



# Psychiatric Inpatients' Lived Experiences of Physical Restraint: A Qualitative Study in Iran

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## Abstract

**Background:** Physical restraint is an intervention, which is sometimes performed in psychiatric wards.

**Objectives:** This study aimed to describe the lived experience of physical restraint in psychiatric inpatients.

**Methods:** This qualitative study, in-depth unstructured interviews were conducted with 12 female and eight male psychiatric inpatients with experience of physical restraint. The participants were at the hospital at the time of the interview. The transcript of the interviews was analyzed using a phenomenological-hermeneutic method, based on Van Manen's approach.

**Results:** In this study, four main themes and 12 subthemes were extracted. The main themes included "captivity", "insult", "oppression", and "punishment". Based on the results, individuals hospitalized for mental disorders considered physical restraint as suffering. Hermeneutically and metaphorically, they felt as if they were "oppressed slaves", who had been held captive and awaited freedom. This intervention could traumatize or re-traumatize the patients. However, the staff's attitude, empathy, debriefing, and giving explanation to patients might reduce the traumatic effects.

**Conclusions:** Considering the significant number of negative experiences, alternative methods should be applied in hospitals as much as possible.

**Keywords:** Hermeneutics, Psychiatric Hospital, Psychological Stress, Physical Restraint, Qualitative Research

## 1. Background

Physical restraint is a containment method used for psychiatric patients in psychiatric inpatient wards to prevent and manage the risk of self-harm due to acts, such as violence, aggression, and self-injury (1). The frequency of physical restraint varies in different hospital wards, hospitals, and cultures. In Canada, nearly a quarter of people admitted to psychiatric hospitals have experienced at least one form of physical restraint (2). It is estimated that about 12% of psychiatric patients in the UK experience physical restraint (3). In Iran, this number is estimated at about 22.5% (4).

Physical restraint can have many side effects, including sores, lacerations, falls, asphyxiation, aggressive coercion, feeling of dehumanization, psychological re-traumatization, physical injury to nurses, and even death (5). In a previous review study (5), physical restraint had four consequences, including negative psychological impact, re-traumatization, perceptions of unethical practices, and broken spirit. Since 2010, several remarkable studies have addressed this issue (6-10). Overall, physi-

cal restraint is an experience with both positive and negative outcomes for patients and nurses. The patients' negative experiences include anger, fear, loneliness, unmet basic needs, poor activity, poor communication (7), feelings of powerlessness, feelings of derealization (11), lost autonomy, being unheard, and rejection. Other patients' negative experiences include lost trust, neutrality, need for physical freedom as part of recovery from physical restraint (9), frustration, perceptions of conflict with the staff, and illness-related behaviors (11).

Additionally, there are moral conflicts and dilemmas regarding physical restraint among nurses (6, 8). Besides, nurses expressed fear and blame for both the use of physical restraint and its consequences (12). They believed that the use of these methods was deleterious to their relationship with the patients (1). On the other hand, the positive experiences may include communication between the patients and the staff in case of debriefing and discussing the event (7), safety and understanding, improvement of professional attitude, improvement of information presentation to the patients (11), and genuine calmness and relax-

ation (10).

Most previous research conducted in Iran has focused on the nurses' experiences, which include the challenging nature of this intervention (13), concerns about its safety and security (14), high level of distress (15), and negative feelings and uncertainty about the use of physical restraint (15). Our search in both English and Farsi language databases to find valid articles on the lived experiences of psychiatric patients regarding physical restraint in Iran did not yield any results; therefore, the low priority of this phenomenon for researchers can be speculated in Iran. Besides, it may reflect the overall negligence of this issue. Therefore, it is necessary to focus on this phenomenon in future research to modify the system.

Generally, understanding the patients' lived experiences may lead to a deeper understanding of physical restraint, increase the staff's empathy, and reduce its frequency by applying alternative methods. Therefore, the present study aimed to describe the lived experiences of psychiatric inpatients undergoing physical restraint. As the lived experiences of psychiatric inpatients regarding physical restraint have been already explored in many countries and cultures, this question may arise as to whether it is necessary to address this experience in Iran. Although there may be similarities between the findings of this study and similar research in other cultures, the circumstances and culture of each community may influence the lived experiences.

Iranians have the historical experience of social restraint, which was often imposed on them by absolute monarchy. In the history of Iran until today, the ruling power has been always absolute and vicious, and no rules or regulations (eg, feudalism) could influence the ruler (16). It can be assumed that Iranians have collective subconscious memories and feelings of restraint that may be relived in moments of life (even at a psychotic level); these memories may differ from one nation to another with different historical backgrounds.

## 2. Methods

In this qualitative research, a phenomenological approach was employed. Hermeneutic phenomenology was used in this study (17), with an emphasis on six overlapping dynamic activities proposed by Van Manen (18). This study was conducted between October 2018 and January 2019 in Ruzbeh Hospital, a referral psychiatric hospital in Tehran, Iran. This psychiatric hospital, which was founded in 1940, has been training medical students and psychiatric assistants since 1950's. It contains 210 beds with 185 nurses, 35 psychiatrists, and almost 80 psychiatric assistants.

By using purposive sampling, the participants were selected among inpatients who had experienced physical restraint and met the inclusion criteria (consent to participate and ability to speak Farsi). The head nurse was asked to identify eligible participants and introduce people with experience of physical restraint to the researchers. The researchers visited each introduced candidate and asked them if they were willing to discuss their experiences. Individuals who were not fully conscious were excluded from the study. All the participants were satisfied and pleased about allocating time to this research. To decrease the interval between the interview and physical restraint, the interviewees were deliberately selected among hospitalized patients. The participants were at the hospital during the interviews.

Unstructured in-depth interviews were conducted to collect information. The interviews were conducted individually while considering all privacy-related issues for the free expression of thoughts, feelings, and perceptions by the patients. Because some psychiatric patients did not have enough patience to speak for a long time, the interview duration varied from 15 minutes to 40 minutes (one or two sessions). The sampling process continued until no new data emerged during data acquisition (data saturation). This research was approved by the Ethics Committee of the Medical School of Tehran University of Medical Sciences (code: IR.TUMS.MEDICINE.REC.1398.504) and was performed according to the ethical standards of the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Six overlapping dynamic activities proposed by Van Manen were used for data analysis (18). The transcript of each interview was considered as a whole, and the main concept of the transcript was described in one or more paragraphs (a holistic approach). The holistic study of the interviews yielded 20 descriptions (some were repeated). Next, each interview was read several times, and the sentences or phrases which seemed to be related to the described or revealing phenomenon were selected (a selective approach). Detection of thematic sentences and conversion and deformation of quotations were performed separately for each interview (experimental or initial themes).

The primary categories were extracted, and the themes were classified into these categories. By changing and shifting the themes, combining common and overlapping themes, and eliminating the misplaced ones, the common basic themes emerged. Based on the opinions of experts and specialists reviewing and confirming the extracted themes in different stages, the researchers could reach an in-depth understanding of the participants' intent in the transcripts. In the thematic analysis of data,

more than 300 initial themes were extracted from the interviews. These themes were gradually reduced by removing similar and overlapping themes. Finally, 14 subthemes and four main themes were extracted.

To ensure trustworthiness, the Lincoln and Guba's framework (19) was used. To increase the credibility of the results, the participants' quotations were followed by new questions. At the time of interviews, to increase the interviewer's understanding of the participant's experiences, the quotations were shared with them. Conformability was achieved by describing different steps in the analysis process. The two researchers tried to have a non-judgmental attitude toward the statements. They were familiar with the context and interested in the phenomenon under study; they also had long-term contact with the data and tried to gather the opinions of other experts in this field.

Ethical issues were considered in this study. Before the interviews, the participants were informed about the objectives and importance of the research. Participation and withdrawal from the study were voluntary, and the interviews were recorded with the participants' permission. Written informed consent was also obtained from the participants for publication of data.

### 3. Results

Of 20 participants in this study, 12 were female, and eight were male. Eight participants had a university degree, six had a high school diploma, three had education below high school diploma, and two were illiterate. Also, 10 participants were married, two were separated, and eight had been never married. The results of analysis indicated four main themes and 12 sub-themes, including "captivity", "insult", "oppression", and "punishment" (Table 1).

#### 3.1. Captivity

One of the most important themes in the participants' experiences was captivity, with two sub-themes of "limitation" and "suffocation". In their views, captivity refers to a feeling of imprisonment, as they are confined to a bed and are not allowed to leave. Deprivation of freedom, restrictions on movement, suffocation, and difficulty breathing were frequently repeated in the participants' speech. In this regard, a 35-year-old man said:

"Human's life is suffering... When a normal person sleeps on one side of his body, he gets tired soon... I felt like I was being captured... Like a prisoner... I felt that my freedom had been taken away from me by tying my hands and feet... Well, they take away your freedom, and you are no longer free."

**Table 1.** The Lived Experiences of Physical Restraint in Patients Admitted to Psychiatric Wards

	Themes	Sub-themes
Patients' lived experience of physical restraint	Captivity	Limitation
		Suffocation
	Insult	Humiliation
		Violation
		Harassment
	Oppression	Innocence
		Sadness
		Hatred
		Fear
	Punishment	Waiting for freedom for reflection
		Waiting for recovery

Moreover, a 17-year-old female participant stated:

"It's a very bad feeling that you cannot jump or move your arms and legs; every moment, you feel as if you can no longer breathe. I slept on my side, with my hands and feet tied up for a long time; my face was itching, and I could not scratch it..."

Also, a 39-year-old woman stated:

"There is a feeling of fear and a feeling of suffocation when you lie down on the bed; you feel like you're being suffocated; I felt cold..."

Moreover, a 26-year-old man said:

"It feels like a grave." "Physical restraint is so scary. Everything is tied up, and you cannot move. What do you do with all your pent-up energy?"

#### 3.2. Insult

Another extracted theme in this study was insult. In the participants' experience, physical restraint is an offensive and insulting intervention; in other words, they are treated with disrespect or scornful abuse. The participants described three subthemes of "humiliation", "violation", and "harassment". "Degrading behavior", "cowardice", and "coercion" were among themes repeated in the participants' speech. In this regard, a 39-year-old man said:

"I feel like everyone is sane and healthy, except me. It really bothers me. The looks and words of others bother me a lot when they tie me to the bed. They laugh at me; I feel humiliated. We are also humans."

Also, a 26-year-old man said:

"We are not sheep, but they behave as if they want to butcher a sheep... I think about it so much, the fear and the panic. What did I do? I feel that my rights have been violated. Here, it is written on the board that the patients have

rights... But I had the experience of rape as a child, unfortunately. It comes back to me again and again; the violation; the mental abuse; the physical abuse.”

Besides, humiliation was part of the patients’ lived experiences. One of the participant’s statements, disclosing that “this was not a human behavior”, indicates this theme. A 52-year-old man said:

“Are we animals? If they want us to be good, they have to be patient with us. They cannot tolerate us? Actually We cannot tolerate them...”

Usually, some trained and physically fit personnel are in charge of physical restraint. This may be perceived by the patient as a form of unfair coercion. A 24-year-old woman said:

“Several large and tall men came to my room. I wanted to resist and fight it. It is as if you are caught in an act of robbery... I was so angry with them that I wanted to strangle them...”

Moreover, a 39-year-old woman said:

“It was a bad feeling. I was screaming for help and begged them to let me go, but they forced me to stay and held my hands and feet; death is much better than restraint... I was crying.”

### 3.3. Oppression

Another theme emerging in the participants’ experiences was oppression. They reported a feeling of being oppressed or wronged. They also described a feeling of being uncomfortable and concerned because of the unfair conditions of physical restraint. Physical restraint was defined as a cruel approach that restricted their freedom. The four sub-themes of “innocence”, “sadness”, “hatred”, “worry”, and “fear” were extracted for this theme. The themes of “sadness”, “hatred”, “ignorance of guilt”, “depression”, “panic”, and “begging” were also repeated in the participants’ speech. A feeling of innocence was reported by most of the participants. In this regard, a 38-year-old woman said:

“I was very upset. Why are they tying me up for? Did I do something wrong? Did I steal anything? What sin have I committed?”

Also, a 30-year-old man said:

“It is not the right thing to do. Every conflict can be resolved with a warning, and there is no need for physical restraint. It was useless. I did not do anything wrong, but they restrained me.”

Moreover, a 27-year-old woman stated:

“I was crying, I was very upset and sad.”

When the participants were asked to use a color to describe the physical restraint experience, they often used black and red colors. In their speech, they mentioned their imploring state:

“I remember the belt, the tears, the sadness, and the color of black and red belts; the color of appeal.”

The theme of hatred is evident in the statements of a 35-year-old female patient:

“It makes a person nervous. It’s like you can’t leave the house; imagine your husband locking the door and refusing to let you leave the house, or imagine imprisoning a child in a room; they may hate you. Now, imagine being tied up to your bed, the bed where you sleep at night. You will hate this bed too.”

A 55-year-old woman described her feeling of disgust toward physical restraint:

“I feel bad... I was thrown into that room intentionally. I did not do anything to be sent to that room... That room was very uncomfortable for me, and I am so afraid of it...”

Regarding the theme of fear, a 45-year-old woman said:

“I call it the horror room, because it is really horrible... The horror room was uncomfortable for me... I’m afraid of that room; I have a feeling that a person will die and not come back to life.

Also, a 38-year-old woman stated:

“I thought I was going to die.”

“I wish there was someone to mediate and untie me... I was left alone... I was afraid too.”

### 3.4. Punishment

One of the most important themes in the participants’ experience was punishment. The participants believed that physical restraint as a therapeutic experience was so harsh that they felt as if they were being punished. The three sub-themes of “waiting for freedom”, “reflection”, and “waiting for recovery” formed the theme of punishment. Regardless of how the treatment team operates and their willingness to treat the patients humanely, the patients perceived physical restraint as a form of punishment. Freedom, salvation, error, remorse, wish, and self-blame were the themes repeated in the participants’ speech. In this regard, a 25-year-old woman said:

“I just wish they would release me sooner. I wish I were free like everyone else. When I hear the sound of other people’s laugh, I wish I were with them, free and fine...”

This participant clearly felt as if she had been punished in some way. A 45-year-old man perceived physical restraint as an opportunity to reflect and said:

“I think to myself... Why did I make that mistake? Why did I break the hospital law? Restraint doesn’t really bother me. Someone might think that restraint is annoying, but in fact, they were helping me. They did not want to bother anybody. I broke the law. They tied me to the bed so I could be alone with myself and think. So, I had time to reflect on what I had done before and what I need to do in the future.”

Evidently, this approach may not be effective as a treatment. In this regard, a 25-year-old man said:

“When you regret what you have done and accept it, it’s time to remove the restraints. At that moment, they give you an injection that will calm you down.”

A 36-year-old woman described physical restraint in her painting. She used a golden color, which was a positive sign. She said:

“I colored physical restraint gold because my reward is with God... God brings me good days... I decided to control myself. I will never do anything to be restrained again. Although they were supposed to release me today, my family did not come. Again, there is nothing to be angry about, because I will regret it later.”

Based on the findings, it can be assumed that the use of a golden color may refer to a kind of reaction.

#### 4. Discussion

Many findings of the present study are consistent with the results of similar previous research. They reflect the negative aspects of the participants’ lived experiences of physical restraint. It can be assumed that part of this negative experience is not a result of physical restraint itself, but is related to the hospital environment and the hospital staff and their approach; this assumption is certainly based on reality. Although the hospital staff make efforts to provide a more humane experience of physical restraint, the lack of skilled manpower and a disciplinary approach may be among factors influencing this negative experience, as speculated in a developing country; therefore, comprehensive research is needed in this area. It seems that part of this negative experience is related to physical restraint itself, as in other studies conducted in developed countries, these negative experiences have been repeatedly reported (3, 5, 7, 9, 10). Therefore, it is suggested to accept the negative experiences of patients during physical restraint globally, and it should be only used when there is no other option, or there is a risk of harm to oneself or another. As stated by Wilson, “it is a necessary evil when used as the last resort” (3).

Wilson’s research describes relational outcomes, involving power dynamics and quality of patient-staff relationship. In this study, both the staff and the patients were interviewed. This is an important finding which also emerged in the present study, although in the present study, only interviews were conducted with the patients. Based on the findings, the themes of “captivity”, “insult”, “oppression”, and “punishment” vividly refer to the communicative component of this experience. The patient’s limbs are usually tied up for a few minutes during physical restraint. This may be a very difficult time for a patient who

may be affected by psychiatric symptoms, such as hallucinations or delusions; there is even the possibility of delusional misinterpretations. It can be assumed that patients experience severe anxiety due to being restrained. Some evidence suggests that stimulus deprivation causes or exacerbates psychiatric symptoms (20).

The patients likened physical restraint to a grave. This analogy, while representing the patient’s anxiety, indicates the severity of stimulus deprivation. Obviously, some of these experiences may be related to the symptoms of psychiatric disorders. Nevertheless, physical restraint can lead to an unpleasant feeling (either primary or secondary to the symptoms). In the patients’ experience, they felt like oppressed people, who had been held captive. It can be assumed that the staff are oppressive prison guards, and the hospital is a prison; also, the sub-theme of “waiting for freedom” can be inferred from the patients’ experiences. After an experience of physical restraint or even its mere observation, the dynamics of patient-staff relationship in the ward may be disturbed drastically and do not revert to the initial state (3). Overall, physical restraint may produce or exacerbate negative emotions that will remain in other forms (10). In the present study, the subtheme of hatred from the theme of oppression suggests this experience.

The present findings are consistent with previous research, which showed that physical limitations, especially in people with a traumatic experience, can cause re-traumatization (5). In the current study, the themes of captivity and oppression suggest re-traumatization, and one of the interviewees explicitly described re-traumatization. The use of butcher’s metaphor in the participants’ statements, along with childhood traumas, reflects the perception of physical restraint as unkind and traumatic for some patients. As mentioned earlier, another patient likened physical restraint to a grave. Another perception of physical restraint is fear, which is the fear of dying to some extent; this explains how the grave metaphor is associated with physical restraint.

Regardless of all the negative experiences of physical restraint, some positive experiences have been also reported. In a study by Kontio, positive experiences were reported during and after physical restraint, which were mostly due to debriefing and communication with the staff (7). In this study, at first glance, the sub-theme of reflection may refer to these positive aspects. However, reflection can be achieved under more comfortable conditions than physical restraint. When a patient claims that they have reflected on their behavior, they are probably referring to a sense of punishment; perhaps, they believe that the conditions of punishment have made them reflect on the issue, similar to the way a mother puts her child on a time-out to regain calmness and contemplate on their ac-

tion.

The professional behavior of the staff and explaining the issue can also lead to a reduction in negative experiences and even create positive experiences (11). Based on the available evidence, the presence of staff during and after physical restraint, especially their communication with the patients, can reduce negative emotions and even lead to the emergence of some positive feelings. One of the strengths of this study was conducting interviews with psychiatric inpatients. Lanten et al. preferred the participation of outpatients to avoid the impact of psychiatric symptoms on the interviews (11). However, we believe that interviews with inpatients are more genuine and closer to what they have perceived. In other words, even if it seems unreal, it is closer to the patients' lived experiences.

In this qualitative study, the findings were limited to the participants' expressions and interest in discussing the phenomenon. Besides, part of this experience was related to living in a psychiatric hospital, the hospital staff, and the hospital conditions and cannot be generalized. Also, part of this lived experience may have been influenced by the culture of Iranians. These factors may play an important role in the negative experience of physical restraint and challenge the absolute generalizability of the findings. In other words, old subconscious memories and feelings can be relived by physical restraint. Perhaps, part of the lived experience can be explained by this hypothesis; of course, it should be noted that the authors' minds (consequently the content analysis) are not free of these old subconscious memories. Also, some interviews were very short, and it is not clear as to whether they were long enough to reveal the actual meaning of restraint. However, patients described their most important experiences, even if in some cases, it was only a single experience.

Physical restraint is an experience with predominantly negative emotions in patients. Besides efforts to reduce coercive treatments (eg, organizational interventions, milieu interventions, and educational programs), caregivers need to be trained to help the patients reflect on their actions and provide a suitable atmosphere for debriefing of restraint experiences.

#### 4.1. Conclusions

Patients hospitalized for mental disorders consider the experience of physical restraint as suffering. Hermeneutically and metaphorically, they feel as if they are oppressed slaves, who have been held captive and await freedom; this experience may even traumatize or re-traumatize them. The staff's attitude, empathy, debriefing, and explanation may reduce the traumatic effects. Considering the significant number of negative experiences, alternative methods

are preferred in hospitals. It is also recommended to conduct similar relevant studies. For example, the staff can be exposed to the extracted themes, and changes in their approach can be examined; such findings can be applied in staff training programs.

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#### Footnotes

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**Data Reproducibility:** The dataset presented in this study is available on request from the corresponding author during submission or after its publication. Data are not publicly available to respect the patients' privacy.

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