The Term Restraints is Archaic

I have just finished reading the April 1990 issue of AJOT with the usual relish, having been especially lured in by the cover title of “Improving Feeding Skills in a Child With Rett Syndrome” (Sharpe & Ottenbacher, pp. 328-332). While attending the American Academy of Cerebral Palsy and Developmental Medicine Conference in 1989, we were privileged to hear Dr. Sarojini S. Budden’s address on hand function in persons with Rett syndrome, in which she cited supporting evidence for the use of elbow orthoses. With great excitement we began the process of setting up our own research model to study the effectiveness of these devices in two girls in our school who had Rett syndrome.

Dr. Budden stressed the importance of referring to all upper-extremity devices as splints or orthoses and strongly advocated the avoidance of the term restraints as archaic and misleading. If a device is a restraint, it is understood to be a passive inhibitor of a given behavior, but Sharpe and Ottenbacher did not study the inhibition of stereotypic behaviors, and the use of the word restraint in the cover title was an unfortunate choice.

We encountered resistance to our study because parents and the educational administration perceived the orthoses to be restraints, and restraints are not allowed in California schools. All splinting must be justified as a necessary adjunct to therapy and function. Hence, we were dismayed to see the word restraint in the complete title of the article. It is noted that the only other study known to date regarding upper-extremity orthoses in persons with Rett syndrome was done in 1988 by Naganuma and Billingsley, and the devices were called “splints.” Must an upper-extremity device be called a “restraint” if it is applied proximal to the hand? We might be technically correct in calling the hand splint a restraint, because it restrains thumb opposition/abduction and stereotypic finger play. We will still attempt to replicate Sharpe and Ottenbacher’s study as well as compare elbow to hand orthoses in reducing stereotypic behaviors and enhancing function. However, the appearance of restraint in the title makes it virtually impossible for us to use this study to support our own or to solicit support.

It is also noted that a reference from the American Journal of Medical Genetics, “Operant Studies of Self-Injurious Hand Biting in the Rett Syndrome” by Iwata et al., is found on pages 157-166, not 153-141 as cited in the AJOT article.

I would be most interested to know if other professionals were as disturbed by this nomenclature as we were.

Thank you for a fine journal.

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Author’s Response

I appreciate Ms. Wenbeg’s comments and her interest in Rett syndrome. Her point regarding use of the word restraint is a valid one, although the terminology was not a problem for me in obtaining approval for this study or a subsequent one in which I used the same device. I referred to the device as a restraint because my goal was indeed to restrain the subject’s left upper extremity and to inhibit stereotypic behaviors in order to encourage more functional hand use (i.e., self-feeding). Certainly the term orthosis could have been substituted.

It is unfortunate that Wenbeg’s efforts to carry out her research are meeting with resistance simply because of terminology. The need for further study in this area is great, and to deny the use of a therapeutic technique because of its label seems very shortsighted. In my subsequent study, “Comparative Effects of Bilateral Hand Splints and an Elbow Restraint on Stereotypic Hand Movements and Toy Play in Two Children with Rett Syndrome,” both subjects showed a decrease in stereotypic hand movements when they wore the restraint. I hope that parents and administrators in Wenbeg’s area will reconsider their decision and realize that whether the device is called a restraint, a splint, or an orthosis is really not the point. It should be judged by its effectiveness as a treatment technique, not by its name.

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