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Experiences of Intensive Care Nurses in Their Practice of Physical Restraint Among Patients: A Qualitative Study

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ABSTRACT

Introduction: Although physical restraint causes mental and physical harm to patients, such practice occurs worldwide to ensure patient safety. It is non-standard practice for a number of reasons, including the lack of education, training, and protocol.

Objective: This study aims to determine the experiences of nurses who apply physical restraint to patients.

Methods: A descriptive phenomenological method was employed in this study, wherein semi-structured interviews were the data collection method. In this qualitative study, the data consisted of semi-structured individual interviews with nurses ($n = 20$). The data were analysed phenomenologically and were arranged with MAXqda 22 analysis software. The study complies with the COREQ checklist.

Results: Six main themes were found from the data. The themes were (i) experiences related to nurses' physical restraint procedures, (ii) ethical balance in nursing, (iii) nurses' emotions, (iv) the meaning of physical restraint, (v) nurses' observations regarding patients' reactions to physical restraints, and (vi) the experience of ethical dilemmas. The nurses perceived physical restraint as being uncomfortable, a necessity or an obligation, as beneficial for patients, and a practice seen as punishment.

Conclusions: The findings showed that physical restraint elicited diverse thoughts and emotions among nurses, who reported difficulties in coping with these emotions and insufficient knowledge of restraint procedures. Nurses also described the need to protect patient safety while preserving patient autonomy, highlighting the ethical balance involved in decisions concerning physical restraint.

Implications for Nursing Practice: This study has provided insight that can guide clinician nurses, educators, and policymakers in improving physical restraint administration. The lack of knowledge held among nurses as to physical restraint procedures emphasizes the importance of education and training on this topic and can suggest areas of development for pertinent policies and guidelines.

Patient or Public Contribution: No patient or public contribution.

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1 | Background

Physical restraint is defined as an action or procedure undertaken to prevent a person's body from moving, thereby restricting a patient from harming themselves, others, or their surroundings (Bleijlevens et al. 2016). Physical or mechanical means are used in the application of physical restraint (Turna and Gürsoy 2021; Vedana et al. 2018). Some countries or practices consider any physical or mechanical device, material, or equipment that impedes a person's ability to move for extended periods of time as physical restraint, while others include manual restraint by another person as physical restraint (Maccioli et al. 2003; Wong and Bressington 2022). In this research, the application of physical restraint includes manual methods, physical or mechanical devices, materials, or equipment that are attached to any limb of an individual and restrict their free movement. The aim of utilizing physical restraint is to take precautions against possible complications that may occur during the treatment of a patient (Putkonen et al. 2013). Physical restraint is used more frequently on individuals experiencing agitation. Agitation is one of the most common problems, particularly in intensive care units. In patients hospitalized in intensive care units, factors such as unwanted noise, abnormal lighting, sleep deprivation, stress, and anxiety may contribute to agitation (Salehi et al. 2021). Studies have shown that physical restraints are applied more frequently to particularly agitated patients (Braga et al. 2016; Goethals et al. 2013; Migon et al. 2008; Suliman et al. 2017). Although physical restraint is generally used to prevent accidental extubation, falls and other adverse events, alongside the wider enhancement of patient and employee safety, such practice is recommended as a last resort method as the application of physical restraint can cause physical and psychological trauma—such as delirium, local skin or nerve injury, peripheral circulatory disorders and muscle atrophy as well as prolonged hospitalization and even death among patients (Burry et al. 2018; Cui et al. 2021). It is also stated in the literature that physical restraint is a major risk factor in unplanned extubation (Ai et al. 2018). In a retrospective study, unplanned extubation was found in 48% of patients restrained via the wrist (Lucchini et al. 2018). Physical restraint usage can also negatively affect patient freedom, dignity, and comfort. Due to these negativities, the employment of physical restraint continues to be a controversial and ethically questionable practice (Fariña-López et al. 2014; Lao et al. 2023).

Although various legal regulations exist as to physical restraint application in many countries around the world, the practice of this type is witnessed frequently, especially among patients in intensive care units (Cui et al. 2021; Rose et al. 2016). In Türkiye, rather than a standalone legislative act, physical restraint practices are executed under the scope of the Ministry of Health's Quality Standards in Health (SKS), the Nursing Regulation, and the Patient Rights Regulation. The initiation of physical restraint strictly requires evaluation and an order by a physician, while the implementation process is managed by nurses and documented through regular patient monitoring (Tural Büyük 2022). In alignment with international guidelines, it is recommended that physical restraint be applied only when necessary to ensure patient and environmental safety, and for the shortest possible duration (Kılıç and Polat 2021). The most common reasons set out for the practice of physical restraint are that it limits the exposure of healthcare professionals to violence by patients, restricts the ability of patients to reject the delivery of healthcare (including drug administration), allows the overcoming of patient agitation or self-harm, and protects against damage being caused to property (Kılıç and Polat 2021; Woldekirkos et al. 2021). Nurses have an important role in the use of physical restraint, as they are in direct contact with patients and spend the most time with individuals in need of healthcare. In this context, nurses have the authority to apply appropriate restraint methods while considering the safety and comfort of the patient (Lao et al. 2023). Notably, the perceptions, attitudes, and experiences of nurses regarding the use of physical restraint significantly affect the decision-making raised towards this practice (Lei et al. 2022). Studies have shown that intensive care nurses often possess insufficient knowledge towards the appropriate use of physical restraint and lack an understanding of the alternatives available (Almomani et al. 2021; Ertuğrul and Özden 2021; Woldekirkos et al. 2021). Other studies have demonstrated similar low levels of knowledge about physical restraint practice and its complications among nurses, with such healthcare professionals also being found to experience ethical dilemmas about physical restraint usage (Flatharta et al. 2014; Krüger et al. 2013). Many quantitative studies have been produced investigating the attitudes and behaviour of nurses regarding their physical restraint practice.

Additionally, several factors contribute to the limited research on this topic, including ethical concerns surrounding the use of physical restraint, the narrow scope in which this issue is typically explored, the lack of qualitative studies examining its effects and outcomes, and the evaluation of the emotional impact of physical restraint from the perspective of nurses using qualitative research methods. However, it is necessary to collect, synthesize, and interpret qualitative evidence to understand the decision-making experiences and processes of nurses here. This study aims to address the role and effects of physical restraint in medical applications, discuss issues related to the safety of both patients and healthcare workers, and particularly understand the experiences and decision-making processes of nurses regarding the practice of physical restraint in intensive care units.

2 | Methods

2.1 | Study Design

In this study, the descriptive phenomenological method, one of the qualitative research methods, was used. The phenomenological method is employed to study a specific situation by exploring individuals' experiences, lives, and perspectives related to that situation (Giorgi and Giorgi 2003). This design is uniquely suited for this inquiry as it allows for a profound understanding of a specific human experience from the first-person perspective of those who live it. In reflection of this, the present study

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has aimed to demonstrate the participants' thoughts towards physical restraint usage and the meanings they attribute to this practice. The study has been reported in accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al. 2007).

2.2 | Recruitment and Sampling

A sample group consisting of 20 nurses working at Artvin State Hospital. Participants were recruited using purposive and snowball sampling methods. Initial participants were reached through an announcement made by the hospital administration. The interviewed nurses were asked to inform other nurses who might meet the inclusion criteria about the study. Nurses who were interested in participating then contacted the researcher directly, and those who met the inclusion criteria and agreed to participate were included in the study. The hospital has a total of 170 patient beds, including 38 intensive care beds and 132 regular patient beds. The hospital contains a single, mixed (general) intensive care unit where all 38 beds are located. In this hospital, physical restraint practices are strictly executed according to standard national institutional protocols applied across all healthcare facilities in Türkiye. The institutional workflow mandates a written procedure for physical restraint, which requires a physician to officially order the intervention by specifying the explicit justification, the specific type/method of restraint, and the exact duration. Upon this order, the nurse implements the restraint and assumes legal responsibility for the continuous monitoring, patient safety, and systematic documentation of the process via standardized observation forms. In the hospital, physical restraint is preferred to chemical restraint. In cases where physical restraint is not effective, chemical restraint (sedation with drugs) is used. The inclusion criteria necessitated that the respondents had at least one year of professional nursing experience, had implemented physical restraints during their professional life, had current or previous intensive care unit experience, and volunteered to participate in the study. The exclusion criteria pertained to those who had utilized physical restraint on someone they knew. Population and sample selection were not undertaken in this research. The interviews were concluded after the engagement of the 20th nurse, when no new or meaningful information was obtained from additional interviews, indicating that data saturation had been reached (Creswell and Poth 2018; Lim 2025).

2.3 | Procedure

After obtaining ethical and institutional permission for the study, the hospital management was informed about the purpose and nature of the study by the researcher. The hospital administration was then asked to inform the nurses working in the institution about the study. A contact number was provided for those nurses interested in participating in the study, allowing them to contact the researcher. Those who agreed to participate in the study were informed about what such participation would mean. Verbal consent was obtained from the participants, and a time was set for their meeting.

2.4 | Ethical Considerations

Ethical approval was obtained for the study from the Ethics Committee of Artvin Çoruh University (Approval Number: E-18457941-050.99-68846; Approval Date: 01.11.2022) and the institution where the study was conducted. The ethics approval covered the use of verbal informed consent and audio recording of the interviews. This study complied with the Declaration of Helsinki. The participants were informed about the purpose of the study and that they could withdraw from the research at any point. The participants did not receive any fee or incentive to participate in the study. The privacy and confidentiality of the participants were protected. To ensure the confidentiality and anonymity of the data obtained, each participant was given an alphanumeric code. Any documents and records were stored on password-protected computers that only the researchers could access.

2.5 | Data Collection

Semi-structured interviews utilizing open-ended questions were employed in the study (see Table 1). The interview consisted of six questions about the application of physical restraint, including the procedure, participants' experiences, their feelings during application, and patient reactions. The interview questions were developed to allow the participants to express their own views while also addressing the practice of physical restraint (Alase 2017). The interviews were conducted by G.A., a female researcher who was working as a lecturer at the time of data collection. She had no prior relationship or acquaintance with the participants before the study. The interviews were conducted in a meeting room at the institution where the study data were collected. No other individuals were present during the interviews. Each interview lasted approximately 25–30 min and was audio-recorded using a voice recorder and subsequently transcribed verbatim. The number of interviews conducted was determined based on the principle of data saturation; participant recruitment was discontinued when it

TABLE 1 | Semi-structured interview questions for nurses.

No.	Semi-structured interview questions
1	What are your thoughts on the physical restraint procedure?
2	What have been your experiences with physical restraint, if you don't mind sharing?
3	What feeling or emotion comes to mind when applying physical restraint?
4	Do you have a mental image of physical restraint, or how would you define it?
5	What was the patient's reaction or statement that you will never forget while applying physical restraint?
6	Do you experience an ethical dilemma when applying physical restraint?

Note: The interviews were conducted using the open-ended questions presented in the semi-structured interview form. When necessary, the researcher asked probing questions to obtain more detailed information from the participants.

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became apparent that additional interviews no longer yielded new or meaningful information (Creswell and Poth 2018; Lim 2025). The interviews were held between December 2022 and March 2023. The interviews were conducted in Turkish, and all interviews were transcribed and analysed in Turkish. The manuscript, including the participant quotations, was initially prepared in Turkish and subsequently translated into English by an academic specializing in English Language and Literature. The English version was then edited by a native English speaker for linguistic clarity and appropriateness.

2.6 | Data Analysis

All interviews were transferred to the qualitative data analysis software MAXqda 22, where the descriptive phenomenological analysis was managed. Qualitative data were analysed using a modified Colaizzi's descriptive phenomenological method (Tavakol et al. 2026). The modified approach involved six steps of Colaizzi's method; the final participant-validation step was not performed. Data analysis was conducted on the same day as the interviews. The first stage of data analysis involved reading the interviews multiple times to achieve familiarization. Then, relevant sentences and phrases related to the desired phenomena (physical restraint, nursing care experiences) were identified as significant statements. Formulated meanings were extracted from these significant statements, and emergent themes were created based on the resulting meaning clusters (Tavakol et al. 2026). In this descriptive phenomenological approach, all data were analysed by extracting formulated meanings directly derived from participant data, without using predetermined themes. Here, all data were processed to identify significant statements, which were then grouped into formulated meanings and reduced to meaningful clusters of themes. The resulting themes were integrated into an exhaustive description of the phenomenon, and the fundamental structure of the phenomenon was subsequently formulated from this description. The principal researcher undertook the first phenomenological extraction. Subsequently, other researchers analysed the data independently, and the resulting formulated meanings, theme clusters, and emergent themes were discussed among the research team to achieve analytical compatibility and consensus. The principal researcher concluded the analysis. Participant validation, the final step of Colaizzi's method, was not performed; therefore, the analysis was identified as a modified Colaizzi approach. The data are presented as themes and frequencies.

2.7 | Rigour and Reflexivity

Lincoln and Guba (1985) have proposed several means through which to strengthen the reliability of qualitative research. Reliability, in this sense, pertains to how accurately the findings gained reflect reality and how the researchers of a study represent this. As the conducting of interviews and analysing data by a single person may affect the outcome of a study, the roles of data collection and data analysis were strictly separated to support the dependability of the present research. The researcher who conducted the semi-structured interviews did not participate in the primary data analysis phase. Regarding researcher positioning, the research team consists of academic nurse researchers who do not possess clinical experience specific to intensive care units (ICUs) but have prior clinical experience with implementing physical restraint in general hospital wards. The researchers acknowledged that their professional backgrounds and prior experiences with physical restraint could influence their interpretation of the data. During data analysis, the results and interpretations were discussed among the research team and examined in relation to the original transcripts and participant quotations. This process allowed the researchers to reflect on their interpretations and consider the potential influence of their professional perspectives throughout the analysis. The detailed and carefully written transcripts further allow the study's conclusions to be reproduced if analysed or the data to be regained by other researchers if repeating the study design—thus enhancing the dependability of the conclusions reached. Reliability in the data analysis produced was supported by the analysis team's coding and MAXqda 22 training. As the results and findings were written, each finding was supported with quotations from the original interview. This contributed to the confirmability of the findings by demonstrating their correspondence with the participants' accounts. Determining the sample size based on data saturation, defined as the point at which additional interviews yielded no new or meaningful information, contributed to ensuring adequate data collection (Creswell and Poth 2018; Lim 2025). Finally, the recording of all relevant documents, including records and transcripts, was instituted to serve the quality of the study.

3 | Results

3.1 | Sample Characteristics

The sample of this research consisted of 20 participants—12 women (60%) and 8 men (40%). The participants' ages ranged between 23 and 50 (mean: 34.50, SD = 8.11). 15 (75%) of the participants stated that they held an undergraduate degree, 2 (10%) held a graduate degree, 2 (10%) held a vocational high school degree, and 1 (5%) held an associate degree. The total years of working at the institution were between 1 and 32 years (mean: 13.20, SD = 9.01). 12 (60%) participants stated that they had not received physical restraint training, while 8 (40%) participants stated that they had received such training. It was found that they received this training in school. 16 (80%) of the participants reported the number of physical restraints they had applied as 'quite high', 3 (15%) of the participants reported this as 'between 11 and 20', and 1 (5%) reported this as 'between 21 and 30'. The sub-themes derived are given in the form of a code cloud (see Figure 1).

3.2 | Theme 1: Physical Restraint Procedures: Effectiveness, Efficiency, and Benefits for Patients

Upon the respondents talking about the useful, necessary, and sufficient nature of the restraint procedure as utilized among patients, one of the most striking statements made was that the application procedure was not comprehensively understood (see Frequency-Table 2). The respondents stated that they applied physical restraint when they considered it necessary and that

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the patient (or their relatives) signed off on such applications upon the patient being hospitalized. Yet, these figures may not understand the implications of this approval.

> When patients are hospitalized, we have them sign an approval document alongside the hospitalization documents, although I haven't read the details of this document
>
> (P10).

> I am aware of the existence of the procedure, but I do not know much about its content
>
> (P2).

> I don't know about its content
>
> (P4).

The respondents mostly stated that the physical restraint procedure is beneficial for patients ($n = 9$) and that it prevents patients from harming themselves.



FIGURE 1 | Code cloud.

> When patients are agitated, we tell them that their movement will be restricted so that they do not harm themselves, the devices around them, or us
>
> (P6).

> Although the practice is perceived as negative for someone looking at the patient from the outside, I think it is undertaken to improve the patient's well-being
>
> (P11).

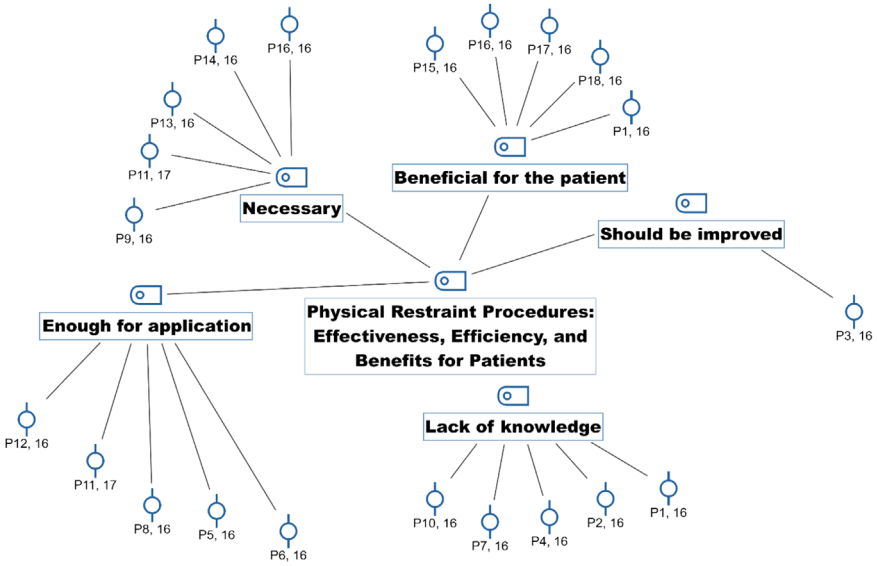
The respondents stated that the physical restraint procedure is necessary ($n = 8$) and sufficient ($n = 6$). Yet, there should be a procedure imposed for the application of physical restraint whose content is sufficient and clear on the steps required. The presence of a physical restraint procedure was also perceived as necessary both for patients (and their surroundings) to be protected from harm and for nurses to feel safe in its application.

> A procedure prevents patients from unconsciously attacking themselves, people nearby, and us
>
> (P14).

> I think the current procedure is enough for now. I mean, we have a good document detailing how long we can physically restrain a patient, at what intervals we should perform check-ups, and which areas should be restrained. I think that's enough for now. In other words, it is very clear and understandable for a new nurse
>
> (P8).

> I think the current procedure is a very good one
>
> (P6).

FREQUENCY-TABLE 2 | Physical restraint procedures: effectiveness, efficiency, and benefits for patients.



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3.3 | Theme 2: Ethical Balance in Nursing: Conflicts Between Freedom and Security

In terms of their experiences with applying physical restraint, the respondents mostly stated that this arose when the patients had hurt themselves ($n = 11$), when the patients had to be restrained ($n = 11$), and/or when the patients had damaged their surroundings ($n = 5$). Furthermore, some of the respondents were not in favour of such restraint ($n = 5$), noted that human dignity should be respected during the application of any restraint ($n = 2$), that nurses assume a degree of responsibility when restraining a patient ($n = 1$), and that restraining someone left nurses feeling bad (see Frequency-Table 3).

The respondents stated that they experienced patients harming themselves by trying to prevent medical interventions that would adversely affect their vital signs.

> Patients can harm themselves. They can jump out of bed or dismantle the equipment that maintains their vital functions and expose their vital risks. That's why we have to apply restraints. I have a lot of experience with that. I have seen people who have removed their catheters many times, who have pulled at their chest tubes, and who have ripped their wounds or stitches. We've encountered people who have attempted to escape from their bed or to commit suicide
>
> (P1).

> One patient had pulled out his tube
>
> (P10).

The respondents noted that restraints were applied when necessary, such as when patients become very agitated, have started to harm themselves or damage the surrounding environment, and/or when the doctor has ordered the restraint.

> We try to calm patients first. When patients do not calm down, either through talking or through tablets, we restrain them when it feels like they will hurt themselves
>
> (P16).

> I mean, we have had to restrain a lot of patients
>
> (P17).

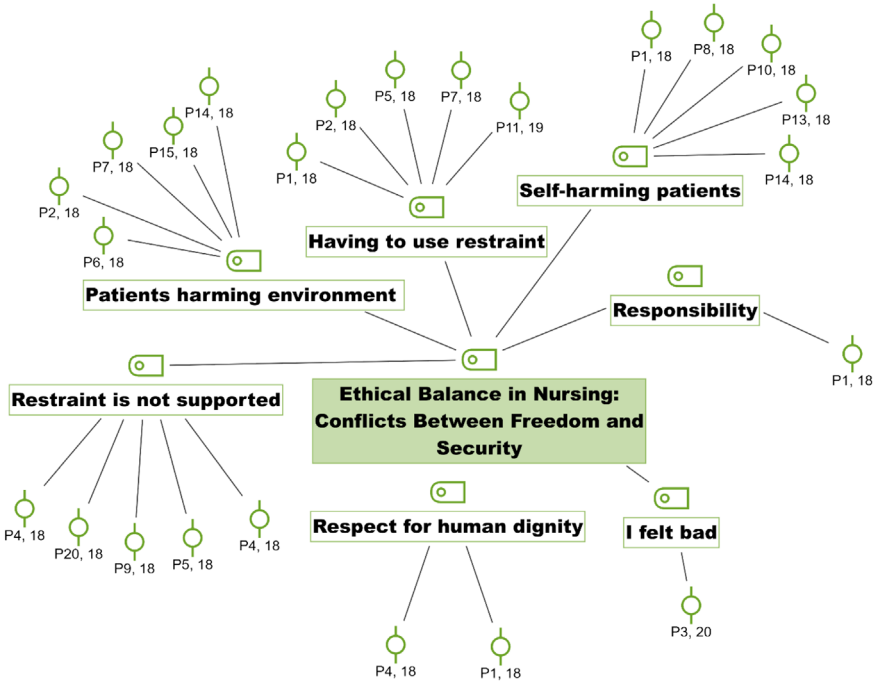
> I do it at the doctor's order, mostly at the doctor's order, in consultation with the doctor, without using my own initiative
>
> (P5).

The respondents stated that agitated patients often damage their environment and those around them, as do healthcare professionals. Thus, the respondents noted, physical violence is often experienced by patients during their care.

> I do not know how many times patients have beaten us... Patients hit us and squeeze our arms. For example, someone bruised my arm very badly
>
> (P7).

> We restrain patients who remove the vascular access, pull the NG, the catheter, so that they do not harm themselves or their surroundings
>
> (P14).

FREQUENCY-TABLE 3 | Ethical balance in nursing: conflicts between freedom and security.



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> A patient kicked me right in my stomach. Thank God that, at that moment, my friend came and pulled me back and saved me
>
> (P6).

The respondents stated that, when utilizing physical restraint, they were not satisfied with this practice and were not in favour of its employment. This is due to the belief that such an application does not benefit patients and that their patients were also dissatisfied with its use.

> I am not a nurse who is very in favor of such physical restraint. I don't think it's very beneficial for the patient
>
> (P4).

> I'm in favor of not tying people up. Maybe better things can be achieved by talking and not simply giving medicine – just talking and understanding each other
>
> (P5).

> It is not something we like very much. Of course, it is important for the patient and their relatives, so I think we have to. Actually, patients are not happy about it. We are not happy either
>
> (P9).

The respondents also noted that, when applying physical restraint, the dignity of patients should be respected and that a sense of responsibility is felt by nurses in this context. In this regard, it was stated that it should not be forgotten that the patient being restrained is human and that they deserve respect even if they are unconscious. It was also conveyed that it should always be kept in mind that the patient undergoing restraint is under the responsibility of that nurse.

> You are a human. Even when you tie animals, they make a sound. They show their discomfort. They also enter into what we call delirium. We can think of people that way, too. I mean, they are human... After all, it is necessary to evaluate humans holistically. Not just by considering their one-time aggressiveness or just seeing that side of them. We should consider people as patients rather than as a disease because, when you look at them like this, the person in front of you inevitably turns into a device. So, you think of 'it' like a machine in your hand. You can interpret 'it' however you want. You make 'it' any shape you want. But the patient is not a machine, they are a human
>
> (P4).

> If the patient is unconscious or has a deep tendon reflex, I think that the restriction is only ours and we should control it, not the patient
>
> (P1).

3.4 | Theme 3: Nurses' Feelings About Physical Restraint

The respondents stated that, while using physical restraint, they mostly felt an intensely bad/disturbing emotion ($n = 17$), comfort ($n = 7$), sadness ($n = 4$), and/or that they were confining/punishing ($n = 4$), experiencing a painful feeling ($n = 3$), and/or enacting cruelty ($n = 2$) (see Frequency-Table 4). A sense of deep discomfort while applying physical restraint among patients was conveyed here, noting the practice as very disturbing when they put themselves in the place of the patients. In this regard, the restraint process was viewed as not being very humane, as torturing patients, and as not being something that nurses would want done to themselves.

> I feel really bad
>
> (P3).

> I feel bad; I feel pretty bad. I put myself in their place. I empathize. And it's really something bad
>
> (P5).

> I don't find it very humane
>
> (P12).

> I feel like I am torturing them
>
> (P16).

Nonetheless, it was also noted by the respondents that the application of physical restraint can invoke a feeling of comfort, whereby the use of physical restraint is necessary in cases where patients are at risk of harming themselves or damaging their surroundings.

> Actually, it's something that I don't want to experience myself, but in a way we feel comfortable because we think it is beneficial for the patient
>
> (P2).

> After all, these are the things that need to be done
>
> (P19).

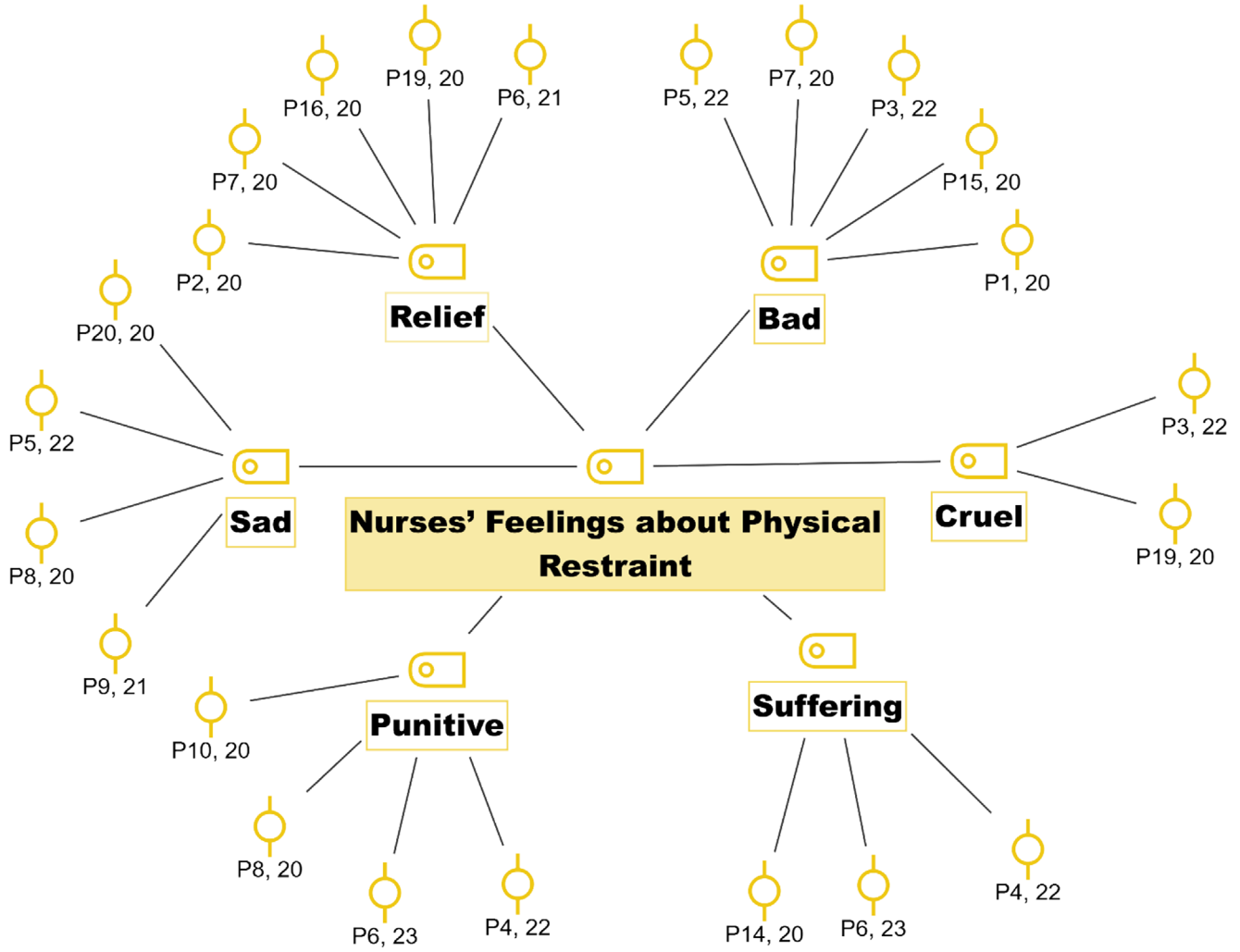
> If the patient pulls his catheter out or pulls the vascular access, he is hurting himself or other people or us (i.e., my nurse friends), so I don't feel uncomfortable anymore
>
> (P7).

Another emotion expressed by the respondents when utilizing physical restraint is sadness, especially when reflecting upon the first time they performed such application.

> I mean, when I first performed physical restraint, I was very upset
>
> (P9).

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FREQUENCY-TABLE 4 | Nurses' feelings about physical restraint.



> I cried a lot when I first did it. I was thinking, 'What am I doing? I will quit this profession'
>
> (P20).

Furthermore, some respondents detailed that they felt as if they were confining or punishing patients through the physical restraint application, whereby they removed their freedom or confined them to a bed.

> When you confine the patient, it is actually not nice. After all, he is somehow confined to his illness, confined to the environment where he is, and you are then confining him to a bed. Is this the right thing to do?
>
> (P4).

> It feels like you are limiting their life
>
> (P10).

The respondents further noted that, when physically restraining a patient, they felt cruel and that they were causing pain. They described themselves as remorseless while practicing physical restraint, and that it was painful for nurses when they thought about what they did.

> It hurts
>
> (P6).

> I feel so cruel
>
> (P3).

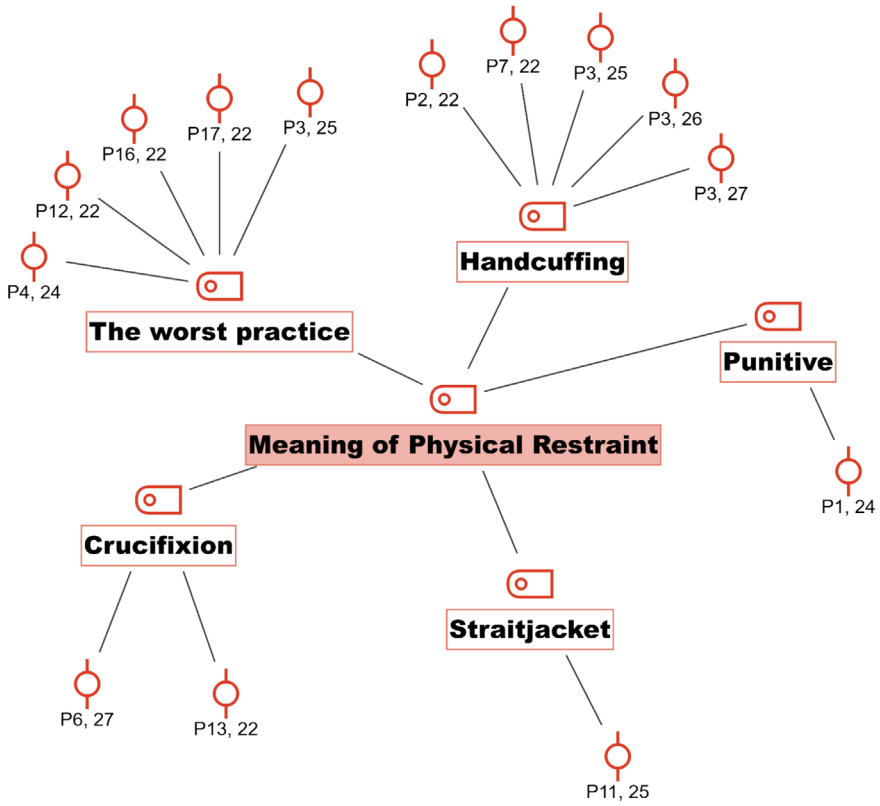
> I felt like I was remorseless
>
> (P19).

3.5 | Theme 4: Meaning of Physical Restraint

The respondents noted that, when thinking about physical restraint, a number of images and ideas formed in their mind—including handcuffs ($n=8$), worst practice ($n=5$), crucifixion ($n=2$), punitive ($n=1$), and straitjacket dressing ($n=1$) (see Frequency-Table 5).

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FREQUENCY-TABLE 5 | Meaning of physical restraint.



Respondents described the practice of physical restraint as witnessing the patient being tied or handcuffed, briefly having their freedom restricted in some way.

> I consider it like a guard who uses handcuffs because we are talking about a person who is tied up in a troubled situation, suffering from movement. It's not a pleasant situation. So, for me, a handcuffed person
>
> (P2).

> Like a prisoner
>
> (P3).

> Tying someone up
>
> (P14).

Another notion, that of physical restraint being the worst practice in the nursing profession, was also raised, namely in relation to such practice being perceived as inhumane.

> I don't find it very humane
>
> (P12).

> It's a very bad thing. So I'm thinking about it right now. It's not nice at all, it's not nice at all
>
> (P4).

> Physical restraint is normally not a pleasant thing
>
> (P17).

Other images invoked by the responses related to physical restraint practice being akin to crucifixion, employing straitjackets, and manifesting a punitive approach. The nurses stated that when a patient's hands are tied, it appears as if they are being crucified, dressed in a straitjacket, or being punished.

> I think it's like the crucifixion of Jesus Christ
>
> (P6).

> I felt, when I first did this, that they were wearing a straitjacket
>
> (P11).

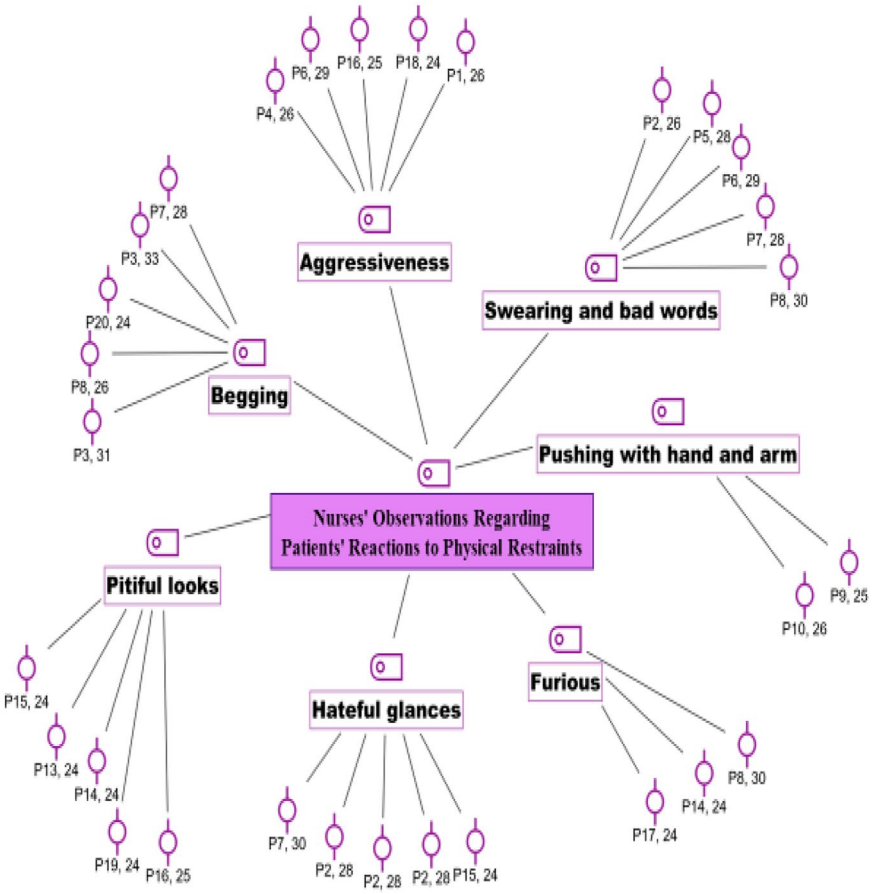
> For a patient, it is a punitive process
>
> (P1).

3.6 | Theme 5: Nurses' Observations Regarding Patients' Reactions to Physical Restraints

When the respondents were asked about patient reactions or statements that they could never forget, the answers given mostly pertained to swearing/abusive words ($n=12$), aggression ($n=8$), begging ($n=7$), pitiful looks ($n=6$), hateful looks ($n=5$), anger ($n=3$), and the pulling of hands and arms ($n=2$) (see Frequency-Table 6). Nurses reported that when applying

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FREQUENCY-TABLE 6 | Nurses' observations regarding patients' reactions to physical restraints.



physical restraints to patients, the patients resisted these restraints and cursed at them or used insulting language. However, it was detailed that nurses do not react to such swearing or abuse and fail to take such outbursts personally in acknowledgment of the situation that the patient is in.

> Of course, we do not take patients seriously, but they say very insulting things
>
> (P12).

> We hear a lot of swearing, but it feels normal to us now. We laugh when they swear
>
> (P19).

Nurses reported encountering a great deal of aggressive behaviour while performing physical restraints. Nurses noted that patients who were restrained exhibited aggressive behaviour towards nurses, doctors, and their own relatives, or engaged in behaviours that could harm themselves, such as attempting to tear off the restraining area.

> While restraining a patient's leg, he hit my friend's chin with his leg, and that chin was bruised
>
> (P18).

> The biggest and most frightening thing in my career has been getting kicked during my pregnancy. This has worn me out
>
> (P6).

> So we are now protecting ourselves. We can't get close. They attack us. If we take the patient's relatives with us, he will attack the relatives... When his doctor comes, he attacks the doctor
>
> (P1).

> A patient may constantly take off the vascular access. If we hook up oxygen, he may constantly pull it out. He may hit his relatives
>
> (P12).

Another reaction or comment mentioned by the nurses is that patients beg them not to be physically restrained during the procedure. Nurses stated that they believed some patients did not understand why physical restraints were being applied or perceived the procedure as a form of punishment; therefore, patients would make statements such as begging nurses not to restrain them, promising not to cause trouble, or expressing a desire to be released from restraints.

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> An old lady asked: 'What crime have I committed that you are tying me up for?' I mean, criminals are tied up and handcuffed. So I think she thought this was happening to her
>
> (P8).

> As I said, most promise 'I won't do it again'. They think that we're punishing them. 'I promise. I will not do it again'. This is a reaction I get from most people
>
> (P3).

> Those who beg to be untied...
>
> (P13).

Other expressions noted by the nurses included looks of pity and looks of hatred. The nurses stated that when they were unable to prevent patients from being restrained during or after physical restraints, the patients appeared helpless and cried, and seemed unable to make sense of what was happening or appeared sad. They also stated that they directed hate-filled glances at those carrying out the procedure.

> Some of them look so pitiful
>
> (P14).

> There were also those who looked at me as if to say 'What are you doing?'. There were also those who were sad and weeping
>
> (P16).

> Sometimes, of course, they look emotional. When they look emotional, you become more upset
>
> (P19).

> They usually look at us with hatred
>
> (P2).

> Actually, they want to kill us at that moment
>
> (P7).

> They look and say, 'Don't you believe in God?'
>
> (P15).

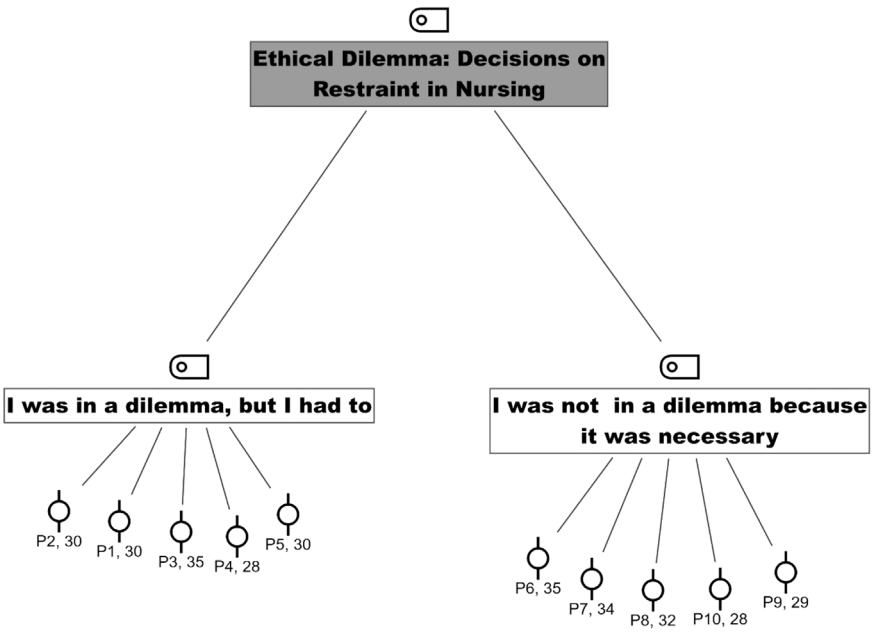
3.7 | Theme 6: Ethical Dilemma: Decisions on Restraint in Nursing

When asked whether ethical dilemmas were experienced as a result of applying physical restraint, the respondents replied in the vein of 'I face a dilemma, but I have to do it' ($n = 10$) and 'I do not face a dilemma because I think it is necessary' ($n = 10$) (Frequency-Table 7). The respondents also detailed how they question themselves while performing physical restraint, putting themselves in the place of the patient, questioning whether the application is truly a measure of last resort and whether the practice shall result in more harm or benefit to the patient.

> Sometimes there are patients we don't want to tie up, but when we see the consequences, we have to. We've had a lot of dilemmas like this
>
> (P2).

> Why did we do this? What if we hadn't? You question this because we see it as a last resort. So, even if I don't like to do it, there are situations where we have to choose it. The restraint is short-lived, though
>
> (P4).

FREQUENCY-TABLE 7 | Ethical dilemma: Decisions on restraint in nursing.



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> Of course, I have been thinking from the very beginning that it is not right to tie up a person. But when it is for his benefit, there is only an ethical problem within yourself. We are then applying whatever the procedure is
>
> (P5).

In contrast, some respondents stated that no ethical dilemma is faced and that physical restraint is a procedure that should be done only when necessary.

> I wasn't in a dilemma. Think of it this way: if the patient cannot urinate, we insert a catheter. Why? Because this is something beneficial for the patient... Physical restraint is just like that. Yes, it is something that needs to be done because of the benefit-harm relationship here
>
> (P13).

> No, one doesn't have a dilemma. After all, it's a procedure; I have to implement it. In other words, doctors and nurses mostly consider it appropriate. Sometimes we tell his doctor, the patient is agitated and we need to restrain him
>
> (P14).

4 | Discussion

In addition to the ethical and legal realms surrounding physical restraint, the practice can also invoke negative physical and psychological effects among patients and nurses (Bleijlevens et al. 2016; Perez et al. 2021). Although an 'unrestrained' care model is encouraged worldwide, the rate of physical restraint application continues to be high—especially in intensive care environments. Experts agree that physical restraint is a limitation imposed on patients, regardless of its purpose (Bleijlevens et al. 2016). This present study has been produced to evaluate this practice from the perspective of nurses and to determine the situations experienced here. Physical restraint procedures have been created to improve patient management and care by guiding the practice of healthcare professionals (Cui et al. 2021, 2022). Limited knowledge of these procedures and the undertaking of unsafe practices reduces the quality of care available to patients (Cui et al. 2021, 2022).

The nurses who participated in our study emphasized that they considered the existing procedures to be useful and necessary for the patient. On the other hand, it was determined that some nurses lacked knowledge about the procedures. Studies have shown that nurses working in intensive care units receive insufficient training in physical restraint practice and lack knowledge about the subject, which results in the implementation of unsafe practices (Salehi et al. 2021; Suliman et al. 2017). It has further been shown that nurses assume a very important role and responsibility in the implementation and termination of physical restraint, despite not being included in the development and modification of relevant procedures (Cui et al. 2022; Perez et al. 2019; Shen et al. 2021). In a review on the application of physical restraint, it was concluded that training can effectively improve the knowledge, attitudes, and behaviours of nurses towards this practice (Lei et al. 2022; Putkonen et al. 2013). Thus, it can be seen that education and training are necessary to enhance the implementation of physical restraint procedures.

According to the theme of ethical balance in nursing, which emerged from exploring nurses' experiences with physical restraint, there is a conflict between the desire of nurses to protect patients' freedom and the necessity of ensuring their safety. A reluctance to use restraint, along with feelings of discomfort when it is necessary, reflects nurses' ethical understanding and respect for human dignity. However, the risk of patients harming themselves or others may create a need for restraint. Similarly, a recent qualitative study conducted with intensive care nurses in Türkiye reported that ethical principles, particularly nonmaleficence and beneficence, were considered in nurses' decision-making regarding physical restraint (Kuzgun et al. 2026). This result is consistent with the findings of a meta-synthesis review by Kodua and colleagues. The authors found that the studies they reviewed generally indicated that healthcare providers and recipients experienced the practice as an 'unpleasant but necessary' measure to protect them from various harms (Kodua et al. 2023).

In our study, it was concluded that physical restraint by nurses was performed to prevent patients from harming themselves. The purpose of preventing self-harm among patients can be associated with the responsibilities of nurses towards ensuring and maintaining patient safety. Studies have shown that physical restraint is most commonly used to prevent patient self-harm, such as the accidental removal of drains, to ensure patient safety and occupational safety, and is also considered an important strategy to prevent patient falls and interactions with medical devices (Burry et al. 2018; Canzan et al. 2021; Cui et al. 2022; Lao et al. 2023; Shen et al. 2021; Via-Clavero et al. 2019). Nurses who believe that physical restraint is a cruel intervention realize that it is crueler to reintubate the patient as a result of unplanned extubation due to a lack of physical restraint. This awareness enables them to manage their negative feelings and accept that physical restraint is for the benefit of the patient (Chuang and Huang 2007).

Nurses experience various emotions during physical restraint practice (Canzan et al. 2021). It was determined that nurses experienced the worst and most disturbing emotions the most. Other studies have found that nurses feel anxiety, empathy, guilt, frustration, shame, and helplessness here (Lao et al. 2023; Perez et al. 2019; Sönmez Güngör et al. 2023). When they identify with patients undergoing physical restraint, they further experience negative emotions such as anxiety, pain, disappointment, distress, guilt, sadness, and helplessness (Canzan et al. 2021; Cui et al. 2021; Salehi et al. 2021; Suliman et al. 2017). These feelings may reduce the self-confidence of nurses, thereby demoralizing them and causing such healthcare professionals to experience feelings of helplessness and inadequacy (Salehi et al. 2021). It has been reported that these feelings can negatively affect the health of nurses and gradually cause mental and physical problems—such as insomnia, headaches, anxiety, fatigue, and ultimately, burnout (Salehi et al. 2021).

On the other hand, some nurses have stated that they do not find this sometimes-necessary practice pleasant but feel comfortable in administering physical restraint because it is instituted to

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ensure patient safety (Canzan et al. 2021; Cui et al. 2022; Salehi et al. 2021). When evaluated within the context of intensive care culture, this feeling of comfort or relief highlights how deeply the defensive patient safety discourse is embedded in critical care environments. Under the pressure of a high nursing workload, continuous monitoring, and the institutional dread of adverse events like self-extubation, physical restraint becomes an indispensable, systemically institutionalized coping mechanism. Nurses subconsciously trade off the patient's immediate comfort for the guaranteed preservation of vital parameters, rationalizing their psychological relief through the prism of clinical necessity. In this regard, the beliefs, attitudes, and experiences of nurses regarding physical restraint practice influence its employment significantly (Lao et al. 2023). Nurses manage the emotional and psychological effects of caring for physically-restrained patients by perceiving this practice as necessary for patient safety and by ignoring their own feelings (i.e., by becoming desensitized). Nonetheless, a number of nurses believe physical restraint constitutes worst practice, with the work of Canzan et al. (2021) supporting this stance. Nurses must have an attitude that physical restraint is used for the benefit of the patient and that the situation does not harm the patient. In this way, although they may feel uncomfortable during the physical restraint, they ensure that the care they are going to provide to the patient is of a high quality, thanks to their positive attitude (Köse et al. 2020).

The respondents to this research stated that they considered themselves as handcuffing, crucifying, and punishing patients when applying physical restraint. In this rubric, physical restraint is often seen as equivalent to the use of coercive measures applied to criminals, as it constitutes nothing but the depriving of individuals of their freedom (Burry et al. 2018). In this case, some nurses described such practice as enacting a kind of 'captivity' (Canzan et al. 2021). In our study, the respondents detailed that they did not find the practice very humane, that they felt as if they were torturing patients, and that they would not want it to be done to themselves. At the same time, physical restraint is considered a terrible experience, an assault, or unjustified imprisonment for patients and among the relatives of patients (Burry et al. 2018; Suliman et al. 2017). These intense descriptions of 'torture', 'crucifixion', and 'handcuffing' signify a profound process of psychological dehumanization and a stark violation of nursing ethics. Within the highly technical, task-oriented culture of modern intensive care units, patients risk being reduced to data lines and mechanical safety hazards. By equating their actions to punitive measures, nurses reveal severe moral distress born from the conflict between the philosophical ideals of holistic, humanistic nursing care and the pragmatic, mechanical pressures of the unit. To shield themselves from the traumatic reality of forcibly restricting another human being, clinicians are forced into a state of emotional detachment, which paradoxically conflicts with their professional identity. It may be that nurses hold this stance as they do not want to see themselves as using force, restraint, and/or punishment in line with both cultural and professional philosophy. The emotions and expressions of nurses regarding physical restraint practice can be considered as an indication of humanism, as is the philosophy of nursing, wherein they identify strongly with their patients.

This study has also identified how, when physical restraint is being administered, patients often verbally abuse nurses in response. In one study, it was reported that nurses experience superficial wounds and bruises as a result of patient aggression (Putkonen et al. 2013). Intensive care nurses have stated that communication with patients could allow more effective outcomes (Canzan et al. 2021; Lao et al. 2023; Shen et al. 2021) if undertaken prior to the application of physical restraint and even that effective communication with patients may act as an alternative to physical restraint as it helps patients to manage better their fear or pain (Lao et al. 2023). This reflects how therapeutic communication is indispensable for nursing.

The final theme of our study highlights the ethical dilemmas nurses face when applying physical restraints and the obligations they feel during this process. Nurses may struggle with the decision to use restraint, believing it to be necessary, while simultaneously feeling compelled to act in order to ensure patient safety (Cui et al. 2021; Kılıç and Polat 2021; Perez et al. 2021; Salehi et al. 2021; Shen et al. 2021). This contradiction reflects their efforts to balance professional responsibilities with ethical values. Physical restraint, a life-saving but painful and irritating practice, enforces the principle of utility over autonomy (Burry et al. 2018; Canzan et al. 2021; Kılıç and Polat 2021; Salehi et al. 2021). Indeed, it may be held to violate the principle of autonomy (Shen et al. 2021). Although physical restraint practice is not advocated in a humanistic perspective, it is believed to be necessary to ensure patient safety (Lao et al. 2023). When nurses are faced with ethical dilemmas about the use of physical restraint, they often believe that it is in the best interests of the patient (Kılıç and Polat 2021). In this sense, it is extremely important to protect the dignity and comfort of patients during any physical restraint (Suliman et al. 2017). Nurses may rationalize their moral distress in relation to the practice of physical restraint in line with the principle of usefulness. Still, they may also blame themselves for neglecting the provision of holistic care (Lao et al. 2023). It can be held that this practice has a negative effect on nursing philosophy. Studies have shown that while nurses view the practice as beneficial for ensuring patient safety, they encounter ethical dilemmas due to its impact on patients and their families. Another reason for the dilemma is that the legal and medical procedures regarding physical restraint are not clearly defined (Chong et al. 2024; Salehi et al. 2021; Shen et al. 2021).

This study contributes to the literature by providing an in-depth understanding of intensive care nurses' experiences with physical restraint, particularly regarding their emotional burden, ethical dilemmas, and decision-making processes. The findings demonstrate that nurses continuously balance patient safety and patient autonomy while experiencing various negative emotions associated with restraint use. Furthermore, the metaphors used by participants provide insight into how physical restraint is perceived and emotionally experienced by nurses. These findings contribute to a more comprehensive understanding of the ethical and emotional dimensions of physical restraint in intensive care settings.

5 | Limitations

One of the limitations of the present study is that all of the respondents worked in a single hospital. Furthermore, differences in the

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number of years in which the respondents worked as nurses and the frequency of their application of physical restraint may also influence their perspectives on this area. Due to these limitations, the study's findings may not be generalizable to all environments. However, as qualitative studies and natural research do not aim to generalize the findings gained, this study provides valuable information as to the experiences of nurses in employing physical restraint among the patients they care for. Notably, these results can be used to improve future practice and as a means through which to consider alternative methods. Another limitation is the small sample size of the study. Nonetheless, data saturation has been reached, and the extensive and in-depth insight gained as to the participants' experiences has provided significant value.

What does this paper contribute to the wider global clinical community?

- This paper provides new insight into the experience of physical restraints from an intensive care nursing perspective. This applies to the global community as physical restraints are prevalently used in intensive care worldwide.
- The results of this study have the potential to help guide policy and education regarding physical restraint practices in intensive care worldwide.

6 | Conclusion

Physical restraint, as a compelling practice, negatively affects the relationship of nurses with their patients, namely in causing both physical and psychological harm. Talking about such practice is important for nurses, with this group of healthcare professionals often considering physical restraint when they do not see an alternative solution. Here, nurses seek to balance their ethics and the benefits of physical restraint practice with the principle of autonomy. The importance of promoting education, training, and policy development regarding physical restraint practices is evident.

7 | Implications for Nursing Practice

The findings of this study indicate several areas that should be considered in nursing practice related to physical restraint. Nurses' limited knowledge of restraint procedures highlights the need for education and training to support appropriate restraint practices. Educational initiatives should also address the emotional and ethical challenges nurses may experience when using physical restraint. In clinical practice, nurses should be supported in evaluating the necessity of restraint, considering alternative approaches whenever possible, and maintaining a balance between patient safety and respect for patient autonomy. The experiences reported by nurses may also contribute to the review and development of institutional policies and guidelines for physical restraint.

Author Contributions

Elanur Uludağ: writing – review and editing, writing – original draft, formal analysis, conceptualization, supervision. **Gamze Akay:** writing – review and editing, writing – original draft, data curation, conceptualization. **Özlem Albayrak:** writing – review and editing, writing – original draft, conceptualization. **Yasemin Erden:** writing – review and editing, writing – original draft, conceptualization.

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Ethics Statement

Ethical approval was obtained for the study from the Ethics Committee of Artvin Coruh University (Number: E-18457941-050.99-68846) and the institution where the study was conducted (Number: E-17720518-602.05).

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data supporting the findings of this study are available within the article.

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