

# Restraint Use in Critical Care: Beliefs & Guidelines

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## Introduction to Restraint Use in Critical Care

The application of physical or chemical restraints within critical care settings represents one of the most ethically challenging and emotionally charged interventions employed by healthcare professionals. Defined generally as any manual method, physical or mechanical device, material, or equipment that restricts a patient's freedom of movement or normal access to their body, restraints are typically utilized when patients exhibit behaviors deemed disruptive, dangerous, or detrimental to their own clinical stability, such as self-extubation or aggressive removal of vascular lines. Understanding the deeply ingrained beliefs surrounding the efficacy and necessity of these devices is paramount, as these convictions directly influence clinical decision-making, institutional policy, and ultimately, patient outcomes. The tension inherent in this practice arises from the conflict between the professional duty to ensure patient safety and the ethical imperative to preserve individual autonomy and dignity, a dilemma that often leads to significant moral distress among nursing staff who implement these measures daily.

Current beliefs about restraint usage are not monolithic; they vary significantly across disciplines, institutions, and even individual units, often being shaped more by anecdotal experience and historical precedent than by rigorous empirical evidence. While providers universally acknowledge the potential harms associated with prolonged immobilization, many continue to view restraints as an indispensable tool for managing acute behavioral crises in an understaffed or high-stress environment. The fundamental belief driving this utilization is one of risk management: that the immediate threat posed by a confused or agitated patient (e.g., pulling a central line) outweighs the long-term psychological and physical detriments of restriction. This framework necessitates a careful exploration of the underlying cognitive processes and systemic pressures that reinforce the perception of restraints as a necessary evil rather than an intervention of last resort.

Furthermore, analyzing beliefs requires differentiating between the stated, formal policies and the actual, informal practices that occur at the bedside. Often, institutional guidelines mandate thorough documentation, continuous monitoring, and prompt reassessment; however, the reality of high patient-to-nurse ratios and the intensity of critical illness can lead to shortcuts where restraints are applied proactively based on predictive risk factors rather than in response to imminent danger. Therefore, any comprehensive study of beliefs must account for the impact of the critical care environment itself--an environment characterized by sensory deprivation, sleep cycle disruption, and the frequent administration of psychoactive medications--all of which contribute to the delirium and agitation that often precipitate the need for restrictive measures.

## Historical Context and Evolution of Restraint Practices

The historical context of restraint use is deeply rooted in paternalistic models of healthcare, where the patient's capacity for autonomous decision-making was often discounted in favor of the

clinician's perceived expertise regarding the patient's best interest. In earlier decades, restraints were frequently used liberally, sometimes for the convenience of staff or as a primary method of managing non-compliance, reflecting a belief system that prioritized institutional order and control over patient rights. This historical legacy has left an indelible mark on current practice, contributing to an ingrained cultural acceptance of restraints as a standard component of acute care management, despite decades of advocacy for less restrictive alternatives. The subsequent evolution of medical ethics, propelled by movements emphasizing informed consent and patient advocacy, mandated a critical re-evaluation of these practices, shifting the belief paradigm towards minimization.

The standardization efforts initiated by accrediting bodies, such as the Joint Commission (TJC) in the United States, played a crucial role in challenging historical norms by imposing strict regulations regarding documentation, time limits, and required justification for restraint application. These external pressures forced institutions to formalize their beliefs about when and why restraints were appropriate, moving the practice from an arbitrary staff decision to a highly regulated medical order requiring physician oversight. This regulatory framework cemented the belief that restraints are an intervention of last resort, permissible only after exhaustive attempts at de-escalation and behavioral modification have failed. The contemporary belief system, therefore, is a hybrid, attempting to reconcile the historical emphasis on control with the modern ethical demand for respect for patient autonomy.

It is important to note that the shift in beliefs has been uneven globally. While many Western nations have adopted stringent standards aimed at restraint reduction, cultural and legal differences in other regions continue to influence the perceived legitimacy and frequency of use. For instance, in settings where litigation risk is high, the belief in the protective power of restraints--that they shield the hospital and staff from liability in case of patient self-harm--can override evidence suggesting their detrimental effects. Thus, the evolution of practice is not merely clinical; it is deeply intertwined with legal frameworks and institutional risk tolerance, reinforcing differing beliefs regarding the appropriate balance between safety and freedom.

## Clinical Justifications and Perceived Benefits

The primary clinical justification for applying restraints centers on preventing immediate, critical harm to the patient or others. Healthcare providers widely hold the belief that restraints are effective in preventing accidental removal of life-sustaining equipment, such as endotracheal tubes, feeding tubes, and intravenous catheters, which could lead to catastrophic clinical deterioration. In the context of mechanical ventilation, for example, the perceived risk of self-extubation--a potentially fatal event--is often cited as the strongest rationale, driving a belief that proactive restraint application is a necessary protective measure, particularly for patients experiencing severe delirium or agitation. This belief is reinforced by high-stakes situations where

the potential consequence of non-restraint application is immediate mortality or morbidity.

A secondary, though equally pervasive, belief is that restraints contribute to the maintenance of therapeutic continuity. When a patient continually interrupts necessary treatments--such as dialysis or continuous monitoring--restraints are sometimes viewed as the only viable mechanism to ensure the uninterrupted delivery of care crucial for recovery. This utilitarian perspective suggests that temporary restriction is justified if it facilitates the overall goals of critical care and leads to a faster recovery and discharge. Furthermore, in cases involving severe violence or aggression directed toward staff or other patients, the belief shifts toward protecting the therapeutic environment itself, justifying the use of restraints as a necessary measure for maintaining a safe workspace.

However, the perceived benefits often overshadow the demonstrable lack of robust evidence supporting the efficacy of restraints in preventing adverse events. While providers believe restraints prevent line removal, studies have paradoxically suggested that restrained patients may be at a higher risk of injury, including falls, pressure ulcers, and psychological trauma, potentially due to increased agitation and struggling against the devices. This gap between professional belief (that restraints confer safety) and scientific evidence (that they introduce new risks) highlights a significant challenge in translating research into practice. The reliance on subjective clinical judgment, often influenced by stress and fear of negative outcomes, perpetuates the cycle of restraint use, even when safer, non-restrictive alternatives are available.

## Ethical and Psychological Implications for Patients

The ethical dimension of restraint use revolves around the fundamental conflict between beneficence (acting in the patient's best interest) and autonomy (respecting the patient's right to self-determination). When restraints are applied, the belief system shifts temporarily toward prioritizing physical safety above all else, often overriding the patient's expressed or presumed wishes. Ethicists argue that this practice can constitute a profound violation of personal liberty, leading to significant psychological distress, fear, and a loss of trust in healthcare providers. Patients often report feelings of humiliation, powerlessness, and confusion when restricted, experiences that can contribute directly to the development of post-intensive care syndrome (PICS).

From a psychological perspective, the belief that restraints calm an agitated patient is often contradicted by clinical reality. For many patients, being physically restricted intensifies feelings of panic and claustrophobia, leading to a paradoxical increase in agitation and the need for higher doses of sedative medication--a phenomenon known as the restraint-sedation cycle. This negative feedback loop reinforces the perception among staff that the patient is uncontrollable without restriction, further solidifying the belief in the necessity of the intervention. Addressing these psychological harms requires a fundamental shift in belief: recognizing that the patient's agitation is

often a symptom of underlying delirium or pain, rather than willful non-compliance.

The long-term psychological impact is a critical factor often overlooked in the acute decision-making process. Surviving patients frequently recount the experience of being restrained as the most traumatic aspect of their critical care stay. This trauma can manifest as nightmares, anxiety, and avoidance behaviors long after discharge. Therefore, a modern, ethical belief about restraint use must incorporate the principle of minimizing psychological harm, demanding that providers actively seek alternatives and ensure that if restraints are necessary, they are applied with utmost respect, continuous communication, and frequent release for range-of-motion exercises, mitigating the feeling of abandonment and cruelty that often accompanies immobilization.

### **Staff Perspectives: Nurses' Beliefs and Decision-Making**

Nurses, who are primarily responsible for the initiation, monitoring, and removal of restraints, hold the most immediate and influential beliefs regarding their use. A dominant belief among critical care nurses is that restraints are essential tools for maintaining patient safety in high-risk situations, particularly when staffing is inadequate or when patients are highly unpredictable. Many nurses report feeling legally and professionally vulnerable if a patient harms themselves while unrestricted, leading to a strong belief in the protective function of restraints against litigation and professional blame. This defensive practice is often rooted in institutional culture rather than clinical necessity.

Decision-making processes among nurses are also heavily influenced by their perceived level of control and the acuity of the unit. When nurses feel overwhelmed, under-supported, or morally distressed by the conflicting demands of maintaining safety and respecting autonomy, they may default to restraints as a quick, albeit imperfect, solution. Studies indicate that nurses' beliefs about the appropriateness of restraints correlate strongly with their experience level; less experienced nurses may rely more heavily on restraints due to uncertainty in managing complex behavioral issues, whereas highly experienced nurses often demonstrate greater confidence in implementing de-escalation techniques and non-pharmacological interventions.

Furthermore, a significant element of staff belief involves the concept of the "slippery slope"--the concern that if a patient is unrestrained, they will inevitably cause harm. This belief often persists despite evidence showing that structured environmental modifications and enhanced observation can effectively mitigate risk without physical restriction. To successfully reduce restraint use, institutions must therefore focus on changing the fundamental belief that restraints equate to safety, replacing it with a belief system that equates proactive behavioral assessment and skilled de-escalation with superior patient safety and quality of care. Educational programs must specifically target the cognitive biases and fear-driven rationalizations that underpin routine restraint application.

## Institutional Policies and Legal Frameworks

Institutional policies serve as formal declarations of an organization's collective beliefs about the appropriate use of restraints. High-quality policies emphasize the principle of “least restrictive measure,” mandating that all alternatives be exhausted before physical restraint is considered. The underlying belief here is that the institution has a primary duty to protect patient liberty while managing risk. These policies typically require detailed documentation, specific ordering procedures (often requiring a face-to-face assessment by a physician or advanced practitioner), and time-limited orders that necessitate frequent re-evaluation. The legal framework reinforces this belief structure by holding institutions accountable for practices that violate patient rights or lead to preventable harm.

Compliance with these rigorous legal and policy standards is often viewed by staff as burdensome, leading to a disconnect between the espoused institutional belief and the enacted bedside practice. While policies may dictate a rapid transition away from restraints, the practical belief among staff might be that the paperwork burden associated with restraints is less demanding than the constant one-on-one supervision required for agitated, unrestrained patients. Consequently, institutional commitment must extend beyond written policy to robust resource allocation, ensuring adequate staffing levels and dedicated behavioral support teams that can uphold the spirit of restraint minimization.

The legal implications heavily influence institutional beliefs regarding documentation. The widespread belief that “if it wasn't documented, it didn't happen” drives meticulous record-keeping, particularly around the rationale for restraint application and the monitoring of the patient while restrained. This documentation serves not only as a clinical record but as a legal defense, reflecting the belief that adherence to protocol mitigates liability risk. Key components of a legally defensible restraint belief system include:

**Imminent Danger:** The belief that restraints are only justified when the patient poses an immediate threat of serious harm.

**Alternatives Exhausted:** The documentation must reflect the genuine belief that all less restrictive measures were attempted and failed.

**Continuous Monitoring:** The belief that restrained patients require heightened, specified observation to prevent complications such as aspiration or circulatory impairment.

## Alternatives to Restraint and De-escalation Strategies

A crucial component of evolving beliefs about restraint use involves the proactive adoption of non-pharmacological and environmental alternatives. Shifting the core belief from “restraint is control” to “environment is therapy” necessitates intensive training in de-escalation techniques and behavioral assessment. The belief that agitation is manageable without physical restriction is

supported by evidence demonstrating the effectiveness of strategies focused on addressing underlying causes, such as pain, hypoxia, hypoglycemia, or sensory deprivation (delirium).

Effective alternatives require a multidisciplinary belief in their utility and feasibility. These strategies include:

**Environmental Modification:** Adjusting lighting, reducing noise, ensuring the presence of familiar objects, and promoting consistent sleep-wake cycles to manage delirium.

**Enhanced Observation:** Utilizing sitters or dedicated one-to-one observation to provide constant presence and redirection, based on the belief that human engagement is inherently safer than mechanical restriction.

**Family Engagement:** Encouraging the presence of trusted family members who can offer familiar comfort and help orient the patient, leveraging the belief that familial support is a powerful therapeutic tool.

**Non-Pharmacological Comfort Measures:** Employing massage, music therapy, or relaxation techniques to reduce anxiety before it escalates to dangerous agitation.

The successful implementation of restraint alternatives requires institutional leadership to foster a cultural belief that restraint minimization is a quality indicator, not merely a compliance requirement. This involves investing in staff education on specialized delirium assessment tools (like the Confusion Assessment Method for the ICU, or CAM-ICU) and behavioral management techniques. When staff firmly believe that they possess the skills and resources necessary to manage agitation without resorting to physical force, the reliance on restraints naturally diminishes, transforming the unit culture toward one that prioritizes compassionate, holistic care.

## Future Directions in Restraint Minimization

The future trajectory of beliefs about restraint use in critical care is moving decisively toward elimination, viewing physical restriction as an indicator of systemic failure rather than a necessary intervention. This aspirational belief is driving innovation in technology and care delivery models. Future research will likely focus on identifying precise biomarkers and predictive models for delirium and agitation, allowing for pre-emptive, individualized interventions that negate the need for crisis management. The integration of advanced monitoring technologies, such as continuous video monitoring systems equipped with artificial intelligence to detect early signs of dangerous patient movement, supports the belief that technology can enhance safety without compromising freedom.

Furthermore, there is a growing belief in the necessity of interprofessional collaboration centered on behavioral health. Future critical care units are envisioned to include dedicated behavioral specialists, psychiatric liaisons, and specialized geriatric care teams integrated directly into the ICU team. This staffing model supports the belief that complex agitation requires specialized expertise

that exceeds the bandwidth of traditional critical care nursing alone. The goal is to standardize the belief that managing challenging behavior is a core competency of the ICU, requiring specialized resources, rather than a deviation requiring mechanical correction.

Ultimately, changing beliefs about restraints requires a continuous process of auditing, feedback, and cultural reinforcement. Institutions must regularly review restraint usage data, linking frequency to patient outcomes, staff moral distress, and financial costs. This transparent approach reinforces the belief that minimizing restraints is beneficial for all stakeholders--patients, staff, and the organization. The ideal future state is one where the default belief is that every critical care patient deserves to be restraint-free, and any deviation from this standard triggers immediate, mandatory review and system-level intervention, firmly establishing autonomy and dignity as non-negotiable elements of high-quality critical care.

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