained, they often experience distress, anger, and mistrust toward the healthcare providers. They may question the necessity of the intervention and worry intensely about the potential for injury or abuse, especially if communication surrounding the event is poor. Institutions with

transparent communication protocols and staff who demonstrate **empathy** regarding the family's concerns tend to foster more positive relationships, even following a necessary restraint application. Conversely, defensive or dismissive staff attitudes can solidify family skepticism and contribute to a negative view of institutional practices, leading to formal complaints or litigation.

Incorporating patient and family feedback is essential for fostering a culture of restraint reduction. When patients are given the opportunity to debrief after a restraint incident, their input often reveals triggers, environmental factors, or communication failures that contributed to the crisis. Staff attitudes must be open to this critical feedback, viewing it as actionable data for improving preventative care rather than simply a complaint or criticism. Restraint reduction initiatives that successfully integrate the patient's voice--for example, through personalized **safety plans** developed collaboratively--tend to achieve greater success because they shift the underlying staff attitude from reactive control to proactive, individualized support, recognizing the patient as a partner in care.

Organizational Culture and Staff Training Imperatives

Organizational culture is perhaps the single most potent determinant of staff attitudes toward restraint use. In institutions where high restraint rates are normalized, staff attitudes tend to reflect a resigned acceptance, viewing restraints as an inevitable part of the job and failing to question their necessity. Conversely, organizations committed to a "Zero Restraint" or "Restraint Minimization" philosophy actively cultivate staff attitudes that prioritize safety through prevention. This cultural shift requires strong administrative support, clear policies that restrict the use of restraints to extreme emergencies, and the allocation of resources for comprehensive preventative measures, including adequate staffing and environmental improvements.

Effective training is paramount in modifying attitudes and building staff confidence in alternatives. Training programs, such as comprehensive crisis prevention and intervention models, focus not just on the mechanics of safe restraint application, but crucially, on the early recognition of agitation, verbal de-escalation techniques, and environmental management. Staff who receive high-quality, recurring training are more likely to develop attitudes rooted in **competency**, believing they can manage escalating situations through communication and therapeutic presence rather than physical force. This training must address the underlying psychological factors, such as staff fear and frustration, that often lead to the premature decision to restrain, helping staff manage their own emotional reactions during crises.

Furthermore, the concept of psychological safety for staff is critical in modulating attitudes toward restraint. If staff feel unsupported, burned out, or constantly at risk of injury due to chronic understaffing or inadequate resources, their attitudes may gravitate toward defensive, restrictive practices as a perceived necessity for survival. Organizations must foster an environment where

staff feel safe reporting concerns, accessing adequate staffing levels, and debriefing after violent or stressful incidents. When staff feel valued and protected, they are better equipped to approach agitated patients with patience and therapeutic intent, rather than adopting an attitude of self-protection that often precipitates the use of restraints. Therefore, a positive organizational culture reinforces **positive staff attitudes**, creating a virtuous cycle leading to reduced restraint usage and improved patient outcomes.

The Impact of Attitude on Implementation and Duration

Staff attitude directly impacts both the decision to initiate a restraint and the duration for which it is maintained. An attitude of skepticism toward alternatives, or a belief that a patient is inherently manipulative or dangerous, can lead to a quick, almost reflexive decision to restrain at the first significant sign of agitation. This contrasts sharply with an attitude rooted in **therapeutic curiosity**, where the professional seeks to understand the underlying unmet need driving the behavior before escalating intervention, such as pain, fear, or sensory overload.

The attitude held by the monitoring staff is crucial for determining the duration of the restraint. If staff view the restrained patient as simply "contained" and shift their focus away, the restraint may be unnecessarily prolonged, increasing the risk of complications like circulatory impairment or aspiration. A proactive, restraint-averse attitude mandates **continuous monitoring** with a therapeutic goal: actively seeking opportunities to terminate the restraint safely. This involves frequent reassessment of the patient's emotional state, offering verbal reassurance, and attempting less restrictive alternatives (e.g., offering PRN medication, repositioning, or moving to a quieter space) while maintaining strict safety protocols. The termination of the restraint is often the most challenging phase, requiring staff confidence and a commitment to restoring autonomy as soon as clinically possible.

Moreover, the documentation process is significantly influenced by staff attitude. When staff view documentation as a perfunctory, compliance-driven task, the records may lack the detail necessary to justify the intervention or guide future preventative care. Conversely, when staff adopt an attitude that prioritizes accountability and learning, documentation becomes a rich source of data, detailing all failed alternatives, specific behavioral triggers, and the rigorous rationale for maintenance. High-quality documentation, driven by a professional attitude of transparency and rigor, is essential for internal review processes aimed at **continuous quality improvement** and reducing future restraint events, demonstrating that all less restrictive measures were exhausted.

Non-Physical Alternatives and De-escalation Strategies

A key indicator of progressive attitudes toward restraint use is the comprehensive knowledge and skillful application of non-physical alternatives. These strategies are not merely techniques but

represent a fundamental commitment to proactive, relationship-based care and the principle of **dignity in care**. The spectrum of alternatives ranges from basic environmental modifications to highly specialized therapeutic interventions. Staff must possess a strong, positive attitude toward these alternatives, believing in their efficacy and dedicating the necessary time and effort to implement them before resorting to physical control, even when faced with high levels of stress.

Effective de-escalation hinges on specific communication techniques and an empathetic attitude. This includes maintaining a calm demeanor, using non-threatening body language, validating the patient's feelings without agreeing with destructive behavior, and offering clear, simple choices that allow the patient to regain a sense of control. If a staff member approaches an agitated patient with an attitude of fear or confrontation, the situation is likely to escalate rapidly, justifying the staff member's initial negative attitude toward verbal intervention. Therefore, training must focus heavily on developing the emotional intelligence and **self-regulation skills** necessary to maintain a therapeutic attitude under extreme duress, recognizing that one's own anxiety can fuel patient agitation.

Specific non-physical alternatives that reflect a restraint-reduction attitude include:

Environmental Adjustments: Reducing noise, dimming lights, managing crowding, or moving the patient to a private, less stimulating area.

Verbal De-escalation: Using reflective listening, setting limits calmly and consistently, and offering brief, factual statements tailored to the patient's level of comprehension.

Comfort Measures: Offering warm blankets, food, hydration, or allowing patients access to sensory tools (e.g., weighted blankets, music, stress balls) as outlined in their individualized care plan.

Pharmacological Interventions: Judicious and timely use of PRN (as needed) medications, administered voluntarily by the patient whenever possible, as a preemptive measure to manage anxiety or agitation before it reaches crisis level.

The consistent, successful application of these alternatives reinforces positive staff attitudes, demonstrating that safety can be maintained while respecting patient **dignity and autonomy**.