RESPONDING TO RESTRAINT ISSUES

To the Editor:

I truly enjoyed the article by Lindsey (“Psychiatric Nurses’ Decision to Restrain: The Association Between Empowerment and Individual Factors,” September 2009, Vol. 47, No. 9, pp. 41-49) and found it very interesting to look at the factors affecting nurses’ decisions to restrain. Some thoughts that occurred after reading this were why not have some research where nurses would take a test or survey involving moral dilemmas (i.e., Kohlberg’s stages of moral development [Crain, 1985])? I am also interested in strictly comparing the educational backgrounds of nurses who make decisions about restraint. I work in adolescent psychiatry and was in orientation with a friend I used to work with in adult psychiatry. We pretty much had the same feelings and views on trying to avoid restraints as much as possible and especially avoiding prone restraining, which is our facility policy unless contraindicated by a medical condition or abuse, such as a previous history of sexual abuse. I have read several articles that specifically criticize prone restraints due to the danger of asphyxia and because of previous deaths, especially among obese teenagers. I am more than interested in reading about the use of prone restraints and would love any suggestions for further reading.

My suggestion is that I would like to see some research comparing RNs’ educational level and the decision to restrain using real incidents (i.e., chart reviews on restraint use in hospital settings rather than hypothetical scenarios) as compared with the individual RNs’ educational level. Interestingly, my friend and I have master’s degrees in education-counseling from the same university, and I also have a MSN in psychiatric-mental health nursing. My null statement is that there is no relationship between nurses’ educational level and their decision to restrain.

In addition, I love the Journal! Where else can we get great articles pertinent to today’s world of psychiatric nursing? Any articles about adolescents are greatly appreciated!

REFERENCE


Response:

I greatly appreciate Ms. Hutter’s interest and thoughtful comments about my article. It has been established that nurses do view the decision to restrain as a moral practice dilemma in which they must balance the patient’s right to self-determination with the desire to protect the patient and others from harm (Bower, McCullough, & Timmons, 2003; Lee et al., 2003; Maragos-Frost & Wells, 2000). It has been suggested that the focus of research regarding aggression management should now move toward prevention and safe alternatives to restraint. To accomplish this, it is essential that leadership establish a culture that values restraint reduction and clear restraint reduction plans. This has been shown to be possible, and models exist that can be applied to this end (Huckshorn, 2004). We should move beyond questions about who, what, or how we use restraint. Now is the time to seriously question why we use it and it is becoming increasingly clear that there are ways to either minimize or eliminate its use altogether. For those who have boldly taken this stance, the key seems to be establishing an organizational commitment and a strategic plan to reduce or eliminate restraint use. Some argue whether the elimination of restraint use altogether is a realistic goal (Liberman, 2006), but certainly it is a worthy aspiration.

REFERENCES


Nursing and Mental Health Services, 42(9), 22-33.

Pamela L. Lindsey, DNSc, RN
Normal, Illinois

To the Editor:

I am writing in response to Lindsey’s article in the September 2009 issue (“Psychiatric Nurses’ Decision to Restrain: The Association Between Empowerment and Individual Factors,” Vol. 47, No. 9, pp. 41-49). As a senior nursing student about to start practicing as an RN, restraint use is an issue that is essential to be aware of.

It is interesting to me that the research presented throughout this article showed that nurses with more years of experience were more likely to restrain, because I would be inclined to think the opposite. One would think that after years of experience dealing with situations that are worthy of restraint, nurses would have a better understanding of interventions to help de-escalate a client rather than immediately restraining. It seems that better education and nurse empowerment is imperative to better handle this issue.

Despite federal regulations that physical and chemical restraints are equal, it seems that it is much easier to chemically restrain someone than to physically restrain them. Perhaps this is because when we physically restrain someone, we are the ones to do the restraining, whereas when we chemically restrain someone, it is simply a pill or injection that does the work for us, and we can walk away from the situation. However, both methods have psychological effects for the client and the nurse. Many times in the assisted living facility at which I work, I have seen as-needed medications administered to clients when they probably could have been de-escalated with more one-on-one attention from the staff.

Although overall there has been an improvement in the use of seclusion and restraints in hospital settings, there is still room for improvement. With better staff education on interventions for de-escalation, we will continue to improve patient care and reduce the negative psychological effects restraints have on clients. It is inspiring as a student about to enter the field to see that there is an effort to reduce seclusion and restraint, and that simply with better education and empowerment I will be entering a field in which I feel comfortable caring for all kinds of clients.

Victoria Miner
Old Town, Maine

OCCUPATIONAL THERAPY SHOULD BE PART OF CONVERSION DISORDER TREATMENT

To the Editor:
The article “Treatment of Conversion Disorder: A Clinical and Holistic Approach” by Tocchio (August 2009, Vol. 47, No. 8, pp. 42-49) caught my attention and interest as a graduate student of occupational therapy. The reason this article interested me was because of an occupational therapy fieldwork experience I had encountered in an acute care hospital setting. On the primarily orthopedic floor, we received a referral for a client with a sudden onset of not being able to walk. Along with occupational and physical therapy services, the client was also being extensively evaluated by various physicians and neurologists to determine a diagnosis they had believed to be medical or neurological in nature. After approximately 2 weeks, it was determined that the client did not qualify to attend an inpatient physical rehabilitation facility because the physicians were not able to make a diagnosis that deemed it appropriate to receive rehabilitation services. It was eventually determined that the client’s condition was psychiatrically based, and he was referred to an inpatient psychiatric facility at hospital discharge before a diagnosis of conversion disorder was formally made. It was after the client was discharged that my fieldwork supervisor and I did some research and realized it was probable that he was experiencing conversion disorder.

In terms of treatment, the experience of the client I had seen was similar to Teresa’s case from the article. In both cases, the treatment teams were challenged with how to address the clients’ needs. This is where I see occupational therapy as being an important part of the team, because occupational therapy focuses on using holistic treatment approaches and client-centered care. The vision of the author and the health care team who were responsible for Teresa’s case incorporated techniques including adapting the environment and implementing therapeutic use of self in regard to the client’s treatment. Although it was indicated that the treatment team had undefined hospital staff

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contributing to treatment, I have assumed that occupational therapy was not part of Teresa’s treatment plan, because occupational therapy was not identified throughout the article. If this is the case, I find it unfortunate because occupational therapy could have played a role in Teresa’s treatment.

Hardaker, Halcomb, Griffiths, Bolzan, and Arblaster (2007) performed a review of the literature to identify the role of occupational therapy in adolescent mental health. They emphasized the importance of occupational therapy in mental health settings, because the roots of the profession are embedded in psychology. Occupational therapy’s role in all settings, including mental health, entail “assisting individuals to gain and maintain independent living, manage in community settings and engage in productive, meaningful and enjoyable activities” (Hardaker et al., 2007, p. 2).

In conclusion, I believe incorporating occupational therapy in the treatment of conversion disorder and other mental illness is important, as supported by the evidence from Hardaker et al. (2007). Due to occupational therapy’s emphasis on client-centered and holistic approaches to practice, Toczchio and the treatment team working with Teresa may have benefited from having an occupational therapist as a member of the team.

REFERENCE


Stephanie Acker
Sidney, New York

A CLOSER LOOK AT CAREGIVING
To the Editor:

I am writing in response to the article “Caregiver Burden or Caregiver Gain? Respite for Family Caregivers” by Cangelosi (September 2009, Vol. 47, No. 9, pp. 19-22). Although Cangelosi does a sound job calling attention to a relevant issue as it pertains to the older adult population—particularly in consideration of the growing demographic and imminent changes in health care services—her article seemed to lose its focus and address issues more relevant to the individuals receiving care rather than concentrating on the relevance to caregivers.

For many individuals within the older adult population, aging in place has become both a desire and a necessity. The independence and quality of life associated with aging in place is appealing to many individuals within this population, although with rising health care costs and the current state of the economy, many more Americans are forced to reassess where they spend the latter days of their lives, without consideration of the state of their health and well-being. According to Mason et al. (2007), an estimated 22 million older adults currently receive care from spouses or adult children, with an anticipated increase to 40 million by 2050. In addition, spouses comprise 38% of this cohort in North America (Sussman & Regehr, 2009). In addressing the needs of caregivers explicitly in terms of the experiences of adult children provid-
Letters to the Editor

Caregiver BURDEN or Caregiver GAIN?
Respite for Family Caregivers

ABSTRACT
Many caregivers of older family members do not realize the need for respite until their own health begins to deteriorate. The mental, emotional, and physical strain of caring for a family member can seem overwhelming. Creative options for respite care are emerging, but there are barriers to effective use of these programs. This article discusses common barriers and proposes suggestions for overcoming them.

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Please include your full name and mailing address. Letters may be edited for clarity and length, and may be sent to the article authors for a response.

Molly Harris
Norwich, New York

Editor's Note. The corresponding author was contacted and chose not to respond.

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