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Post-Traumatic Stress Disorder and Physical Restraint

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Abstract | **Original Research Article**

Background: Post-traumatic stress disorder (PTSD) manifests through intense and dysfunctional reactions following an event perceived as life-threatening or severely distressing. In psychiatric settings, involuntary hospitalization and the use of physical restraint may represent potentially traumatic experiences. ***Objective:*** To explore the relationship between PTSD and physical restraint among patients hospitalized in the psychiatric emergency unit at Arrazi Hospital, Salé. ***Methods:*** A descriptive study involving 30 patients admitted to the psychiatric emergency department. Sociodemographic, clinical, and experiential data regarding restraint were collected through a standardized form and analyzed using Meta-chart and Visuel-chart software. ***Results:*** The sample included 53.3% women, aged between 17 and 46, mostly single and unemployed. The most frequent diagnoses were schizophrenia (53.3%) and schizoaffective disorder (26.6%). A majority (67%) experienced physical restraint during hospitalization, with 96.6% restrained for less than 12 hours. Predominant emotions were anger (23.3%) and mixed feelings of respect with loss of trust toward caregivers (29.1%). No patient met the diagnostic threshold for PTSD (mean PCLS score: 14.4). ***Conclusion:*** Although sometimes clinically necessary in acute agitation, physical restraint can be perceived as a traumatic experience. Acknowledging the patient's psychological experience is essential for developing more humane and ethical care practices.

Keywords: Restraint; Post-traumatic stress disorder; Psychiatry; Patient experience; Ethics.

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INTRODUCTION

Post-traumatic stress disorder (PTSD) is defined as a set of emotional, behavioral, and cognitive reactions that occur following a traumatic event threatening one's life or physical integrity (APA, 2022). In psychiatry, coercive measures such as physical restraint or seclusion can be perceived by patients as potentially traumatic experiences (Friard, 2004; Palazzolo, 2002). The use of restraint, long debated, resurfaced in the 1990s with dual aims—ensuring safety and providing therapeutic control (Guivarch & Cano, 2013). However, it raises major ethical dilemmas between the necessity of maintaining safety and the obligation to preserve patient dignity.

Within this framework, our study adopts both a clinical and ethical perspective, aiming to explore the relationship between physical restraint and the potential onset of PTSD symptoms among hospitalized psychiatric patients.

Objectives

- To identify possible psychopathological links between physical restraint and post-traumatic stress symptoms.
- To explore the emotional and relational experiences of patients toward this practice.
- To emphasize the importance of integrating the traumatic dimension into psychiatric care strategies.

METHODS

Study type and population

This descriptive study was conducted among 30 patients admitted to the psychiatric emergency unit at Arrazi Hospital (Salé). All participants had been subjected to at least one physical restraint episode during hospitalization.

Data collection

A standardized questionnaire was used to collect sociodemographic data (age, sex, marital status,

education level, employment) and clinical data (psychiatric diagnosis, duration and type of restraint, associated emotions). PTSD symptoms were screened using the *Posttraumatic Checklist Scale* (PCLS).

Statistical analysis

Data were processed and presented as frequencies and percentages using Meta-chart and Visuel-chart software.

RESULTS

The sample included 53.3% women, aged 17 to 46 years, mostly single (46.6%) and unemployed (56.6%). Secondary education was the most frequent level (46.6%), reflecting a young, socially vulnerable population.

Clinically, schizophrenia was the most common diagnosis (53.3%), followed by schizoaffective disorder (26.6%), bipolar disorder (10%), and depressive disorder (10%). These pathologies are often associated with agitation episodes that may require restraint to prevent self-harm or aggression.

Regarding restraint conditions: 67% of patients were restrained during hospitalization, 57% in regular rooms, and 96.6% for less than 12 hours. Half (50%) also received medication, indicating a combined pharmacological and mechanical control approach.

Patients expressed diverse emotions during or after restraint—anger (23.3%), fear, humiliation, and loss of trust (29.1%). Nonetheless, 28% reported kindness or respect from caregivers, emphasizing the moderating role of relational quality in how coercion is experienced.

The mean PCLS score was 14.4, with no confirmed PTSD cases. However, some patients described transient hypervigilance or intrusive recollections, suggesting subclinical traumatic effects.

DISCUSSION

The findings highlight the complexity of the relationship between restraint and subjective experience. Even in the absence of a formal PTSD diagnosis, emotional reactions such as anger, fear, and mistrust indicate a potentially traumatic perception of restraint. Guivarch and Cano (2013) underline this paradox: restraint may protect both the team and the patient but can simultaneously provoke feelings of helplessness and loss of autonomy. In this study, the short duration of restraint (under 12 hours) and the quality of staff interactions likely mitigated long-term psychological consequences. Nonetheless, the frequency of negative emotions shows that the absence of a PTSD diagnosis does not exclude the experience of trauma.

Moylan (2009) emphasized that communication is a core component of humane psychiatric care: restraint should not represent a rupture of the therapeutic alliance but rather an accompanied intervention. The perception of kindness and respect from caregivers in this study was associated with less distress, reinforcing the notion that the relational dimension determines the emotional outcome of restraint.

From an ethical standpoint, Touzet (2004) and Beauchamp & Childress (2001) remind us that therapeutic coercion can only be justified by the principle of beneficence—it must remain proportional, time-limited, and clearly explained to the patient. Institutional reflection should aim to reduce coercive practices through verbal de-escalation, relational mediation, and environmental adjustments.

The World Health Organization (WHO, 2021) promotes a rights-based approach to mental health care, advocating for the reduction of physical restraint and the implementation of post-restraint debriefing sessions to help patients process their experience. Restraint should thus not be seen as a failure but rather as a clinical signal requiring collective reflection and enhanced therapeutic support.

CONCLUSION

Physical restraint remains a last-resort tool in psychiatry, justified by the need to prevent immediate harm. However, its use is not devoid of psychological consequences. Recognizing the patient's subjective experience and training healthcare staff in ethical crisis management are key levers for humanizing psychiatric practice and minimizing potential trauma.

REFERENCES

- Beauchamp T. L., & Childress J. F. (2001). *Principles of Biomedical Ethics.* Oxford University Press.
- Cano N. (2009). *Psychiatric practices and ethical perspectives. Ethique & Santé*, 6:3–10.
- Friard D. (2004). *Attacher n'est pas contenir. Santé Mentale*, 86:16–26.
- Guivarch J., & Cano N. (2013). *Use of restraint in psychiatry: caregiver experience and ethical perspectives. L'Encéphale,* 39:237–243. Moylan L. B. (2009). *Physical restraint in acute care psychiatry: A humanistic and realistic nursing approach. Journal of Psychosocial Nursing*, 47(3):41–47.
- Palazzolo J. (2002). *Chambre d'isolement et contentions en psychiatrie.* Paris: Masson.
- Prinsen E. J., & van Delden J. J. (2009). *Can we justify eliminating coercive measures in psychiatry? Journal of Medical Ethics*, 35(1):69–73.

- Touzet P. (2004). *Toward an ethics of restraint. Santé Mentale*, 86:54–57.
- World Health Organization (WHO). (2021). *QualityRights: Mental health care and human rights.* Geneva: WHO.
American Psychiatric Association (APA). (2022). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR).* Washington, DC: APA.