The Phenomenology of Being Restrained

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LOYOLA UNIVERSITY CHICAGO

THE PHENOMENOLOGY OF BEING RESTRAINED

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

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BY

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CHICAGO, ILLINOIS

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CHAPTER I

THE PHENOMENON OF INTEREST

Introduction

The practice of restraining patients has had a long history in the behavior management of aggressive individuals with mental illnesses.

If a madman suddenly experiences an unexpected attack and arms himself...the director speaks in a thunderous voice....At the same time, the servants converge on him at a given signal...each seizing one of the madman’s limbs....Thus they carry him to his cell while thwarting his efforts and chain him if he is very dangerous...(Pinel, 1794/1992, p.731)

Current Illinois statute dictates that "restraint may be used only as a therapeutic measure to prevent a [patient] from causing harm to himself or physical abuse to others" (Illinois Department of Mental Health and Developmental Disabilities, 1994, p.13). Although the concept therapeutic is vague and ill-defined, the practice of restraining patients is traditionally considered to be therapeutic if physical restraining devices are used with the intent to prevent a patient from causing harm to self or others (American Psychiatric Association, 1984; Bursten, 1975; Moss & LaPuma, 1991). In that sense, physical restraining devices, according to Fisher (1994) "work."

This conclusion, however, is derived from the observation that the patient’s behavior is interrupted and controlled by the use of these devices and from research that has focused almost entirely on identifying behavioral precipitants to the restraining of patients (Bornstein, 1985; DiFabio, 1981; Guirguis & Durost, 1978; Phillips & Nasr, 1983; Roper, Coutts, Sather & Taylor, 1985; Sheridan, Henrion, Robinson & Baxter,
1990; Soloff, 1979; Telintelo, Kuhlman & Wing, 1983; Way, 1986). There is no
evidence that patients learn more adaptive behavior (Walsh & Randell, 1995).

The problem with the majority of the research about restraining patients,
however, is how this practice has been conceptualized. And it is this
conceptualization that then drives the methods used to investigate this phenomenon.
In most of the studies, the use of physical restraining devices has been viewed as an
event that is without context. The researchers rarely acknowledge that the practice of
restraining patients occurs to a person, by other people in a particular setting, under
particular circumstances, for particular reasons. They do not acknowledge that this
practice is part of a whole and that this practice not only comes out of a tradition of
managing psychiatric patients, but involves individuals who bring their own history to
the experience.

The majority of researchers who have investigated the phenomenon of
restraining patients search for generalizations regarding (1) who is likely to be
physically restrained, (2) the frequency of the use of physical restraining devices and
(3) the behavior that precipitates the application of these devices. However, this
research results in generalizations that are either inconclusive or obvious. Therefore,
these conclusions do not provide any meaningful understanding of this practice. For
example, one may conclude from the psychiatric research that violence or aggression
usually precedes restraining a patient. This conclusion seems obvious and is not
extremely helpful because it is difficult to predict who will become aggressive (Cahill,
There continue, then, to be unchallenged assumptions regarding the practice of restraining patients on psychiatric units. These are:

1. Restraining patients is necessary for the protection of the individual, other patients and staff.
2. Patients on psychiatric units lack internal self-control and therefore need to be controlled or violence will prevail.
3. Restraining patients is a therapeutic practice. Because psychiatric patients lack internal control, they are relieved or comforted by these external limits or controls.
4. Restraining patients is not a harmful practice.

Those who restrain patients continue to assume that without devices to physically restrain patients, they would be unable to control the aggressive patient and consequently, be unable to provide a safe environment. There is, however, no empiric evidence for this conclusion and in fact, there is some evidence that the practice of physically restraining patients may actually increase violence on the inpatient psychiatric unit (Morrison, 1990b; Roper & Anderson, 1991).

Traditionally, justification for the practice of restraining patients has focused on the safety needs of the patient and others and the underlying belief that patients who are out of control feel a sense of safety and comfort in being restrained. There is also the belief that other patients feel anxious and threatened when there is the threat of aggression or violence on a unit. While these beliefs may be supported by clinical experience, there has been no research to support these beliefs. To date,
there has been only one study (Sheridan, et al., 1990) that has asked psychiatric patients how they felt about the restraining experience. In this study, 41% said that being physically restrained calmed them or prevented them from hurting someone, yet 51% expressed negative reactions to being physically restrained. There have been no studies that have asked patients how they felt about seeing other patients who were aggressive and/or restrained.

A Tradition of Restraining

In psychiatry, devices have long been used to restrain the psychiatric patient. Their use is usually justified as protecting the patient and others from harm. But historically these devices have often been used as methods to coerce the patient into behaving “appropriately.” If one looks at the use of restraining devices throughout history, the treatment of the mentally ill person was more harsh in Colonial America than it had been in previous centuries. Some authors have attributed this change in treatment to the influence of Puritanism and to the common belief that mental illness was caused by demonic possession.

Puritanism, with its stern repression of healthy human instincts, its abnormal orientation around religion and its exaggerated expressions of alternate suspicion and credulity, offered a fertile soil for the development of this mania [witch hunts] (Deutsch, 1949, p. 32).

As a result of these beliefs, the sufferings of the afflicted members of the community were looked upon as the natural consequences of a stern, unyielding God, who passed judgement on the "wicked" and "innately inferior." Those whom the community perceived to be destitute and dependent were therefore treated with contempt.
At that time and until the Nineteenth Century, patients in mental institutions were chained to their beds or to rings attached to the floor (Hunter & Macalpine, 1963; Kraepelin, 1962). During this period, insanity was treated primarily by confinement in institutions. These institutions were less medical establishments than systems of order, more closely resembling judicial systems (Foucault, 1965). These methods of confinement arose from fears that the mentally ill person possessed unusual strength and from the underlying belief that insanity uncovered the person’s underlying animality (Foucault, 1965; Zwelling, 1985). Thus, the patient was viewed as foolish, stubborn, insolent, wicked, malicious or insubordinate. Since patients were seen as comparable to stubborn, ill-mannered children, they were thought to require the same stern treatment (Kraepelin, 1962). Therefore, the primary purpose of restraining a patient was behavioral coercion. The primary goal was to suppress the patient’s behavior and, consequently the symptoms of insanity (Zwelling, 1985).

This period of repressive confinement continued through much of the Eighteenth Century and according to Deutsch (1949), was the worst in the history of the treatment of the mentally ill. The principles underlying this treatment were custody, repression and behavioral control through coercion. Control was maintained because discipline was rigidly enforced. Those patients who broke the rules were severely punished. Various methods were used to accomplish these outcomes:

She was lifted up by force, plac’d in and fixt [sic] to the chair in the bathing tub....I kept her under the fall thirty minutes, stopping the pipe now and then....A week later I gave her another tryal [sic] by adding a smaller pipe so that when the one let the water fall on top of her head, the other squirted it in her face...till her spirits being almost dissipated, she promised to love him as before. (Blair, 1725/1963, p.328)
It was formerly supposed that lunatics could only be worked upon by terror, shackles and whips....In the furious state, the arms and sometimes the legs must be confined....When the patient is mischievous and unruly, I ship him up in his cell, order the window to be darkened, and allow him no food but water-gruel and dry bread till he shews [sic] tokens of repentance...(Ferriar, 1795/1963, p. 545)

In the most violent state of the disease, the patient should be kept alone in a dark and quiet room....The hands should be properly secured, and the patient should be confined by one leg; this will prevent him from committing any violence...(Haslam, 1809/1963, p. 635)

Other methods of coercion included the coercion chair, the tranquilizing chair, the rotary chair, baths, such as the bain du suprise, whereby the patient was suddenly dropped into a bath of cold water, the strait waistcoat (strait jacket) and the douche, which consisted of spraying a strong stream of cold water on the patient’s head.

Beginning in the Eighteenth Century and culminating in the mid-Nineteenth Century, there was primarily in England and Europe, a movement toward "moral treatment" of the mentally ill. This movement included an attempt to eliminate the practice of restraining patients. Conolly was most well-known for advocating the elimination of this practice in England (Kraepelin, 1962). The aim to eliminate the use of restraints, however, was but one aspect of a method of treatment that advocated improved accommodations, adequate food, sympathetic care of the patients and activities to occupy the patients (Conolly, 1856/1973). In other words, moral treatment meant that the staff should approach the patient with compassion and understanding, thereby creating an environment where spontaneous recovery could take place. The patients were treated with respect and dignity and were dealt with as if they possessed all of their faculties. The psychiatric staff, at this point in history,
felt a sense of hope and optimism that their patient's illness could be cured. Patients were treated as respectfully as possible and were allowed as much freedom from personal restraint as feasible, hoping that this treatment would effect a cure. And yet the safety of the patient and others remained central. Therefore, while staff treated the mentally ill person with kindness, they also maintained the expectation that the patient would modify unacceptable behavior.

Moral treatment might be defined as organized group living in which the integration and continuity of work, play and social activities produce a meaningful total life experience in which the growth of individual capacity to enjoy life has maximum opportunity. (Bockoven, 1963, p. 76)

Thus, one objective of moral treatment, as it was practiced by the Quakers, was to develop in the patients internal means of self-restraint and self-control. Whereas physical measures were previously used to achieve these goals, the Quakers, as major advocates of moral treatment in England and the United States, were convinced that their religious values were conducive to social harmony and stability (Grob, 1973). They believed that self-restraint was fostered by the powerful influence of the Quaker religion.

Because of this strong religious influence, Foucault (1965) did not think that the release of the mentally ill from their chains was the celebrated act of liberation that others have declared it to be. Foucault argued that the strong principles of the Quaker religion served to create a milieu that coerced the patient into constraint. Religion was simply another method that those in authority used to exert control over the mentally ill person. Since those in authority believed that the influence of religion was strong enough to exert its restraining power over the insane, the atmosphere
became one of threat and fear. This created an institution where "the free terror of madness [was substituted by] the stifling anguish of responsibility" (Foucault, 1965, p. 247). This moral milieu, imposed from those who ran the institutions, controlled the person's madness but did not cure it. Consequently, the milieu became one of anxiety, with the insane person being threatened with physical controls should the rules of the institution not be obeyed. In other words, the suppression of the practice of physically restraining patients was really only a substitution of the pressure to restrain oneself.

Moral treatment and the move to eliminate the practice of restraining patients, were met with antagonism in the United States (Bockoven, 1963; Deutsch, 1949) and ultimately failed. There are several theories that attempt to explain this failure. According to Bockoven (1963), those in the United States who advocated the elimination of this practice did not understand that moral treatment was a complex and all-encompassing method of treatment and not simply the elimination of physical restraining devices. Deutsch (1949) stated that those who supported the continued practice of restraining patients believed that restraining patients actually improved the patient's self-esteem. They also believed that the use of restraints was necessary in order to prevent violence. Proponents of restraining patients believed that physical restraining devices were peculiarly necessary in America because of the nature of its people and the influence of its climate. These individuals felt that the climate of England bred mild and complacent people, while the climate in America bred more
violent people. As Deutsch (1949) quotes one psychiatrist who was against the abolition of restraints:

The patients in European institutions, accustomed as they were to unquestioned acceptance of authority, might willingly submit to "moral" restraint, but not your liberty-loving American who, sane or insane, would never agree placidly to the imposition of authority by an individual, and hence could be restrained only by mechanical means. (p.216)

If the practice of restraining patients was abolished, these psychiatrists believed that other practices to coerce the patient would inevitably emerge (Deutsch, 1949). The insinuation was that Americans, by nature, and especially those who were mentally ill, were more aggressive and in need of external control. Therefore, they would not comply with verbally imposed controls nor be influenced by the environmental changes that were promoted by moral treatment.

The failure of moral treatment has also been attributed to the death of its major supporters, who left no one to carry the legacy. Of the thirteen original founders of American psychiatry who had been proponents of moral treatment, only two were still practicing in the 1870's (Freedman, Kaplan & Sadock, 1975). After their death, the passing of this tradition was further complicated by the reality that moral treatment as a philosophy was difficult to articulate since it reflected social and intellectual trends, rather than medical theory. Moral treatment consisted of treating the insane person in a particular way. Moral treatment meant treating the patient in a kind and humane manner.

Another reason given for the failure of moral treatment was the overcrowding of state hospitals with paupers, criminals, alcoholics and vagrants. There was also, in
addition to the overcrowding of the state hospitals, a shortage of well-trained staff. In New York, for instance, state mental hospitals were staffed with inmates from the penitentiary (Grob, 1973). At this time in history there existed neither the numbers of staff nor the caliber of staff to practice moral treatment. Consequently, the treatment became more and more custodial in nature (Grob, 1973; Zwelling, 1985).

Finally, in these state hospitals, the numbers of chronically, mentally ill patients greatly increased. This increase contributed to a growing sense of pessimism regarding the patients' curability (Grob, 1973; Zwelling, 1985). A shift in emphasis regarding the cause of mental illness from environmental factors to heredity also contributed to this pessimism (Bockoven, 1963; Freedman, et al., 1975). Therefore, intolerance toward victims of misfortune resurfaced under the guise of science and along with it, a belief that the social order was fixed by laws of nature analogous to those of physical order (Bockoven, 1963).

To have been successful, Grob asserts, moral treatment would have required small, personalized institutions. As the institutions expanded and the patient population became more heterogeneous, and without adequate staffing, the issue of maintaining control became dominant. Of central concern to the staff was how to manage the behavior of the patients who were disruptive and threatened the safety of others. In these situations, the superintendents of these institutions could not trust that their staff could manage these patients' behavior without the staff, themselves, becoming aggressive. This resulted in the staff's increased practice of relying on physical
restraining devices and the belief that this reliance on physically restraining patients was preferable to other means of physical control (Grob, 1973).

While these reasons for the failure of moral treatment in America give one a sense of what was occurring historically, they do not address underlying reasons why these events might have occurred. Why, for example, were the state hospitals permitted to become so large? Why were untrained staff hired to attend to the mentally ill patients? Why were there not adequate numbers of staff hired to successfully implement moral treatment? It might be, as Bockoven states, “that the way a society treats its mentally ill is but a manifestation or particular instance of the way the members of that society treat each other” (Bockoven, 1963, p.89).

An answer may be found first by exploring the prevailing view of the nature of the person in America, who at that time was seen as violent, unruly and aggressive and therefore more apt to need to be restrained by another individual. And it may, secondly, be found by exploring how this view of the person has contributed to attitudes toward individuals whose behavior places them on the fringes of what is generally considered acceptable. There are two tenets of Calvinism as practiced by the Puritans that are particularly relevant to this discussion. These are the depravity of human nature and the immutability of the person. These tenets have helped shape America’s cultural view of the nature of the person and may therefore assist us in understanding why moral treatment and the move to abolish the practice of physically restraining patients failed in the United States.
As a result of the Fall of Adam, Calvinists believed that all people were born depraved, corrupt and with a propensity to sin (Anderson & Fisch, 1939; Brand, 1991; Edwards, 1970).

Man was happy enough at first and might have continued so to all eternity...if he had not willfully and sinfully rebelled against God...By our fall, we are cast down so low into sin and misery, so deeply plunged into a most miserable and sinful condition...(Edwards, 1992; p.392-393)

Evidence of this depravity of human nature was grounded in the observation that individuals not only have a tendency toward sin, but that this tendency to sin is greater than one’s tendency to perform virtuous acts (Edwards, 1970).

The state which has been proved mankind are in, is a corrupt state in a moral sense, [and] is inconsistent with the fulfillment of the law of God....This depravity is both odious, and also pernicious, fatal and destructive...[and] shews [sic], that man, as he is by nature, is in a deplorable and undone state, in the highest sense. (Edwards, 1970, p. 129)

I presume that...a tendency to guilt and ill-desert [is] in ... vast overbalance to virtue and merit; or a propensity to that sin, the evil and demerit of which is so great, that the value and merit that is in him...are as nothing to it; then truly the nature of man may be said to be corrupt and evil. (Edwards, 1970, p. 130)

Therefore, one only had to observe the behavior of individuals over time to conclude that efforts to restrain them from sin have been unsuccessful, thus confirming the belief that the disposition of the heart was naturally corrupt and evil. Edwards concluded that this propensity for evil could be inferred from the observation of “a tendency to continual sin; a tendency to [a] much greater degree of sin than righteousness, and from the general extreme stupidity of mankind” (Edwards, 1970, p. 158).
Therefore, Calvinists believed that without the influence of God (grace), the depraved nature of human beings was **determinate** and **unchanging**.

The general continued wickedness of mankind... proves each of these things, viz, that the cause is fixed and that fixed cause is internal, in man's nature and also very powerful. (Edwards, 1970, p. 193)

We are weak and unable to save ourselves. We cannot do without God's help... We are like persons that are falling from a precipice into some dreadful pit and cannot possibly stop ourselves from falling still further. We must look and pray to God for help, or else we are inevitably lost. (Edwards, 1992, p. 332)

Since Calvinists believed that it was God who determined which individuals were saved, one's behavior would eventually reflect this status. Therefore, social behavior was considered to be an indication of this election. In other words, good social conduct was considered to be the **result** of salvation, rather than the cause of it (Morgan, 1966; Vaughan, 1972).

One's character, then, was thought to be fixed. Therefore, there was little one could do to change one's behavior. Those whose behavior fell outside of what was considered acceptable were thought to be, and were treated as if they were locked into particular social roles (Erikson, 1966). Calvinists believed that those elected to be saved eventually moved into positions of leadership, whereas those not elected to be saved eventually sank to the lower levels of society.

Productive work was thought to be further indication that one was elected to be saved. Persons would illustrate their chosenness by acquiring a vocation (Carroll, 1977; Vaughan, 1972). Puritan society demanded and valued personal initiative, therefore, individual members of society were expected to contribute diligently to the
good of the whole. Each person was expected to responsibly and successfully conduct one's life business (Myers, 1970).

Despite this inclination to sin and despite the inability to influence one's final outcome, individuals were held responsible for their own behavior (Carroll, 1977; Vaughan, 1972). Societies were also held responsible for the behavior of individual members (Vaughan, 1972). Therefore, it was the duty of societies to exercise strict control and discipline, as well as surveillance of its members. Otherwise, God would punish the community for not maintaining its part of the bargain. Societies, therefore, not only had the right, but they had the obligation to expel members of that society who disobeyed the laws of God. These members were seen as wicked thereby deserving to be rejected and abhorred (Edwards, 1970; Vaughan, 1972).

Justice then, was rendered with certainty and with little effort to understand the purpose behind the behavior (Erikson, 1966). It did not matter how severely the person was treated because this punishment was thought to be only a preview of what was to come. The substance of Puritan philosophy, then, was to control the person in every phase of one's social life, through discipline (Anderson & Fisch, 1972). Since one's behavior indicated one's status in the eyes of God, this status would then be reflected to the outside world. Therefore, disorder was seen as the result of sin.

Erikson (1966) has argued that these Puritan values continue to influence the way America as a nation feels about and responds to individuals whose behavior has drifted outside the boundaries of what is considered acceptable. According to Erikson, every society has different practices for designating people to "deviant"
status and for regulating the movement of these individuals into and out of these roles. In Puritan New England, deviance was seen as a static position whereby individuals would be more or less confined to particular roles in society. Characterizing an individual as deviant was said to describe that person’s state of grace and spiritual condition.

[This] reflected a theory of human nature which was largely unique to America....Although Puritanism started as an international movement and left its imprint on many corners of the world, the peculiar ethos it generated took root mainly in the United States, and this heritage is still evident in methods we use to handle deviant conduct. (Erikson, 1966, p. 204)

**Significance to Nursing**

Historically, the practice of restraining psychiatric patient has been underpinned by the need to control the person in order to provide safety on the unit. Yet this rationale is rarely overtly acknowledged. When it is alluded to, it is in the context that the behavior needs to be controlled (Grigson, 1984), not the person. The person, however, cannot be disconnected from this event, for it is the person who is being restrained. In the psychiatric research, this person has been hidden behind the behavior that precedes and is said to justify this intervention (American Psychiatric Association, 1984; Grigson, 1984; Hay & Cromwell, 1980; Lion, Levenberg & Strange, 1972). This focus on behavior objectifies the person as inappropriate behaviors and a diagnosis.

There is a notable absence of discussion in the current psychiatric literature relative to whether we ought to be restraining patients. Of further note is the absence of an attempt by researchers to understand the experience of being restrained and the
impact of being restrained on the restrained person. This neglect of interest in and investigation of the person's experience of being restrained may be accounted for by two phenomena. The first is a philosophy of science that describes the aims of science as explanation, understanding, prediction and control. The goal of this view of science is to identify general laws regarding behavior so that the scientist will be able to explain and predict events (Kerlinger, 1986). In this case, it is the prediction of who is likely to be restrained. Science in this view is objective, systematic and controlled.

The second phenomena is related to current notions of the psychiatric patient as a person. Despite laws that have been developed to protect the rights of the psychiatric patient, there continues to be a stigma attached to being mentally ill. This attitude can be traced historically to values, present at the founding of this country that persist despite their current lack of relevance. Consequently, because the voice of the mentally ill person has not been regarded as important, it has remained unheard.

This neglect of interest in and knowledge about the experience of being restrained becomes important, however, as one questions whether psychiatric nurses ought to restrain patients. This question has been lost in a tradition in psychiatric nursing that has come to value controlling the patient and justifies restraining patients as a means to provide safety on the unit.
**Purpose of the Study**

While safety on the unit is important, concern for the person and the needs of the person should be primary. Because of the paucity of knowledge available regarding the use of restraints, this practice of restraining may violate the moral imperative of nursing, which is to promote the well-being of the patient through excellent practice (Bishop & Scudder, 1990). Since excellent practice requires an understanding of the meaning that our practices have for the patient, it is essential that we understand what being restrained means to the people we restrain. The purpose of this study, therefore, is to understand the meaning of the experience of being restrained to those who have been restrained on a psychiatric unit.
CHAPTER II

THE MEANING OF RESTRAINT

Introduction

In order to articulate the meaning of being restrained we must first be clear about what meaning is and where it originates. Thus we need a theory of meaning. Traditionally, there have been two schools of thought regarding the origin of meaning. The first school of thought places meaning within an entity and thus assumes that the properties of that entity (what constitutes that entity) are contained within it. If one wishes to articulate the meaning of that entity, one needs to elucidate the essence of that entity. The second major school of thought places meaning within the perceiving subject and assumes that meaning is then projected upon the entity from the subject. If one wishes to articulate the meaning of an entity, one needs to understand the intentions of the subject, asking, “What do you mean by X?” For either school of thought, however, queries of meaning have traditionally been in the form of “What is X?”

Traditional theories of meaning that place meaning either within the subject or the object are really two sides of the same coin. Both arise from the premise of a distinction between the “inner” world and the “outer” world. They presume a distinction between the subject and object. Those who search for essential criteria for
meaning presume that objects are “out there” waiting to be discovered. If they begin with this distinction however, they are then challenged by the skeptic to explain how it is that one can become free of one’s conceptual taking-as in order to have access to and knowledge about conceiver-independent reality (Moser, 1993). Those who doubt whether one can free oneself of one’s conceptualization have then turned to the subject as the source of meaning. Thus, the meaning of an entity is what one determines it to be.

The important point, however, is not the disagreement that has ensued over whether meaning originates within either the subject or the object, or whether one can or cannot have access to conceiver-independent reality. The important point is the ontological premise that grounds these disagreements. When one begins with a distinction between the inner and the outer world (between the subject and the object), one is necessarily committed to a theory of meaning that says meaning is either objective or subjective. This beginning premise has furthermore committed philosophers either to a quest for the kind of certainty that can never be attained or a kind of relativism and indeterminacy that makes some uncomfortable (Bernstein, 1983; Hacking, 1988; Moser, 1993). According to Bernstein (1983), it is our “Cartesian Anxiety” that underlies this debate. This anxiety arises from the belief that either there is a secure foundation for knowledge (and meaning) or we become lost in the “chaos” of relativism. And so, the objectivist believes that there must be some fixed, stable anchor to which we can appeal for knowledge, while the relativist believes that the only anchors are those we create and accept.
Traditional views of meaning—indeed the meaning of meaning—can be criticized on both meta-epistemological and ontological grounds. More importantly for this present study, however, thinking about meaning only in terms of “What is X?” can be further criticized on pragmatic grounds. While theories of meaning that answer “What is X?” questions can and do tell us something about a term’s meaning, (i.e. “What is restraint?”) these theories do not provide a horizon for answering questions about the meaning of an experience, i.e. being restrained. To that end, an alternative to traditional theories of meaning must be pursued. This chapter will begin with a review of the literature on restraint. This review will begin broadly, looking at the various uses of the concept and will conclude with the relevant research related to restraining hospitalized patients. From this, it will become evident that there is a significant dearth of knowledge about the patient’s perspective of these restraining practices. Finally, this chapter will conclude with the theory of meaning that underpinned this study.

Review of the Literature

What is Restraint?

Within nursing, concept analyses have traditionally been the methodology used to answer our “What is X?” questions (Chinn & Jacobs, 1983, 1987; Chinn & Kramer, 1995; Walker & Avant, 1988). These methods have originated from theories of meaning that assume that an entity’s essence was stable and existed independently from our conceptualizations. These methods assume that meaning is objective. Therefore, if one wants to know what is meant by X, one looks for and
aims at delineating those essential features that constitute that entity. From these essential features, one then obtains a "real" definition, i.e. a notion of what the thing really is, in itself, out there (Hempel, 1952). This is deemed useful because once one articulates these features, one is then able to pick out an object as an example of X. In other words, "criteria will not precisely define the concept but rather will provide guidelines for determining whether or not the reality basis for the concept exists in a given situation" (Chinn & Jacobs, 1983, p. 87).

This view of meaning as essence may be objected to on meta-epistemological grounds (Moser, 1993). According to this objection, there are no non-circular criteria for determining how one might know that one has satisfactorily delineated the essence of X. "How is it possible," the skeptic asks, "to have access to and knowledge about an entity?" "How is it possible," the skeptic asks, "to step out of one's own conceptualizations to know what a thing is?" Furthermore, "how does one know that anything really exists out there, separate from us?" In an effort to answer these questions, philosophers have sought an Archimedean point--a foundation for knowledge that requires no further justification. Influenced by logical positivism, the sciences sought this foundation in that which is "given" to the senses. Therefore, definitions were reduced to observation sentences. Concepts that could not be reduced to "observables" were considered not meaningful. Thus in nursing, the goal of concept analyses became one of obtaining an operational definition. And the focus for the concept analysis became one of measurement of the concept.
Wittgenstein (1953/1968) was one philosopher who criticized theories of meaning that assumed stable, essential criteria as constitutive of the entity. Likewise, he rejected theories of meaning that privileged the subject. He saw meaning as a relation between the subject and the object. Rather than assume fixed criteria and sharp boundaries between what an entity is and what it is not, he said one should “look and see.” “Don’t say ‘there must be something common, or they would not be called “games”’—but look and see whether there is anything common to all...don’t think, but look!” (Wittgenstein, 1953/1968, p.31). He said one might find instead, that the similarities are more like relationships, something more akin to “family resemblances.” Rather than identify rules for the use of a term, one might instead point to certain cases, or paradigms and say, “This is what I mean by such and such.”

In keeping with Wittgenstein’s directive to look and see, the restraint literature was reviewed broadly. This review included general literature, psychology, law and economics, as well as medicine and psychiatry. Despite these varied uses, there were commonalities. In general, one can say that to be restrained involves one holding oneself back or being held back from some action that has been determined by someone to be harmful. Restricting a person’s freedom of movement is generally justified by a perceived larger good that may be very specific, as in protecting a person from harm, or more universal, as in protecting a society from harm. In addition to holding one back from certain activities, some forms of restraint or some restraining practices may more subtly constrain one, i.e. they may compel one to act
in a certain manner. For example, the threat of punishment may restrain one or inhibit one from acting aggressively, but the threat of restraint may more subtly be seen as forcing one to act in a particular way.

Non-medical uses of restraint

In psychology, the concept restraint has been used theoretically to explain eating disorders (Klesges, Klem, Epkins & Klesges, 1991; Ruderman, 1986; Wardle, 1990), certain patterns of drinking (Bensley, 1991; Bensley, Kuna & Steele, 1988; Curry, Southwick & Steele, 1987), aggression (Dipboye, 1977; Dunand, Berkowitz & Leyers, 1984; Feldman, Rubenstein & Rubin, 1988; Feldman & Wentzel, 1990; Ho, 1990; Wentzel, Feldman & Weinberger, 1991) and suicide (Davis & Short, 1977).

The theory of eating restraint states that eating patterns are influenced by the desire for food and the efforts to resist that food. When these efforts to resist food are relaxed, paradoxical overeating can result. Restraint, then is defined as a cognitively mediated effort to resist eating. The theory of drinking restraint is similar to eating restraint. Restrained drinkers are preoccupied with controlling their alcohol intake. These individuals experience psychological conflict between desiring to drink and resisting this desire. Consequently, these drinkers are apt to engage in a restraint and binge cycle of drinking.

Restrain can be seen as one controlling one’s aggressive impulses (Dunand, et al., 1984; Feldman, et al., 1988; Feldman & Wentzel, 1990; Wentzel, et al., 1991). In studies of family relationships, achievement and self-restraint (Feldman, et al., 1988; Feldman & Wentzel, 1990; Wentzel, et al., 1991), those individuals with self-
restraint could regulate their own behavior, thereby balancing their own personal needs with those of others. Restraint-related skills were considered to be those skills associated with social adjustment—such as controlling one's impulses and adhering to rules. In a study of the audience effects of viewing aggressive movies (Dunand, et al., 1984), the authors concluded that individuals learn to control their behavior by socializing with others. The theory underpinning this study proposed a correlation between viewing aggressive movies and a subsequent disinhibiting of and acting upon the viewer's aggressive feelings.

In all of these studies, the restraining effect seemed to be something within the person that controls or inhibits certain impulses and desires. Stovall (1931), in discussing the poet Shelley, described Shelley's conflict between his desires (gratifying his own physical appetites) and barriers to these desires. In this context, restraining practices were either internal or external inhibitors of behavior. Internal restraints were those internal inhibiting activities that are one's own. External restraints were those inhibiting practices that are imposed upon individuals through laws, customs or convention. Desires were seen as either egoistic or altruistic, promoting one's own well-being or promoting the well-being of others and society. Life, according to the author, is balancing these desires with restraint.

There are social practices that seem to have a restraining effect on individuals. For example, in Davis & Short's (1977) study of restraint in relation to suicide, suppressing one's urge to commit suicide occurs when a person identifies with and complies with the constraining influence of social structure or personal relationships.
This external structure was hypothesized to influence the urge or desire to commit suicide.

In a study of domestic violence in Asian women (Ho, 1990), the author focused on the constraining influence of culture in relation to physical violence toward Asian women. According to the author, Asian cultures value one restraining oneself, i.e. holding back one's feelings and keeping one's behavior in check. When this inhibiting effect is not present, physical aggression, especially toward the woman can become violent and explosive. This problem of physical violence is compounded because Asian women are reinforced for enduring this hardship and not speaking up. Therefore, they are apt to tolerate and remain silent about this abuse.

Black (1901) and MacDonald (1989) wrote about the relationship between culture and restraint. The Christian church, by valuing restraining oneself, has strongly influenced its members insofar as the members agree that self-denial (fasting, celibacy and solitude) is an important part of one's quest for holiness. By repressing oneself, present gratification is resisted for the sake of a larger good, usually articulated as religious communion or holiness. In Western Europe, socially imposed laws, primarily influenced by Christian ideology and/or group pressure, reinforced restraining one's sexual behavior and attitudes, thereby reinforcing monogamy. Black (1901) argued that only by disciplining oneself could one control one's appetites and passions. He further argued that without discipline and restraint, one's "animal" instincts would be undirected and the order of life destroyed.
Dipboye (1977) theorized that individuals who feel a loss of identity and individuality in society will no longer feel that society’s constraining effects. This loss of identity releases, according to the author, the “violent” or “primitive” side of human nature, resulting in (1) decreasing concern for how the person appears to others, (2) lowering of self-consciousness and (3) weakening self-control. This was thought to result in increasing aggression, sexual deviance and vandalism.

Governmental practices may also restrain another’s activities. For example child restraining devices, manufactured for the transporting of children under the age of five in motor vehicles equipped with seat belts, restrict the freedom of movement of these children. Since they do restrict the freedom of the child, the constitutionality of the use of these restraining devices has been questioned (Regan, 1982). The courts have decided, however, that protecting the child from injury supersedes restricting the freedom of the child because the young child cannot appreciate the dangers of unrestrained travel. A child of this young age is therefore not able to make an independent decision.

Restraints of trade (Attorneys General, 1985; Hamilton, 1985; Kintner, 1980) are those legal agreements that restrict one party from either following an occupation, industry or trade or conducting the industry in a particular manner or place. Restraining trade is an attempt to limit, obstruct, control or eliminate competition in a given market. Restraints of trade are also those agreements, such as tariffs or import quotas, that constrain the free flow of trade in the international market. The purpose is restricting the flow of trade across international markets.
Cole (1983) discussed governmental practices that restrain science. By prohibiting certain activities or by dictating which ideas are followed and which are censured, the activity of the scientific community is constrained. Likewise, there are governmental practices that attempt to prevent the writing, publication or circulation of so-called objectionable material, thereby censoring reading (Gellhorn, 1956). The proponents of these constraining practices argued that censoring actually preserves freedom because it reinforces "true" values and beliefs, whereas those who oppose these practices see censoring as jeopardizing one’s freedom. Finally, Howard (1979) discussed those governmental practices that attempt to control and limit war. Discipline in relation to war was considered necessary to protect countries from random violence or total destruction. Therefore, these restraining practices were thought to moderate war.

Medical Restraining of Patients

In both the descriptive and research literature related to restraining medical and psychiatric patients there was no consistent definition for restraint. In addition to four-way leather restraints, other means considered to be restraints were posey vests (Anderson & Reeves, 1991; Guirguis & Durost, 1978; Moss & LaPuma, 1991; Robbins, Boyko, Lane, Cooper & Jahnigan, 1987; Strumpf & Evans, 1988), "holding" (Dabrowski, Frydman & Zakowska-Dabrowska, 1986; Westermeyer & Kroll, 1978), strait-jackets (Dabrowski et al, 1986; Way, 1986), forced medications (Anderson & Reeves, 1991; Dabrowski, et al., 1986; Fann & Linton, 1972; Jeffries & Rakoff, 1983; Rapp, 1987), cold wet packs (Kilgalen, 1972; Ross, Lewin, Salzberg...

Most of the research on restraining patients has focused on the reasons for restraining them, most often cited as protecting the patient or others from harm. In the psychiatric research, patients were most often restrained in response to an act of violence or threat of violence that the patient has directed at either self or others (Bornstein, 1985; DiFabio, 1981; Guirguis & Durost, 1978; Phillips & Nasr, 1983; Sheridan, et al., 1990; Soloff, 1978, 1979; Way, 1986), thereby concluding that the patient is out of control (Outlaw & Lowery, 1995). In the geriatric literature, restraining patients was seen as a way to protect the patient from injury—either from falling or from wandering into dangerous situations (Berland, Wachtel, Kiel, O'Sullivan & Phillips, 1990; Burton, German, Rouner, Brant, & Clark, 1992; Ramprogus & Gibson, 1991; Robbins, et al., 1987; Strumpf & Evans, 1988; Tinetti, Lui, & Ginter, 1992). Other reasons that were given for restraining patients were: violating the rules, manipulating the staff, behavioral regression (Soloff, 1978; 1979),
agitation (DiFabio, 1981; Guirguis & Durost, 1978; Way, 1986), disruptive behaviors (Berland et al., 1990) and pulling out equipment such as intravenous lines (Robbins et al., 1987; Strumpf & Evans, 1988).

Both the psychiatric researchers and the gerontological researchers have attempted to identify characteristics of the patient that might predict who was most likely to require physical restraining. Because of the differences in settings, populations and methodologies and the absence of control groups, however, it is difficult to extract any meaningful conclusions. With some hesitancy, one can conclude that the persons who are most likely to be physically restrained on psychiatric units were young, psychotic males, who have a history of aggression (Bornstein, 1985; Carpenter et al., 1988; DiFabio, 1981; Phillips & Nasr, 1983; Roper et al., 1985; Sheridan et al., 1990; Way & Banks, 1990). Patients who were physically restrained on the psychiatric units were most often diagnosed as schizophrenic (Phillips & Nasr, 1983; Roper et al., 1985; Sheridan et al., 1990), but in many cases either no diagnostic criteria were identified, or different criteria from study to study were used to diagnose the patient.

Dementia seems to also predict who will be physically restrained in both the psychiatric (Carpenter et al., 1988) and the nonpsychiatric settings (Berland et al., 1990; Burton et al., 1992; Lofgren et al., 1989; Robbins et al., 1987; Tinnetti et al., 1991). Persons who were physically restrained on nonpsychiatric units tended to be older, female, cognitively impaired, dependent with regard to activities of daily living
and have a history of falls (Berland, et al., 1990; Burton et al., 1992; Lofgren et al., 1989; Tinetti et al., 1991).

Roitman, Orev & Schreiber (1990) reviewed the six-year records of restrained patients to determine whether there was any annual rhythm to violence in these hospitalized psychiatric patients. Of these 551 patients, they found that there was no correlation with the photoperiod in nonaffective disorder patients, while the patients with affective disorders seemed to have a circannual rhythm that peaked in June and December.

There were two studies that examined the social structure of the psychiatric unit and its relation to the practice of physically restraining patients. Morrison (1990a), using grounded theory methodology, explored the relationship between organizational factors and violence. One of her findings was that a practice she called "reciprocity" was used by the more experienced staff in order to socialize newer staff members into restraining patients. She found that in situations of potential violence, newer staff members would request assistance from certain experienced staff members she called "enforcers." If, however, these newer staff members decided that, rather than restrain the patients, they would talk to the patient in order to calm the patient down, the "enforcers" would "retaliate" in the future by not responding to the staff member's call for help, thus leaving that staff member open to potential assault. The author concluded that staff members were thus "socialized" to restrain, rather than use alternative methods to deescalate the patient.
Fisher (1995) had a similar finding in her study of a locked commitment unit and a forensic unit. She described the tension that staff feel between “doing the right thing” and getting along with coworkers. The participants in her study said that when they used less restrictive interventions, other staff often labeled them “as inexperienced, as victims of manipulation, or as not acting as a team member” (Fisher, 1995, p. 202). Thus, these staff members felt that if they challenged the unit norms, they risked not being supported during times of dangerousness. The dominant culture of control was therefore, reinforced.

Kalogjera, Bedi, Watson & Meyer (1989) measured the number and duration of secluding and restraining episodes for a five month period preceding and following the implementation of a "therapeutic management" protocol. This protocol consisted of identifying stages of aggressive behavior and utilizing specific interventions during each of these stages. The authors found that despite an increase in the patient to staff ratio, there was a significant decrease in the number of restraining episodes, as well as a decrease in the actual number of patients who required restraining and seclusion.

There were two studies that included as part of a larger design, an assessment of the patient’s responses to or perspective of the restraint experience. Sheridan et al., (1990) briefly interviewed all patients who were physically restrained on a psychiatric unit between 1987 and 1988. From this data, they concluded that 66% of these patients had good recall of the actual event. Of these patients (N=48), 39 perceived that being restrained was a consequence of conflict between either staff or other patients. The nature of the conflict and how it resulted in being physically
restrained were not discussed by the authors, however. Twenty-two patients recalled paranoid or delusional thinking prior to being restrained. Forty-one percent had a "positive" response, stating that being physically restrained calmed them and fifty-one percent had a "negative" response, saying that they were angry or frightened. The patients suggested that better communication or discharge could have prevented their being physically restrained.

Strumpf & Evans (1988) briefly interviewed, again as part of a larger study, twenty medical patients who had been physically restrained. Categories of responses to the restraining experience included anger, fear, resistance, humiliation, demoralization, discomfort, resignation, denial and agreement. The patients offered the following alternatives to being restrained: increasing the numbers of staff, more explanations by staff, easier access to the bathroom, more diversionary activities and discharge from the hospital.

There were three studies that focused on the nurses' responses to restraining the patient. One (Scherer, Janelli, Kanski, Neary, & Morth, 1991), administered questionnaires to staff in a nursing home. The authors concluded from the responses that the staff were not conflicted about the practice of restraining patients. One must be cautious, however, about drawing conclusions from this study, as the response rate was very low--21% of the nursing assistants, 19% of the of the LPN's and 17% of the RN's. In addition, the tool itself was subject to social desirability bias. Staff usually know what the "right" answer is to the question of why and when physical restraining devices should be used. It would take careful construction to develop a
tool that elicits actual attitudes and feelings about restraining patients. DiFabio (1981) and Quinn (1993) both interviewed staff to elicit feelings about restraining patients. Both authors concluded that staff acknowledge the need for restraining patients, but experienced distress with their use.

The only psychiatric research that focused primarily on the outcome of restraining patients was Sheridan et al. (1990). The authors concluded that neither the positive or negative responses of the patient predicted the number of hours actually physically restrained or the number of subsequent restraining episodes. These findings did not support their hypothesis that the patient’s attitude toward being restrained would influence subsequent behavior. The authors suggested that some patients view being restrained as a deterrent to aggressive behavior, while others found being restrained "rewarding." The authors further concluded that alternative interventions were needed for those patients who found the experience rewarding.

In the gerontological research, there have been studies to determine whether the practice of physically restraining patients increases or decreases agitation and whether this practice increases or decreases the number of serious falls. There seems to be some indication that the practice of physically restraining patients increases the patient’s agitation (Werner, Cohen-Mansfield, Braun & Marx, 1989) and, rather than decrease the number of serious falls, may in fact increase the number of serious falls (Tinetti, et al., 1992).

Lofgren et al. (1989), in a prospective study of restraining patients on a medical service, concluded that the patients who were restrained longer, had a higher
rate of nosocomial infections and pressure sores. Patients who were restrained also
had a higher rate of in-hospital deaths. Given, however, that these patients also had
more diagnoses, they may have been more acutely ill than patients who did not
require restraining.

Of interest in terms of outcome of the practice of restraining patients is some
of the animal research related to stress. In these studies, the use of these physical
restraining devices (harnesses, wire meshes, pens or small, Plexiglas cylinders) were
used to elicit the stress response, thus enabling the researcher to measure hormonal
activation (Becker et al., 1989; Imperato, Angelucci, Casolini, Zocchi & Puglisi­
Allegra, 1992; Sigg, Keim & Sigg, 1978) and its relation to healing (Derr, 1981),
immunosuppression (Flores, Hernandez, Hargreaves & Bayer, 1990; Zwilling et al.,
1990) and the development of gastric ulcers (Gaudin, Safar & Cuche, 1990; Lanum,
Campbell, Blick, Knox & Wheeler, 1984; Wyrwicka & Garcia, 1979) in these
animals. Despite the differences in the hypotheses and the outcomes of these studies,
the general consensus seemed to be that physically restraining these animals is a
stressor that activates the hypothalamo-pituitary adrenal axis (Pare & Glavin, 1986).
Lanum et al. (1984), using a Learned Helplessness Model, immobilized rats for 0, 2,
8, 14, or 18 hours. Following the episode of being restrained, they then observed the
rats' behavior and concluded that the restrained rats learned more slowly and had an
overall decrease in their activity.
Secluding the Patient

Although one can argue that the practice of secluding patients is conceptually different than the practice of restraining patients, it is relevant to this study for two reasons. The first is that in some of the descriptive literature, as well as the research literature, secluding patients is considered to be a form of restraint. Conceptually, however, these two practices are different in that, although the secluded patients are restricted, they continue to have free movement of their bodies. They are restricted in space, not movement. On the other hand, secluding patients is related to restraining patients in that there is a significant restriction imposed on one by another. Another reason that the seclusion research is relevant is that there have been some qualitative studies of the patient's experience of being secluded. In these studies, patients were either (1) interviewed, using brief, structured interviews (Binder & McCoy, 1983; Norris & Kennedy, 1992; Plutchik, Karasu, Conte, Siegal & Jerrett, 1978) or (2) given questionnaires (Soliday, 1985; Tooke & Brown, 1992) whereby the patients were asked to identify their perceptions and feelings about being secluded. In all of these studies, patients overall felt negatively about being secluded, saying that they felt angry, anxious, powerless, confused, sad, frustrated, resentful, or other such negative feelings. In these studies, however, some of the patients felt positively about the experience, saying that being secluded helped calm them down, keep them safe, or comfort them.

In another qualitative study of the seclusion experience (Wadeson & Carpenter, 1976), researchers on a National Institute of Mental Health research unit
analyzed the patients’ art. The researchers found that although they had not specifically asked these patients to draw pictures of the seclusion experience, they often did. These researchers reported that even at one year follow-up, the patients felt bitter about being secluded and that this bitterness influenced the patient’s perception of the entire hospitalization. Since these patients were often not medicated, their drawings were often of their hallucinations and delusions while they were secluded. The hallucinations tended to be pleasurable and comforting, whereas the delusions tended to be unpleasant, terrifying and often persecutory. For these patients, being secluded was perceived as punishment for some unknown crime. In general, these patients tended to have intense, negative feelings about this experience.

**Summary of the Review of the Literature**

There seems to be then, a balance between restraining oneself and being externally restrained. If, for some reason, a person actually has or is believed to have diminished ability to control oneself, either naturally or as a result of circumstances, society (large or small) will, in an effort to constrain that person, exert more of its own external control through the use of some kind of threat or force. If a particular society fears that an individual will lose control more effort will be exerted to constrain that person.

Therefore, being in control does not merely describe behavior. There is a normative component to it. Individuals, as members of a larger culture, place at least some degree of importance on being in control. Individuals, as part of societies and cultures, form some consensus as to which behaviors qualify as an indication that one
is in control or out of control. In that sense being in control or being out of control are relative concepts. There is no one standard to measure being in control. Control therefore, cannot be understood in isolation or as separate from the person and the tradition out of which that person emerges. The importance one places on maintaining control is intertwined with a particular society's notion of the nature of the person, in relation to a balance between expecting one to restrain oneself and the need for one to be restrained by others. Therefore, different cultures develop their own methods to handle individuals whom its members view as out of control.

Psychiatric nurses have a long history of being with patients who are losing control and with assisting them in regaining control, yet little is known about the practices of restraining patients. Psychiatric nurses, as part of their everyday practice must evaluate whether patients are in control or out of control. At times this determination is fairly clear. But, at other times that fine line between being in control and being out of control becomes fuzzy. That point at which the patient has lost self-control is not entirely clear. Listen to the words of an experienced psychiatric nurse:

See, that was the fine line...On the unit, when no one was watching him, he was crazy as can be. But then, when we asked him to take a look at his behavior and work on it, he was able to do that...We could wait until the middle of the day and see if he acts out a little more...

The dilemma for the psychiatric nurse becomes one of trying to determine when to "leap in" and take over for the patient who is losing control and when to "leap ahead," allowing the patient to utilize his or her own resources, accompanying the patient in the effort to regain control. This is a difficult decision because, if a
nurse prematurely leaps in and restrains the patient, the danger is one of domination
(Heidegger, 1927/1962). The experienced nurse says:

Sometimes I’ve gotten the impression that when patients are behaving
bizarrely, but not self-destructively, that sometimes the nurses feel that they
have a responsibility to stop that behavior because its bizarre...That they have
some responsibility in controlling that behavior.

The other risk the psychiatric nurse must face is not leaping in when there are
potential conditions of dangerousness, e.g. when a person is losing control and the
safety of the unit is in jeopardy. These may be the times when patients welcome
others leaping in and taking over. The ideal circumstance would be to "be with" the
patient who is losing control in order to give the patient space, time and an
opportunity to regain control. This same nurse describes how this might look:

Wouldn’t a patient benefit from you saying, "We were making a decision to
put you into restraints because we felt that you needed something to
calm...[for you] to be calm. But you showed us that you could get back into
control so I’m glad"...And talk it over...Talk to the patient about what worked
and what didn’t...

These are the everyday practices of the nurse on a psychiatric unit, trying to
maintain safety with patients who vary in their ability to restrain their own behavior
and consequently are at risk for losing control. The psychiatric staff also vary in
their ability to “be with” the patient whose behavior is escalating out of control.
Likewise, they vary in their ability to leap ahead and deescalate a patient who is
losing control. Those who are less skilled in distinguishing when an individual
patient is losing control and less deft at deescalating the patient often depend on the
structure of a more restrictive environment to maintain control of the patients. Aside
from the impact of this restrictive environment on the person, there seems to be at
least some evidence that these highly restrictive environments actually increase the potential for violence. This, then, results in a cycle of tighter controls which can contribute to an increase in aggressive acting out (Morrison, 1990a,b; Morrison, 1994).

Although typically conceptualized as such, restraining oneself or being restrained is not simply an isolated act or an event. It occurs within a context. Expectations of self-control and assumptions about an individual’s ability to self-control emerge from societal, cultural and religious customs. Thus, a particular society (such as a psychiatric unit) establishes practices that convey to its members which behaviors are acceptable and which are unacceptable. How a society views a person determines the relative balance between the need to exert external control and an expectation of internal control. If an individual is deemed to be unable or unwilling to control one’s own behavior, society will exert more external control. If a particular society fears the consequences of decreased self-control, more external control will also be exerted.

This review of the literature has provided us with a background understanding of the practices of restraining, i.e. What is restraint? When is it used? Why is it used? What is missing from the literature, however, is the meaning of this state of being restrained (for one). This absence has occurred primarily because this practice has (for the most part) been studied within a tradition that views phenomena objectively and as separated (in a way to be specified) from human interests. Scientific inquiry typically requires a change-over from the practical to the theoretical. In this change-
over, practical activity (praxis) disappears and likewise, the lens through which one views the phenomenon also changes. For example, in practical activity, i.e. when one is using a tool, one may comment about the tool’s heaviness or lightness and easiness or difficulty in handling. Heaviness or lightness, however, only have relevance in relation to using the tool, e.g. it is too light to do the job. While the tool’s heaviness or lightness is related to certain properties of the tool (its weight), one can still talk about these properties even when the tool is taken out of this context. In fact, the properties are all that one can talk about. Any talk about the tool’s lightness or heaviness no longer has relevance. Thus, when the tool is removed from the context in which it is used, its “tool-character and “world-point” (its place in someone’s world) are both overlooked (Heidegger, 1927/1962).

This viewpoint that the entities one studies are objects that are merely present is exemplified in the reported research about restraining patients. This research has primarily sought to identify properties about the restrained person (sex, age, diagnosis, previous history) as if that person was merely present as an object might be. In this kind of research, not only is the person taken out of context, but the person is objectified. This research comes out of a paradigm that (1) assumes the world is structured and ordered and that it behaves in a predictable way, (2) assumes that the world can be broken down into distinct, separate variables (Allen, Benner, Diekelmann, 1986) and (3) attempts to control the context by (a) controlling the situation in which the experiment is conducted, (b) controlling who receives a certain
treatment or (c) controlling the procedures in order to control threats to valid inference (Cook & Campbell, 1979).

To say that the practice of restraining patients has meaning to those involved is to say, however, that this practice occurs within a context. Therefore, to study the meaning of this experience, one must study this experience utilizing a paradigm that embraces context, rather than controls context. According to Heidegger, what an entity is or "the beingness of beings is not something 'out there' in beings but rather is the meaningful relatedness, the intelligible presentness, of things to and for man" (Sheehan, 1981b, p. x). Heidegger's central problematic, however, is not the being of entities (the presence of entities to one), but the being of being (what makes meaningful presence possible). He is interested in the meaning of being. Heidegger, by articulating what he calls a fundamental ontology, has thus opened up the possibility of an alternative methodology for the study of meaning.

Heidegger and Meaning

Meaning, according to Heidegger, does not reside in a word or within an entity. Nor is meaning something that a person simply projects onto an entity. When entities have "come to be understood--we say they have meaning (Sinn)" (Heidegger, 1927/1962, p.192), but, strictly speaking, it is not the meaning that is understood, but the entity (Heidegger, 1927/1962, p. 192). For Heidegger, meaning "is that from which something is understandable as the thing it is," (King, 1964, p.7) where the that-from-which is "a world of human existence" (King, 1964, p. 7). In other words, it is only from a human world of purposes that an entity can be understood as
something that is relevant to one. Therefore, meaning is the center of reference around which the understandability of an entity is organized (Caputo, 1987).

Accordingly, Heidegger asserts that meaning emerges because of the way human beings relate to the entities they encounter that is possible because of the particular structure of human beings. Heidegger calls this way of relating to entities “being-in-the-world” and the structure of human beings “sorge,” usually translated as “care.” Fundamentally, however, it is temporality that gives meaning to this structure and how we relate to both ourselves and other entities. Since humans are finite, they are always ahead-of-themselves, living into possibility. Thus, finitude makes it both possible and necessary that humans will form a world of purposes (King, 1964).

**Being-in-the-World**

Being-in-the-world is a unitary phenomenon that Heidegger uses to capture the sense of how humans are in relation to other entities. Being-in, therefore, is not a spatial relation, but indicates the way that human beings dwell among other entities (both human and nonhuman) in a familiar world (Heidegger, 1927/1962). This implies a certain kind of involvement with these entities. “It is a profound intimacy of [one] with the world, by reason of which other beings that are within the world may be ‘encountered’, sc. reveal themselves for what they are” (Richardson, 1963, p.52). Therefore, these entities (things, experiences/events) do not simply exist out there in a detached manner. Human beings have an interest and investment in them. Being-in-the-world discloses these entities as meaningful and relevant.
Practical world. Heidegger, in order to uncover the structure of being (how entities are meaningfully present to one), begins his analysis with “everyday,” practical activity (taking-as-for) (Heidegger, 1927/1962). In this analysis, he describes the way human beings actually encounter certain kinds of entities (tools, zeug). In one’s everyday activity, one does not come upon these tools in a flat and detached manner (as merely present, vorhanden). Tools are not objects that are just there. In Heidegger’s often cited example of hammering, Heidegger illustrates how our usual way of being-in-the-world is one of practical involvement. There, one does not first-off weigh the hammer or identify the properties of the hammer. One uses it. We know that we have some purpose for which we need a tool. We understand that the tool, itself, would be useful for that purpose. Therefore, we pick up the tool and use it.

Reflectively, when we observe someone who is engaged in such an activity, all we “see” is the person’s practical taking-as. In the hammering, the focus recedes from the hammer itself such that the focus for the person using the tool is on the work to be done. In the work to be done, then, the tool refers to something beyond itself. “For example, the hammer will have its immediate destination in a hammering, the hammering in a nailing, the nailing in building of house” (Richardson, 1963, p.55). And, the house is to be built for someone. The important point that Heidegger is trying to illustrate in this example is that in our using the tool, the related purposes (the “in-order-to’s”) and goals (the “for-which’s”) remain hidden
(in the background) and yet are present. The context that renders the instrument meaningful recedes and remains implicit.

Waking up to world. There are, however, certain circumstances that will explicate this hidden context. If, for instance, one is unfamiliar with one’s surroundings, one might have to think about one’s purposes in relation to the entities one encounters. At other times, the tool that one needs may be unavailable. Or the tool may be broken or missing. One is then caught up short. And, suddenly, one misses the item one needs and wakes up to the realization that one needed the item for a particular purpose. Thus, the previously implicit purposes and goals now come into the foreground. We wake up to world.

World. For Heidegger, world is not a “thing.” It is not the totality of entities that exist within the world. World is the context of involvements that give meaning to the entities one encounters within one’s individual world. World is a “matrix of relationships” (Richardson, 1967, p. 291) from which entities are meaningful. Consequently, because of our understanding of this contextual wholeness, entities are not presented to us as isolated entities. The equipment and tools that we use are not mere objects. They are disclosed to us within this contextual whole as interconnected entities that are useful to our purposes (Heidegger, 1927/1962; 1983/1995). Therefore, we can comport ourselves toward these entities in the world by producing them and otherwise involving ourselves with them. And, while we cannot comprehend the totality of all entities, we do comport ourselves in the midst of these
entities as a whole. Thus, while our everyday existence may appear fragmented, we are always dwelling within a unity of a whole (Heidegger, 1993).

Transcendence

As we have seen, one can take and use an entity as a tool only because one already knows entities as-being-for some purpose. “Man can get involved with an entity only by being already beyond it, by having already understood it as for something” (Sheehan, 1983, p. 303). Heidegger calls this being-already-beyond-it transcendence. Thus, being-in-the-world is transcendence. Therefore, as transcendence, human beings already (necessarily) “step over” entities or go beyond entities, thereby understanding the being of these entities. As transcendence, human beings are already ahead of themselves, living into possibilities, thereby disclosing entities as meaningful.

The Care Structure

Human beings exist as being-in-the-world. Thus, for Heidegger, being-in-the-world means being human. The ontological structure of being-in-the-world is care. Therefore, being human is care (Heidegger, 1927/1962; King, 1964; Sheehan, 1983; 1984; 1995a). And, the structure of care is to be “already-out-ahead-in-possibilities as being-present-to-entities” (Sheehan, 1983, p. 306). Although the care structure is usually defined as three co-equal moments (existentiality, facticity and falling-in-with), the first two are really two sides of the same phenomenon (one’s being already-ahead into possibility) and thus may be collapsed into one moment. It is these two
moments, as one, that then make the third moment (access to entities) possible. And, it is temporality that both unifies and makes the care structure possible.

**Existentiality.** To be human is to be ahead of oneself, living into possibility. "Man is never merely here and now like a thing, but is constantly out beyond himself, relating himself, in the first place, not to other beings, but to his own ability-to-be" (King, 1964, pp.137-138). In other words, human beings are first-off concerned with their own being, i.e., their own ability to be. We are beings for whom our own being is an issue. (Heidegger, 1927/1962).

**Facticity.** To live ahead into possibility is not a choice that one makes, however. To begin with, humans are not the origin of their own being. As human beings, we are by virtue of being human, already (necessarily) moving into the possible. We are thrown into being-in-the-world. To be thrown means that one finds oneself in particular circumstances that are always present and influencing one. Therefore, our possibilities are not unlimited possibilities. Our possibilities are limited by (1) the culture or family that one is born into, (2) the reality that when one chooses one possibility, one is not choosing another possibility and (3) the reality that one will not live forever, thus limiting all possibility.

**Falling in with.** Thus, as entities who are already ahead of themselves in a world, human beings find themselves in a world with other entities to which humans are present to, but mostly absorbed with. "Man's already-ahead-ness holds open the realm of intelligibility within which man has access to, and in everydayness is 'fallen
into,' the things of his concern” Sheehan, 1981 p. xvi). Thus, the entities we encounter in the world matter to us and are of concern to us.

**Temporality**

For Heidegger, temporality is not a distinct series of nows. Nor is it a separate past, present and future. For Heidegger, temporality is a much more unified phenomenon that grounds (makes possible) the care structure. Therefore, as one who is ahead of oneself living into possibilities, one is becoming what one already is, i.e. finite, mortal becoming. “For Heidegger, temporality connotes becoming, and human temporality entails becoming oneself” (Sheehan, 1997, p. 4). Thus, this aheadness is oriented toward an existential future--one's finitude that is concretized by one's death. We are becoming our ownmost possibility (our finitude).

As one who is ahead of oneself living into possibilities, however, one is becoming what one already and essentially is (Sheehan, 1981). This alreadiness, which is usually interpreted as one's past, connotes that which is “always prior to and beyond our determination” (Sheehan, 1995a, p.217). Thus, one goes out toward the possibility of one’s finitude and comes back to and accepts what one already is (finite mortal becoming). This movement discloses not only our selves, but the entities we encounter as meaningful. In other words, “man as ‘excess’ (ahead of himself and already in a world) holds open the area of access to (or intelligibility of) beings” (Sheehan, 1981, p. xv). Thus, the entities we encounter are made present to us. Temporality, therefore, makes both being-in-the-world and our understanding of being
possible (Sheehan, forthcoming). Temporality is the horizon from which an entity is understandable or intelligible as the entity it is.

**Conclusion**

Finitude, then, is the condition for the possibility that humans will have a world, i.e. that we have a matrix of relationships out of which the entities we encounter are revealed to us as meaningful. In other words, as humans, we are always incomplete. Thus, there is always lack or need that will pull us along (so to speak) or draw us in, toward a completeness that can never be attained.

To ask “What can I...?” is to ask “What can I not?,” hence to betray an essential limitation; to ask “What should I...?” implies not only “What should I not?” (therefore negativity) but also an intrinsic incompleteness; to ask “What may I?” implies hope, therefore expectancy, therefore indigence. (Richardson, 1963, p.32)

Therefore, to be human is to imply limitation and incompleteness. But, rather than view this limitation as negative, this limitation may be seen as the dynamism that thrusts us forward into possibility. Thus, as beings who are moving into possibility, we have purposes, things matter and we comport ourselves concernfully with the entities we encounter. We have an interconnected world.

As part of who we are as human beings, however, we tend to forget this intrinsic finitude that is our dynamism. Thus, in our everydayness, we tend to think that we do have unlimited possibilities and that we can control everything. In science, this forgetfulness is manifested in the quest for certainty. We think we can know everything and solve all problems. We focus our attention on an entity, itself,
and neglect that which makes it present as it is. We forget that hiddenness is intrinsic to disclosure (Sheehan, 1995b).

If, then, meaning recedes and remains hidden, the question for a research study about meaning is how to access those meanings. One of the assumptions of this study is that meanings are embedded in the stories that people tell. Therefore, individuals who have been restrained were asked to tell a story about what happened to them. It is then the task of the researcher to interpret or make explicit these meanings. The methodology used to interpret these meanings was hermeneutic phenomenology since "hermeneutics is the countermovement to the pull of withdrawal, concealment and fallenness" (Caputo, 1987, p.63).
CHAPTER III

METHODOLOGY

Introduction

Narratives or the telling of stories about the events in one’s life, are a way that one communicates to oneself or another the meaning of an event within the context of one’s life (Benner & Wrubel, 1989; Carr, 1986; Polkinghorne, 1988; Sandelowski, 1991). In living these stories we are always interpreting our experiences. In that sense, as human beings, we are hermeneia. Thus, individual events acquire significance within the whole to which they belong. Likewise, our individual stories are related to a larger social context with which we are involved. Therefore, our stories also come out of an historical tradition that we have inherited.

The stories that we tell reveal meaning, as well as a sense of organization, i.e. how and whether an experience fits or doesn’t fit within the context of our lives (our own significances and involvements). Thus, this sense of organization or fitting together implies that there is a coherence to how one’s stories unfold. This fitting together and sense of significance also means that experiences are context dependent. Therefore, the events in one’s life may be interpreted differently at different times during one’s life.
Hermeneutic Phenomenology

The question for this study, "What is the meaning of being restrained?" is not simply a question about what happened, although that question will get answered. This question is really a question about the way that the experience (of being restrained) is present to those who have been restrained. In order to understand the way the experience is present to one, we must also understand the meaning of the experience (the person's referential context). In other words, we must understand how the participants interpret this event within the context of their world. Hermeneutic phenomenology (Allen, Benner & Diekelmann, 1986; Benner, 1994; Polkinghorne, 1988; van Manen, 1990) was the methodology employed for uncovering this understanding.

Heidegger (1927/1962), drawing from the work of his teacher, Edmund Husserl, saw hermeneutic phenomenology as a way to uncover and understand the being of entities (the structure that make it possible for entities to be present to us in a meaningful way). Phenomenology, according to Heidegger, is "the work of laying open and letting be seen, [which is] understood as the methodologically directed dismantling of concealments" (Heidegger, 1979/1985, p. 86). Therefore, phenomenology, which derives its name from the Greek verb, phainesthai, meaning "to show itself" (Heidegger, 1927/1962, p. 51) and the Greek word, logos, meaning "to make manifest what one is 'talking about'" (Heidegger, 1927/1962, p. 56), allows something to show itself as it is. And, "that which shows itself, the manifest," is the phenomenon (Heidegger, 1927/1962, p.51). Phenomenon, as derived from
phainesthai, is further derived from phaino, which means “to bring to the light of
day, to put in the light” (Heidegger, 1927/1962, p.51). Thus, Heidegger tries to
capture the notion that an entity, as it moves from unintelligibility to intelligibility, is
no longer merely present among all other entities. It becomes present to one in a
meaningful way. As such, Heidegger talks about entities coming out into the open,
appearing, coming into the light or moving from concealment to unconcealment.

For this to happen, i.e. for an entity to become meaningfully present, there
must, however, be a structure that lets or makes it possible for this entity to come out
into the light and be meaningfully present. For Heidegger, this structure is the
structure of human beings--being already ahead, living into possibility. It is this
structure that makes all disclosure possible. Therefore, “‘hermeneutics’ in Heidegger
has less to do with interpreting texts than it does with revealing--within all forms of
human behavior--the often overlooked structure of being-in-a-world and the
hermeneutical understanding underlying predicative knowledge of entities” (Sheehan,
forthcoming, p.4).

Hermeneutics, which is derived from the Greek word hermeneia, means
“expression, manifestation, or communication” (Sheehan, 1988. p. 71). In its most
general form, hermeneia refers to any sort of communication, including animal
communication. More specifically, hermeneia can refer to human communication
about one’s being-in-the-world. This is communication about one’s practical world
that then conveys an understanding of something as-being-for a particular use. This
“as-being-for” is often referred to as the “hermeneutical-as” and may be disclosed
preverbally through one’s practical activity or verbally through language. Either way, however, in this form of hermeneia, one is prepredicatively disclosing one’s being-in-the-world. Therefore, “one can get involved with an entity only by being already beyond it, only by having already understood it as being for something. This...is what Heidegger called the ‘hermeneutical as’” (Sheehan, 1988, p. 79). In its most specific form, hermeneia refers to predicative disclosure in the form of declarative sentences (this is that) (Sheehan, 1988). This is a more derivative form of communication that distances one from one’s practical being-in-the-world.

Thus, according to Heidegger, there is an intimate relationship between the process of disclosing and the structure that underlies all forms of disclosure. Heidegger, in trying to “discover something about the givenness (ousia/parousia) of entities and about how human beings enact the givenness of entities” (Sheehan, 1988, p. 68) asserts that it is human existence, as finite mortal becoming (thrown projection), that makes any and all meaningful communication possible. Therefore, “phenomenology taught Heidegger that Being means to be manifest, truth means unconcealment and human existence is the clearing in which beings are manifest (true)” (Zimmerman, 1986, p. 19).

**Understanding and Interpretation**

Hermeneia in its most general form means the same as semainein, which means “indicating something to another”(Sheehan, 1988, p.72). This is the same meaning as the Latin word, interpretari, the connotation of which is “to lay out in the clear” (Sheehan, 1988, p.72). Thus we get our notion of hermeneutics as
interpretation. For Heidegger, understanding is not a kind of cognition in the sense that one might differentiate understanding from explaining and conceiving. That which is understood "has the structure of something as something" (Heidegger, 1927/1962, p. 189) and the "as" constitutes the interpretation. Therefore, that which is understood has the structure of the hermeneutical-as. For Heidegger, there are no presuppositionless interpretations. All interpretations are grounded in fore-having, fore-sight and fore-conception. Thus we do not come upon an entity and cast meaning upon the entity. "We do not, so to speak, throw a 'signification' over some naked thing which is present at hand....The thing in question already has an involvement which is disclosed in our understanding of the world, and this involvement...gets laid out in the interpretation" (Heidegger, 1927/1962, p. 190-191).

Therefore, every interpretation presupposes that we already have a world, a particular point of view and a way of conceiving that which is understood. And it is language (speaking, hearing, as well as keeping silent) that discloses one's world and thus makes shared understanding possible (Gadamer, 1960/1989). Communication "creates the possibility of extending understanding by allowing us to share it with the other who is not in a position to experience it himself" (Caputo, 1987, p. 73-74).

**Getting the Story**

Therefore, the general aim of phenomenological research is to provide an open horizon for a phenomenon to emerge as it is understood and be communicated to another. Since the aim of this study was to understand individuals' experiences, it was assumed that those who have been restrained know more about the phenomenon
than the researcher (Gadamer, 1960/1989). Therefore, for this study, ten adult individuals were recruited who (1) have had the experience of being physically restrained in leather restraints, (2) remembered that experience and (3) were able and willing to share their experiences. Elderly, demented individuals were not included. The participants were referred for this study by the staff of two inpatient psychiatric units. The participants were then invited to participate and if they agreed to participate a mutually agreeable appointment was made for the interview.

Of the ten adults who agreed to participate, five were male and five were female. Eight participants were Caucasian and two were African-American. For one participant, this had been the first restraint experience, whereas the other participants had been restrained more than once in their lives. The interviews themselves were conducted using an unstructured format. Each interview began with the following statement, which was a modified version of that developed by Nancy Diekelmann, RN, Ph.D, FAAN, of the University of Wisconsin, Madison:

Tell me about a time, one that you'll never forget, when you were restrained in leather restraints on a psychiatric unit. It could be a recent story, or one from long ago. Please include as much detail as possible, and stay as much as you can in the story, rather than analyzing the story. After you have given the details, please describe why this story is important to you and what it means to you. Your story will be tape recorded.

**Telling the Story**

In essence, the participants were asked to recall an instance of being restrained that stood out in their minds. In the perspective that grounds this study, the participants were not being asked to talk about an experience that was considered to be over and done with. When a person remembers and retells a story, the story itself
may have occurred in the past, but the “human ‘past’ lies not behind but in front of man (SZ 20) precisely by operating in and determining the structure of man’s present and future” (Sheehan, 1977, p. 306). In other words, when a person remembers something that already took place, that experience, in shaping the person’s future possibilities, is made present to the person (Olafson, 1995). In phenomenological research, then the researcher is interested in the past event, not as a description of something that happened and is done with, but the researcher is interested in how the experience is made present to the participant. Since the participant, by remembering and retelling an experience, is interpreting and disclosing his or her understanding of an experience, the researcher is not interested in objectively validating whether or not the participants correctly remember what happened to them. The researcher is interested in the participants’ understanding of that experience as it continues to be present in their lives.

**Listening to the Story**

The interview, itself, may be viewed as a form of dialogue or conversation between two people. As with any conversation, neither person knows what will emerge. The aim of the interview, therefore, is to come to an understanding (Gadamer, 1960/1989). At the end of the interview, the researcher should have an increased understanding of the phenomenon being studied. But the participant by virtue of being asked to think about and reflect back on the experience, may also come to a new understanding of that experience.
Since the goal was to obtain a narrative account of the experience of being restrained, I initially listened to the participant’s story with as few interruptions as possible. The participants decided where to begin the story. Consequently, it was not always clear at the beginning of the story what was the story. Therefore, I was not quick to refocus the participant if the conversation seemed to wander. It was only when the conversation drifted far out of the story or into discussions of causal explanations, generalizations and abstract interpretations that I refocused the participant (Benner, 1994).

While listening to the story, I tried to get a sense of the experience from the participant’s perspective. Thus, I tried to remain open to what they were telling me, continually asking myself, “Is the experience like this or is it like that?” Without necessarily agreeing with the participant, I tried to understand how it came to be that this participant person has formed his or her particular view. Thus, by listening and being open to what I was hearing, I was able to transpose myself into the participant’s world—into the other’s horizon (Gadamer, 1960/1989).

Once the story was told, I then asked the participant further questions in order to obtain a clearer, deeper, richer description of what happened and how it happened. It is by asking questions that the being of what is talked about is broken open (Gadamer, 1960/1989). Questions open possibilities and keep them open. Questions provide a sense of direction. In order to be able ask a question, one must want to know something about something. And, one must know what one does not know. Therefore, when one asks a question, it means that on the one hand the answer is not
known. And yet, inevitably, the question also limits the boundaries of what is going to be talked about. In this sense, asking a question implies an openness, as well as a limitation. The threat, therefore, is that the researcher will too greatly limit the boundaries by asking the participant questions that are too leading or too narrow in focus.

**Interpreting the Story**

The successful interview will yield a story about the events that have occurred that will then provide the researcher with a coherent understanding of how and why something happened. In other words, the datum is the story of what happened and the analysis is the researcher organizing these events into meaningful themes (Polkinghorne, 1988). In order to be able to analyze the interview, the interviews were transcribed verbatim, thus producing a written text.

The interpretation of the story is another disclosive event whereby the researcher strives to extract the participants' understanding of the experience being investigated (Gadamer, 1960/1989). To this end the researcher enters into a dialogue with the text that involves further questioning and answering. The researcher not only asks certain questions of the text, but listens for questions that come out of the text. Each—the researcher and the participants via the text—enters this dialogue with prejudices and preconceptions. Rather than necessarily distance oneself from these fore-conceptions, the researcher may use these fore-conceptions to increase the understanding of the text.
In the analysis of the text, the researcher must maintain a stance of openness in relation to the text. The researcher must be open to hearing what the text is saying. In that sense, an understanding of the text is given to the listener (Gadamer, 1960/1989). On the other hand, meaning is not always readily available. Meaning also recedes and remains hidden. Thus the researcher must bring out or uncover these meanings. The meanings must be taken out of their hiddenness. Thus, the goal of the interpretation is to not simply retell the events as they happened, but to go “beneath” what happened in order to extract an understanding of the meanings disclosed by the text. Consequently, there may be multiple understandings of the text. Since the researcher strives to present the voice of the participants, the interpretation should be true to the text, in the sense that the interpretation has emerged out of the text and can be supported by text (Benner, 1994).

Although the actual method used to analyze the texts of these interviews was a modification of that described by Diekelmann, Allen and Tanner (1989) and recently modified by Diekelmann (1995), it is important to remember that one does not obtain an understanding of the text by following a linear set of steps. In the beginning, each story was read in its entirety in order to obtain an overall understanding of the text. I then identified common themes that emerged from the text. For each of the interviews, I wrote an interpretation utilizing the themes that emerged from the text and data from the text to support the themes, thus organizing the interviews into a coherent story. Since there were often several stories embedded within the interview, the aim at this point was to get the story straight. At this phase, the threat is (1) that
the researcher will not be true to the text, thus reading too much into the text by either imposing the researcher's own bias onto the text or approaching the text from a viewpoint that cannot be supported by the text, or (2) that the researcher will impose theoretical categories onto the text. The themes should not be theoretical concepts, but should emerge from the text and from the words of the participants. The themes should name that which is emerging.

Since each person comes from a tradition that forms one's thinking, there are no presuppositionless interpretations. The researcher brings to both the interview and the analysis certain expectations. But, these fore-projections must be revised as an understanding of the person and the text deepens. Therefore, one may find that one's fore-meanings are not be supported by the data. The text, then, must be allowed to assert its own truth (Gadamer, 1960/1989). The researcher cannot hold onto one's own fore-meanings and understand the meaning of another. To ensure that the interpretations emerged from and were supported by the text, several interviews and the written interpretations were shared with colleagues who were either familiar with the method or with psychiatric nursing. We discussed any lack of clarity in the interpretation or questions that arose from the interpretation, returning to the entire text for clarification, if necessary. This dialogue with colleagues also served to deepen my own understanding of the text.

With the subsequent interviews, I began a dialogue between the texts. This involved moving back and forth between the parts of the individual texts, the whole of the texts and the historical tradition (my own and the participants) out of which the
understandings were emerging. This dialogue also included a dialogue between the texts of the interviews and the texts of Heidegger and Foucault. Consequently, my understanding of the text both deepened and went beyond what was concretely said by the participants (Gadamer, 1960/1989). As my understanding of the participants deepened, new meanings in the texts emerged. In this dialogue with the texts, patterns of themes that were present across the texts also began to emerge. Finally, these patterns were organized into a written, coherent whole, including sufficient text to enable the reader to evaluate the findings.

**Evaluating the Findings**

Since all investigations are fraught with finitude, there can be no complete understanding of the participants. There is also not a correct interpretation of the text. There can, however, be wrong interpretations—those that are unsupported by the data and therefore, do not present a voice of the participant. Madison (1988) suggests the following guidelines for evaluating an interpretation:

1. The analysis must be **coherent**. It should present a unified picture and not contradict itself, even though the text itself may be contradictory.

2. The analysis should be **comprehensive** and should contain more than a superficial understanding of the text.

3. The analysis should bring out the underlying intention of the text, which is to resolve a central problematic. Therefore, the interpretation should **penetrate** a specific problem.
4. The interpretation should address all the questions that were posed in the study. The interpretation should be thorough.

5. The interpretation must appropriate and should address any questions raised by the text itself.

6. The text must not be read out of its historical and cultural context. Therefore, it must be contextual.

7. While there must be agreement between the interpretation and what the participant says, a good interpretation will also disclose new perspectives.

8. A good understanding will raise questions to stimulate further research. It should be suggestive.

9. Ultimately, a good interpretation is validated by its potential to extend to the future.

Protecting the Participants

Approval for this study was obtained from the Institutional Review Board for Protection of Human Subjects of Loyola University Chicago and from the Human Investigation Committee at the participating institution. I met with potential participants to explain the purpose of the study and to arrange for a time for the interview. At the time of the interview I obtained written consent. The participants were told that they were free to withdraw at any time and that they could stop the interview at any time should they feel uncomfortable. Written consent to audiotape was also obtained. A copy of the Information Sheet (Appendix A) was given to each participant. They were also told that they might contacted a second time, should
there be a need for clarification or more information. However, only one person was contacted a second time. I then transcribed the interviews verbatim and removed any identifying data from the written transcript. The transcripts were then numbered in order to maintain confidentiality.
CHAPTER IV

RESULTS OF THE STUDY

Introduction

Although this was a study of the meaning of being restrained, it surprisingly became a mode of access into the participants' world. On the one hand, this finding should not have been a surprise. If one thinks of events in one's life as meaningful within a context of significances, it makes sense that an event like being restrained would be inseparable from the whole of being mentally ill. On the other hand, we have inherited a tradition that attempts to compartmentalize and decontextualize experiences. In that tradition, it makes sense that one would expect only to hear about being restrained. After all, that is the story one is looking for. In his discussion of ethnographic allegory, Clifford (1994) defends the position that several voices or stories are simultaneously revealed within a text. He cites as an example, the story of a !Kung village woman giving birth. This story of giving birth is, on one level, the description of particular cultural practices. On another level, however, the story also tells of a common human experience— that of a woman who is giving birth to a baby. On yet another level, the researcher's own account of doing fieldwork is recounted, thus revealing a third voice. According to Clifford, "the outcome of an encounter...cannot be rewritten as a subject-object dichotomy. Something more than
explaining or representing the life and words of another is going on—something more
open-ended” (Clifford, 1994, p. 214).

This chapter is the reporting of three stories that are distinct yet intimately
connected. On the one hand, this chapter reveals the participants’ stories of being
restrained—of the movement of power back and forth between the patient and the
staff. On a deeper level, however, this chapter reveals the voice of human beings
with mental illnesses. We will hear what their lives are like, struggling with being
constrained, wondering why it is that they have been thrown into this kind of existing.
To hear both of these stories, however, I needed to enter into the participants’ world.
Because entering another’s world cannot be separated from what was heard, a third
story will be told—that of the researcher getting the story and entering into the
participants’ world.

Being-in-the-World

Unexpectedly, these stories did not always begin where one might expect.
Each person had a unique telling of the story. Each person had a unique way of
bringing me into his or her world. Listen as one participant (all of the names of the
participants have been changed in order to maintain confidentiality) begins her story
of being restrained:

“I’ll tell you about the latest incident [being restrained]. My parents always
lived with my grandparents. A story and a half, a two-flat. And the first
husband [her grandmother’s] was an abusive alcoholic. The second one was a
pedophile. Everybody else worked during the day...He worked nights for the
railroad. He was home during the day. Before I even started kindergarten, he
would, you know, sexually molest me.”
She proceeded, then, to talk about the many years she was sexually abused and the impact this abuse has had on her life. At one point in the interview when it seemed that she was truly off the subject, she connected her being sexually abused to her being restrained:

“He always wore this ring. A Mason ring. The Masons. I knew that it was a Mason ring, but, I didn’t know what the Masons stood for. And Saturday, we had O.T. open. And I was making a leather key chain. I was going to the box, and they had these things that stamp leather. And, they had the usual things--cats, dogs, frogs and mushrooms. All of a sudden, I saw this Mason ring. And I just shoved it in my pocket. And it started eating away at me all day….The last thing that I expected to find was that….It brought back so many bad memories. I just closed down. I wouldn’t talk. I was laying in here [in the room], in the dark. I wouldn’t talk to anybody.”

Another participant, Diane also began her story with events that happened before she was admitted into the hospital:

“Okay, like last year, I met this guy [in June]. I got pregnant. I went to take a test. To get more pills. And they told me I was positive. And my youngest child at the time was 5. And the other one was 6. By my taking Lithium and all those kind of medications, everybody thought that my baby would be born with brain damage and no spine and all that. I went through all that. And so I entered the hospital [in July]...So when I got here...I was so upset I fell to my knees.”

It is a different sort of connecting, stepping into another person’s world. The usual stance one takes as either a researcher or a clinician is one of distance. For the clinician, the paradigm most often used is a framework of pathology. Within this paradigm, one seeks to diagnose and treat a patient. Within this paradigm, the clinician applies psychological theories to help understand the patient. The danger with a paradigm of pathology, however, is that in pathologizing the person, one
discounts and diminishes the significance of what is said. One, therefore, can hear clinicians say in a pejorative tone, “Oh, she’s just a Borderline.”

For the researcher, the usual stance is one of objectivity. The researcher assumes and values the distance between the researcher and the subject. Within this paradigm, the researcher’s responsibility is to collect data from the subject that is uncontaminated by the researcher’s experiences and understandings. The danger with this stance of objectivity, however, is that one centers one’s concerns around the truth and validity of what is said. One then asks, “How do I know that this really happened?”

By contrast, when the researcher is open to what emerges and is open to understanding the other’s experiences, that distance diminishes. It does not close completely, however. This distance diminishes because the focus of the interviewer’s attention is on trying to understand the other person by listening and trying to piece together what the participants are saying. The focus is on trying to understand how another person is experiencing living a life. According to Heidegger (1927/1962; 1949/1995), understanding another person is possible because of being-in-the-world—because of the relational structure between human beings and the entities encountered. Transcendence is another term that Heidegger uses to denote being-in-the-world. Transcendence, which means “overstepping,” is the originary mode of being that makes it possible for a human being to be attuned to other human beings. Transcendence makes it possible to connect with another and to understand another. Transcendence makes the fusion of horizons between two people possible.
If there is to be a fusion of horizons and an overcoming of the distance dictated by the dominant paradigm, interviewing another person cannot simply be the collecting of the data. Interviewing another is a mode of engagement that brings the researcher to a more fundamental way of being with another. The researcher is engaged in a conversation that connects the researcher and the participant. While engaging in this connecting conversation, the interviewer asks the participant to describe what an experience is like. "Is it like this? Or is it like that?" By way of the interview, the participants then reveal part of themselves. By way of the interview the participant's world is unveiled. Yet, this world is never completely revealed. There is a part of their world that will always remains hidden. It is important to remember that part of who we are always remains concealed. The question for the researcher, then is not "How do I know they are telling me the truth?" The question becomes "How much of who they are have they revealed to me? And how much remains undisclosed?"

Caputo (1987) cites the face as an example of the play between concealment and unconcealment, of disclosure and undisclosure, of aletheia (unconcealment) and lethe (concealment). The face is the setting for language. It enables one to conceal what shall remain hidden. Yet the face also has the capacity to reveal what one wishes would remain hidden. "The cold look with which the words are calmly delivered discloses an even greater anger than angry words. The look of hurt says more than the words which say it does not matter" (Caputo, 1987, p. 273-274). One's being-in-the-world is given away in the face. Yet, we are not always sure of
the messages that are given away and received. Often, these signals are uncertain and confused. The face as a place of opening, as a clearing, is not neat and unambiguous.

The face is a shadowy place, a flickering region where we cannot always trust our eyes...It is...a hall of mirrors, a play of reflections, a place of dissemblance and dissimulation, sometimes a place which we manipulate in order to produce an effect, sometimes a place where the truth gets out of the bag on us against our will. Sometimes our face betrays us, and sometimes we give the lie to others by putting on a convincing face. The human face is anything but simple and unambiguous, anything but just surface. It is streaked with hidden depths and concealed motives. (Caputo, 1987, p.273)

It is, however, the look of the other that draws one into both mystery and confusion as the listener attempts to answer the question, “Who is speaking here?” It was often the face that drew me into the story. “Why is she smiling here? “Why does he look away?” “What does that mean?” It is the unknown that drew me into the story in order to answer the questions, “Who are you?” and “How have you come to see things this way?”

It was by looking into the face of the other that I could feel what they were telling me. I felt a sadness that could not be conveyed merely in the words they spoke. Yet the sadness was there. The sadness was in the drop in the voice and in the look in the eyes. It was how Marcia looked when I asked her if she remembered what she thought about while in restraints. And she answered,

“A lot of times I’d think about my mother. She passed away a few years ago. And I’m just thinking, ‘Sorry, Mom.’”

We both pause in silence. And Dan’s response to the same question:

“A lot of times I would start thinking about. It was over the Christmas holidays, so I would start thinking about all the people who were having a
good time. What I could be doing. What I. I would start thinking about my ex-girlfriend. I would get mad. I would start thinking about my brother. My family. Everybody else.”

I looked in Barb’s eyes when she told me that she cut her throat before the Emergency Medical Service arrived. I looked at her, trying to encourage her to go on, thinking, “You did that? Why?” And, she looked away as if it was nothing. Or was it shame that caused her to look away? The face does not reveal the feeling and the words cover over the feeling.

“My friends called the EMS. And the EMS showed up. And I was here, split from here to here. I said, ‘Its a sharp knife.’ I was just playing around. And said, ‘Shit, this is really sharp!’ And I split myself very bad. And, here they are. Now, what are you going to tell ’em? Here I am, bleeding down the neck. ‘It’s okay, really.’ They go to all these houses and everybody has split necks. I tried to convince them that I was fine. Which we had a long discussion over.”

Another participant tells me about jumping in front of a subway train six years ago. I looked at him. I looked for the face to reveal something. There was no expression on his face and no change in the tone of voice. These spoken words bring a slight pause to the interview; the words surprise me. But, the spoken words do not surprise me as much as the participant’s lack of affect or feeling. This participant recounted the story as if it was nothing.

“I took a bunch of medicine and drank about a six-pack of beer and then stood in front of, on the El. This was about 6, 7 years ago. And it didn’t. The train goes on top of me. And I’m saying, ‘Oh it didn’t work again.’ It went over the top and he [the train] scrapes the shoulder. And, then, what happened was that I’m laying there and I’m telling myself it didn’t work again. This was about the seventh or eighth time I tried to kill myself. And then, what happened was that I put my foot forward and I hit the electrical line and then I woke up in the hospital...That’s when they gave me Tegretol and Depakote.”
And Barb told me that she “shoots” Morphine and Versed. She can’t remember what it was like to be “clean.” How little I know of her world. And yet, I am drawn in to her as I try to understand that world.

“So, what happened was that I had a week off by myself, and well, now, what would you do? You’re drinking beer, shooting Valium. Yeah, I’m shooting Valium, IV’ing Versed and Morphine. I have a whole week of wondering what’s going to happen to me.”

While there were parts of each of these interviews that were easier to comprehend, these experiences were difficult to understand. It was difficult for me to understand the detachment and the lack of affect surrounding the spoken words. “What does this mean?” I thought to myself. I could only speculate an answer to that question because the participants were not going to reveal that part of who they are.

There were other instances, however, when I could sense that I had connected with who this person was. These were the times I was getting a glimpse of who they really are. According to Caputo (1987), whatever shows itself to another comes from the deepest depths. Yet it is not something that we can touch or hold. It comes out and then hides away. Who these individuals were would come out and then hide away. It was something I could feel as we moved through the interview. The early tentativeness would give way to more openness and then the tentativeness would return. It is this hiddenness, this mystery that Caputo says inspires a respect for the other. It is the mystery that inspires awe, fear and admiration. It was the mystery and the unknown that pulled me into their worlds.
Being Mentally Ill

Struggling

For these participants, living was difficult. Each participant, in a unique way, told of his or her individual struggling. This struggling became apparent, concretely, as the participants struggled with the staff or struggled to get free from restraints. Their personal struggling, however, became more apparent as their worlds were opened up to me. Barb was one who struggled in a very concrete way with the staff about the rules on the unit:

“They were coming into my room, and they wanted me to go out to the day room. And, I didn’t want to. Well, they thought I should go to the day room...Well, there was a whole gob of people, standing out there. And, I stepped into the hallway, and I said, ‘I’m not going.’ And they said, ‘No, you have to go.’ And so, I planted my feet and about 20 big guys, maybe a hundred, jumped on me. I’m not a TV person. You know? They think it would be better if we get out and socialize, well, I’d be better if I sleep. They wanted me to go do something, make beads or something, and I didn’t want to.”

She also struggled while in restraints:

“Well. I struggled more. And she [the nurse] said, ‘Why are you struggling? You can’t get free, you’re not going to go anywhere. Why are you struggling?’...[And they said,] ‘What are you doing?’ ‘Well, what does it look like I’m doing. I’m taking a shower. Give me a break.’ So they did. They tightened the restraints down.”

Diane, on the other hand, struggled with the difficult choices in her life. She had to decide whether to keep her baby despite the threat of birth defects. She struggled with choosing to go off her medication while she was pregnant. And she struggled with the symptoms of her illness that resulted from that choice--from going off her
medication. Finally, she struggled with trying to take care of her sick baby. One can hear her struggling in her voice:

“I couldn’t stand up and walk. I guess mainly because my doctor took me off my medication, for myself. I was just so weak. Carrying this baby. I gotta carry him 9 months. I made this decision. I chose. I made the decision to go on and have this baby. It just took so much strength...And my youngest child at the time was 5. And the other one was 6. By my taking Lithium and all those kind of medications, everybody thought that my baby would be born with brain damage and no spine and all that. I went through all that. And so I entered the hospital...The only reason I came cause I had to stop taking my medication in order to carry this child. Which was my choice, whether I wanted to keep the child or not. But I chose. I wanted to keep it. And I had to stop taking my medication in order for this child to grow in me, to develop in me or whatever...They could save what is left of the child. You know, if the child had brain damage or whatever. So when I found out I was pregnant, I called my [doctor]. She told me just come in and she completely took me off all the medication I was on. For my health. It was a very, very difficult pregnancy...The baby’s father didn’t want to have nothing to do with me. Didn’t want to have nothing to do with me. He said he didn’t want no relationship, no commitment. ‘Cause he had been in a 5 year divorce, marriage and was pending divorce. The divorce was in process. You know. It was like I was caught in the middle of all that.”

Diane then tells of a second episode of being restrained. She began the story when she was at home taking care of her sick baby. She was worried about her baby, but could not quite figure out what was wrong with the baby nor what to do about it.

Finally, her mother intervened and somewhere in the middle of the scenario she was hospitalized.

“Yes. And see won’t nobody listen to me. You know. Every time I say something, ‘Oh, she crazy.’ ‘She don’t know what she talking about.’ But, this is a life here. You know, I’m trying to save my baby’s life. Cause its wrong. They telling me, not my mother, they telling me he got an ear infection. If a fever persists more than three to four days, take him to the doctor. And it was almost eight days. You know. So I just came here and I just left everything in the world in my mama and daddy’s hands. When my mom couldn’t break his fever after Friday, after Saturday, she brought him into the hospital.”
Sometimes the participant’s struggling was around distinguishing what was real from what was not real. This prompted the participants to ask themselves “Could I really trust the staff? How do I know the staff won’t hurt me?” “Was I really going to be safe?” “What is happening to me?” Although the participants’ pain and suffering were apparent in the interviews, struggling with their illness seemed to be underneath this pain and suffering. Dan best describes this struggling. His actual restraining episode was precipitated by his fears that the other patients on the unit had AIDS. In his mind, if he went into restraints the staff would put him in another room on another floor. That did not happen. He was restrained on the same floor. His thoughts about staff and his distress that he never quite knew what anybody was up to were intertwined with his description of being restrained.

“It all started because I was afraid I was going to get AIDS at [a hospital]. Because there were no sanitary conditions...I had roommates that were picked up off the streets...I was telling myself that I almost had AIDS...I finally went up to the desk. I said, ‘I want to be located. Put me down somewhere. I want to go downstairs...Put me down there so I could be at less risk.’ Anyway, they agreed. And after doing that, they said, ‘Okay, we’ll put you down. We’ll put you down and then all of a sudden, they’re like, ‘no’...and I’m suffering in the hospital with my mental illness because they don’t know what they are doing. And I can’t get in touch with my doctor. Because they’re too busy playing their games...It was at staff [his anger]. And it was at my. It was at. Well, it was kind of at myself. That I had let myself get into an outburst. But, I said to myself, ‘If I don’t do it, how long will this go on? If I don’t go into outbursts now.’ I try to cooperate. I’ve been in this hospital, say, it must have been two weeks. Or a week and a half. If I don’t do it now, you know, when will they stop? I mean, it’s like, you know. It’s like Hitler kept. I mean, I remember from seeing the movie ‘The Godfather.’ They said they should have stopped Hitler at Munich. Or something. It’s like if you think about Desert Storm. Or World War II, any war. It you think about something where it should have been stopped. You know, at a certain point, but some reason, some force. Another force, kept on going. That’s what I thought. I thought that if I don’t let these people know that I’m serious and I’m not meant to be played around with, next thing I know I’m going to
be in there two months. They’re going to keep on tormenting me. So, it’s like, I have to do something. And I think that worked. Though it didn’t work in my favor, I got injured and stuff. I think it made them realize that I was not to be toyed with. And then there was another. Oh, another reason, another reason why I almost got...And I thought they were going to try to get me again. Cause they were making. They were making the same moves. Fast moves. And everybody was jumping around. So, okay, here goes my blood pressure. I’m getting all ready. Everything’s going. Everything’s racing inside, but on the outside I’m calm. I’m cool and kind of like walking around smiling, kind of like I am now. Just looking happy. Like I’m just all doped up on whatever, on Valiums, whatever happy pills. All of a sudden in my mind, I’m thinking, ‘What the hell are they doing? What the hell are they doing?’”

It is difficult to imagine what living life is like when one is psychotic and unable to organize or make sense out of what is happening. Because Dan did not know what to expect and he was never quite sure if he could trust the staff, he was quite frightened while in restraints:

“I was scared. I was scared out of my mind. I was scared that I might get AIDS. I was scared that somebody might come in...and stick me with a pill that might kill me...Just out of watching movies. And television. What happens in hospitals. Afraid that somebody might just come in there and, ‘Hey, this guy is really a nuisance. He’s talking about suing the hospital. Why don’t we just go in there and give him a dose of this thing...So, I had a definite fear of death...The AIDS factor, too. Could have been prevalent. And didn’t know who they would have sent in there or what they would have done to me. They might have sent a guy in there to bite me who’s got AIDS....I mean, I knew at the time that they [his thoughts] weren’t true. But, everything or anything was racing through my mind.”

In a broader context, then, these participants were struggling to live their lives as individuals with mental illnesses. For them, it was a struggle to simply deal with the things they needed to deal with in life. Several participants described how the illness had affected their lives. Diane, for example, talks about what it was like to be home, pregnant and off all her medication:
"I cried so hard. I ain't cried again since then. If I watch a show or something and they talking about children and something happened to the children, you know, I might well up with tears in my eyes. But the way I was crying. It was like I had lost somebody through death. You know?...Then when I was finish in the hospital and I go home and I be crying like my grandma. I'd be feeling this way because I don't have no medication in my body for myself. You know, helpless, so I couldn't do nothing. Nothing...Talk about eating. I couldn't eat. I had to force myself to eat. Force it."

And Doreen described what it was like for her as she looked back at what happened, now knowing she had not been thinking clearly:

"I just couldn't sleep, so I kept cleaning whatever and my mind just. I imagined things that weren't real. Like it was the end of the world. And stuff like that...I thought I was a fountain. So, I'd take some water, and drink it, and I'd sit on the table and spin around and squirt water over. But, as far as being out of control, I don't really think that I was...I was doing dumb things. I was really not in my right mind..."

When Barb reached those moments when nothing mattered to her, she struggled with wanting to die:

"I don't really, really have a lot to say, because when I get in these moods, people get scared of them. Because I'm just flat out not afraid to die. And, I could care less...No, I didn't want to be protected. I wanted to kill myself. Very sad, isn't it? You guys are stuck with me. I can't even kill myself."

Orlando struggled with wanting to kill himself. It seemed, however, that he also struggled with wanting to live. He had a history of a seizure disorder and recently had been switched to a new anti-convulsant medication. One side-effect of the medication was a severe, suicidal depression. He was hospitalized following a suicide attempt and at the time of the hospitalization, his primary goal was to be switched back to his previous anti-convulsant medication.

"What was happening is the fact that I tried to kill myself over the fact this medicine I was taking...Now the medicine worked perfectly. I didn't have any seizures. But, it gave me depression. So, I tried to kill myself. Twice, since
November...I didn’t have any seizures, but, I had depression. And, I wanted to get rid of it. And what I wanted to do was that I wanted to stop taking the [medication]. I wanted them to give me the Depakote. And they wouldn’t do it. They said what they’ll do is, ‘We’ll reduce it slowly, and give you the Depakote’. And I got mad.”

Because he was still suicidal, he needed to be out of his room in order for staff to watch him. His anger over his medication, his persistent depression and his being watched precipitated a struggle with the staff. He wanted his medication changed.

The staff wanted him in their sight. As we will see later, he won the struggle.

“They had me in the bed where they could watch me ‘cause I was suicidal. And plus, they had me with what do you call it, with fluids...So, what I did was just. I said, ‘We’re going to do it this way.’ And so, what I did. I said, I was going to walk in the bedroom and lay in my bed. And you can check me out here. I don’t want all these people walking by and looking at me. And they said, ‘You can’t do it that way.’”

Why Me?

According to Heidegger, we are thrown beings. We are situated in a particular time and place and are born into particular circumstances. Thus, by virtue of our existing, our possibilities are limited. These participants were attuned to this thrownness. They were attuned to the constraints that limit their lives. Therefore, living into their possibilities, they were reminded of their finitude. They struggled with their thrownness. For these participants, their sense of their own thrownness was manifested in the question “Why me?” On one level, the “Why me?” question was very concrete and literal--“Why was I thrown into restraints?” or “Why was I watched more closely?” But, on another level, it was an existential question--“Why am I the way I am?” “Why am I mentally ill?”
Carl’s interview was somewhat unique in that asking “Why me?” was mostly related to his not remembering what happened when he was restrained. He had two restraining episodes while in the hospital. The first was particularly disturbing to him because he could not remember what precipitated being restrained. And consequently, he believed that he was unjustly put into restraints. Interestingly, between the time he agreed to be interviewed and the actual interview, he went to staff to ask them what happened. Therefore, at the time of the interview, he felt more resolved about the first restraining episode. He still, however, did not understand the reasons for the second episode. He continued to wonder “Why me?” This is what he said about the first episode as he described what he was thinking about while in restraints:

“So, it’s like I’m the victim, what did I do? When, in fact, there was good reason...I thought about Jesus Christ. What he must have gone through, to be nailed to the cross. And that, I think, helped. The suffering and the. Well, at that time, I felt like I wasn’t justified to be there. So, I rationalized Jesus Christ. How he was not justified to be nailed to the cross. I was not justified to be in restraints, you see. But, the fact of the matter, very well could, and probably is different with the first time. Now, the second time is another matter.”

After the second episode of being restrained, he saw other patients on the unit who he thought were more out of control than he felt he was. Thus, he was never able to reconcile his being restrained this second time:

“The second one that happened right outside my door here, was within a day, or less of the first one. And I said something to one of the nurses, a male nurse, big guy, about my size. And I went like that to talk to him, to get my point across like that. That was it. Restrained. And then, after the fact, I find out. I see an episode where a girl is smashing a chair in a room, to splinters. Just recently. No restraints. Doesn’t seem very fair to me. And the second one, I think was definitely uncalled for. They could have told me,
'Stay in my room 15 minutes.' There was no, there was no option there....I’ve since made, what’s the word, accepted the situation. So, I have no animosity towards him. He did what he thought was best....I saw this trapestry [travesty], in the second time, afterwards, as far as the guidelines, and I realize that there’s human error there. You know, there’s two different people and they’re going to think. They’re going to have a different viewpoint of the situation, so that’s why I came to the point of like, that’s okay.”

Dan was another participant who compared himself to others around him, wondering, not only why he was in restraints, but why he was hospitalized on a psychiatric unit. His response to the “Why me?” question was to get angry--at both himself and the staff.

“Just anger and confusion. And like, ‘Why am I here?’ I mean like I’ve seen people along the whole hospital that were more messed up than I was. And I said to myself, ‘Why am I in restraints?’ It was at staff [anger]...Well, it was kind of at myself....Here I am thinking, ‘I’m paying’...I go, ‘You fucking animals. You’re treating me like. What is this, a Nazi Camp?’ And that’s what I was saying. It was like a Nazi Camp...After I stopped struggling, I lay down and started thinking...It was over the Christmas holidays, so I would start thinking about all the people who were having a good time. What I could be doing...I would start thinking about my ex-girlfriend. I would get mad. I would start thinking about my brother. My family. Everybody else. I felt that they had abandoned me. I would get mad. And I would continue to struggle.”

Diane wondered why she was put in restraints. From her perspective, here she was, pregnant and still she was restrained:

“I was like, ‘Why me?...I’m pregnant. and I’m in restraints.’...I’m coming here to help my self, volunteering. You know, volunteering without being paid...And they still want to treat me like the rest of the patients? I said, ‘Un-unh.’ I said, ‘I’ve been coming here over six years. I don’t know how many years, but, I’ve been coming here a long period of time.’”

With some participants, the “Why me?” question was less concrete and direct. Many participants talked about their anger at staff. Yet, their anger seemed to be a way to cope with how things are for them. The anger seemed to cover over the
“Why me?” question. For these participants, the question remained implicit and hidden. James was one whose “Why me?” question was more tacit. He was angry at being restrained and felt he was undeservedly restrained. His response to being restrained was to wish bad things for the staff. Underlying these statements, however, was the wish that things could be different for him. His anger covered over his sense of powerlessness:

“I was saying things like, ‘You could pay for this because I don’t feel like I was out [of control].’ ... I felt like they’re going. Somehow they’re going to pay for it. [By] things happening to them. I can predict things happening to people. I was wishing a lot of bad things happening to people. Getting into car accidents. Having migraine headaches. Getting into arguments with their family members. Any kind of negative things that you could think of... I was just angry, so I said a lot of things that I didn’t mean. When you get angry, you say things you don’t mean. I was saying things like, ‘I hope you get hit by a semi on your way home from work.’ And things like that. I just kinda lost control, but I was in a lot more control than they realized.”

Being Restrained

Relations of Power

Foucault (1965; 1977; 1980a; 1980b; 1980c; 1983; Deleuze, 1986) defines power as actions that are exerted upon actions, with the intention of guiding another’s conduct and ordering the outcome. For Foucault, power is diffuse. Power is not something concrete that is possessed by particular individuals or groups of people. Power moves from person to person and is available to everyone. Power, therefore exists only within the activity of people and is exercised within a network of relationships.

There are two characteristics of power (Foucault, 1983) that are particularly relevant to these interviews and to the restraining of patients. The first is that power
can only be exerted over one who has a field of possible action. This means that there must be freedom in order for there to be power. In other words, there must be the possibility of recalcitrance and a struggle. There must be the possibility of resistance. This means then, that relations of power are reversible. If one removes the possibility of action, there no longer is a power relationship. It is now a relationship of constraint. Foucault does acknowledge that there are certain asymmetrical relations of domination (Hindess, 1996). Yet even in these relationships, power is never completely one-sided. There is always the possibility of resistance and the reversal of that power.

In these interviews, we can see power struggling between the participant and the staff and the movement of power back and forth between the participant and the staff. Most often, the actual restraining episode began with an altercation between the participant and the staff. These episodes began with the participant and the staff struggling with each other about the rules of the unit. Therefore, a typical scenario began with the patient violating one of the rules of the unit. The staff would respond to the patient by reiterating the rules, or by setting a limit. At this point, the participant would refuse to follow either the rule or the limit, resulting in a stand-off between the participant and the staff. Ultimately, however, power would be exerted by a staff “show of force.” And then the participant would be restrained. Thomas is fairly typical in his description of this power struggle:

“She said something, then I said something back. Then I said a curse word like ‘damn you’ or something like that. She asked me to go to my room. I said I wasn’t going right then. She said, ‘I want you to go to ... your room...’ I started going to my room. Before I went to my room, about 6 nurses-
nurses and 2 orderlies came. And I said, 'Um, either one of you touch me, I'll break your mother fuckin' arm.' So they started walking behind me. I went to my room. I slammed the door. Ten minutes later, they had some security come up from downstairs."

For this participant, the actual restraining episode occurred the next day. Thomas was in the day room, watching television and started talking with the other patients about the interaction that had occurred the day before. This violates one of the unwritten rules of the unit. "Do not discuss your issues with other patients in the day room," especially if it involves a disagreement with staff. And so, he was told not to discuss the events with the other patients. What follows is his response to staff setting a limit and the stand-off between the participant and the staff:

"So I said, 'No, I will not. I can discuss it with who I want to.' She said, 'If you want to discuss it, discuss it with another staff.' I said, 'I don’t want to discuss it with another staff.' She said, 'Well, then, I’m going to ask you to go to your room and take 15 minutes.'...And then I sat there for a few minutes and she said, 'If you will not get up. We'll get some help.'"

Marcia also talked about her struggling with a staff member who was setting a limit:

"I was just feeling anxious and bored. I was just playing cards with somebody, and I had been here for so long. I was just so bored...So, I was just like tapping on the table or something, talking with this other girl and just tapping on the table, and this one nurse came over to see me and she said, 'Marcia, quit tapping on the table.' And I got all upset and saying, 'I can tap on the table if I want to tap on the table.' And so, she started calling people over already, you know. And I knew what that was. I thought, 'Gimme a break. I can't do so many things in this hospital. I can't do anything. I can't even go outside for a second. If I want to tap the table, I'll tap the table.' I mean, the whole thing was kind of ludicrous...But, at the time, it was just too much. Just them trying to tell me that I can’t go like that [she taps]. It was too much. It made me feel angry, like that they have a lot of nerve coming and telling me something so banal as that. And, pretty much, upset about it."

And Diane also struggled with staff around the limits they set with her:
"I'm coming here to help myself, volunteering. You know, volunteering, without being paid...I just wanted them to leave me alone. Yeah, you know. You're not telling me to go to my room. I come here and want to smoke a cigarette...and tell me to go back to my room. You know, I'm not here to hurt nobody...They don't like you to curse. They say,'go to your room.'...She's going to tell me to go in there until 8:30. Then I've been stretched to 9:30. What am I going to do in here until 9:30?"

In the preceding examples, the struggling and resistance were around the rules on the unit. At other times, the participants resisted being watched by staff. Both the rules of the unit and the surveillance of the patient are practices, instituted by the staff, in order to maintain safety on the unit. For Foucault, however, these practices are also disciplinary techniques that are exerted by one in order to control the conduct of others (Foucault, 1965; 1977; 1980a). In medicine, surveillance takes the form of the "gaze," whereby a person becomes a subject to be watched, diagnosed and categorized. In the prison, the method of surveillance was the panopticon, an efficient system that consisted of a centralized tower that enabled the maximum number of prisoners to be within view of a minimum number of guards. Medical institutions have also adopted this panoptic notion, positioning the nursing station centrally, so that a maximum number of beds are within view of the nursing staff.

On psychiatric units, staff often want the patients to be out of their rooms, within sight of staff. If a particular patient is suicidal, that patient is kept in constant view of staff. The participants often struggled around being out of their rooms in view of staff. The participants resisted being visible to and being watched by staff. Rather than feeling taken care of and safe, the participants felt constrained. Orlando and Barb both described their feelings about being watched:
"And I got mad. They had me in the bed where they could watch me 'cause I was suicidal. And plus, they had me with, what do you call it? With fluids. They had me on the IV’s because I tried to OD. And they slowly had to get that out of my kidneys. So, that’s the way it was. I was on 24 hour watch and plus, I had an IV on. So, what I did was just. I said, 'We’re going to do it this way.' And so, what I did. I said I was going to walk in the bedroom and lay on my bed. And you can check me out here. I don’t want all these people walking by and looking at me. And they said, 'You can’t do it that way. We gotta be able to watch you. You can’t go in there.' So, I went in there. I wouldn’t stay in the hallway...I knew they were going to do something. I knew that they weren’t going to let me in there. They were going to do something. But, I didn’t know that they were going to put me in and strap me down. I didn’t realize how far they were going to go with it...”

“They were coming into my room, and they wanted me to go out to the day room. And, I didn’t want to. Well, they thought I should go to the day room...Well, there was a whole gob of people, standing out there. And, I stepped into the hallway, and I said, ‘I’m not going.’ And they said, ‘No, you have to go.’”

This theme of being watched came up in other contexts. For instance, some participants felt that they were being watched more closely than other patients. These participants felt singled out by the staff and consequently, they felt that their activity was more closely scrutinized. Marcia felt that staff watched her more closely because, in the past, she had lost control of herself on the unit:

“I remember one [instance] in particular where I had felt that they were going after me a little bit more than other people. I had been here for over three and a half months and so things that I would do, they would jump on the gun. And other people, it wouldn’t be as big deal. That’s what I felt....I already had instances in the past where I had started, like hittin’ the walls and stuff, right? So, there were other times where I felt it was more reasonable for them to come out after me like that. 'Cause I was actually doing something. But, here, I was just tapping the table and I thought that they just kind of saw me doing that, and said, ‘Oh, well, she’s going to start hitting the walls and all this, so we’ve got to stop her now.’”

It was not clear why Diane thought she was being watched more closely:
“I knew that whatever little move I make, they going to watch me and gonna end up making me go into restraints.”

Finally, some patients had feelings about being watched while in restraints. Marcia’s comments, in particular, support Foucault’s assertion that the person is made subject by this surveillance:

“Usually they’ll check on you through the window slot. It’s always pretty creepy, because they have this little... You can’t even talk to them through that and then they’ll go shhtt [she demonstrates closing the little window]. There’s a little thing on the wire, and they’ll lift it up and go like that, and you’ll see their face and everything. And they’ll be just like staring in on you. And then they’ll just close it down again, right away... I hate that. It just. That just kind of furthers the feeling of being just kind of like a specimen at that point, you know?”

Most of the participants were restrained in specially designated rooms that were locked and had small windows on the door. The staff are required by law to check on the restrained patients every fifteen minutes. Diane described her experience seeing staff check on her through the window:

“They would peek through the window. I guess if I’m woke, then they go back out. They wouldn’t even come in. That would make me feel so bad. They locked the door after they leave out. Left me up in this room, by myself. And it just. I just don’t like it... When I would hear them unlocking it, I would be like, ‘I guess I’m fixin’ to get out of here.’”

Both Marcia and Laurie had feelings, not only about being watched, but also about not being talked to. They were in the restraint room, separated by locked doors, being watched and yet were unable to communicate with staff. Two other techniques of power that Foucault (1965/1977) discusses are being separated from others and not being talked to. In a sense, not being talked to and being physically separated are both separations. When staff stop talking to the patient, they sever
contact with the other person. When one stops talking to another, it is as if the other person was not there. Marcia described how staff, at some point during the take-down, stopped talking to her:

“And so, they just dragged me down, and everybody was like yelling at everybody to leave the room, leave the room, sort of like high pitched. And everybody screaming, and everybody. They like had ceased to talk to me, cause I guess that they felt that I couldn’t be reached. And that wasn’t true.”

Laurie also reacted negatively to not being talked to while she was in restraints:

“Well, I didn’t like it when I heard them at the outside, the very outside door. And they didn’t come in and open that door. They were watching me. Well, what were they watching for? I couldn’t move, get out of it.”

Thomas had a cardiac condition. While in restraints, he was alone and separated from the staff. He worried that he might get sick and no one would know. He worried that he might die. In order to regain contact with the staff, Thomas moved his bed around the room, making noises and hoping the staff would come in and check on him:

“And there’s not a bell for you to ring. I had to kick the bed to make noise for them to come in to let me use the bathroom the first time...By them can’t hear me. No one coming right in. There’s 2 doors. You have to bang, bang. What if I had congestive heart failure? Or if I had problems breathing? Or if I would have had a heart attack? They didn’t check on me like every five minutes. They only came there when they thought I was doing something, or I banged real hard with my feets, kicked against the bed and it made a big bang noise. I would slam back and I kicked real, real hard. Then they came in to see was I trying to break loose. That was the only chance. Thoughts that went through my head. What if I have a heart attack. And it take them so long to come from. What are they doing? Way up here or just sitting in the day room? Or just laughing? What if I would have had a heart attack? And no one came in?”

Dan also made noises so that the staff would come in:
“I couldn’t be heard. So, I finally. I started moving. I moved my bed to the window. And what I would do is that I would pound. I would pound, and that would get their attention. Or I would move to the door. And after I got done bloodying my knuckles a little bit. What I would do is that I would get the restraining strap and banging that on the door. And that would carve a little, carve a little wood off there...Now, that got their attention right away. Cause that was loud and I enjoyed that thoroughly.”

The staff did come in to check on Dan, but it was usually to give him medication to help him calm down. Whereas he was trying to make contact with the staff, they probably thought he was still out of control:

“And they come in there and shut me up and they give me a pill or something or stick me with a needle. Something like that. And, you know, it would do me up for a while. I’d go to sleep for a half hour. My body was, and still is so resistant to medicine. It’s like it didn’t matter, because all of a sudden, I was up again singing...At least the other time, I had some kind of AIDS patient next to me. And some nurse left the door open...This time, I had the fucking door closed. Nobody out there, and I was on the other end of the unit. Nobody could hear me. Over at the other...somebody could hear me. If I started freaking out, they’ll come in there and they’ll give me another. They’ll dope me up. At least put me to sleep...I was completely alone. And when the lights went out, that’s what really scared me. I was in a room about this size... At first I asked, can they keep the light on. And they said, ‘Yeah’. And then, after my outburst, they turned it off. Lower and then they turned it completely off. So, there I am, sitting for 12 hours, probably which 8, 9 of them were completely in the dark...I was scared. I was scared out of my mind.”

The second characteristic of power that Foucault discusses is the rooting of these power relations within social networks (Foucault, 1983). These systems of social networks not only differentiate between members of the community, but these systems authorize certain individuals to act upon the actions of other. On the psychiatric unit, patients and staff are differentiated into a system of hierarchy.

Patients are constantly reminded of this hierarchy by the reality that some people carry keys while others do not. Marcia put this relationship most cogently:
“A lot of time when you’re in doctor or nurse and patient relationships, you get little hints of that all the time...But, when it gets down to this [being restrained], there’s like no question. You have no power whatsoever.”

Within these social networks, there must also be a purpose to the action upon others. On psychiatric units, the primary purpose for having rules, setting limits, watching the patients and using restraints is safety. The staff are held responsible for the safety of the patients. These practices, therefore, come from staff concern (and anxiety) that patients will lose control and hurt themselves and/or others. The consequence of these actions, however, is to control the actions of the patient. Often this control (setting limits, imposing rules) is exerted early before things escalate and get out of control. This may account for why none of the participants felt they were dangerous or out of control. This perception of not being out of control contributed to some participants feeling singled out by staff, especially if they saw others whom they thought were more out of control. Thomas was one participant who felt that he was not out of control to a degree that he thought would require restraining:

“I have seen other people on the floor while I’m up here, have been outrageous more than me and they just take them to their room for out time. They never been restrained. To me, restraints should be when its out of hand. Really out of hand, when you can’t do any more. I didn’t hurt no one. Sure, I know they supposed to take cautious. They never know what a person going to do. But, they could have gave me a shot. They’re already holding me down. They could have just gave me a shot and made me relax. Other than chaining you up like an animal. I’m against restraining, up to the point to it’s really necessary to be used. I’m not saying that I was right, totally. Cause some of it was my fault, but still.”

James was another participant who felt he was not out of control. He, however, had some understanding of how the staff might interpret his actions. In his situation, James was resisting the rules on the unit. He knew that he could scare staff with his
voice and his verbal threats, so out of a sense of powerlessness, he started yelling:

“I was tired of being controlled by the system here in the institution. So, I got angry and I started yelling...And saying very threatening things to them, [like] I was going to kill them and all this kind of stuff. And, I had power over them. Which I do anyway. I already know that...See, the thing of it is, they were the ones that were getting upset with me and they thought that I was going to harm them...I could harm them through my verbal expression, and they were getting very scared about the whole thing...I was just verbally threatening them. I wasn’t going to do anything to them...I was in full control of myself, except they were the ones that got me angry. See, I got them angry because of the threatening things I was saying, and I was yelling. I was yelling at the top of my lungs. And, I have a lot of power in my voice. And, it is very scary. So, it scared them to the point where they thought that I needed to be in restraints.

Within these networks of social relations, there must also be the means to bring the power relations into being. These processes for bringing the power relations into play may be more or less elaborate as they are adjusted to different situations. On a psychiatric unit, the final means of controlling the person is through the show of force. Once the decision is made to put someone in restraints, staff are mobilized to “take down” and restrain the patient. All of the participants described this show of force:

“And they called Bill and them from the [other] floor...and they grabbed me, turned me around, put me to the ground, to the floor.”

“And a swarm of them came in. And they had to drag me, fighting, to the restraint room. They finally, cause I’m pretty strong, got me down. They finally turned me around and dragged me.”

“About ten minutes later, three of XX’s security officers, carrying guns and rubber gloves and walkie talkies, and the staff up here, grabbed me by my arm.”

“Well, there was a whole gob of people, standing out there. And, I stepped into the hallway, and I said, ‘I’m not going.’ And they said, ‘No, you have to
go.’ And so, I planted my feet, and about 20 big guys, maybe a hundred, jumped on me.”

"And, all of a sudden, about five hundred people came up and grabbed me, carried me and put me in the quiet room. Put the 'straints on me. It was probably 10 people.”

“But, just a whole flock of people came in. Maybe 8 or 10 or 12 of them came in and just threw me in restraints. And, what could I do?...They just came out of nowhere. There was nobody on the floor and all of a sudden, there was 10 people in my room.”

At some point, either right before or right after the patient was contained by the staff, the participants struggled, trying to get free. Marcia best described the entire sequence of events—the show of force and the physical struggle:

“And I knew what that was. That meant that they were going to try to physically hold me down or something. So, I kinda freaked out and I just kinda started running around the room, and they were all coming in. They were all going out there with their hands all like this. So, I was throwing stuff on the ground and one of them finally got behind me and reached and grabbed my arm. And then once one of them grabs your arms, like they all come in. And so, there were 5 or 6 of them and they were trying to get me down and I was really pumped up, so I was pretty strong...Just because I was so excited. And so, they just dragged me down, and everybody was like yelling at everybody to leave the room, leave the room, sort of like high pitched. And everybody screaming...I felt real trapped and I fought off as best I could, but there was just too many of them and I couldn’t do it...I would have struggled no matter what. 'Cause, in the past, I had always struggled. Just because its a real tense situation all the way around. They’re trying to get you under these leather straps, and you’re trying to do everything you can not to. And, so, just something clicks in you. Its like animal instinct, or something. You’re fighting and. Yeah, but you do get a burst of energy. At least, I always did. I always got a big burst of energy. And that’s what made it really difficult for everybody, every time...I would become more anxious when I knew, as soon as I realized that they were trying to. What they were thinking. Or what I thought they were thinking about maybe I might have to go in there. And the physical burst came as soon as I could see them coming out for me...The burst, in and of itself, was good. But, you knew where you were ending up, so it wasn’t that great...I was just thinking at that point that I don’t want to go in there. 'Cause I knew when they were leading me toward that room over there, that that’s something that I didn’t want to do.”
Diane also described a burst of power that came over her right before she went into restraints:

“When I fell, I put my two arms on the floor and my two legs. I was on my knees and I was on my hands. And I had so much power. Like I had power like a lion. Or a tiger. I don’t know where it come from, but it was like my blood just...I just rose up. Rose up like that. Like Jesus or God didn’t want me to fall. Just to give up like that...I rose up on my knees. And the palm of my hands. It reminded me of being a tiger. I thought I was a lion...It was like the Holy Spirit had come within myself. And helped me along the way...and that’s when the people came to help me.”

At the point of being restrained, some participants continued their struggling. Others stopped resisting. Dan was the participant who struggled the longest. He described “movies” that were going through his head. While in restraints, he heard voices that kept telling him to keep up the struggle. The voices were telling him that he could get out of restraints:

“...I sort of injured myself because I tried to get free. Well, what I would do was that I would pull at each, pull at each restraint with my arms...Kind of kick back and forth with my legs. I did a pretty good job. I managed to move the bed and managed to get halfway free out of each restraint...I was in restraints for 14 hours. Probably struggling for 8-10 of them....I would pull the arm back and forth, back and forth. I would kick back and forth. And, it did no good...Well, I kept on hearing voices, to tell me to get out, get out. Get out of these restraints. There were movies that went through my mind. Well, ‘Rocky’ movies, particularly ‘Rocky 1,2,3,4,5’. Told me to get out of it. Movies like ‘Scarface’. Violent movies. All violent movies. ‘Carlito’s Way’. Things they would say, like in the ‘Rocky’ movie...They were friendly to me...they were like out of a movie or was out of the past or it was just me, saying, ‘You asshole.’ They were telling me, ‘You can get the hell out of these restraints’. Yet they were screaming at me in a loud way. They were telling me in a nurturing way. Like, ‘You shouldn’t be in them. Come on. You’re better that this. Get out of them.’...It’s almost like the holocaust...It’s almost like the power of execution. That you have that power over someone. To be able to just push a button and kill them...press a button. And security comes and ties somebody down....They don’t understand what it does to their mind. What it does to their body....They have no respect for life...If I didn’t do the behavior that I did...I had to show them that someone, that, who’s
boss. I'm the boss of my own self. To have that much power over somebody to put 'em in restraints...It's like using the electric chair. Just push a button, and you got somebody tied down. It's inhumane."

On the other hand, there were other participants who surrendered and gave up the struggle once they were in restraints. Some of these participants knew that if they stopped struggling they would come out of restraints more quickly. Doreen was one participant who struggled and yelled for a while and then stopped. She also received medication which probably helped her calm down.

"And I'd fight and everything, and then they'd shoot me with a needle...And then, I just yelled and yelled until I couldn't yell. I was hoarse. Then, I decided that if I went to sleep, I'd get out of there. Or maybe I would wake up and they would let me out. Well, they told me I guess, if I'd stop yelling, that they'd let me out, sooner, if I'd shut up. I guess I was yelling a lot."

Carl also struggled initially and then gave up and surrendered:

"I think I gave up when they got me in the room. I knew what was going to happen. But prior to, I was trying to struggle from. And try to get away. [Staff decided to take me out of restraints when] they figured I'd been in there long enough. And that I was calmed down. Surrendered. Calm and to the point of surrender. That they knew that I was, admitted defeat and was giving up. And back to my original frame of mind, I guess."

Marcia and James stopped struggling almost immediately once they were in restraints:

"When they used restraints, at least I just stop struggling immediately, because it's no use. I mean, I'll stretch around a little bit, depending on how much space I have. But, you just feel like an animal."

"In the beginning I resisted, and then they did some things that were very uncomfortable to me...And then it got to the point where I just stopped resisting...I didn’t want to resist anymore because it wasn’t worth it. I was in a lot more control of myself than they realized...As soon as I lay down on the bed, I stopped resisting and they thought that I was going to keep resisting. So, they kept putting more pressure on different parts of my body so they could get the restraints on me faster."
Finally, within these social networks the techniques of power have become institutionalized. On psychiatric units, the legal structure supports these relations of power. Thus staff are permitted by law to restrain patients for protection of self or others. But, more subtly, the structure of an inpatient psychiatric unit has its own culture with its own rules that govern the way things are. There is a web of staff practices that, in essence, constrain the patient into conforming to that structure. Patients who have been hospitalized understand this culture and for the most part, conform to that structure. Thomas was one participant who was unfamiliar with the rules and the culture of a psychiatric unit. He had never been hospitalized on a psychiatric unit before. Nor had he ever been in restraints. According to him, the lesson he learned was that it was:

"their way or no way. The staff way... The only thing it tell me, that if you don’t do it their way, you’ll get restrained... I never. I didn’t know what they were going to do. I heard a lot of the nurses talk about the back room... if you don’t behave, you will go to the back room. I thought maybe the back room was just a room you go in and sit down for an hour. I didn’t know they would restrain you. I never been in a place like this."

In Foucault’s view, relationships of power are reversible. However, only one participant, Orlando, was able to turn that power around. Recall that he was the participant who was severely depressed from his anti-convulsant medication and wanted his medication changed. The physicians, on the other hand, wanted to wait before starting another medication. Once he was in restraints Orlando refused to come out until his physicians agreed to change his medication:

"They weren’t hurting me in any way. I mean, what they did was they put me on the bed and then moved me all the way down there. And then picked me up and brought me into the room. You know, I didn’t fight ’em at all. I
says, ‘Hey, let me get up and I’ll walk in there.’ And they says, ‘Its too late now. You gotta stay down.’ So, they carried me in there. You know, it didn’t matter. I didn’t give ’em. I didn’t fight ’em or nothin’. I would have stayed in there a long time.”

Ironically, being restrained became his bargaining tool. The staff wanted him to come out of restraints, yet he was willing to remain restrained until he could get his medication changed. Therefore, for Orlando, being restrained was enabling. It was a means to get him what he wanted.

"It didn’t bother me. I mean, if they’re going to keep putting medicine into me anyway to calm me down, what difference is it going to make. I told them all’s they gotta do is...I was just thinking about laying there, gettin’ over on ’em, because they kept coming in there, trying to get me to get outta restraints. ‘No’, I says. ‘I want my medicine.’ But, I did get it that day. All of a sudden. There was a doctor that ordered it, but, I got it. And I’m on it now. And, that one that I didn’t want to be on, I won’t be on it in a couple of days...It was great. I was tied down here. I could sleep. I don’t know, maybe after 20 or 30 hours, I wouldn’t have been able to handle it, but, once I started yelling and screaming, they would have gave me more medicine and shut me up...I would have stayed in there a long time. I think that it was my wife that sort of give me a talk. She talked to me. And I said, ‘Alright, I’ll get out of restraints.’”

**Powerlessness**

For most of the participants, the experience of being restrained was disempowering. Most of the participants identified their feelings of powerlessness and subsequent helplessness as the worst part about being restrained. For many of the participants, being restrained was also dehumanizing. They felt vulnerable to harm and humiliated because they could not take care of their own basic human needs:

“I asked to use the washroom. They would not allow me to use the washroom. They brought me a urine cup. And they all stood there, so it was uncomfortable. I could not use the washroom. So, after a while, they sent just one man in there...They unhandcuffed one hand for me to eat...It was like I’m chained up, I’m helpless. I can’t do anything...You can’t do anything. I
think its worse than prison. At least in prison you can walk around. Back there you can't. Just lay in your bed...They brought a bedpan. I told them I cannot use a bedpan because its uncomfortable. I have to make a bowel movement. And she told me 'You either use this or you don't use it at all.' ...Ten minutes later I had to use the bathroom. They wouldn't come. So I urinated. All in the bed."

[The worst part is] "Not being able to. To be stuck there. Not being able to do anything. Not being able to scratch your nose if you had to, even. And laying there and trying to. The harder that I tried to get out of them, the tighter they got. And then, with people peeking in on me, like a. In the first place, I just wanted to go someplace where it was quiet. I didn't want to be strapped down...It's frightening to be locked in somewhere, but, its not as frightening as to be laying there, strapped to the bed, and can't move."

“They had to feed me from the spoon. Feed me...They had to feed me like I'm helpless. Which I was. In restraints, you are helpless. Arms tied down. Ankles tied down...Like I say, make you feel like you're a helpless person.”

“And then, the fun part was that I had to urinate twice. And defecate twice. Or 3 and 4 or 4 and 3. And so, here I am like a convalescent, like, I was picturing Christopher Reeves...They gave me a urinal, but it fell out....Nobody could hear me, so I couldn't hold it no longer. So, I just had to urinate all over myself. Which was a fun feeling, 'cause it warmed me up...They came in. They rolled me up and dried me up as best they could...Four or five times I had to urinate and defecate. And that was just an unpleasant experience.”

Several participants described feeling like they were tied up like an animal. Thomas was probably the most explicit:

“I felt very uncomfortable. Like I was an animal being chained up. Only difference was, wasn't chains around my neck...I felt dirty. I felt cold. Back there is cold. You can't do anything. You're chained down to a bed. I think its worse than prison. At least in prison you can walk around...Not being funny, but, my mind went back to stories my grandma told me about slavery days. I felt like I was a slave. I was chained up, I couldn't do anything. I was under somebody else's command. Eat when they tell me to eat. Use the bathroom when they wanted me to use it.”

Since the participants were unable to move, they realized that they could not protect themselves should something happen to them. While in restraints, they were
completely dependent upon the staff. They would not be able to defend themselves if
someone would try to hurt them. Some participants felt frightened by this
helplessness, especially if they did not know or did not trust the staff. As Thomas
said:

"It was like I'm chained up, I'm helpless. I can't do anything. What if they
wanted to just beat me. I'm not saying they would have. But, I'm just saying
that's the thoughts I had in my mind. What if one of the nurses would have
came in or just triggered, or their mind snapped. How can I protect myself?
Or if the hospital would have got on fire. Who said they was fast enough for
them to unchain me to get me out. Those were my thoughts and I was afraid.
More than 'fraid, I was terrified. Thoughts like that. Came to my head, the
place catch on fire and I'm locked up to the bed and can't move. And they try
to get all these patients out and here I am. They gotta find the key and unlock
this door. Unlock two doors. And then unlock all the chains you have on me.
What type of chance would I have to live?"

Barb said that the worst part of being restrained was:

"giving up the freedom totally...I think its the sense of helplessness."

As she said this, there was a sadness in her tone of voice. She was barely audible.

After a long pause, she continued:

"If anything were to go wrong, that'd be it. If you were in restraints, the
delay of time it takes to get the restraints off...You know. Being in restraints
would be terrible if you didn't know for sure, that people around you weren't
going to hurt you. I can't imagine it."

It seemed that those participants who had been restrained before and those who
knew the staff felt the same sense of helplessness, but they were less afraid. Laurie
said that knowing the staff helped her not feel afraid:

"'Cause I knew. I had worked with those people. I had been here before. I
knew them. I knew that they were trying to help me."

Carl had also been in restraints before:
Marcia compared this event with other times she had been restrained. There was a difference between this episode and the first one in the sense that she knew what to expect—what to do and how to act. The first was more anxiety-producing because she didn’t know how long she would be restrained. She didn’t know if she would be left in there all night, like a friend of hers.

"[The first time I was restrained], I think that I was really kind of out of it, at that point. But, I still was aware of some of what was going on. That’s true, I didn’t really know as much. ’Cause you don’t know if they’re going to leave you there for a long time, and like a friend of mine told me that they left her there overnight, and she had to urinate and everything. It was really, just totally, no reason for any of that. But. Time went by so much slower [the first time]...There was some uneasiness in there. I don’t know why I wasn’t really scared, but. Yeah, more anxious, but [pause]. See, most of the time, it was right after some physical, you know, entanglement, or whatever, and so, for the first half hour, I was coming down from it. And then usually, they’d check once or twice. And then, so, I was never like terrified."

**Conclusion**

This chapter has presented the experiences of ten individuals who were restrained while they were hospitalized on psychiatric units. The themes that emerged from the interview texts were organized into three distinct, yet interconnected patterns. Thus, three stories emerged. These were: (1) Being-in-the-world (2) Being mentally ill and (3) Being restrained. Being-in-the-world constituted the relation between the participants and the researcher. Basically, this relation was one of engagement and involvement, rather than distance. In this mode of involvement, the researcher and the participants join in both telling and listening to the story. As the story emerges, there is movement back and forth between the researcher and the
participant. Whereas the story is how the researcher gains access to the participant's world, it is the unknown that first draws the researcher in. It was the unknown that first prompted me to ask about the meaning of being restrained. Then, as the interview progresses, the answers to the questions prompt one to go deeper into the unknown. It is this unknown that continues to draw the researcher in. Thus there is movement between absence and presence and an unveiling of how things are for the participants.

It was apparent that these participants struggled with how things are for them. They struggled with the symptoms of their illnesses. Consequently, they were not always sure what was happening to them nor whether they could trust and count on others. They struggled with trying to figure this out. They struggled with trying to understand how they were situated with the people they encountered. They struggled also with how their lives were affected by their illnesses. They struggled with trying to make choices or trying to decide if there was anything for them to live for. Finally, on the inpatient psychiatric unit, they struggled with the staff about the rules. Once restrained, they struggled to get free.

In essence, then, they struggled with their thrownness. They struggled with how things are for them. This struggling prompted them to ask “Why me?” “Why,” they asked, “was I thrown into restraints?” They wondered “Why are things the way they are, and not some other way?” Often, with the participants, the “Why me?” question was not directly asked. Often, this “Why Me?” question was covered over
by their angry feelings toward staff and their anger about being restrained. These participants did not feel that they deserved to be restrained.

In their descriptions of being restrained, there is the movement of power between the participant and the staff. The typical sequence of events began with a struggle around the rules of the unit, usually with the participant resisting those rules. This induced the staff members to exercise their power, ultimately by restraining the patient. Therefore, the participants experienced being restrained as an exerting of staff power, thereby disempowering the participants. As Marcia said, most of the time she was aware of this power relation, but being restrained brought this relation to the foreground. For these participants, then, the worst part of being restrained was the powerlessness and subsequent helplessness that they felt. When they were restrained, they felt dependent on staff to take care of their most basic needs and they felt vulnerable to harm.

Restraint, then, became a metaphor for their lives. If one thinks of restraint as being bound, being confined, or being constrained, then their illnesses and the symptoms they experience are constraining. Their symptoms restrict and limit their possibilities. While we all, by virtue of our thrownness, have limits to what is possible, these participants are reminded that their illnesses impact how they are living their lives. And so, for instance, Dan thinks of his friends and family over Christmas, who are enjoying themselves while he is in restraints. According to Foucault (1983), freedom is having an open field of possibilities. In a very concrete way, psychiatric patients experience the constraining power that is exerted by others,
literally by the use of leather restraints and more subtly by the rules and structure of
the unit. Less obvious, however, are the limiting and restraining effects of their
psychiatric illnesses. Mental health professionals rarely acknowledge that these
patients are struggling to be free of the constraining effects of their patients’ illnesses.

This study has provided us with an understanding of what the experience of
being restrained was like for these ten participants. In this chapter, I have taken apart
this experience in order to deepen an understanding of how this event has come to be
the experience that it is for those who have been restrained. Therefore, for example,
we have a sense not only that being restrained is disempowering, but how it has come
to be disempowering for the participants. We have sense also how, for Orlando, this
experience came to be empowering for him. The threat, however, in taking apart an
experience is that we lose a sense of the whole. What still is lacking, then, is a sense
of what being restrained, as-a-whole, was like for these participants. A sense of

being restrained, as-a-whole, is best captured by this quote from *Prometheus Bound*:

**Strength:** Here we have reached the remotest region of the earth,…
Here is Prometheus, the rebel:
Nail him to the rock; secure him on this towering summit
Fast in the unyielding grip of adamantine chains…

**Hephaestus:** …With heart as sore as yours I now fasten you
In bands of bronze immovable to this desolate peak,
Where you will hear no voice, nor see a human form;
But scorched with the sun’s flaming rays your skin will lose
Its bloom of freshness. Glad you will be to see the night
Cloaking the day with her dark spangled robe; and glad
Again when the sun’s warmth scatters the frost at dawn.
Each changing hour will bring successive pain to rack
Your body; and no man yet born shall set you free…

**Hephaestus:** The iron wrists are ready.
**Strength:** Hammer with all your force, rivet him to the rock.
**Hephaestus:** All right, I’m doing it! There, that iron will not come loose.
Strength: Drive it in further; clamp him fast, leave nothing slack.
Hephaestus: This arm is firm; at least he’ll find no way out there.
Strength: Now nail his other arm securely. Let him learn
That all his wisdom is but folly before Zeus...
Prometheus: O divinity of sky, and swift-winged winds, and leaping streams,
O countless laughter of the sea’s waves,
O Earth, mother of all life!
On you, and on the all-seeing circle of the sun, I call:
See what is done by gods to me, a god!
See with what outrage
Racked and tortured
I am to agonize
For a thousand years!
See this shameful prison
Invented for me
By the new master of the gods!
I groan in anguish
For pain present and pain to come:
Where shall I see rise
The star of my deliverance?... (Aeschylus, 1961, p.22-24)
CHAPTER V
DISCUSSION

Introduction

We, in psychiatric nursing, have inherited a tradition that no longer thinks about the practice of restraining patients. As I reflect back to the beginning of this study, I recall comments other colleagues made to me about this study. “Why,” one physician asked, “would you ever be interested in that? If they need to be restrained, it doesn’t matter what they think.” Other nurses said, “Do you think they can tell you anything?” Or they asked, “How will you know that what they are telling you really happened?” Other colleagues commented on the study itself--on the meaning of being restrained. They said either “It doesn’t mean anything to them” or “Don’t you already know what it means?” These comments reflect a tradition in psychiatry that takes this practice for granted and no longer sees this practice as problematic.

One reason for not seeing the practice of restraining patients as problematic is that we persist in not challenging the assumptions that underlie the use of restraints. The findings from this study, at least from the perspective of the participants, do challenge these assumptions. These findings challenge our assumptions by calling into question the underlying belief that patients who are restrained are out of control. One
of the surprises of this study was that none of the participants felt they were out of control. Nor did they think they were a danger to self or others.

Whereas these participants did not feel they were out of control, some did seem to have a sense that the situation they were involved in was escalating and could potentially get out of hand. It is interesting to note the words they used to describe their situations:

"Okay, one time I came into the hospital and I guess that I was a little uppity or something, I don't know, but they didn't really know who I was, or anything..."

"The second time was about two weeks ago. You'd think I'd be getting smart by now. And, I wasn't getting any smarter. So, I got a little ornery here. Got into their restraints, too."

"I was getting very bored. And there was hardly anything to do and I was pacing the floors, and I guess I'm just. I want to go home. And I was tired of being controlled by the system here in the institution. So, I got angry and I started yelling."

Even when the participants acknowledged that they needed some external control, they usually felt that using restraints was too extreme. They often felt that something else could have been done in order to calm them down.

Since we assume that patients who are restrained are out of control and that being out of control is frightening, we believe that patients will feel relieved, safe and comforted by these external limits. None of the participants talked about feeling safe and protected. In fact, they most often felt vulnerable. Those who felt most vulnerable were also most frightened by the experience. These participants were worried that since they were unable to defend themselves, anyone could come in and
harm them. One would think that if the use of restraints is intended to provide for the safety of the patient and the unit, it would be important that patients experience this safety.

Whereas we assume that the use of restraints is therapeutic for the patient, these participants most often perceived their being restrained not as therapeutic, but as a consequence for not following the rules on the unit or doing what they were told. Rather than experience the comfort of feeling safe and cared for, these participants experienced these practices as coercive. As Doreen said:

“It’s frightening to be locked in somewhere, but, its not as frightening as to be laying there, strapped to the bed, and can’t move. And the only thing that it did was that it might scare me into being a little more, watching what I did and said. But, as far as inside, I was still angry. And I was very angry at everybody around it...I still feel it sort of.”

Furthermore, we assume that restraining patients is not a harmful practice. For some of these participants, being restrained did seem to be harmful to them. Dan was physically harmed by struggling while in restraints. For others, being restrained was an experience that stayed with them. A few of the participants seemed to be greatly affected by this experience. Even though they could not remember all of the details of being restrained, they remembered the totality of being restrained. And, for the most part, they remembered this experience as unpleasant. Listen to how Carl felt about being restrained:

“All the times I've been in leather restraints, I think maybe four times in my lifetime--two times being with this hospital stay, I feel that they're all traumatic and I think all of them, like I said, would have been less traumatic if after the experience. I mean, I'm not saying that they're not necessary. What I'm saying is that after the fact, see, myself, speaking for myself, it was so
traumatic, and my state of mind was to the point where I wasn't thinking correctly, that I could not remember what happened—the events. So, the answer to your question is, I'd say, they're all traumatic, with most recent being the most.

Implications Related to Nursing Practice

"The aim of a science of nursing is to contribute to better practical nursing" (Fjelland & Gjengedal, 1994, p. 4). While one must be cautious about generalizing from this sample to an entire population, there are implications for nursing practice that one may glean from what the participants have said. Often, these stories were difficult for me to listen to. It was hard for me to believe that, at times, the nurses could treat the patient so uncaringly. At times, the nurse in me wanted to defend the nurses. I wanted to say, "Surely, they didn't really say that." "Surely they didn't let him lay in urine for that long a period of time." And yet, regardless of my feelings and the temptation to sink back into the tradition out of which I came, these were the participants' stories. Even if the details of the story did not happen exactly as the participant told them, these stories were the experiences of those who were restrained. And while we rarely acknowledge this, we can learn from these stories.

Avoiding Restraining

We need, first of all, to remember that this is a practice whereby we do something to another person. This is a practice that renders another human being helpless. And we need to think about a practice that does that to another person. Clearly, being "tied down," immobile and helpless were the most disturbing aspects for the participants. They felt dehumanized. Diane states it most graphically:
"I thought I was going to die...Because I had lost all strength...I lost all strength in my legs and my arms. I was helpless...Like they strapped that tiger down...The only thing keeping me alive was my blood that's pumping my blood in my heart...I felt like an animal, strapped down...It's worse than handcuffs...Cause they're leather....They're tight around the wrist and they lock it with a key."

Therefore, we need to truly use restraints as a last resort. We must intervene with psychiatric patients in order to avert the need to restrain them. To this end, several of the participants thought that an early verbal intervention could have prevented their being restrained. As Marcia suggested:

"I would think that if they had come to me right off and just said, whatever they were thinking. Like, if they were thinking, 'Marcia, you're tapping this table. And, I'm thinking that maybe you're getting yourself real revved up here, so what I want. I don't want you to end up in there.' If somebody had come up and says all that to you, you'll think, 'No, I don't want to end up there. I'm just a little nervous. And maybe I'll take a walk around the thing.' You know, something like that...And a lot of times, when you're a patient and you're kind of drugged out or ECT'd out, you don't have the best perspective in the world. Sometimes, you need the nurses around to be. And, they are, in most cases."

Dan had similar suggestions:

"All they had to do. All I, all someone else had to do was say, 'Dan, calm down. Let's talk about it. Let's see what we can do about it.' I would have responded. I'm an educated man. Though, I'm not. I'm not stupid. I know when someone is pulling my leg. And I don't want to know. Just say 'Dan, why don't we just talk about this. There's no need for you to swear. And holler and get all crazy about it. That's no, that's no. You know as well as I do that you're here. And you know why you're here. So, that's no way to behave.' And I would have said, 'Alright, let's talk about it.'"

While it seems simple and obvious to say that the nurse could/should have talked to the patient in order to deescalate an escalating situation, this is not always so simple. In the first place, there are many reasons (the patient's past experience, the patient's illness, the patient's relationship with the staff member) why the necessary trust
between the patient and the staff member may not be there. For example, Dan realized after making the above statement that he wasn’t sure if he would have trusted the staff member. In the past there had been times when he had calmed down, yet he was still restrained:

“And then what probably would have happened, what probably would have happened. Is that they would have … pulled the old trick of ‘Okay, that’s no way to behave. Calm down.’ Once I got calmed down, bingo, get the guys. Get security in… Wait a minute. No, it’s not actually what they did. But that’s what they did on many occasions to calm me down. They would calm me down and then threaten me or have security guards around me. Or have somebody, or like nursing staff around me. You know, like ‘calm down, it’s alright.’ Yeah, you’re right, it’s alright. Then, all of a sudden, look around, five guys stand around ya. Of course it would agitate me more. Because it’s a complete lie. If you say to someone ‘Calm down, let’s talk this out’ And then, you do talk it out, but, you do it one on one, or with the people that are there. You don’t have five people come around. What’s going to happen? If you’re so worried about it, why not put up bars?”

Thomas spoke of being let down and disappointed by the staff. From his perspective, he had gone to his room when staff had asked him to (albeit kicking the garbage can and slamming the door) and yet he was still restrained:

“And after they told me to go to my room, I did go to my room. And I asked that question to them and they said, ‘We never know what you’re going to do.’ And I said, ‘Well, I went to my room and laid down.’ They said, ‘Yes, you did. But we didn’t know what you were going to do if we come in there.’ I said, ‘You guys came in there with six or seven.’”

In the second place, intervening verbally is difficult because there are subtleties to intervening with escalating patients. In order for the nurse to know what to say and how to say it, the nurse must understand the particular needs of an individual patient. The nurse must understand and be aware of an individual patient’s subtle movement between being in control and being out of control. In other words, the nurse must be
aware of an individual patient's pattern of escalating. This knowledge and skill can mean the difference between escalating a situation and defusing it.

Often, the psychiatric staff do not appreciate the subtlety involved in intervening verbally. Therefore, they equate this intervention with setting limits. While setting limits are important, the danger with focusing on setting limits is that the staff priority becomes one of stopping the behavior rather than attending to the context surrounding the behavior. Consequently, while these limits do not help the patient feel safe, they do make the patient feel like a child. Thus, these limits begin a chain of events whose inevitable endpoint is the participant being restrained. Here is how Diane described her situation:

"I was cursing one person. I know, Jane. Her name's Jane... 'Cause she kept nagging me like I was a child. Instead of asking me or talking to me like I could understand her or just would allow it. I told her she wasn't no nurse. So, you know, I felt like she couldn't tell me nothing....and then they came and surrounded me."

Other participants thought that medication would have helped them calm down. In fact, they would have preferred to be medicated rather than be restrained physically. While Thomas objected to getting both the medication and being restrained, he asked why the medication wasn't given to him earlier:

"But, they could have gave me a shot. They're already holding me down. They could have just gave me a shot and made me relax. Other than chaining you up like an animal. I'm against restraining, up to the point to it really necessary to be used. I'm not saying that I was right, totally. Cause some of it was my fault, but still...All you had to do was give me a shot to calm me down and make me go to sleep. You gave me a shot once you restrained me. What was that for? To give me a shot while you were restraining me. For what? You already had me in restraints. Why should I have to go to sleep? If that was the case, you could have gave me a shot in my room and just made me relax...To
me, restraints should be when it's out of hand. Really out of hand, when you can’t do any more. I didn’t hurt no one. Sure, I know they supposed to take cautious. They never know what a person going to do. But, they could have gave me a shot.”

Doreen also suggested using medication. She was manic when she was admitted to the hospital and told the physician she needed Lithium. And yet, for some reason it took several days before her physician listened to her:

“I told them they should give me Lithium and I would start to feel better, which I do, most of the time. But, it just doesn't seem to keep me from going up, but once I'm up, it will bring me down. But, he gave me something. Then after few days, after me telling him all the time, he decided to use the Lithium.”

Not being listened to was a common theme among the participants. Doreen has had many years of experience with her psychiatric illness and yet when she came into the hospital, she knew what she needed, yet she was not listened to. James also has had many years worth of experience with his illness. During the interview, he kept asserting that he knew more than the physicians did about his illness. This was probably true. What seems to have happened to psychiatric patients, especially those who are hospitalized on psychiatric units, is that they have no voice. They have no voice because we do not listen to them. We assume that they will not be able to tell a coherent story. We assume that they do not understand their illness. We assume that they do not know what they need. We, as professionals, assume that we know what is best for the patient. Consequently, they are left feeling powerless. In trying to assert his own sense of power, James said the following:

“It’s very complicated. I have a lot of power and influence over people right now and it’s a lot stronger than any staff member’s here. Just because they’re in the position of being staff members, I've been dealing with my illness for
thirty years. I have thirty years of experience...And you know, I've been dealing with this for thirty years. I know more than any, I know more than probably most of these doctors know.”

Knowing The Patient

In order for the staff to intervene effectively with escalating patients, the staff must know the patients. The challenge for the psychiatric nurse, however, is to understand the world of the patients who, because of a psychiatric illness, may form idiosyncratic interpretations of events in their lives. These idiosyncratic interpretations will consequently be less likely to be shared and understood by others (like the staff). While these idiosyncratic ways of interpreting events sometimes do make sense if one explores them more fully, this task of trying to understand the world of the patient becomes more difficult when the patient is escalating and things might get out of control. It becomes more difficult when a patient is unknown to the staff. The key, however, to being able to avert an escalating situation is knowing the patient. Dan said it most directly:

“The way I'm proposing. Where the patients. When you say something to patients, especially a patient and you should know their history. I believe every nurse, every staff, every nurse, every doctor that interacts with a patient should know, somehow, I know it takes time, should know the patient's history. I mean, this unit I'm on is comprised of, I don't know, how many...whatever number of people...What does it take for a staff of I don't know how many to look over the general makeup. Or general positioning. Or history of [these] patients.”

Although experienced clinicians understand what it means to say that one knows the patient, knowing the patient has only recently been articulated in the nursing literature as an important concept that is central to skilled nursing judgment (Jenny &
Logan, 1992; Radwin, 1996; Tanner, Benner, Chesla & Gordon, 1993). For expert critical care nurses, "knowing the patient's patterns of responses" and "knowing the patient as a person" emerged as two important components of knowing the patient (Tanner, et al. 1993). It from this understanding of the patient that the nurse is then able to individualize care (Radwin, 1996).

Knowing the patient might have made a difference in the outcome of the situations these participants described. Marcia, for instance, said that the nurse who was working that day did not know her:

"It's just that I think she panicked a little bit, too. I didn't know this particular one as well, that's true."

If the nurse had known Marcia better, she might have felt more comfortable approaching Marcia and asking her what was going on. Thus, the focus would have shifted from stopping the behavior to understanding the patient. The focus would have also shifted from intervening for the sake of the milieu to intervening with the individual patient. When the needs of the milieu are held to be primary, staff set limits for the sake of keeping the milieu under control. Or, stated positively, the staff set limits with the individual in order to keep the milieu from escalating and getting out of hand. The problem with this focus, however, is that whereas the milieu is kept quiet, the needs of the individual may be overlooked. It is only by knowing the patient that the nurse can understand the patient and understand (know) what a particular patient might need at a particular time. It is only by knowing the patient that the nurse can
know that this person needs "space," another person needs firm limits and still another needs to talk.

The flip side to staff knowing the patient is the patient knowing the staff. It seemed that when the participants knew the staff there was a qualitative difference in how these participants felt about the experience. Dan had recently been admitted to the hospital. Therefore, not only did staff not know him, but he did not know the staff. It seemed that participants who did not know the nurses were more frightened by or angry at the restraint experience. When patients knew the staff, they trusted the staff members and knew that they would not be harmed by the staff. They also believed that despite disagreement with the decision to use restraints, the nurse was trying to help the patient.

Caring For the Patient

Despite the most expert nurse’s efforts to calm an escalating patient, however, there still will be times when restraining a patient is unavoidable. When this happens, there must be ways to make this practice more humane. It seemed that those who were restrained longer were more disturbed by the experience. In the first place, these participants eventually needed to use the bedpan or urinal. They found this experience humiliating and embarrassing. Those participants who were restrained longer also experienced being restrained as dehumanizing. They were the participants who felt like they were chained like animals. Thomas was in restraints overnight. Since he was unable to get staff attention, he urinated in his bed. Here he describes what it was like to lay in a wet bed:
“I had to use the bathroom again. They brought a bedpan. I told them I cannot use a bedpan because it’s uncomfortable. I have to make a bowel movement. And she told me ‘You either use this or you don’t use it at all.’ And she walked out. Ten minutes later, I had to use the bathroom. They wouldn’t come. So I urinated. All in the bed. They let me lay in urine for an hour. I felted dirty. I felted like I was in prison...The next shift came and I told them I had to use the bathroom and I had urine on myself. One nurse said she’ll be back. She never came back. About eleven o'clock, that’s when someone came in, took my clothes, gave me gowns. They washed my clothes. Put them in my room...I felt dirty. I felt cold. Back there is cold. You can’t do anything. You’re chained down to a bed. I think it’s worse than prison. At least in prison you can walk around... I was angry, bitter, [because] they let me lay in my urine...One nurse that I really thought care for both [the] hospital and patient, I found out it wasn’t true. So I felt bitter... I was disappointed. Kinda angry, but I got over it. But, it’s something I’ll never forget.”

Other participants commented about the physical discomfort they felt while they were restrained--the room was too cold or the restraints were too tight. Other participants found the restraints, themselves, physically uncomfortable. Most of the participants were unable to sleep while they were restrained. Still others were hurt either while being placed in restraints or while struggling in restraints:

“It was real cold in there. I had a jacket on, and they took it off to give me the shot, and then, I was freezing in there...The worst part of it was the covers down at the foot of the bed. I couldn’t get to them.”

“In the beginning, I resisted, and then they did some things that were very uncomfortable to me. They kept pushing, pushing my face away from my neck, and twisting my face, which was very uncomfortable.”

“No, there was a nurse that allegedly was checking on me. And I was screaming. My knee was in pain. And they finally said, ‘I’ll check’ and she came back. She came back, I think it was an hour and 45 minutes later. She said she’d be back in 15 minutes. And my knee was in pain because I hurt it. And she said, ‘Ok, here’s an ice pack.’ So it was just like to torment me. Like to say, ‘Okay, asshole. We know you are in pain. You're bluffing us.’ And, I was in pain. ‘Cause I put myself in pain. By trying to get out.”
There seem, therefore, to be some basic (and obvious) interventions that would help the patient feel more cared for.  

1. At the very least, the room should not be cold. If the temperature cannot be regulated, then blankets should be provided to the patient. 

2. As the patient is calming down, the restraints could be loosened in order to give the patient more freedom of movement. 

3. Dan talked about being frightened when the lights in the room were turned off. It would seem obvious to give the patient some choice as to whether he or she wanted the lights on or off. 

4. The law requires staff to check on the restrained person every fifteen minutes. At these times, the patient should be queried about the need to use the bedpan or urinal. The nursing staff should provide assistance, yet some degree of privacy if the bedpan or urinal is needed. 

5. The law also requires staff to remove the restraints every two hours in order to do range of motion. Some basic skin care might also be done at this time. 

6. Since there was not a clock in the restraint room, some of participants could not get a sense of how long they were restrained or even what time it was. A clock would help reorient them to the passage of time. 

It requires, however, more than one merely performing these physical measures in order for the patient to feel cared for. Another basic nursing intervention is the nurse’s physical presence. Some of the participants felt that they were alone and abandoned while in restraints. Although staff would check on them, the staff member often would not physically come into the restraint room. Instead, the participant was checked through the window in the door. Other participants could not remember if the staff checked on them at all. This contributed to the participant feeling abandoned.
For these participants, it seemed important that they have both physical and verbal contact with the staff. It seemed that the physical presence of the staff would have given the participants some reassurance that they would be safe and taken care of. It would also have been helpful had the staff given the participants some idea about what was going to happen to them while they are in restraints. While the staff often assume that patients know what to expect, those who have never been restrained do not know. This contributed to the participants' sense of fear and helplessness.

For these participants, then, it seemed that what was often not present was perceived caring. As it is articulated by Swanson (1991; 1993), caring on the part of the nurse consists of: (1) Maintaining belief in the other person, including a hopeful attitude and realistic optimism toward the patient. This includes those actions by the nurse that help patients attain meaning from their experiences. (2) Knowing the patient, including recognizing the individuality of each patient as the patient is responding to different life experiences. (3) Doing for the other which consists of those physical measures that the nurse performs when the patient is unable. These include comforting the patient, protecting the patient and preserving dignity. (4) Being with the patient, which consists of those actions by the nurse that convey to patients that they matter to the nurse. By being with the patient, the nurse conveys a sense of emotional availability to the patient. And (5) enabling the patient. This includes those actions whereby the nurse is supporting, encouraging, and assisting the patient to eventually be able to take care of oneself.
It seemed clear that these participants were asking for these caring actions. What is not clear from the interviews, however, is whether these caring practices were not done for the participant or were not remembered. It is possible that the participant did not remember what was done. For all of the participants, there were parts of the experience of being restrained that they could not remember. Some would say directly that they couldn’t remember, whereas others did not know why or if something was done to/for them. For example, some of the participants did not seem to understand why they were restrained. Was this an issue of not remembering what happened? For Carl, this was his main concern. He could not remember what he had done to warrant being restrained. Consequently he was unable to put the pieces together. Other participants said that staff didn’t check on them. Was this also an issue of not remembering? Other participants could not remember details of the event and cited the medication as the reason they couldn’t remember. In these situations, their concern was knowing that they could not remember events that were happening in their lives.

An obvious solution is to talk to the patient. Staff need, first of all, to acknowledge that being restrained is a significant event and, as with any significant event, they should give the patient an opportunity to talk about it. This means that the staff need to talk about what led up to the restraining event. The staff and the patient should share their understanding about how and why things happened the way they did. There should also be some opportunity for patients to discuss how they were feeling about being restrained, as well as what might have helped them stay out of restraints.
Since the event itself seemed to stay with the participants, processing the event may help the patient resolve it. Carl was the one participant who seemed most determined to feel settled about the staff and the situation before he was discharged:

"I realize that there's human error, there. You know, there's two different people and they're going to think. They're going to have a different viewpoint of the situation. So that's why I came to the point of like, that's okay. But...I was mentally out of it the first time and communication, lead by the staff, was certainly. If nothing else happens with all the people you've been talking to, there's some kind of communication. And it's going to have to be something that's going to have to be worked out, as far as how long after, is it norm. And how to approach. What kind of questions. Will certainly have to. That's your job to detail out."

**Limitations of the Study**

The major limitation of this study is related to the sample. This study consisted of a small sample of individuals who were fairly similar in that they were restrained on similar kinds of units and had similar diagnoses. For example, none of the participants had a diagnosis of schizophrenia. Although some patients with this diagnosis had been restrained, they tended to be too disorganized to be able to be interviewed. It would, however be interesting in the future to try and interview these individuals. It would also be interesting in the future to investigate this phenomenon with patients on different kinds of units (such as a Veterans Administration hospital or a state hospital). It seemed that the perceptions of the participants were dependent upon the particular culture of the unit, thus, a different kind of unit might change the kinds of responses the participants would give.

The other limitation is that this study only presents the voice of the participants. That was the purpose of the study, but, one must remember that since the use of
restraints occurs in interaction with others (the nurses), there are other voices and stories that could be told. It would be interesting to hear those voices in the future.

**Implications Related to the Methodology**

Heideggerian phenomenology was introduced to nursing via Benner's work (1984). This work is based upon the Dreyfus Model of Skill Acquisition and Dreyfus' (1991) interpretation of Heidegger's three modes in involvement in the world—ready-to-hand, unready-to-hand and present-at-hand (Benner & Wrubel, 1989). As Benner & Wrubel articulate it, in the ready-to-hand mode all activity is running smoothly. The person who is engaged and involved in an activity does not deliberate or think about what he or she is doing. Similarly, in this smooth-running activity, the equipment one uses becomes an extension of the body. Thus the piece of equipment, itself, goes unnoticed. Benner extrapolates the ready-to-hand to include the body. Thus, when the body is working smoothly, it also remains unnoticed and taken for granted. It is only during times of breakdown that the equipment (or the body) is noticed. Therefore, in the unready-to-hand mode, smooth functioning is interrupted and one no longer takes the activity for granted. In the third mode of involvement, the present-at-hand, the situation one is involved in is viewed from an objective, detached stance. Therefore, in the present-at-hand mode, both the context and the activity are absent. The piece of equipment one used is now described in terms of objective properties that omit the lived situation one had been involved in.

Benner's research with nurses has been based on the assumption that expert nursing practice is an engaged activity. Since expert nurses are skilled practitioners,
they no longer deliberately think about what they are doing. Their practice is one of skilled involvement and smooth functioning. Thus, the practices of expert nurses remain unnoticed and are taken for granted. The goal of her research, then, has been to identify and describe nursing knowledge that is embedded within nursing practice. In other words, she has tried "to capture [the] everyday skills, habits, and practices" of nurses (Benner, 1996, p. 351). Her contribution to nursing has been to articulate and make explicit some of these taken-for-granted practices.

Diekelmann (1991; 1992; 1993) and Rather (1992) have expanded Benner’s work and have utilized interpretive phenomenology as their research methodology in order to articulate the common meanings and shared practices of students and teachers of nursing. Chesla (1995) and Plager (1994) have proposed using this same methodology to study the practical activity of family life on order to articulate family meanings and concerns. And Walters (1995a; 1995b) has used this methodology to study the caring practices of critical care nurses and the lived experiences of the relatives of critically ill patients.

In general the research studies that utilize Heideggerian phenomenology share the following assumptions: (1) Humans are “situated within meaningful activities, relationships, commitments, and involvements that set up both possibility and constraints for living” (Chesla, 1995, p. 66). (2) Humans both constitute and are constituted by the world in which they live. In other words, “the world of meanings and practices into which we arrive sets up who we are as well as how we understand ourselves and our possibilities” (Chesla, 1995, p. 69). (3) “The way humans live in the
world is in engaged practical activity" (Chesla, 1995, p. 71). (4) "The way that humans are engaged in their world is set up and bounded by what matters to them" (Chesla, 1995, p. 74). (5) Humans understand something as something because of a background of shared human practices (Plager, 1994).

Since these researchers are interested in what people do in the ready-to-hand mode, practical activity has been used as the starting point for their research. Thus, the researchers access practical activity by observing others who are involved in an activity, talking to others about what they do in this activity or eliciting narrative stories from others about the situations they are involved in (Chesla, 1995). Since the researchers assume that shared practices and meanings are embedded within these everyday activities, the aim of the research has been to articulate these hidden practices and meanings. Meaning, then, is said to reside in everyday activity (Rather, 1992), since "meaning is shared and handed down culturally through language, skills and practices and is directly perceived by the individual" (Allen, Benner, Diekelmann, 1986, p. 29).

Since this interpretation of Heidegger has been the framework for interpretive research in nursing, studying the phenomenology of being restrained presented me with some methodological questions. First of all, being restrained is a practice that one person (the nurse) does to another person (the patient). While restraining another or setting limits or calming an escalating patient may all be viewed as the everyday practices of psychiatric nurses, restraining is not a practice that the patient is engaged in—at least not in the sense that Heidegger talks about the ready-to-hand mode of
involvement. Being restrained is not the same kind of intentional activity because the patient is not doing the restraining. And yet, the patient is definitely an involved person. Thus, while one could study the practices of restraining, this study was to be a study of being restrained. It was to be studied as an experience that the participant was involved in and went through, but not in the same sense as an activity that one is doing. Being restrained was seen as an event or experience in the participant’s life. Therefore, I was less interested in the practices of restraining (how the patients were restrained) and more interested in the participants’ understanding of being restrained.

Secondly, being restrained is not an “everyday” practice. While it greatly impacts the patient’s everyday activities, being restrained is an unusual event. It usually results, not when things (interactions between people) are going along smoothly, but when things go awry. Therefore, since I was not studying everyday practical knowledge or events and since I was not studying the practices of restraining, I wondered how/if Heidegger would fit theoretically with the aim of the study.

To understand how the philosophy of Martin Heidegger fit within the aims of this study, I would first like to make a distinction between the methodology and the method. The methodology is the theory (or theories) that underpin what one does as a researcher and the methods are the particular techniques the researcher uses to collect and analyze the data (Harding, 1989). Therefore, while all qualitative research methods direct the researcher to listen to what a participant is saying, how the researcher chooses the participants, how the questions are asked of the participants and what the researcher listens for in the interview will vary depending on the
methodology. Similarly, while all qualitative methods direct the researcher to analyze the interview texts for themes, what the researcher "sees" in the text and what/how the researcher names the themes will reflect the methodological framework one uses.

Methodologically Benner's research (and others) is based on the assumptions articulated earlier, which were based on a particular way of interpreting Heidegger. While this interpretation is not wrong, it is not fundamental to what Heidegger is trying to say. Therefore, I would argue that a more fundamental interpretation of Heidegger (such as that suggested earlier) expands the usefulness of the philosophy of Heidegger as a framework for interpretive phenomenology as a research methodology. The key to understanding this possibility lies in the first assumption that Chesla articulates: Humans are "situated within meaningful activities, relationships, commitments, and involvements that set up both possibility and constraints for living [emphasis mine]" (Chesla, 1995, p. 66). This assumption has emerged from Heidegger's explication of involved, practical activity (our practical taking-as) as exemplified in Heidegger's discussion of the work-shop and hammering. Thus, we have a practical activity (hammering) that is situated within someone's (the carpenter's) world (the referential context). And, hammering has meaning within that referential context. Heidegger has used the example of practical activity in order to further explicate the structure of the entity for whom the hammer has meaning (human beings). Heidegger (1953/1959; 1975/1988; 1984/1994), in his investigation, questions how it is that an entity (or anything at all) is meaningful to one. He is interested in explicating the grounding for that meaning. In other words, abstracting from his starting point (hammering),
Heidegger (1927/1962) ultimately shows how temporality (finitude) grounds the meaningful presence of an entity to human beings. Heidegger thus concludes that entities have meaning to humans because we are finite mortal becoming. It is not the activities, relationships and involvements, per se, that set up possibility and constraints, but it is our always already aheadness that then is the condition for the possibility that we can be involved in these relationships and activities. This is a subtle, yet significant difference.

Therefore, if finitude grounds our forming a world from which entities have meaning and an entity is a thing or an experience or an affect, it seemed logical that one’s finite mortal becoming would be the grounding for an experience (such as being restrained) to be meaningful to one. It seemed apparent that, just as humans understand the being of tools, individuals also understand the being of other entities, such as experiences. Heidegger, in articulating the meaning of being, provides a framework for research studies that aim to articulate how an entity (such as an experience) is meaningfully present to one. Heidegger provides a framework for the researcher who is interested in context and how an event fits within that context. Heidegger provides a framework for meaning that is an alternative to methods that presume a subject/object distinction.

Heidegger, in privileging an engaged mode of involvement also provides the methodological framework for a particular stance or way the researcher is in relation to the participants and the data. This stance is one of openness, thus allowing something to emerge from both the participants and the data. Finally, Heidegger reminds the
researcher that finitude is intrinsic to this disclosive process. Thus, the researcher, in addition to being open, must actively “bring” something out of concealment, while at the same time remembering that there will always be concealment.

**Limitations Related to Heidegger**

While the philosophy of Heidegger has provided the methodological grounding for this study and, to some extent, has helped deepen our understanding of the participants’ experiences of being restrained (in terms of understanding how this experience was made present to the participants), there are limitations related to Heidegger’s philosophy. The major limitation, related to interpretive research, is Heidegger’s productionistic metaphysics (Zimmerman, 1990). Heidegger’s main concern is about working and producing. Thus he privileges our practical taking-as. For Heidegger, meaning is manifested in these activities. Thus, we use a tool in order to do something (to make something or produce something) for the sake of our own being—our own future. Therefore, Heidegger’s focus is on things and how they are produced, analyzed and used—not on social institutions and practices (Zimmerman, 1990).

Whereas the nurse researchers have taken Heidegger’s examples of using tools and practical taking-as and have applied these concepts (ready-to-hand, present-at-hand, unready-to-hand) to the body, as Zimmerman points out, Heidegger contends that “it is a categorical mistake to conceive of animal organs as ‘tools’. Tools have the character of ‘readiness’ (Fertigkeit); they are separable from the user, and can be used by anyone at any time. Organs, such as the eye, however, are not separable from the organism;
organs are not external 'parts' with which the organism is somehow 'equipped'” (Zimmerman, 1990, p. 194). Therefore, the in-order-to that we observe in a tool is different than the in-order-to of an organ in the body.

As humans, we are all involved in practices and activities that do not involve tools and equipment and producing and using. Heidegger does little to explicate these practices. If meaning is disclosed in our practical taking-as (in using the entity for some purpose), how, for instance does a practice such as nursing fit within this context? Nursing as a practice involves more than using tools and equipment. In fact, one could argue that the most important aspects of the practice of nursing do not involve tools, but involve the people we deal with. In Heidegger's philosophy, the practices of being-with another are less well developed. Dreyfus (1992), in contrasting Heidegger with Foucault, says "whereas Foucault is concerned solely with what is happening to people, Heidegger is concerned almost exclusively with what is happening to things" (p. 91).

Although Heidegger recognizes that we are in-the-world with others, he does not fully develop a notion of engagement with others or interaction with others. This became apparent as being restrained emerged as a practice that involves social institutions and practices. Since Heidegger privileges an individualistic, solitary concept of being human, his philosophy had limited usefulness when trying to understand a practice (such as restraining) that involves interactions between people. The only relevant interactional concept was his notion of “leaps in” and “leaps ahead.” Heidegger’s notion of being-with means that we are with others in the world, yet he
does not say how we are with others in the world. Nor does he mention how one ought to be with others in the world. When Heidegger does talk about being-with others, it becomes most fully developed when he discusses our everyday being-in-the-world as falling beings. For Heidegger, fallenness is a deficient way of being-in-the-world whereby we are lost in the masses, taking our possibilities from what “they” say we should be doing. Thus, we forget our individuality. We do not take hold of who we are. Thus we live inauthentically.

Therefore, although Heidegger was helpful in grounding a notion of how one’s being is manifested in the world, he had little to say to enhance my understanding of an interactional event like being restrained. In other words, Heidegger provided the structure for the study, but contributed little to the content, i.e. to enhance understanding. For the content, Foucault had more to say.

One reason for this difference may be that Heidegger and Foucault had two different projects. Heidegger’s project was to articulate a fundamental ontology of being human. Thus, he had little interest in the actualities of living in this world, except to use these everyday examples as places from which to begin so he could then abstract to an ontological level. That is why, I think, that “in Heidegger’s ‘everyday’ world, there are no beggars, lepers, hospitals, homeless people, sickness, children, meals, animals....There are however, plenty of tables, chairs, houses, tools and instruments of all sorts” (Caputo, 1993, p. 65). While these things were not of concern to Heidegger, his lack of concern for them is a limitation in his philosophy. Foucault’s project, on the other hand was “to create a history of the different modes by which, in
our culture, human beings are made subjects" (Foucault, 1983, p. 208). Whereas Heidegger's project was to articulate the structure of human beings, Foucault’s project was to articulate the structure of power relations between individuals and social institutions. This is why, in this particular study, Heidegger’s philosophy could ground the methodology, but Foucault was able to deepen an understanding of being restrained.

Implications Related to Future Study

In many ways, this study raised more questions than it answered. To begin with, I had assumed that the participants would talk about feeling out of control. I had also expected some of the participants to feel a sense of safety by being restrained. Neither assumption was borne out in this study. The participants did, however, talk about feeling controlled in a restrictive environment. They did talk about not feeling safe. There needs, therefore, to be more research in order to understand this balance between control and safety. How much control is really needed for safety? What are the practices that make a patient feel safe and cared for? And at what point does the structure of the unit and the rules of the unit precipitate resistance and struggling?

With these participants, I could not help wonder how much of the power struggling and resistance could have been prevented. How, then, do expert nurses set limits without engaging in a power struggle? How do expert nurses deescalate an escalating patient? How do expert nurses decide when to leap in and when to give the patient space? Diane, for instance, wanted to be left alone. But, was she safe to be left alone? Would space have calmed her down?
"Just leave me alone. I just wanted them to leave me alone. Yeah, you know. You're not telling me to go to my room. I come here and want to smoke a cigarette or anything like that and tell me go back to my room. You know, I'm not here to hurt nobody or no. I'm not here to harm nobody. And I don't want nobody to harm me, but. Give me the benefit of the doubt. I asked you all to leave me alone. You told me to go into my room until 8:30. Its 8:30 already. And they think I'm going to harm the other people in there. Cause they were in there eating. I said. I respect elderly people. I'm not going to hurt them. But, it was just a mix up, man."

How do expert nurses decide when to restrain? How do they decide when verbal interventions are no longer effective? Finally, what does "knowing the patient" mean to psychiatric nurses?

Since one of the limitations of this study was the small and fairly similar sample, this study needs to be expanded to include patients with other diagnoses and patients who are on other kinds of units. It would also be interesting to interview patients who did perceive themselves to be out of control. Would these patients experience being restrained differently? It would be helpful for nurses to know what it is like for these patients to feel out of control.

Finally, in this study, the voice of the nurse was not heard. What is the experience of restraining like for the nurses? What is it like to work with escalating and potentially dangerous patients? And how do expert nurses assess dangerousness? It seems clear from this study that the practice of restraining patients continues to be unnoticed and taken for granted. It is also clear that restraining patients is only one aspect of the practices of psychiatric nurses. Benner is correct when she says that there is knowledge embedded within the practice of expert nurses. Therefore, practices of
psychiatric nurses need to be articulated. Otherwise, we will continue to rely on restraining these patients.
APPENDIX A

SUBJECT INFORMATION SHEET
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SUBJECT INFORMATION SHEET

YOU ARE INVITED TO PARTICIPATE IN A RESEARCH PROJECT DESIGNED TO EXPLORE WHAT IT IS LIKE TO HAVE BEEN IN LEATHER RERAINTS ON A PSYCHIATRIC UNIT.

PARTICIPATION IS COMPLETELY VOLUNTARY. Refusal to participate will involve no penalty or loss of benefits. You may discontinue participation at any time without penalty or loss of benefits to which you are entitled. There are no additional costs to you, the participant.

What does the study consist of?

The study consists of audiotaped interviews, lasting about 60-90 minutes. There will be 10 participants included in this study. Interviews will be conducted by the principal investigator.

During the interview, you will be asked to share your story of your experience being restrained. It is possible that you might be contacted by telephone following the interview for clarification or review of the interview text. If so, you will receive no more than two calls. If you would prefer not to be recontacted, please indicate by placing your initials here:__________.

Are there any risks?

It is possible that through discussion and recollection of your experiences, painful memories could occur. You may stop the discussion at any time.

Are there any benefits?

It is possible that you could feel better having had an opportunity to talk about your experience. It is also hoped that information obtained from this study will help nurses better understand the patient's needs and experiences.

When and where will the interview be done?

The interview will be scheduled at a time and place that are convenient for you.

Who will have access to the interview material?

The audiotaped interviews will be transcribed by the principal investigator or trained
transcriptionist, and then destroyed. Any identifying information from the interview will be removed or altered on the written transcript. The transcripts may be shared with the study committee consisting of the principal investigator and three faculty members. It may also be shared with two other researchers who are familiar with interpretive research. No individual identities will be detectable in any reports or publications resulting from the study.

What if you change your mind?

You are free to withdraw from this study or to refuse permission for the use of your audiotaped interview or transcript at any time.

YOU MAY TAKE AS MUCH TIME AS YOU WISH TO THINK THIS OVER. BEFORE YOU SIGN THIS FORM, PLEASE ASK ANY QUESTIONS ON ASPECTS OF THE STUDY THAT ARE UNCLEAR. I, THE PRINCIPAL INVESTIGATOR, WILL ATTEMPT TO ANSWER ANY QUESTIONS YOU MAY HAVE PRIOR TO, DURING, OR FOLLOWING THE STUDY.

AUTHORIZATIONS: I, ____________________________ have read and understand the information in this Subject Information Sheet and have received a copy. I have volunteered to participate based on this information. My signature indicates that I give permission for information I provide in the interview or the transcript to be used for publication in research articles, books, and/or teaching materials, as well as for presentation at research symposia. Additionally, my signature indicates that I have received a copy of this consent form.

Signature __________________________ Date __________________

Telephone __________________________

If you need further information, please contact the principal investigator:

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4/3/97
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