



EDITORIAL

Persisting use of physical restraint: knowledge translation vs. attitudes

Nicole Walker¹, Theresa Scott^{1,2}, Nadeeka N. Dissanayaka^{1,3}, Fiona Kate Barlow¹, and Nancy A. Pachana¹

Physical restraint in residential aged care (RAC)

The use of physical restraint in residential aged care (RAC) is relatively common [1]. Existing research suggests that the proportion of residents physically restrained in RAC facilities ranges from 12% to 47% [2]. The last two decades have seen much research discussing both the potential benefits and adverse consequences of physical restraint [3].

While at a global level, there are distinctive factors that determine both the prevalence and justification for employing physical restraint on a case by case basis rather than an umbrella explanation [4], the prevalence of physical restraint use in RAC is concerning. If knowledge about the negative impact on quality of care and quality of life could be presumed to decrease the use of physical restraint in RAC, then additional factors could also be presumed to be simultaneously (and strongly) promoting the use of physical restraint. In this paper, *in the moment affective processes* (e.g., emotions, negative attitudes) are suggested as one such likely factor, potentially overriding knowledge-based interventions and thus maintaining the use of

physical restraint. Specifically, negative attitudes towards residents residing in RAC may exist in many populations, and these, in addition to the unique environment associated with working in RAC (including high levels of one on one care, frailty and decrease mobility), perhaps promotes behaviour that is driven by affect, rather than knowledge.

Multiple studies reveal that physical restraint harms residents [2]. In particular, serious injury and mortality are often directly related to both proper and improper use (selection and application) of physical restraint on residents [1], and physical restraint is likewise associated with reduced psychological well-being, and mobility [2]. Further, residents who are managed via physical restraint exhibit rapid cognitive decline compared to those who are not restrained [2, 5].

Despite this evidence, physical restraint is frequently referenced as a protective measure [6]. For example, it is argued that physical restraint reduces the risk of personal injury to residents and employees [2], controls wandering, and facilitates medical treatment [7, 8]. However, the literature suggests that such justifications are not evidence-based and in fact are not supported by the data [8, 9].

¹School of Psychology, The University of Queensland, Queensland, Australia

²Discipline of General Practice, School of Medicine, The University of Queensland, Queensland, Australia

³UQ Centre for Clinical Research, The University of Queensland, Department of Neurology, Royal Brisbane & Woman's Hospital, Queensland, Australia

Correspondence: Nicole Walker

School of Psychology, University of Queensland, Sir Fred Schonell Drive, St Lucia, Brisbane, Queensland, 4072, Australia

Email address: n.walker4@uq.edu.au

Citation: Walker et al. Persisting use of physical restraint: knowledge translation vs. attitudes. *International Journal of Clinical Neurosciences and Mental Health* 2018; 5:1

DOI: <https://doi.org/10.21035/ijcnmh.2018.5.1>

Received: 22 Nov 2017; Accepted: 02 Feb 2018; Published: 13 Feb 2018



Open Access Publication Available at <http://ijcnmh.arc-publishing.org>

© 2018 Walker et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



Approaches to reduce physical restraint

Many different approaches aimed at reducing physical restraint are currently being employed. For example, educational interventions have been implemented to ensure there is precise understanding of physical restraint best practice within the industry and that RAC workers are regularly updated with evidenced-based knowledge [9–11]. Moreover, educational interventions that are designed to reduce the use of physical restraint have been shown to improve RAC employees' professional and treatment practices [9, 10], and have resulted in RAC residents' increased physical well-being [2]. Consequently, such educational interventions have improved adherence to best practice standards in the experimental samples.

Attitudes towards older persons and those living in RAC

Ageism involves stereotypical beliefs and negative perceptions that describe older people as less attractive and less competent [12]. It is surprisingly common for health professionals to hold such stereotypes of older people [3]. These negative stereotypes and beliefs have been shown to influence care practices [6]. Notably, research has reported that health professionals with specialist skill sets and knowledge of older adult health care often have negative attitudinal shifts and report decreased job satisfaction once they commence practice [13]. Further, research has also found that there is a difference between attitudes towards older people residing in the community and older people residing in institutions, such that attitudes are influenced by the characteristics of the contact [14]. That is, the type of intergroup contact plays a role in promoting (e.g. incidental contact) or dampening (e.g. pleasant and cooperative contact) anxiety that underpins which direction attitudes are formed [14].

Managing people with advanced dementia is extremely difficult and challenging. In the case of RAC employees, knowledge of best care may often sit alongside a range of attitudes, fears, anxieties and workplace apprehensions. RAC employees are dealing with very challenging behaviours—a combination that may prompt and even encourage affective driven responses to those behaviours *rather* than responses driven by knowledge. Such **hot affective attitudes** may help explain the continued widespread use of physical restraint.

Negative attitudes associated with underlying affective processes

Attitudes are derived from both motivational factors and contextual information from one's past and present [15]. Both motivational and contextual factors are possibly influencing unconscious negative attitudes towards those in RAC with dementia. That is, the employment conditions,

the organisational policies and the unique resident characteristics. Research supports this assertion, as RAC employees report low job satisfaction and high job related strain when they work with residents with dementia [16]. Both low satisfaction and high strain are unfavourable influences that reinforce negative attitudes toward the resident with dementia, and as such influence negative behaviour when caring for residents [17]. Certain demographic characteristics, such as age, race, gender, income, education and previous employment may also influence decisional processes to use physical restraint in the face of knowledge or organisational guidelines [10].

There is evidence to suggest an association between negative attitudes and physical restraint use and employee's socio-economic status (low income and education level) [2, 9]. Personal factors such as lower education and impoverished personal circumstances coupled with workplace characteristics such as lower remuneration, lower job satisfaction and high job strain contribute to negative health service attitudes [5, 11]. A combination of these employment characteristics may have far reaching implications for attitude formation [16] and the means by which services are delivered [11]. Specifically, negative employment conditions promote formation of negative attitudes, which may be maintained by unfavourable workplace influences; ultimately impacting on residents and the quality of care they receive.

Thus, employee and employment circumstances in RAC may promote negative attitudes towards patients, particularly when staff are under stress. Nevertheless, the relationship between possessing negative attitudes and managing one's responsive behaviour in challenging circumstances has rarely been explored in the context of RAC. The characteristics unique to RAC (low remuneration, low job satisfaction and high job strain) may be more suitable to prompting behaviours that are driven by *affect* rather than behaviours that are driven by knowledge. Affective processes relate to how people automatically or deliberately regulate, maintain, or adjust internal emotional states by magnitude and/or endurance [18]. Research has shown that self-regulation or self-control is not limitless, that in fact, when we exert self-control, self-regulation is depleted [19]. That is, when we use self-control in one domain we have less available in the second or next domain.

Resource depletion of RAC workers

In the case of RAC facilities, carers are often working long shifts, where they are facing similar behavioural challenges repeatedly from residents with dementia. While employees may be able to use logic or knowledge on the first or second interaction, by the third or fourth interaction they will have reached a limit known as resource depletion [19, 20]. Resource depletion is described as an energy resource for mental activity, which when low, frequently impairs self-regulation [20]. Caring occupations require goal di-

rected behaviour, comprising intense involvement and interaction with residents [21]. Goal directed behaviour requires self-controlled processes and interpersonal affect regulation (a state where people deliberately try to influence the internal states of others and demonstrate empathic concern) is associated with resource depletion [19, 20]. In the case of RAC employees, the more interactions in which carers employ interpersonal affective emotions (empathic concern), the more likely they are to increase the probability of depleting the energy resource related to self-control. Thus, RAC employees working with residents who have dementia are *an at risk* population in terms of resource depletion, particularly when considering the interactions, occupational tasks, and workplace environment.

The very nature of ageing where many residents experience sensory deficits, coupled with cognitive decline, often result in difficult and frustrating communication exchanges for both residents and RAC workers [11]. An influential aspect of cognitive impairment is the barrier to interpersonal communication [13, 21]. The circumstance of not being able to communicate effectively is likely to heighten anxiety and frustration [21]. Hot affective processes such as anxiety have been cited as substantially more effective at explaining attitudes and behaviour beyond that of knowledge [22]. For example in race relations, research has suggested that the more we feel intergroup anxiety or anger, the more prejudice and discrimination we display [23]. In fact, comparisons of knowledge compared with these hot affective processes have demonstrated significant predictive reliability [22], suggesting that individuals can intuitively know what the *right* choice is in a given situation, but that this may be overridden by emotionally charged processes. In terms of RAC and physical restraint, carers can at once know that physical restraint is ineffective but may choose this as an intervention at a given time. In addition, these *affective processes* can also impede empathy [24].

Conclusion and future directions

In summary, the challenging RAC environment may lead to the experience of negative affect, which then influences behavioural choices. Individuals who are depleted of self-control struggle to make rational decisions [25]. Further, employees who have low motivation and negative associations have less ability to make rational knowledge-based decisions [20]. Mapping this onto outcomes in RAC, care workers in any given moment may be less capable of drawing on knowledge and more likely to act on hot affective impulses in stressful conditions.

Research aimed at identifying the person-situation nexus that predicts physical restraint, across settings as well as individuals, may be useful in assisting with decreasing physical restraint use in RAC. By identifying the antecedents, researchers and policymakers may be able to develop effective, innovative individual and environmental processes to override the affective emotions that may

influence the frequency with which physical restraint is utilised. Another key imperative is to ascertain whether there are effective means of shifting attitudes towards the care of persons with dementia, as well as towards the environments in which such care is carried out. The potential solution should not be based solely or perhaps even primarily on increasing knowledge. Knowledge or its lack may not be the key; rather, it may simply be inadequate in the face of strong affective attitudes and barriers in the environment that contribute and maintain practices such as physical restraint.

Competing interests

The author declares no conflict of interest.

References

1. Cleary KK, Prescott K. The Use of Physical Restraints in Acute and Long-term Care: An Updated Review of the Evidence, Regulations, Ethics, and Legality. *The Journal of Acute Care Physical Therapy* 2015; 6(1):8–15. <https://doi.org/10.1097/JAT.000000000000005>
2. Evans D, Wood J, Lambert L. Patient injury and physical restraint devices: A systematic review. *Journal of Advanced Nursing* 2003; 41(3):274–82. <https://doi.org/10.1046/j.1365-2648.2003.02501.x>
3. Samra R, Griffiths A, Cox T, Conroy S, Knight A. Changes in Medical Student and Doctor Attitudes Toward Older Adults After an Intervention: A Systematic Review. *J Am Geriatr Soc* 2013; 61(7):1188–96. <https://doi.org/10.1111/jgs.12312>
4. Feng Z, Hirdes JP, Smith TF, Finne-Soveri H, Chi I, Du Pasquier J, et al. Use of physical restraints and antipsychotic medications in nursing homes: a cross-national study. *International journal of geriatric psychiatry* 2009; 24(10):1110–8. <https://doi.org/10.1002/gps.2232>
5. Wang W-W, Moyle W. Physical restraint use on people with dementia: A review of the literature. *Australian Journal of Advanced Nursing* 2005; 22(4):46.
6. Myers H, Nikolett S, Hill A. Nurses' use of restraints and their attitudes toward restraint use and the elderly in an acute care setting. *Nursing and Health Sciences* 2001; 3:29–34. <https://doi.org/10.1046/j.1442-2018.2001.00068.x>
7. Huizing AR, Hamers JP, de Jonge J, Candel M, Berger MP. Organisational determinants of the use of physical restraints: a multilevel approach. *Social Science & Medicine* 2007; 65(5):924–33. <https://doi.org/10.1016/j.socscimed.2007.04.030>
8. Karlsson S, Buchr G, Rasmussen BH, Sandman PO. Restraint use in elder care: decision making among registered nurses. *Journal of Clinical Nursing* 2000; 9:842–50. <https://doi.org/10.1046/j.1365-2702.2000.00442.x>
9. De Bellis A, Mosel K, Curren D, Prendergast J, Harrington A, Muir-Cochrane E. Education on physical restraint reduction in dementia care: A review of the literature. *Dementia* 2013; 12(1):93–110. <https://doi.org/10.1177/1471301211421858>
10. Ryan A, Melby V, Mitchell L. An evaluation of the effectiveness of an educational and experiential intervention on nursing students' attitudes towards older people. *International Journal of Older People Nursing* 2007; 2(2):93–101. <https://doi.org/10.1111/j.1748-3743.2007.00060.x>
11. Moyle W, Hsu MC, Lief S, Vernooij-Dassen M. Recommendations for staff education and training for older people with mental illness in long-term aged care. *International Psychogeriatrics* 2010;

- 22(7):1097–106.
<https://doi.org/10.1017/S1041610210001754>
12. Kite ME, Stockdale GD, Whitley BE, Johnson BT. Attitudes Toward Younger and Older Adults: An Updated Meta-Analytic Review. *Journal of Social Issues* 2005; 61(2):241–66.
<https://doi.org/10.1111/j.1540-4560.2005.00404.x>
 13. van Wyk PM, Stewart S, McGilton KS. The effects of a patient-centred rehabilitation model of care targeting older adults with cognitive impairment on healthcare practitioners. *Advances in Aging Research* 2014; 3(01):48.
<https://doi.org/10.4236/aar.2014.31009>
 14. Allan LJ, Johnson JA. Undergraduate attitudes toward the elderly: The role of knowledge, contact and aging anxiety. *Educational Gerontology* 2008; 35(1):1–14.
<https://doi.org/10.1080/03601270802299780>
 15. Allport GW. Attitudes. In: *A Handbook of Social Psychology*. Worcester, MA, US: Clark University Press; 1935. p. 798–844.
 16. Chenoweth L, Jeon Y, Merlyn T, Brodaty H. A systematic review of what factors attract and retain nurses in aged and dementia care. *Journal of Clinical Nursing* 2010; 19(1-2):156–67.
<https://doi.org/10.1111/j.1365-2702.2009.02955.x>
 17. Brodaty H, Draper B, Low L. Nursing home staff attitudes towards residents with dementia: strain and satisfaction with work. *Journal of Advanced Nursing* 2003; 44(6):583–90.
<https://doi.org/10.1046/j.0309-2402.2003.02848.x>
 18. Scheibe S, Wisse B, Schulz A. Affect and emotion regulation in aging workers. *Encyclopedia of geropsychology*. 2017;33-42.
https://doi.org/10.1007/978-981-287-082-7_32
 19. Baumeister RF, Bratslavsky E, Muraven M, Tice DM. Ego depletion: is the active self a limited resource? *Journal of personality and social psychology*. 1998;74(5):1252.
<https://doi.org/10.1037/0022-3514.74.5.1252>
 20. Vohs KD, Baumeister RF, Schmeichel BJ. Motivation, personal beliefs, and limited resources all contribute to self-control. *Journal of Experimental Social Psychology* 2012; 48(4):943–7.
<https://doi.org/10.1016/j.jesp.2012.03.002>
 21. Higashi RT, Tillack AA, Steinman M, Harper M, Johnston CB. Elder care as "frustrating" and "boring": Understanding the persistence of negative attitudes toward older patients among physicians-in-training. *Journal of aging studies* 2012; 26(4):476–83.
<https://doi.org/10.1016/j.jaging.2012.06.007>
 22. Redlawsk DP. Hot cognition or cool consideration? Testing the effects of motivated reasoning on political decision making. *The Journal of Politics* 2002; 64(04):1021–44.
<https://doi.org/10.1111/1468-2508.00161>
 23. Pettigrew TF, Tropp LR. How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators. *European Journal of Social Psychology* 2008; 38(6):922–34.
<https://doi.org/10.1002/ejsp.504>
 24. Hiraoka D, Nomura M. The Influence of Cognitive Load on Empathy and Intention in Response to Infant Crying. *Scientific Reports* 2016; 6:28247.
<https://doi.org/10.1038/srep28247>
 25. Schmeichel BJ, Vohs KD, Baumeister RF. Intellectual performance and ego depletion: role of the self in logical reasoning and other information processing. *Journal of personality and social psychology* 2003; 85(1):33.
<https://doi.org/10.1037/0022-3514.85.1.33>