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Mental health and human rights: The experience of professionals in training with the use of mechanical restraints in Madrid, Spain

Salud mental y derechos humanos: La experiencia de los profesionales en formación en el uso de sujeciones mecánicas en Madrid, España

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ABSTRACT Mechanical restraint is a coercive procedure in psychiatry, which despite being permitted in Spain, raises significant ethical conflicts. Several studies argue that non-clinical factors – such as professionals' experiences and contextual influences – may play a more important role than clinical factors (diagnosis or symptoms) in determining how these measures are employed. The aim of this study is to understand how the experiences of mental health professionals in training relate to the use of mechanical restraints in Madrid's mental health network. Qualitative phenomenological research was conducted through focus groups in 2017. Interviews were transcribed for discussion and thematic analysis with Atlas.ti. Descriptive results suggest that these measures generate emotional distress and conflict with their role as caregivers. Our findings shed light on different factors related to their experiences and contexts that are important in understanding the use of mechanical restraint, as well as the contradictions of care in clinical practice.

KEY WORDS Mental Health; Physical Restraint; Immobilization; Qualitative Research; Human Rights; Coercion; Spain.

RESUMEN La sujeción mecánica en psiquiatría es un procedimiento permitido en España que despierta importantes conflictos éticos. Diversos estudios sostienen que su uso depende de factores no clínicos, como las experiencias de los profesionales y las influencias del contexto, más que de factores clínicos (diagnósticos o síntomas). El objetivo del estudio es comprender las experiencias de profesionales de salud mental en formación en relación con el uso de sujeciones en la red de salud mental de Madrid. Es un estudio cualitativo de tipo fenomenológico mediante grupos focales, realizados en 2017. Las entrevistas fueron transcritas para su discusión y análisis temático mediante Atlas.ti. Los resultados descriptivos sugieren que estas medidas producen malestar y conflicto con relación al rol de cuidador y se observan estrategias de adaptación a los mismos. A partir de los hallazgos, se reflexiona acerca de aspectos de sus experiencias y del contexto que influyen en su uso, así como de las contradicciones del cuidado en la práctica clínica.

PALABRAS CLAVES Salud Mental; Restricción Física; Inmovilización; Investigación Cualitativa; Derechos Humanos; Coerción; España.

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INTRODUCTION

The context

The use of mechanical restraint and other coercive measures has existed in the discipline of psychiatry since its very origin. [1,2,3] From a conceptual point of view, the definition of the term *mechanical restraint* varies among authors. In Spanish it is common for the terms *sujeción mecánica* [mechanical restraint] and *inmovilización terapéutica* [therapeutic immobilization] to be used interchangeably. In this study we will use the term *mechanical restraint* to refer to any procedure that, through a mechanical device, limits a person's freedom of movement through immobilizing one or more parts of their body.[4] We dismiss other terminologies as we consider them ambiguous (a person can be contained without being restrained) o euphemistic (presupposing a therapeutic action).

The use of mechanical restraints in health contexts is permitted in Spain. Nevertheless, in contrast to involuntary commitments "due to psychic disorder" that are regulated by law,[5] there is no regulation of mechanical restraint through any specific legal precept whatsoever, and such oversight is left to local ordinances and hospital protocols. The relevance of the critical reflection regarding mechanical restraint and coercion in psychiatry has focused on different factors[6,7]: the elevated frequency of these practices,[8,9] their ubiquity,[10,11,12,13,14,15] the variability of the normative frameworks that regulate them,[16,17] the controversies surrounding their use[2,16,17,18,19] in relation to human rights violations, the Convention on the Rights of Persons with Disabilities[20] and the recommendations of organizations dedicated to the defense of these rights,[20,21,22] the ethical conflicts in everyday clinical practice,[22,23,24,25] the lack of evidence regarding their therapeutic effects,[2,26,27] their harmful consequences in users and professionals,[25,28,29,30,31,32,33] the risk of abuse,[21] and the rise in and increasing pressure from user organizations[34] when known alternatives exist.[35]

This controversy is also observed in Spain.[34,36] However, despite various efforts to transform mental health systems,[19,35] the use of these practices is still widespread both in nearby countries[17,37,38] and in Spain itself.[17,39,40,41]

In general, there is a lack of studies of quality regarding the use of coercive measures[18] and to date no clear conclusions can be reached regarding their relation to sociodemographic variables (certain population groups) or clinical variables (specific disorders or symptoms). Nevertheless, a number of studies highlight the importance of the experience of professionals and the characteristics of the context in understanding factors related to the use of restraints.[42,43] Some authors[17] and organizations[44] suggest that the use of these practices depends more on non-clinical variables – such as the philosophy of the service,[45] values and customs,[46] characteristics of the centers[8] or cultural, educational and organizational factors[42] – than clinical issues (diagnoses, user characteristics).

After carrying out an extensive search of the literature, we found different types of qualitative studies that look into the experiences of users,[47,48] as well as multiple quantitative studies on the frequency, demographic characteristics and other epidemiological data[17,49] regarding mechanical restraint and other coercive measures, but very little based on the experiences of professionals.[50,51] The absence of studies on professionals in training is particularly marked.[52]

Our study

Despite the generalized belief that coercion is damaging to the liberty of the people who experience it and therefore should be considered erroneous, there is also a strong social tendency to justify it as necessary for the proper functioning of our societies.[53] Situations that are (potentially) violent challenge professionals to respond in a way that guarantees safety, without overlooking the users' needs for support and care in moments of maximum vulnerability.[54] Due to its

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consequences for the users, mechanical restraint has been defined as a high-risk procedure.[55,56] Such consequences are emotional (fear, traumatization, impotence, dehumanization),[55] as well as physical[57] to the point of being mortal.[19,32,58] It has been suggested that it is also relevant to study this phenomenon in relation to professionals, as the impact for them is also significant.[19,32,43]

The research we present here seeks to study the experience of mental health professionals in training (residents) in relation to mechanical restraint. We understand *experience* as the knowledge derived or acquired from having personally undergone a situation or circumstance,[59] a type of knowledge acquired from what one has encountered. The questions that have guided our research are: 1) *How do health professionals in training describe their experience in relation to the decision to use or carry out mechanical restraint?* and 2) *What aspects of this experience influence professionals when deciding to use mechanical restraints, and in what way?* Preliminary results of this study, prior to the development of the grounded theory, can be found in a technical document of the *Asociación Española de Neuropsiquiatría*.[60]

METHODOLOGY

Study design and theoretical framework

In order to adequately answer these questions, we adopted a qualitative methodology using focus groups. Qualitative methods assume reality and knowledge to be multiple and complex, influenced by the context and sociocultural values and also constructed by what people think, feel and do.[61,62] The choice of this approach allows us, through dialogue, interaction and discourse analysis, to understand the experiences from the perspective of the people who personally encounter the phenomenon of restraints, in the natural timeframe and sociocultural context in which they are situated.[63] This approach is carried out from a phenomenological perspective, that emphasizes how the world makes itself present int the subjectivity of the participants and in the meanings that they offer, in their own terms.[64] Our method is hermeneutical, based on a theory of interpretation that is especially useful for generating hypotheses that give meaning to a complex and conflictive issue about which there is little research.[65] The data collection was carried out using focus groups, which allowed participants the opportunity to freely express their ideas and opinions[66] through interactions and discussion based on the attitudes, points of view and discourses of each participant, supporting the exploration, clarification and deepening of individual contributions. Interactions involve attentive listening and observation in which knowledge emerges in the interplay among the subjectivity of the researchers, the context, and the object of research.[64]

Selection strategy and type of sampling

The strategy for participant selection was intentional and judgmental. The participants were chosen in relation to their representativity and the variability of discourses existing in the population and not using statistical probability. The selection was carried out in the following way: 1) profiles with certain characteristics were defined (based on the experience of the research team, consulted experts and the literature reviewed) to create specific groups relevant for representing the *structure* of the reference population (structural sample); 2) the selection was carried out through key informants who could identify professionals with the characteristics we were looking for and, once located, an informative sheet and informed consent form were provided; 3) when an adequate number was reached, the distribution into groups was carried out in such a way as to favor the richness and heterogeneity of the discourses. During the selection process, great effort was made to assure that the participants did not have a close relationship with other participants or with the team. Nevertheless, it was inevitable that some participants had previously crossed paths in other spaces, given the specificity of

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the reference population and the existence of shared educational environments outside the workplace. In the few cases in which people already knew one another, it was assured the relationship between them was not close and that each person's participation would not be conditioned by the presence of the other.

As inclusion criteria, those considered were mental health professionals in training, who worked in the public health network of the Community of Madrid and who volunteered to participate. As we mentioned, in order for the experiences of the participants to be as similar as possible to those in the natural population to which they belong, profiles were defined that were then used as a reference for the selection of the sample. In the creation of the profiles, different variables were taken into account that divide the population and that it was thought would have a significant influence upon the phenomenon under study.

Professional category

The population was divided into professions of origin: nursing (EIR), psychology (PIR) and medicine (MIR). Although clinical psychologists have less direct contact with the use of mechanical restraint during their training and professional development (they do not usually participate in indicating its use nor in the procedure itself), their implication in the paradigm that sustains these practices is nevertheless important. The study sought balanced participation from all the categories in the focus groups. Contrary to specialized professionals, residents are not assigned to a specific unit or service. However, during their training, especially at the beginning, they all pass through spaces in which the use of restraint occurs more or less frequently. For this reason, it was not necessary to classify professionals according to their workplace.

The area of the hospital or the teaching unit

It is common knowledge among mental health professionals in the region of Madrid that the model of training differs, in part, according to the philosophy or work culture that exists in each teaching unit. In this way, areas can be found with a greater tendency towards theories and practices that are more social, community-oriented and psychotherapeutic, and others that are more medical, biologicist and hegemonic, and therefore related to positions more or less critical of the use of coercive measures in mental health. However, belonging to a particular teaching unit does not necessarily guarantee that that the professionals in training share the general position of support or rejection of mechanical restraints. For this reason, the population was divided into three profiles reflecting the presumed attitude of the professional in training towards these measures: critical ("*they should not be used*"), pragmatic ("*sometimes they are necessary for safety*"), and positive/therapeutic ("*they are necessary for treatment*").[67] To attempt to guarantee that the profile of the professional in training was aligned with what we were looking for in each area, we relied on the informants. Residents of 9 of the 22 teaching units were included.

Other characteristics: gender and years of training

Issues related to gender and years of professional development[19,68] can influence the experiences of participants and were therefore taken into account so that the sample would reflect these differences among the population.

Using these variables, participants were included that covered the largest possible span of characteristics, in such a way that in the focus groups the different experiences and discourses of mental health professionals in training were "represented" as accurately as possible. At the start of the study, no set number of participants and groups was defined. As the groups were carried out, a preliminary analysis of the data was developed, based upon which the following participants were defined, with the objective of finding profiles and data that had not appeared, reaching theoretical saturation and refining the emerging theory (theoretical sampling). Participant

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recruiting was ended when conceptual saturation was reached; although such saturation is never totally complete, it was necessary to establish limits based on time and resources.

Description of the population and the spatial distribution of the study

The study included 21 residents, distributed into three different focus groups with seven people each. One resident decided not participate in a group due to time constraints and could be replaced. The day the focus groups met, two people were unable to attend, and the total number was reduced to 19 residents: seven residents of psychiatry (MIR), six nursing residents (EIR) and six residents of clinical psychology (PIR). The participants included twelve women and seven men, with different amounts of training (some were just beginning, others were well within the training process and others were coming to the end of the specialization). Initially participants from eleven public hospitals of the Community of Madrid were included, but with the loss of two participants, nine hospitals remained in the sample, although the different theoretical positions according to the different teaching units continued to be represented. During the training period all the residents carry out rotations through hospital units in which they come in contact with mechanical restraints and the decision-making process that surrounds them.

Data collection

The focus groups were conducted during the year 2017. Each encounter had a duration of approximately an hour and a half, and were carried out using a semi-structured guide developed by the research team under the supervision of the most experienced researcher. The guide did not act as a rigid questionnaire, but rather as a flexible framework for exploring areas of interest, using open questions to obtain unconditioned answers, as well as focused questions to obtain unique and useful answers. The guide also served to homogenize the interventions of the different moderators, including instructions previously agreed upon by the team regarding how to carry out the interview process. The most important themes centered on the experiences of the professionals with mechanical restraint (attitudes, thoughts, emotions, and actions). The groups took place outside of the hospital, in a calm environment that facilitated an unstructured atmosphere without institutional pressures. Before starting the group, the nature of the study was again explained and informed consent was requested to verify that the information was clear and that participation was voluntary. Instructions were then given to facilitate the proper functioning of the focus group, reminding the participants that they were free to express themselves and converse, without the need to come to an agreement on anything. During the groups, the conversation was fluid and dynamic, with adequate interaction among participants. The groups were conducted by a moderator who was responsible for facilitating and guiding participation and discourse elaboration, while another person observed without intervening in the natural development of the interview, taking note of what happening and recording the content of interview in both audio and video formats.

Data analysis

As a guide, we used the recommendations of Berenguera *et al*.[61] and Charmaz's constructivist reading of Glaser and Strauss.[69,70] Our analysis was a progressive process starting with the description of the data, continuing with the construction and ordering of concepts and categories, and ending with theorization (Figure 1). The recordings of the groups were literally transcribed by the researchers, and notes were added regarding the nonverbal information. The names of the informants were not transcribed, but rather they were assigned alphanumeric codes. The content of the transcriptions was unified in a single textual corpus to facilitate reading

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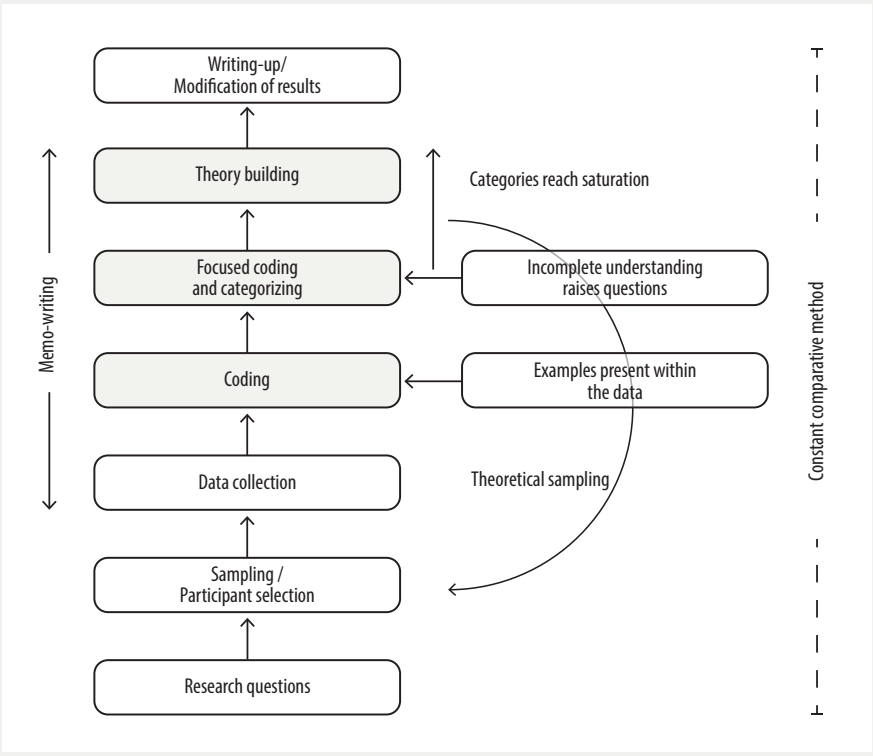

Figure 1. Visual representation of the Grounded Theory methodology.

Source: Own elaboration based on Tweed and Charmaz.[70].

and analysis and was read several times by all the researchers to assure familiarity with the raw data. In the re-readings, preliminary notes were made regarding possible thematic codes and categories, and this exercise was discussed as a team, based on our first intuitions and ideas ("naive reading").[71] The qualitative data analysis program Atlas.ti version 1.6.0 for Mac was used as an auxiliary tool for the labeling and coding. An initial coding was assigned by fragmenting the text into quotations (lines or paragraphs) that act as a *unit of meaning* regarding some aspect of the experience. The first codes are descriptive, connected to the literal content of the quotation. The coding process becomes increasingly sophisticated during the analysis through the iterative and detailed reading of what emerges.[72] Through the *constant comparative method* and reiterative interpretation and abstraction, relations are sought among the codes to refine them and group them into *conceptual categories*, that make up more descriptive categories, reaching the central categories and subcategories (axial coding) when data saturation is adequate. Lastly, theoretical coding takes place, relating the results and the hypotheses with the data, with the objective of understanding the emerging meanings.[72] During the process, the categorization and coding of the content is compared to verify that the emerging theory has its base in what was said, in a logical, systematic and explanatory schema of the constructed concepts.

Strategies to guarantee the quality and rigor of the research

The manner of evaluating the quality of qualitative research is an important object of debate.[73] To guarantee the quality of our research, the proposals of a number of authors were followed.[61,74,75] An effort was made to illustrate the methodological agreement

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among objectives, methodology and methods, carrying out a detailed monitoring of the rigor of the design and the steps taken in a commitment to *transparency*. To increase the reliability and validity of the study, rigorous sampling and analysis were carried out, employing *triangulation* techniques to verify the results and their representativity: triangulation of data, researchers, and theories. A critical, careful and reflexive attitude was maintained regarding the construction of our study, in relation to the object of study as well as in relation to our subjectivity as researchers.

Ethical aspects

All participants received information regarding the study, offered oral and written informed consent, and voluntarily and anonymously agreed to participate. They were aware that they were free to leave the study at any time and that their participation would not be compensated. To assure compliance with ethical requirements, the evaluation of the Research Ethics Committee of the Hospital Universitario La Paz (code HULP: PI-2928) was requested, and the study was approved in October 2017. Subjects were selected fairly, without discrimination among those who met the requirements sought. Possible risks related to known participation in the study were taken into account, and great care was taken to assure anonymity, intimacy and confidentiality in relation to the data and participants.[76] Treatment and communication of data was carried out according to local normative frameworks, ARCO rights, and the principles of the Declaration of Helsinki.[78]

RESULTS

In the data analysis, 978 purely descriptive codes were identified *in vivo*. After ordering them into more abstract conceptual categories, a total of 86 codes were obtained, presented in three overarching categories of meaning in relation to the object of experience, in combination with three other categories related to the origin of the experience (Figure 2).

In this schema, the subcategories and different codes that answer the first research question are organized. The results presented in this article are developed based on the subsequent analysis that lays the base for a grounded theory regarding the use of mechanical restraint in professionals in training, responding to the second research question regarding the different aspects of the professionals' experiences and the way in which they influence the indication and use of mechanical restraint. Three large thematic categories are developed: *A. Experiences preceding mechanical restraint, B. Experiences during the indication of mechanical restraint,* and *C. Experiences after the use of mechanical restraint.*

Figure 3 offers a graphic representation of the grounded theory. The meanings underlying the codes and categories are sustained in the excerpts of discourse (quotations), and it is from this place that sense is made of them (Table 1, Table 2, and Table 3).

Experiences preceding mechanical restraint

Factors related to the environment and the work context

In general, the professionals make reference to a series of circumstances related to the context and work environment when discussing mechanical restraint. They highlight the importance of the different spaces, structure and material means, but also the interaction among professionals, the dynamics of the teams, and the institutional functioning, and consider that their influence is crucial in making decisions regarding mechanical restraint.

Structural and material deficiencies

When the professionals refer to the material and structural conditions in which they work, they relate them to a greater use of mechanical restraint. They name a series of deficiencies that, in their experience, make it more

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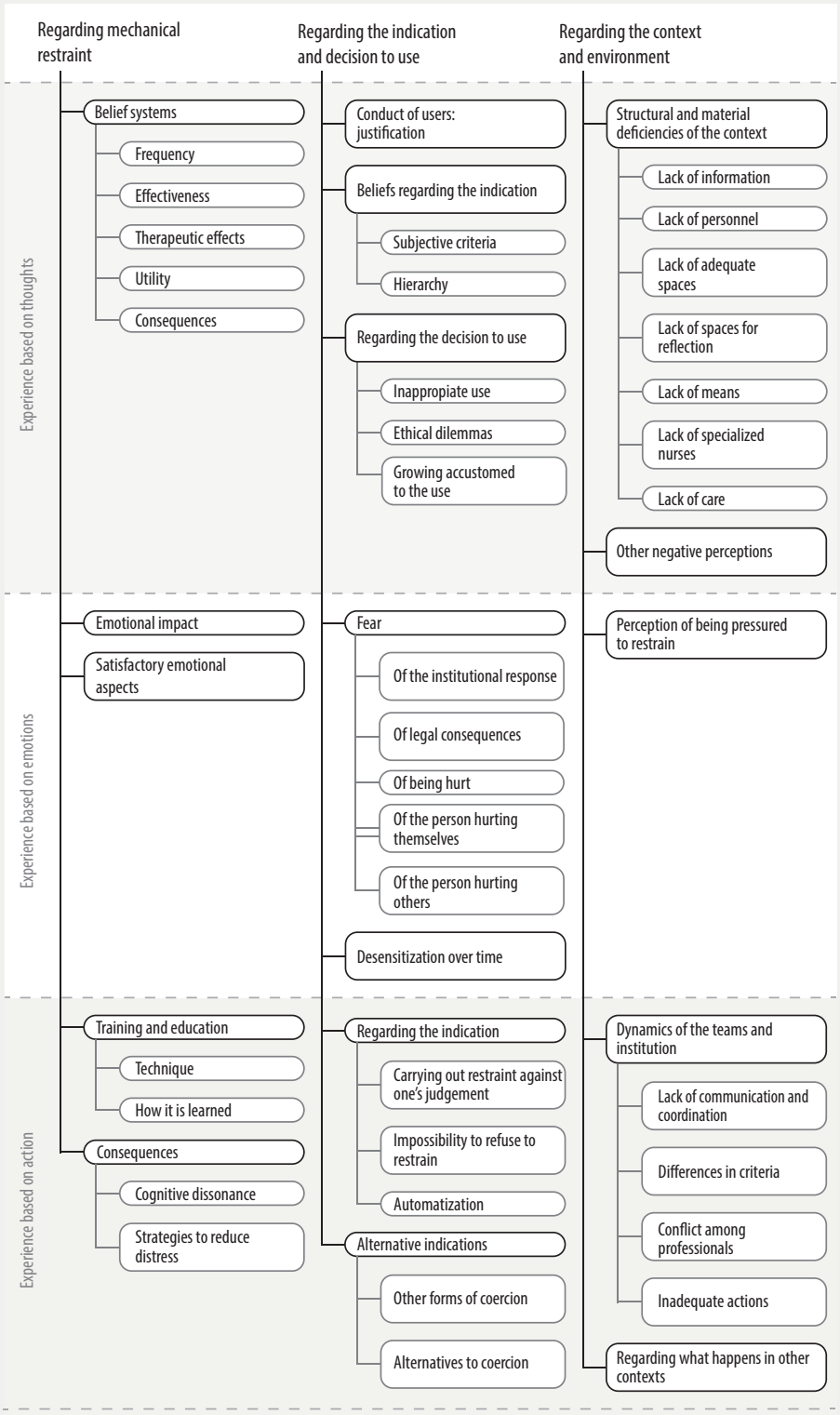

Figure 2. Primary categories, subcategories and codes of the experience of professionals.

Source: Own elaboration.

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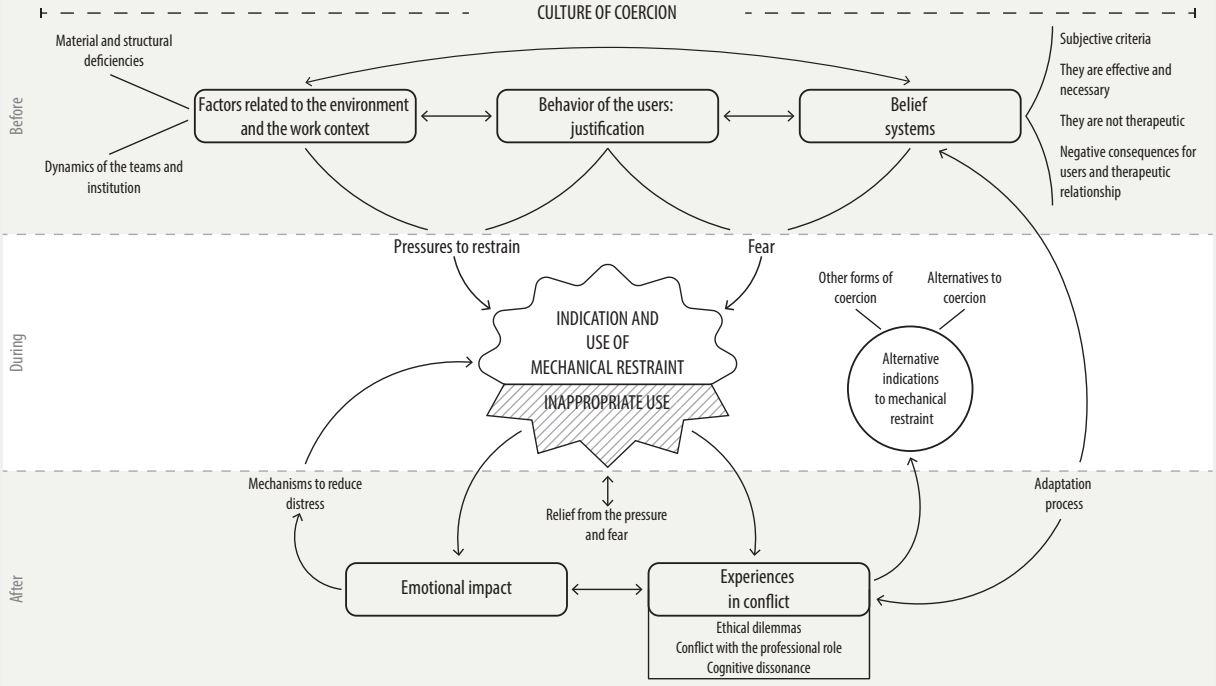

Figure 3. Grounded theory of the experience of mental health residents in the process of deciding and indicating mechanical restraint.

Source: Own elaboration.

difficult to carry out alternative actions and favor the indication of mechanical restraint: lack of personnel in the teams, professionals that are not specialized (nurses, support workers and others, who work in mental health), and the precarious training regarding both the restraints and their alternatives. They perceive the lack of material means, funding or time, that the areas for care are inadequate with relation to users' needs, that there are no formal opportunities to reflect regarding incidents that end in mechanical restraint, and all of that contributes to their use.

Dynamics of the teams and institution

For the residents, discrepancies regarding coercive measures exist between psychiatrists and nurses, as does a lack of coordination and communication in the context of mechanical restraint, which facilitates the appearance of conflicts over the norms and over these measures. In fact, one of the motives for carrying out restraints is to avoid conflict among personnel. The existence of a hierarchy in deciding mechanical restraint can be perceived, in which the criteria of the psychiatric doctors in the end prevails. When there is disagreement, the hierarchy is experienced with frustration as well as relief for not having to take responsibility for a decision considered to be difficult. They also describe a series of attitudes and actions in the teams that can lead to conflicts that end up justifying mechanical restraint: *deceptions, incoherent messages (contradictions among different shifts), imposing attitudes and lack of dialogue, yelling and threats,* etc. This is something that affects professionals from other specialties who care

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Table 1. Experiences that precede mechanical restraint. Madrid, Spain, 2017.

Categories / subcategories	Data (quotations)
Factors related to the environment and the work context / 1. Structural and material deficiencies	*It might have to do with the healthcare capacity itself, that there are a lot of patients and very few professionals and there's no other option but these more or less orthodox types of options.* [P11. Group B – 4:421] *A lot of times it's the lack of physical space in which to develop the work of the teams of psychiatry and nursing* [...] *the psychiatric floor* [...] *isn't adapted to the psychiatric patient. / A lot of the time it's after the hospital has been constructed that they say "we have to put in the psychiatric floor," and a psychiatric unit is opened without taking into account the peculiarities of the patient... For example, when an intensive care unit is opened, one considers where the ventilator, the respirator will go, right?... And that it will be close to the operating room...* [E16. Group C – 4:859/1059-60]
Factors related to the environment and the work context / 2. Dynamics of the teams and the institution	*I've often felt pressured to do containments*, by the people in Urgent Care, by the nurses* [...] *and by my own unit. This pressure often leads to MR [mechanical restraint], especially when it's by the unit, when the hierarchy of the unit is what orders the containment to be carried out. The on-staff specialists or the head of the unit says to you "this patient needs to be contained," after you've said that the patient could be managed some other way, and...* [what's done is] *"containment" like the specialist orders. Otherwise it's you who'll face the disciplinary action or whatever. If it's not done, people can get really upset or something along those lines. And this has happened, I've experienced it in my own flesh, colleagues of mine have experienced in their flesh, that is to say, it's something that exists.* [A1. Group A – 4:78] [...] *I think that the psychiatric patient in Urgent Care* [...] *is a second-class patient... A patient that's bothersome, a patient that isn't given the same consideration, a patient that's relegated and that grates on people. There's a lot of misunderstanding I think. They're not treated well by the generalists either: "this one's crazy, when will you take them to the floor?" The language is very derogatory, stigmatizing, on the part of almost all the personnel.* [A4. Group A – 4:72]
Belief systems	*I think that with containments, the problem is that they are tremendously effective, they serve the function of immobilizing, of making it so that the person can't do whatever they want to do, whatever it is... they can't do it.* [...] *They're done because they are 100% effective: they retrain.* [A1. Group A - 4:747] *I think they harm the dignity of the person. Literally, they are ruining that person's life.* [P17. Group C – 4:1165]
Behavior of the users (conscious justification of the use of restraints)	*The famous risk of absconding in patients that are quote-on-quote waiting for a bed on the pysch floor, but should be involuntarily committed... because they are an absconding risk. It's often said that if we could take them to the floor we wouldn't have to restrain them.* [A1. Group A – 4:145] *She's looking for the bed, yes. She wants to be in the bed. So... well, so she could be put in the bed without a restraint, but she is restrained. In some way as a punishment. Yes, she's restrained as a punishment, that's right.* [M19. Group C – 4:1185]
Culture of coercion	*I've never seen a judicial sentence that went against a psychiatrist, only once for a special circumstance. Even though I'm sure that at least in my hospital we've done restraints that were not at all justified.* [M13. Group B – 4:327] *It's also the paternalism of "I'm responsible for all behavior" and where that leads.* [A4. Group A – 4:131] *What I don't really understand is how having more resources will limit – taking into account the criteria that we have now about restraints – these restraints. It might limit us from tying patients to the bed, but we'll have to contain them somehow.* [M19. Group C – 4:1042]

Source: Own elaboration.
Notes: *In the residents' quotations, the terms contain/containment are used as the translation for contener/contención (which can also mean to hold or support emotionally in a way similar to therapeutic containment in English, although in this case they are used to refer to mechanical restraint).

Table 2. Experiences during mechanical restraint. Madrid, Spain, 2017.

Categories / subcategories	Data (quotations)
Perception of being pressured to restrain: trapped among contradictory demands	*People have gotten really upset with me because I didn't contain* psychiatric patients and then I left the ward... and they've gotten pissed at me.* [M13: me too] */ On the floor they sometimes pressure me to carry out containments.* [M7. Group B – 4:319/357] *A general observation is that for the slightest thing they ask you to do a containment because, for example, there's a 90 year-old man with COPD nearby... and they say "he's getting nervous," even if the patient isn't doing anything, at most the patient wants to go...* [M8. Group B – 4:357]
Fear / 1. That "something might happen"	*What's hard for me is the patient that has clear admission criteria, like what A was saying, a decompensated psychotic in Urgent Care, who is calm at the moment, but there's the risk of unpredictability, that of course isn't something tangible, unpredictability. And you say, shoot, do I restrain them or not?* [M14. Group C - 4:983]
Fear / 2. Of the person hurting themselves	*Of those I've seen and those I've myself indicated, maybe a few were therapeutic. Those cases that are super clear-cut, no? Cases like... "you're going to cut your head open and there's no way you're not going to cut your head open," well, there you go.* [M13. Group B – 4:426]
Fear / 3. Of the legal consequences	*I also think that the specialists* [on staff], *at least in our department, act more out of fear of legal responsibility or consequences than because restraint is really indicated by the protocol. By a longshot the most influential factor is fear, that this calm psychotic person will escape and get hit by a bus on the Castellana* [a main avenue in Madrid] *and the legal responsibility that the emergency team might have in that.* [M13. Group B – 4:288]
Fear / 4. Of being hurt	*The sense of imminent danger. I've had objects thrown at me.* [M7. Group B – 4:42]
Fear / 5. Of the institutional response	*...from that place it's justified: no one will get upset with you for restraining, in an urgent care situation; now, people could definitely get raging mad at you for not doing it. / I agree with what he says: they can get mad at you for not doing it, but they'll never say to you that you were wrong for doing it, I've never seen that in all my training.* [M13. M8. Group B – 4:378/80]
Inappropriate use of mechanical restraint	*...in my hospital the same thing happens: there are a lot of restraints, especially in Urgent Care, and well, in the floor I think some that are done could be avoided, but in the case of Urgent Care, I'll repeat what I said earlier, I think alternatives need to be in place.* [M7. Group B – 4:386]
Alternative indications to mechanical restraint	*Well, if we're talking about changing, going from tying the patient to a bed to locking them in a room, well sure, that could be done, if we had a lot of rooms where we could lock in the patients.* [M19. Group C – 4:1050] *Once we collaborated in teaching and something that came out of that that was a solution was that it occurred to us to ask the person who they wanted to have stay with them, and to let the person of their choice stay with them.* [P12. Group B – 4:314]

Source: Own elaboration.
Notes: *In the residents' quotations, the terms contain/containment are used as the translation for contener/contención (which can also mean to hold or support emotionally in a way similar to therapeutic containment in English, although in this case they are used to refer to mechanical restraint).

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Table 3. Experiences of mechanical restraint. Madrid, Spain, 2017.

Categories / subcategories	Data (quotations)
Emotional impact	*It's not at all pleasant... not at all. They are moments that make you ask yourself if you really want to be doing this. Because it's really hard...* [A3. Group A - 4:20] *I should say that it took me a long time before I was able to do it myself* [...] *I needed someone else to be there, in case something happened. I don't know, I thought: "this is going to be traumatic for everyone."* [A2. Group A – 4:646]
Relief from the pressure and fear	*It's that if you're conservative with the containments*, that's when the problems can come. If you pass around containments like nothing, you don't have problems / You avoid problems from one side / That's how it is.* [M19. M14. Grupo C – 4:997]
Experiences in conflict / 1. Cognitive dissonance	*I think that it's iatrogenic... and even so I use containment in those cases without... I mean, I wouldn't want to, but if I ask the supervising specialist, they are going to tell me that I should contain them, and that psychiatry* [...] *is like that. Today in the Community of Madrid, it's like that.* [M19. Grupo C – 4:949]
Experiences in conflict / 2. Ethical dilemmas	*As a general norm, I feel very angry and dishonest with myself with respect to the values that I have, the ideas that I have, and the person that is contained.* [E15. Grupo C – 4:1092] *To me, while it's happening* [...] *I think that what's missing is the ethical and moral component. To what point is it ethical and moral to do all this?* [...] *And yes, we should be a little bit afraid, not only of what could happen to us legally, but also of the moral or ethical consequences of what we are doing with other people's lives... something as basic as their freedom. To me, mechanical containment is the aspect that causes me the most doubts.* [P11. Group B - 4:295-7]
Experiences in conflict / 3. Conflict with the professional role	*...we are trained to care... and suddenly, we realize that we are carrying out a social role.* [...] *I feel like a jailer... You say, really I'm doing the job of a prison guard, without having studied to be one.* [A1. Group A – 4:629-38] *There's no escape, because you can't choose not to do it. Of course you have to do it. I'd like not to be here, but I have to be here.* [P12-E10. Group B – 4:537/8] *I think over time you distance yourself from it. I'm not sure if normalizing or distancing yourself from it is the same in this case, but it's like you distance yourself from something, I guess the same way that an oncologist distances themselves from death and things like that, you take some distance.* [M14. Group C – 4:1120]
Processes of adaptation to the conflictive experience	*I think that all that ethical and moral part, as you spend more time in the residency, it's not that you forget it, but it's like the process of indicating a physical restraint becomes more automatic, I don't know if it's a defense mechanism, to not feel... Because I felt really bad the first year of the residency and now, it's not like I like it or anything, but I don't feel as bad as a I did the first year.* [...] *The first day it was like "how terrible, I'm going to awful every time," and the truth is that now, sadly, I don't feel as bad as I did at the beginning.* [M13. Group B – 4:300-519]
Strategies and mechanisms to relieve the distress produced by restraints	*Theory helps me a lot. Thinking philosophically helps me to process it and put myself in a role of saying there's a part that isn't my responsibility, there's a part that isn't me 100% the exercising agent, I'm exercising the invisible hand of the State, I'm the exercising hand of the social, the social has made use of me in the same way as it has made use of the police.* [A1. Group A – 4:630] *We rationalize, we normalize* [...] *But you are aware that... you make yourself small to justify that you can't change such a huge system* [...] *I repeat to myself "this is crazy," never more aptly stated, but… I at least go in that direction, I move toward normalizing what isn't normalizable.* [P17. Group C – 4:1112-15-18]

Source: Own elaboration.
Notes: *In the residents' quotations, the terms contain/containment are used as the translation for contener/contención (which can also mean to hold or support emotionally in a way similar to therapeutic containment in English, although in this case they are used to refer to mechanical restraint).

for people with mental suffering, especially in Urgent Care. In these professionals, the residents perceive a lack of interest or collaboration, derogatory language or attitudes, and unequal treatment towards people with psychic suffering. Lastly, in relation to the institution, they feel that little support exists to implement alternative measures and that it would be necessary to change the institutional organization and culture.

Belief systems of the professionals

The experiences of the residents reveal their beliefs regarding mechanical restraint. They consider them to be mechanisms that "work," that are "effective" because they meet the objective for which they were designed. Although some participants recognize that in other places they have been eliminated, the majority sees them as a measure that cannot (and even should not) be eliminated, expressing distrust and suspicion regarding the possibility of care without mechanical restraint, which they consider necessary in order to guarantee safety. Nevertheless, the majority do not think that mechanical restraint is therapeutic in itself. Various participants consider it necessary to specify in what way it is effective or therapeutic, considering these to be ambiguous and interpretable terms. They express, for example, that the restraints can have an indirect therapeutic effect when they avoid the risk of physical of harm, seeing

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mechanical restraints in this case as a form of protection.

It is interesting that, although considering restraints to be effective, necessary and even therapeutic, when focusing on the consequences in the people who are restrained, the residents recognize that the impact is generally negative, describing psychological, physical, moral and behavioral harms that can be inflicted even just by observing others being restrained. In their experience, this harm can also extend to the therapeutic relationship, which can even break down entirely. Some associate this effect in the therapeutic relationship with the conditions in which the mechanical restraint was carried out, the prior characteristics of the relationship between user and professional and other factors. The nurses experience this rupture in the therapeutic relationship particularly closely.

Lastly, one experience that repeatedly appeared was that of feeling that, even though there are attempts to establish certain criteria for the application of mechanical restraint, the decisions that motivate their indication are in the end personal and subjective. Although common sense is often invoked, the *de facto* criteria appear as interpretable, with high inter and intrapersonal variability (due to emotions, beliefs, etc.) and other external variables. In addition, they find that there is a personal tendency to apply them or not. The residents express that often they do not fully understand the reason mechanical restraint was indicated, that is, the criteria and objectives in which they are based. To them, the protocols are ambiguous and therefore or not helpful for guiding indications.

Collective belief systems: the culture of coercion

In the discourse analysis, a transversal category emerged that we have called *culture of coercion*. The culture of coercion can be understood as a set of assumptions that structure the institution, the teams and the professionals, that defines the tasks and organization, and that operates constantly, whether or not one is aware of it, shaping what is and is not possible to do within the conditions imposed by the institutional/group/social context itself. This collective belief system becomes internalized in such a way that it permeates the actions, thoughts and emotions of the professionals in the development of their practice. According to the interviews, some of the common elements that characterize the culture of psychiatric units are: predominance of the biomedical model and the discourse of risk management, paternalism, appealing to the norms and authorities (hierarchy) in treatment, or the naturalization of coercion as part of the job. These elements are reflected within other categories throughout this work, for example: that the majority of alternatives to mechanical restraint are similarly coercive, the group pressure felt to carry out restraints, the perception of mechanical restraint as indispensable, etc. In relation to the biomedical model, the residents state that mechanical restraint is indicated according to diagnostic categories and/or illness insight, which influences the distress or conflict they experience regarding the decision.

Behavior of users (conscious justification of the use of restraint)

Although the residents acknowledge the influence the previous aspects have in the decision to use mechanical restraint, they justify that its use has a place in situations that occur due to certain actions on the part of users, with a variability that enters into tension with the pressures of the context and their beliefs and values. The most common reasons for indicating restraints are: 1) *interference in the functioning of the institution and opposition to the established treatment,* 2) *risk prevention,* 3) *avoiding absconding,* and 4) *defensive use*. In their experience, it is commonplace to indicate mechanical restraint to enforce measures considered therapeutic and necessary (hospital admissions, pharmacological treatments, observation in the emergency room, bedrest after meals, etc.) despite the express refusal of the users and in fact because of their refusal, although restraint is also carried out when the person interferes

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with the functioning of the institution, without there being a clear opposition to treatment nor imminent risk. The prevention of *risks* (whether specific or undetermined) is another justification that sustains the use of mechanical restraint, in which restraint acts as a security measure regarding something the professional fears will occur. The third point (*avoiding absconding*) refers to the restraints indicated to prevent users from leaving the hospital. Although this point shares elements with the first (*opposition to treatment against medical criteria*) and the second (*prevention of a possible risk*), it is included separately given the frequency of its appearance as a specific element in the discourse. The *defensive use* of the restraints refers to the actions of the users (opposing treatment, attempting to leave the hospital against medical criteria, possibility of changes in behavior, etc.) that elicit an indication of mechanical restraint on the part of the professional out of fear of *legal or institutional consequences* if the restraint is not carried out. Lastly, the residents perceive that mechanical restraint is often used as a disciplinary measure, that is, as a punishment, to correct a behavior, establish authority, etc., which is highly alarming.

Experiences during the indication of mechanical restraint

The majority state that there are two types of "pressures" that push them to make the decision to indicate mechanical restraint, and these appear as a consequence of the interaction among the previous points: the environmental and contextual factors, the behavior of users, and the prior belief systems of each professional. These pressures can be experienced as *fear* of the consequences of not carrying out a restraint, and/or as external pressures for them to be carried out. The residents frequently describe the indication to be inappropriate. The factors that can move the decision in a different direction or reinforce the indication of mechanical restraint are considered further on.

Perception of being pressured to restrain: trapped among conflicting demands

The residents describe the sensation of finding themselves trapped among conflicting demands that are difficult to resolve: legal responsibility *versus* the will of the user, or institutional mandates that in themselves are contradictory. They highlight feeling pressured to carry out mechanical restraint on the part of different agents: other residents, doctors, colleagues of other professions, the institution, as part of their professional duty in terms of *social control,* etc. This pressure can be released if they carry out mechanical restraint, but if they do not, it persists as source of conflict or tension.

Fear

This is one of the most relevant points. Fear takes a central place in the emotional experience of professionals in relation to the indication to restrain. The results are presented in order of the frequency of appearance of the object with which this fear is related (most to least frequent), although often different feared situations might be in succession to one another, for example: fear that the user will abscond from the hospital and get hurt, and that that will lead to institutional repercussions in addition to possible legal responsibilities.

1) *Fear that "something might happen":* the experience of a fear that something unspecified but undesired might occur. This fear is mostly oriented toward something that might be harmful, outside of the control of the professional although under their responsibility, and therefore, causes them feel pushed to make a decision to prevent it from happening.
2) *Fear of the person hurting themselves:* a fear that the user might do themselves harm.
3) *Fear of the legal consequences:* experiences that describe a fear of possible legal consequences as a motive driving the indication of mechanical restraint. These ex-

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periences also describe a particular lack of protection that the psychiatrists feel in relation to making these types of decisions.

4) *Fear of being hurt:* fear of experiencing an aggression. The distress of being in danger is based on previous personal experiences or collective experiences that have been shared. It is considered to be a "clear" indication of "containment."
5) *Fear of the institutional response*: residents describe the experience of using mechanical restraint based on a fear of the response of the institution, their unit or their supervisor (warnings, reprimands, complaints, etc.).

Inappropriate use of mechanical restraint

According to the residents, mechanical restraint should be used as a last resort, in certain situations of risk and after having exhausted all of the alternatives. Nevertheless, the residents highlight as commonplace the *inappropriate use* of the indication of mechanical restraint beyond what would be expected according to the protocols: use outside of the expected indications in objective and manner; inappropriate spaces and times of use; poor preparation, procedure, participation and coordination; overutilization; lack of care in the emergency room; etc. The improper use of mechanical restraint was one of the primary categories referenced, and supports the idea that at present there is a high risk of improper use and abuse.

Indications alternative to mechanical restraint

The professionals identify practices and strategies that serve as substitutes or alternatives to mechanical restraint. A group of such practices are not truly alternatives to the exercise of coercive measures but rather represent other forms of compulsion or *coercive equivalents*. Among these, we can find: 1) *threatening the use of mechanical restraint;* 2) *leaving the restraints on the bed;* 3) *admission in closed units;* 4) *presence of security personnel;* 5) *physical containment;* 6) *seclusion;* 7) *forced transfers;* and 8) *informal coercion*. Nevertheless, practices and measures that would reduce or avoid the use of restraints without being themselves coercive were also identified: *individualizing the strategies for confronting the crisis, therapeutic contracts and psychiatric advance directives, accompaniment on the part of a loved one, verbal support, exercises based on attention or emotional regulation, padded rooms, open units, and home-based care and hospitalization*. Some of these alternatives are structural, some have to do with anticipating the moments of crisis, and others have to do with handling the crisis itself.

Experiences after the use of mechanical restraint

Among the experiences stemming from the use of restraints, we can find a number of categories worth highlighting.

Emotional impact

Despite the difficulties encountered in attempting to delve into the emotional life of the participants, the discourse analysis reveals that the use of restraints produces in the majority a negative emotional *impact*, with the use of restraints described as *unpleasant, tough* or *uncomfortable*. Using restraints generates *guilt* and remorse, *impotence, frustration*, and even outrage, when the residents seek out alternatives but do not find them. The restraints can mark the experience of the professionals. They even consider some experiences to be *traumatic*.

Relief from the pressure and fear

With much less frequency, the residents make reference to feelings of relief, security and peace of mind regarding the availability and use of mechanical restraints. These feelings do not appear as explicitly and directly as others. Nevertheless, we consider them to be a fundamental element in the

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perpetuation of the indication of restraints: their use alleviates the tension generated by the context and the fears stimulated by the behavior of the users, reducing concerns over risks and legal and institutional repercussions.

Experiences in conflict

The use of mechanical restraint places the residents before conflicting or contradictory experiences. According to the data analysis, these experiences can be divided into three separate albeit related categories:

1) *Cognitive dissonance:* we used this code to describe experiences in which the residents' beliefs begin to contradict one another, or more commonly, when there is a conflict between the residents' beliefs and their feelings or behaviors. Frequent in their discourse is the use of restraints despite ideas or wishes to the contrary. Among other things, they speak of the application of restraints against their own criteria in order to avoid conflicts with the team, the workplace hierarchy or the fear of institutional repercussions.
2) *Ethical dilemmas*: this code describes the conflicts between principles such as beneficence and autonomy or freedom and safety. The residents highlight that tensions exist between what they consider to be their professional duty and how they feel during the practice of mechanical restraint.
3) *Conflicts with the professional role:* this code describes the questioning of themselves as a caregiving figure that the use of restraints generates among the residents, putting them into conflict with their professional role. Two opposing roles appear: the figure that *provides care* and the figure that *controls/punishes*. The escape from this conflict is the incorporation of the belief that restraints are un undesirable but inevitable part of their work and that it is impossible to refuse to carry them out.

Processes of adaptation to the conflictive experience

If mechanical restraint generates emotional distress and dissonant experiences at the moral level, and yet the residences experience that there is no way of refusing to use them (in the context of safety, hierarchy and fear of consequences), it is understandable that in order to work in this contradictory and harmful situation, different adaptation processes take place. The participants describe changes over time in their feelings (the restraints cause them less distress), their thought processes (they reflect less regarding restraints), and their actions, which they define as a *habituation* to mechanical restraints, a *desensitizing* in their reactions and an *automatization* in their indication.

Strategies and mechanisms to relieve the distress that restraints produce

The professionals recognize the development of involuntary (unconscious) mechanisms as well as conscious strategies and actions to reduce the distress generated by the application of mechanical restraints in their work. Among them, they describe distraction mechanisms, mechanisms of distancing themselves from the emotional experience (intellectualization-negation-normalization) and mechanisms for venting/emotional expression.

DISCUSSION

Culture of coercion, biomedical model and disabling environments

One of the most significant aspects that emerges from this study is the existence of an institutional culture of *coercion* with its base in the biomedical model and the management of individual and social risks. Our results support the observations of Dainius Pūras, Special Rapporteur of the United Nations, in his report on the *right of everyone to the enjoyment of the highest attainable standard of physical and mental health*,[22]

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regarding the underlying justifications of coercive measures: "*medical necessity*" and "*dangerousness*." The findings support that this approach is so relevant that it impregnates the entire institutional organization and the subjective experiences of the professionals,[52] at the same time that it connects to the normative and contextual frameworks in which professionals develop their practice, favoring a work model based on *paternalism* and *beneficence*, *protection*[79] and risk avoidance.[80]

Our research reflects the integration of the positivist biomedical model on the part of the professionals through the concept of "lack of illness insight" and the influence of diagnostic labels in the interpretation of the behaviors and discourses of users and the actions that they carry out. Although authors and organizations exist that have defended the need to expand the biomedical model as a means to reducing stigma,[81,82,83] our results support the idea that such an approach, which explains mental suffering using neurobiological theory, does not (sufficiently) take into account contexts and relationships,[22] intensifies stigmatization,[84] favors paternalist attitudes, and strips people with mental suffering of their rights, justifying damages to their liberty with the objective of achieving a higher good.[6,79] Additionally, this model promotes training that provides few tools to facilitate an effective relationship with users.[80] In our study, a tendency was observed to justify the use of mechanical restraint based on the need to intervene in behaviors (or possible behaviors) of the people who receive mental health care, when it is considered that they require an indispensable treatment, whether or not the person has demonstrated "dangerous" behaviors, if the professional considers that the patient does not have an adequate understanding of what is best for them. This internalized concept of the lack of illness insight serves as an epistemological base for the professionals to limit or suspend the subject's autonomy, and facilitates a shift in attention from the meanings of values of the person who suffers to their behaviors and the evaluation of these behaviors, as their discourse is not considered beyond the *illness* itself.[6]

In this sense, our research makes evident the priority given to the evaluation and management of risk or danger in everyday practice. Placed above the needs of the individual, risk management is an essential principle in mental health.[18] Other studies have also suggested[28] that coercion is one of the first responses to appear in personnel when they perceive that their own safety or that of others is at risk,[85,86] but an overestimation of risk also exists based on an assessment of the behavior of the user,[28,86] and this overestimation of the threat perceived by professionals is related to fear from previous violent incidents, which impedes the exploration of non-coercive care alternatives.[28,85] Indeed, the consideration of people diagnosed with mental disorders as dangerous does not hold with the evidence[87] and tends to be justified through inappropriate prejudices.[22] On the other hand, it is paradoxical that the professionals consider mechanical restraint to be a safety measure when they admit the harmful impact they have on themselves as professionals as well as on the users and the therapeutic relationship, a finding supported by other authors.[25,33,88,89,90] For these and other reasons, it has been considered necessary to move from a model in which mechanical restraint is considered a tool that provides safety to a model in which its use is considered a *sentinel event,* an undesirable, unexpected event that is accompanied by risks and damages, some of them severe, and that therefore requires the implementation of measures to reduce and eliminate it.[56]

This conceptualization has clinical consequences, as the majority of the alternatives proposed have to do with developing other ways of controlling behavior and avoiding risks, rather than transforming the paradigm that generates and sustains such measures.[35] Our analysis suggest that coercion functions in a continuous spectrum, in such a way that having experienced a coercive measure in the past or present predisposes one to new coercive measures in the future.[3,6]

The attribution of dangerousness and incapacity to people with emotional suffering in the residents' discourses finds resonance in the set of legal-normative systems that not

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only legitimize but pressure and force professionals to use coercive measures, preventively even, as a *social mandate*,[6] blaming the professionals if violent behaviors appear[80]; behaviors that, on the other hand, are always difficult to predict.[91] Some authors mention the feelings of professionals regarding being observed and assessed.[39] Indeed, the discourses of residents regarding mechanical restraint cannot be separated from terms related to norms, duty and safety. A recent review[92] highlights the particularity of the legal framework in Spain as compared to other countries, as the legal precept that regulates involuntary hospitalization[5] does not mention at any time the involuntary nature of the treatment, in such a way that the responsibility of applying, after the hospitalization, any other measure considered necessary, including mechanical restraint, falls directly upon the professionals.

The general lack of resources of mental health systems put into evidence by the Rapporteur[22] coincides with the experience of the participants, who denounce the material and structural deficiencies as well as the lack of adaptation of work spaces that, rather than promoting wellbeing, are *disabling spaces* that impede the use of non-coercive alternatives.[88,93] Some researchers do not consider there to be definite proof to show that differences in the incidence of coercive measures are due to lacks in professional training, the funding of mental health services or the user-professional ratio, and suggest that the differences are essentially due to cultural factors, policies, and the traditions of each setting.[17] Nevertheless, others consider that in order to avoid the use of mechanical restraint resources are fundamental, including the amount of time professionals can spend with users.[19] Indeed, structural and material deficiencies stemming from underfunding has been proposed as one of the elements favoring the violation of human rights in psychiatry.[22]

Residents identify dynamics in the teams that favor the use of restraints. The *hierarchy*, in symbolic form or manifested as a direct order, is considered a defining factor in the use of restraints, which professionals indicate despite feeling distress or disagreeing with the decision. As Pértega highlights, certain medical orders are experienced as difficult to question even when others (residents, nurses, etc.) have to execute them.[19] The contribution of the hierarchical structure in this dynamic is crucial, as it generates asymmetry in the distribution of the assigned resources, responsibilities and the separation of roles, spaces and tasks. Residents are part of those who are *not experts*, that, even though they spend a great deal of time with the user, do not have the same resources nor abilities to resolve certain situations, resorting to power and force.

Risk of abuse and improper use of mechanical restraint

The narratives of the residents regarding the experience of tendencies toward an inappropriate use of mechanical restraint contradicts other studies in which professionals show themselves to be mostly in agreement that the use made of restraints is "correct."[94] In our opinion, this finding emphatically encourages the use of these practices to be reexamined; however, we have not found other studies in our region with which to compare these results. On the other hand, the results highlight concepts that could be considered problematic: "agitation," "therapeutic," "dangerousness," "illness insight," "risk of absconding," "last resort," etc.[88,95] All of these terms are central to the creation of a discourse that justifies the use of restraints and, nevertheless, in the experience of the professionals, are also unspecific, polysemic, and subjective. These terms are open to wide interpretation, they are not supported by research, and, according to the Rapporteur,[22] they can favor arbitrariness in the use of mechanical restraint.[21] The perception of the residents regarding the criteria for restraints is that, similar to the diagnosis, the assessment of users and of risks has an important subjective component and the protocols do not effectively guide the actions of professionals regarding these measures. Other works have similar findings.[19]

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Belief systems, fears, insecurity and uncertainty

Parallel to Bourdieu's concept of *habitus*, we consider there to be a correspondence between mental and social-institutional structures.[96] In this way, the perceptions and experiences of the professionals, their categories of representations and views of the world, are the product of the incorporation of structures of the social space. That is, beyond objective events, their experience depends on the internalization of certain schema regarding the world that informs their perceptions, feelings and actions. Based on the interaction between the professional-subject and the group and institutional culture, a system of dispositions that are both structural and structuring are built.[97] In this way, what we have called the *culture of coercion* influences the symbolic systems and informs the perceptions and actions of the residents who, at the same time, are active agents in the construction of reality in the clinical-institutional space. The power relations, hierarchies, conceptualizations of suffering based on the biomedical model and other elements of this *culture* are internalized and incline the residents to perceive the clinic as it stands today as evident and natural. The consideration of mechanical restraint as indispensable, fear regarding the elimination of its use, the assimilation over time of restraint as something that forms part of their work, and the tendency to justify its use could be understood as the product of the internalization of this culture that they perpetuate through reproduction. These experiences have also been presented by other researchers.[98,99]

A transposition appears to exist regarding the feeling of insecurity and unpredictability of the social toward the mental health network. The existence of similar experiences and elements have been described by Pértega[19]: the failure to establish objective criteria that aid professionals faced with the social (and legal) mandates delegated to them to evaluate and manage risk, added to the real impossibility of preventing and controlling all instability in the environments and behaviors of users, submerges the residents in an uncertainty-insecurity in which mechanical restraint serves to generate certainties for the professionals *responsible* for an impossible task. Indeed, in a number of participants concern was observed regarding the possible elimination of mechanical restraint, without which they felt unprotected.

In relation to the psychological process that underlies the use of mechanical restraint in this situation, *fear* appears as a primordial part of the professional experiences, fear of both real physical harm and the consequences that can arise if such harm is produced. In this climate of uncertainty, avoiding risk prevails over any potential degradation of rights and other harms that might appear. Although it could be argued that the fear of professionals has a solid base in prior experiences in which, for example, professionals have been harmed due to postponing the indication of mechanical restraint,[100,101] we consider it indispensable that in the analysis of phenomena as complex as aggression or psychomotor agitation other factors be taken into account (for example, relational factors) or that reflections take place regarding how the lack of preparation or awareness of the influence one's presence and the environment exert on others can determine whether or not a situation of these characteristics occurs.[93,102] Along these same lines, Dozza uses the concept "dreaded scenes"[103] to name those imagined situations that we fear will occur, and that are accompanied by disorientation, not knowing how to respond, a sense of lacking the abilities and tools to resolve the imagined situation[104]; this could explain the influence the collective beliefs exercise in the decision-making of the professionals. From their discourses it can be understood that, on occasion, the use of restraints is more directed at avoiding this *dreaded scene* than toward the needs and care that the user requires. Such scenes are closely related to "catastrophic fantasies," that is, situations for which a professional could be judged or penalized by the institution (suicides, murders, fights) or those that could result in physical harm to the professional themselves

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(physically, psychologically, or in relation to their work, etc.).[104] These fantasies, that in general are not conscious, produce a series of emotions and cognitions that push professionals to adopt conservative and overprotective behaviors, often stereotyped, in order to avoid risks. Often the fantasies and scenes are shared collectively (in the institution, society, teams, etc.) and have a significative influence in subjects initiating their training through the work cultures and philosophy.[105]

Emotional impact and processes of adaptation

The negative impact of mechanical restraint at the emotional and psychological level has been referenced in a number of studies.[25,106] Guilt, remorse, impotence, rage and frustration are emotions frequently referenced.[52] In this sense, Bloom uses the concept of *parallel processes* to address the symmetrical effect that the use of power to manage behavioral alterations has in professionals and users: on the one hand, it makes users fear and distrust the staff and makes them less collaborative and participatory and, at the same time, it incites professionals to feel frustrated and unsatisfied, which favors them using power and control even more.[107] But how does one move beyond the impact following the use, acceptance and reproduction of these measures? Among the psychological processes observed, the residents describe the development of forms of adaptation similar to those detailed by Pértega.[19] The participants narrate a transformation over time in the way in which they experience mechanical restraint. According to their statements, progressively, and through different passive and active psychological mechanisms, desensitization, habituation and automatization regarding the use of restraints take place, with a reduction in the associated distress and the integration of these measures as part of their everyday practice, diminishing the conflict generated by ethical dilemmas and the dissonance between beliefs and actions. The process identified by Pértega can explain the adaptation of residents during three consecutive phases of their training: 1) traumatization and estrangement in the first mechanical restrains; 2) rationalization, frustration and impotence as a defense toward the distress that these measures generate; and 3) incorporation and acceptance of mechanical restraint, when they begin to be considered "part of the job."[19,89] Nevertheless, Pértega suggests at the same time one has the feeling of having become more defensive, less sure of oneself at work, believing that one must protect oneself, without ever having lost the feeling of estrangement and questioning of one's work.

Experiences of conflict

Lastly, not all existing studies recover the professionals' conflictive experiences with coercive measures. For example, coercive measures such as seclusion have been described by some professionals as "very necessary" and "highly therapeutic," and they have suggested that they guarantee safety without being punitive.[108] Other researchers have found that the majority of professions see coercive measures as necessary to guarantee care and safety, putting in to doubt that significant moral conflicts exist.[109] Nevertheless, the results of our work illustrate that the shared experience of the majority of residents in the context of Madrid can be characterized as presenting multiple contradictions that surface when they decide to indicate or carry out mechanical restraint. This difference might be owing to the fact that the denunciation of the consequences of mechanical restraint and the dilemmas surrounding its use have become much more present in the professional and public discourse in the last years. Considering mechanical restraint to be a *necessary* but *damaging* measure for the user and the therapeutic relationship puts residents before conflicts whose resolution depends on self-justification, negation of dissonance,[99] and the acceptance of this contradiction as inherent to present-day psychiatry.

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This can be seen in the decision-making process,[19] conflict with the professional role[89] or in the ethical dilemmas produced.[37]

Strengths and weaknesses

One of the primary strengths of this study is the novel contribution it makes to the literature regarding mechanical restraint in Spain, where the lack of studies on the subject is noteworthy. It also differs from the majority of English-language publications, which tend to be particularly centered on nursing personnel. Having considered the experience of residents of different specialties enriches the understanding of the phenomenon and allows for comparisons with professionals with greater experience. Among the limitations, the controversy surrounding mechanical restraint renders it a topic of high social desirability, which can influence the narratives of the participants. Furthermore, although methodological tools were used to favor the representativity of the sample and the heterogeneity of discourses, it is possible that those with the greatest indifference toward these practices or those that might have felt threatened by the exposure decided not to take part in the study. On the other hand, the data collected should be understood in the context of a particular place and time, and therefore it is important to repeat this study in other environments in order to gain a deeper understanding of the phenomenon where it occurs. Lastly, regarding the analysis, the influence of the researchers' history and subjectivity should be acknowledged; they have been in contact with the use of mechanical restraint in their professional practice, although this does not necessarily represent a limitation, as it was an element that enriched the design and development of the study.

CONCLUSION

The purpose of this work has been to explore in depth the experience of mental health residents with respect to the use of mechanical restraint and understand what aspects influence in what ways the process of deciding to apply restraints. Our results are similar to those presented by other authors[19,52,88,93,99,110,111] and suggest that the decision-making processes regarding the use of mechanical restraints are situated in a complex web of factors and experiences including elements of the sociocultural context and normative framework, relational dynamics and work environments, experiential, psychological and ethical processes, and others that stem from the interactions among these factors. A work culture based on coercion and the discourse of risk management especially stand out. Although they recognize the harmful impact stemming from their use, the professionals undergo an adaptation process through which they internalize and act upon these principles, justifying the need for mechanical restraint at the same time that they face conflicts with their professional role and ethical dilemmas.

Implications in clinical practice

The results of this research push us to demand radical change in the paradigm that promotes the metamorphosis of our practice. This implies that the transformations should transcend concrete areas of intervention and seek political, legislative, institutional and cultural changes, without ignoring the role of teams and professionals. The use of mechanical restraints, because of its implications, should be recognized as a failure in care and a measure to be eradicated. Our study suggests paths towards the elimination of restraints that take into account the complexity of the phenomenon.

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CONFLICTS OF INTEREST

This project did not receive any type of funding. Researchers and participants did not receive any type of economic benefit or compensation, direct or indirect. No particular interests (economic, academic, or others) have been identified that could enter into conflict with the strictly scientific interest of the study.

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