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# It hurts to get forced: Children's narratives about restraint during medical procedures

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## Abstract

According to the UN Convention on the Rights of the Child (UNCRC), children have the right to be involved in decisions about medical procedures affecting them. However, research has shown that healthcare professionals sometimes find this difficult to achieve and those procedures then are performed against the will of the child. The aim was to illuminate restraint from the perspective of children's and young people's experiences of feeling forced during medical procedures. Following the phenomenological hermeneutic method, a secondary qualitative analysis of narrative data from four datasets collected between 2001 and 2020 was performed. Twelve children and young people aged 6–19 years (three male, nine female) from central and northern Sweden narrated their experiences of restraint related to medical procedures in nine narrative interviews and three short written narratives. The analysis revealed that it hurts to get forced, this being illustrated in six themes: *bodily misery*, *emotional rebellion*, *feeling disregarded*, *physically limited*, *desiring escape*, and *leaving deep traces*. From the perspective of children and young people, restraint was interpreted with inspiration from the philosopher Michel Foucault, as being overpowered – not voluntary submission but offering resistance – and according to the theory of caring and uncaring, a relationship in which the healthcare professional is perceived as indifferent to the patient as a person. In conclusion restraint hurts and means powerlessness to the child, leaving deep traces that remain for a long time. The findings call the healthcare profession to take action to support children's self-determination, participation, and integrity in healthcare. How children experience restraint in healthcare merits further investigation from the children's own perspective.

**KEYWORDS**
children and young people, medical procedures, qualitative method, restraint

## 1 | INTRODUCTION

According to the United Nations Convention on the Rights of the Child (UNCRC),[1] children have a right to be involved in decisions affecting them and should be encouraged to express their opinion on issues concerning themselves. Their opinions should be considered and given weight in line with the child's age and maturity. Additionally, children and young people greatly value being involved in healthcare planning and decisions that concern themselves.[2,3] Being included in conversations and discussions about their illness and treatment has been shown to reduce children's anxiety and give them better control over their situation.[3] In Sweden, the rights of children and

young people as patients were almost invisible in healthcare legislation until 2015 when the Patient Act[4] and UNCHR as law from 2018[5] came into force. Before that, no provisions specifically addressed children in general healthcare legislation.[6] According to the Swedish Patient Act,[4] children are to be seen as active participants in healthcare planning, having a say in the choices about their healthcare. However, several sources report that the opposite is actually the case.[6–8]

Decision-making competence is related to the child's developmental level, but the development of the brain is not linear. This means that children's decision-making competence does not automatically increase linearly with increasing age.[9] This argues against an age threshold for children's involvement in healthcare planning.[6,10–12] Decision-making competence can be described as the degree to which the child has various relevant abilities, being able, for example, to weigh risks and benefits as well as advantages and disadvantages against each other, think long term, and understand the consequences of decision-making.[9] However, to dare to make their voices heard and be involved, children and young people need to feel safe and well-informed.[3,8] Additionally, according to the UNCRC,[1] there is a requirement to take into account the best interests of the child. Children thus need to meet healthcare professionals who have the required specific competence and enough time so the child can participate and feel safe.[8] However, often the adults' perceptions rather than the child's decision-making competence and maturity determine the child's opportunity to participate in decision-making.[10,13–15] Not taking the time, not providing age-appropriate information, or presenting only the alternative that the care staff deem most appropriate all limit children's self-determination, decision-making skills, and conditions for participation.[16,17]

A lack of consensus regarding terminology confuses our knowledge of restraint during medical procedures in pediatric care. "Restraint" is described by Bray et al.[18] as the hindering of the child's resistance and movements. As much as 48% of nurses reported that they often held children still during various healthcare procedures.[19] Furthermore, physical restraint was viewed as necessary in stressful healthcare situations.[20] In a review, Bray et al.[18] found that holding children still and overriding their wishes during procedures was more common among younger than older (i.e., age 7 years and above) children. They also found that the child's own perspective on being held during procedures was rarely researched. In pediatric intensive care of children 3–6 years old, anger, resistance, and discomfort were reportedly related to physical restraint.[21] Karlsson et al.[22] summarized that restraint assigns the child a passive role and causes panic, loss of control, and feelings of powerlessness. However, a recent study of children aged 5–9 years diagnosed with cancer offered an opposite perspective, as some of the children explained that they found it supportive to be physically or verbally forced to comply with certain procedures.[23]

In 2021, Lucy Bray gathered an international collaborative expert group, iSUPPORT, that, after extensive consultation, developed rights-based standards for children undergoing clinical procedures.[24] Being involved in this work highlighted the need to let children's and young people's voices be heard regarding how restraint is experienced. In previous research with children and young people performed by authors in the present research team, restraint and being forced came up when participants talked about being afraid of medical care,[25] expectations before vaccination,[26] experiences with needle procedures in type 1 diabetes (T1D) treatment, and fear related to needle procedures in children diagnosed with T1D.[27] In this study, these narratives are analyzed with the aim of illuminating restraint from the perspective of children's and young people's experiences of feeling forced during medical procedures.

## 2 | METHODS

In this qualitative secondary analysis, a qualitative design was applied, inspired by the phenomenological hermeneutic method as described by Lindseth and Norberg.[28] In this method, one does not claim to find a single truth about a phenomenon; instead, the information that emerges from narratives creates a novel and deeper understanding of the phenomenon.[28]

### 2.1 | Sample

The study is based on original data from four datasets, collected between 2001 and 2020, in which children and young people convey their experiences of procedures in healthcare. Included in the current study were children's own narratives that were about experiences of feeling forced. A total of 109 anonymized transcripts from six datasets were reviewed, resulting in transcribed narratives from 12 participants aged 6–19 years, three male and nine female, from four of the six datasets. The participants came from different places in central and northern Sweden, that is, large cities, medium-sized cities, small towns, and rural areas. They had experienced a great variety of procedures, vaccinations, examinations, and treatments because of diverse diagnoses such as benign tumor, cancer, kidney disease, chronic ear disease, T1D, juvenile rheumatoid arthritis, and complications related to spina bifida. Their healthcare experience included contact with the child health service, school health services, general hospital care, specialist medical care, surgery, pediatric cancer clinics, general anesthesiaat, and radiology clinics.

### 2.2 | Data collection

The data collected consisted of narrative data, both spoken ($n = 9$) and written ($n = 3$). Carter and Ford[29] recommended participatory and child-centered methods to facilitate the children's engagement, communication, control, and interpretation of their own experiences.

To allow space for the children's own voices and try to understand the meaning they attribute to their experiences, Clark[30] emphasized that the interviewer must establish trust, overcome power inequities, and provide ways for the child to communicate freely and

fully. Ideally, an interviewer will use child-appropriate vocabulary in a child-friendly setting. The interviewer has to share power with the child, making it clear that the child is the expert in a topic about which grown-ups know little.[30] In accordance with Greene and Hill,[31] narrative interviews with few questions and a focus on the informant's story were conducted by a trained pediatric nurse, skilled in interviewing children but not previously known to the participants (i.e., the first author). To gain access to the child's own experience without parental involvement, for example, by telling of contradictory experiences and/or correcting the child,[32] the interviews were carried out one on one with the child. Based on the child's choice, the place for the interview was the child's home, the psychologist's office, or the playroom at the children's hospital. If requested, a parent was waiting in the room next door and could be invited into the interview at any time on the child's request, although this did not occur. Interviews with children under 7 years old were video recorded; the other interviews were audio recorded. The participants decided when to start and stop the interview and recording.

Narrative data from children can also be in the form of writing[33] and in three of the included sets of data the participants were asked to tell (in writing) about their expectations and/or experiences in relation to healthcare. Grossoehme et al.[34] emphasized that when pediatric patients are given the opportunity to write their stories, about their expectations and/or experiences in relation to healthcare contacts, they can express what really matters to them in authentic stories that yield important insights.

## 2.3 | Analysis

According to Lindseth and Norberg,[28] phenomenological hermeneutic analysis is suitable for better understanding of practice in healthcare. The method was developed for investigating the meaning of various phenomena by analyzing narratives about lived experiences of the phenomena. It follows through the hermeneutical circle in three steps – that is, naïve understanding, structural analysis, and comprehensive understanding – in a dialectical movement between understanding and explaining. The analysis was primarily performed by the second and third authors in close collaboration with the project leader (i.e., the first author).

To gain a naïve understanding, the text was read several times to obtain a preliminary feeling and understanding of it as a whole. To capture a preliminary overall understanding, it is important for the researcher to have an open mind to what the text says.[28] A first reading of texts was done by the second and third authors, separately. The passages of the texts, that is, meaning units, describing restraint were marked in the texts with a highlighter. These passages were compared and discussed until there was agreement that the meaning units corresponded to the purpose of the study. Then the naïve understanding was formulated and discussed with the first author. With this naïve understanding in mind, the researchers read the texts once more to ensure that no relevant material had been overlooked.

In the structural analysis, the meaning units were then condensed and tested against the naïve understanding. Condensed meaning units with similar meanings were brought together into themes; these themes were then reflected on in light of the naïve understanding and discussed with the first author. The text was then reassembled into a whole based on the naïve understanding and the structural analysis. As suggested by Lindseth and Norberg,[28,35] the authors turned to the literature, in this case, Foucault's analysis of power as interpreted by Hörnqvist,[36] to revise, broaden, and deepen their understanding of the meaning of feeling forced. A comprehensive understanding, that is, a holistic interpretation of the phenomenon,[28] was then formulated, tested against the naïve reading and structural analysis, discussed, and reformulated several times. Preliminary findings were presented in a master's thesis. The analysis was then further reviewed and discussed with the last author.

## 2.4 | Ethical considerations

According to the Declaration of Helsinki, children's vulnerability must be considered when conducting research involving them. They also are not deemed legally competent to independently consent to participation in research.[37] However, according to Carter,[38] there is a risk of protecting children to the extent that their perspectives are excluded. All participants in the current study were informed in writing about the study and the voluntary nature of participating; and for those who were interviewed this was supplemented with verbal information, initially when meeting. Children and youths over 15 years old gave independent written consent to participate; in accordance with the Swedish Ethics Review Act (2003:460),[39] for the participation of children under 15 years old, their carer's written consent was a prerequisite, although the child's assent was highlighted as more important. All participants were offered consultation if memories surfacing during the study caused any distress. In two of the included surveys, children were offered cinema tickets for participation. In this qualitative secondary analysis, previously collected data were analyzed, minimizing the burden on research participants.[40] Personal data were protected by anonymization. Children's views of restraint during medical procedures were deemed of great importance and the risk of harm precluded. All four studies included in this research were ethically approved by the Ethics Committee of the Faculty of Medicine, Umeå University (01-061), the Regional Ethics Review Board in Gothenburg (466-12), and the Regional Ethics Review Board in Uppsala (2016/453; 2014/516).

# 3 | FINDINGS

The findings are based on transcribed narratives from 12 participants aged 6–19 years old. The findings of each step of the analysis are presented separately in three parts, that is, naïve understanding, structural analysis, and comprehensive interpretation, as illustrated in Figure 1.

### 3.1 | Naïve understanding

In the naïve reading, the sense of being invisible and not listened to, without any possibility of dissent (see Table 1), appeared as essential to the experience of feeling forced and restrained. It manifested itself in strong emotional reactions and expressions, such as feeling existentially threatened and trying to escape. It started far in advance and lasted a long time.

### 3.2 | Structural analysis

The findings of the structural analysis are presented under six themes: *bodily misery*, *emotional rebellion*, *feeling disregarded*, *physically limited*, *desiring escape*, and *leaving deep traces* (see Table 1).

To clarify the themes, quotations from the children and young people are presented. These were carefully translated by a young bilingual person to be as close to the children's and young person's expressions as possible. The quotations were not grammatical corrected and since spoken language is lacking punctuation the quotations from interviews are presented without any comma and period. Ellipsis indicates a pause.

### 3.3 | Bodily misery

Being restrained manifested itself as strange bodily feelings, as pain and discomfort: "It felt like you were going to suffocate" (boy, 10 years old). The body reacted with sweating, nausea, and stomach pain: "Mm sweaty when kinda like you have cried and been super angry yeah and they have to hold you stuck and try to explain and then you get really sweaty" (girl, 11 years old).

The bodily sensations went worse because the participants knew in advance what was to happen – for example, sitting and waiting for the blood test – giving them time to become stressed. The fact that the participants experienced the procedure as impossible to refuse made the bodily reactions worse: "And then I also freeze and hurt in my stomach … feel sick and …" (girl, 11 years old).

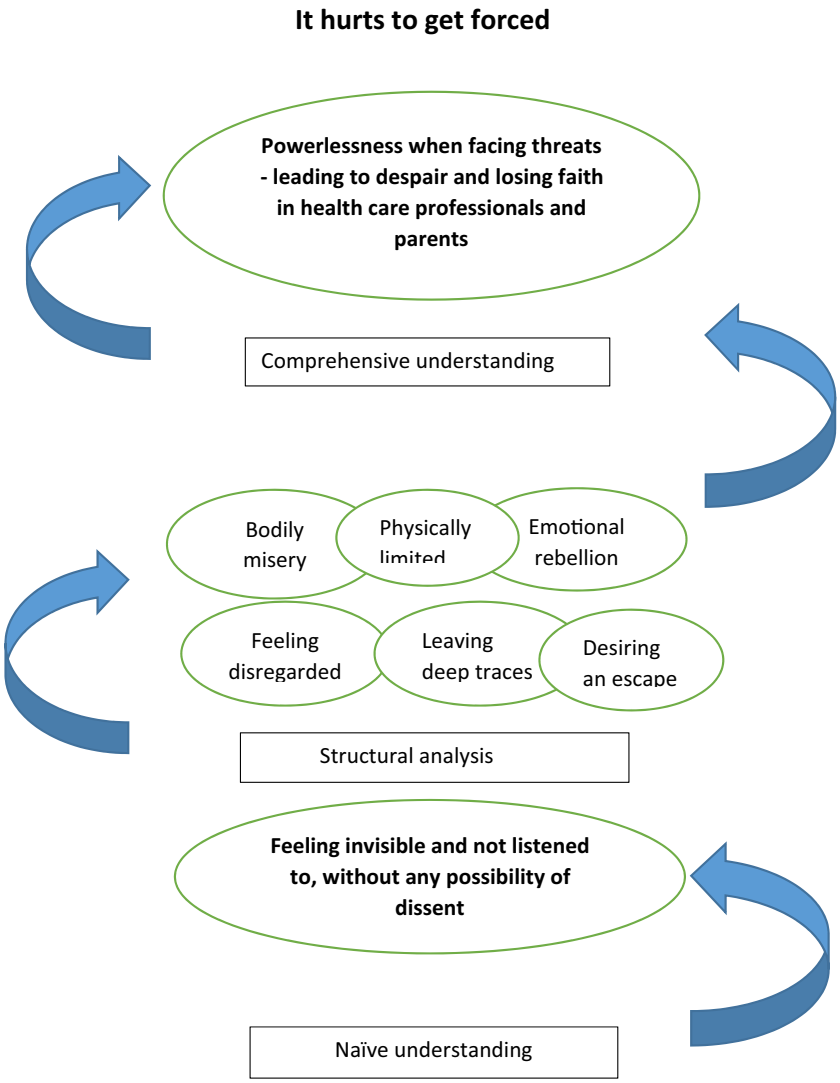


FIGURE 1 A dialectical movement between understanding and explaining.

### 3.4 | Emotional rebellion

Restraint manifested itself in emotional rebellion, fear, and panic: "I panicked when I was about to get it" (girl, 12 years old). Being restrained was described as "wrong", "stupid", "horrible", "strange", and "very nasty". It was understood as the worst experience of all, and as unthinkable and senseless. The participants told that they had been convinced that their parents would never allow them to be exposed to restraint in a healthcare setting; however, they had experienced it, and described either feeling emotionally blocked or having racing thoughts. Participants also reported about regression to younger age; a feeling of being small and thrown back into a similar situation earlier in life: "I kinda see my self sort of … kinda … I regress" (woman, 19 years old).

They described being very scared and crying before a procedure, feeling threatened and wanting to call for help, as well as screaming: "And then when I when I had done it then I started to cry … during yeah like a little bit … I also screamed when I was little actually … I remember that … and then I started to cry when they … when they were to … when they had not even put it on the finger" (girl, 10 years old).

Another reported reaction was anger and wanting to act aggressively: "Nah, I only get mad so I could punch things and so on" (girl, 11 years old). Furthermore, they described losing their joy in, and giving up the reward they had been promised after the procedure.

### 3.5 | Feeling disregarded

Being restrained was to be disregarded, not listened to: "It was like they were king and decided" (boy, 10 years old). Being restrained meant having nothing to say and not being allowed to be "the boss" of oneself and the situation. It meant feeling compelled to do what one did not want, and wanting to shout "QUIT". It meant not having a choice, not being able to say "no", and feeling as though the adults had already decided: "No I would like to decide that I could decide that they wouldn't hold me [looks up at the interviewer]" (boy, 6 years old). Feeling forced was described as having no influence at all, and sometimes not even the parent had any influence on the situation: "Mum sat next to me and looked shocked" (boy, 10 years old).

Not knowing what had been decided, and not receiving any warning or preparation for the procedure, also made them feel disregarded: "But one time it was mostly like this that we were to come here and eh … we were not … they had like not said anything about the tests or anything like that … and when we get there they go like blah blah blah and talked on and … and then all of a sudden yeah we probably need to do some tests today and then and then I go like really scared … like it is okay if they tell you before … then I think it is okay you know" (girl, 11 years old).

### 3.6 | Physically limited

Being restrained meant being physically limited. The situation of being restrictively held was described, and even that their parents helped hold them: "And mommy held me super hard" (girl, 10 years old). They narrated about being held against their will, sometimes by several adults at the same time: "It took many nurses + mummy to hold me when I had my first injection" (girl, 17 years old).

Feeling physically limited meant being stuck, unable to move one's legs because an adult was holding them very tightly. It could also mean feeling cramped and locked up or experiencing the threat of being trapped: "I remember that the nurses needed to put in a drip, but I didn't want to since I was afraid of the needle. So they held me and I started to panic I tried to wriggle free, but then they held me even tighter" (girl, 12 years old).

### 3.7 | Desiring escape

Being restrained evoked flight reactions: "No I crawled under chairs and tables for a long while before they caught me" (girl, 11 years old). Being held during the administration of anesthesia made escape impossible: "No, because they could hold me stuck like this [he demonstrates]" (boy, 7 years old). Their bodies told them to get out of there, as fast as possible, to run away quickly and go home. They had begged to be released but were not, and they were prevented from hiding or sneaking out through the door and running away: "I have to, like, I'm not allowed to run … then they … they will push me into a cage … and do it to me without mommy being there" (girl, 10 years old).

### 3.8 | Leaving deep traces

Being restrained turned out to leave deep scars. Memories remained for a long time and emerged in similar situations later in life, still frightening them: "Then they, like, held me so I couldn't move – that's why I don't like injections as well" (girl, 11 years old). Feeling forced was described as no longer wanting to go to the dentist even though one liked going there before, or as losing faith in a parent because

**TABLE 1** Findings for each step of the analysis

| Naïve understanding | Feeling invisible and not listened to, without any possibility of dissent | | | | | |
|---|---|---|---|---|---|---|
| Themes of structural analysis | Bodily misery | Emotional rebellion | Feeling disregarded | Physically limited | Desiring escape | Leaving deep traces |
| Comprehensive understanding | Powerlessness when facing threats – leading to despair and losing faith in healthcare professionals and parents | | | | | |

he/she had previously taken part in imposing restraint: "I don't remember so much what happened that day. I know they did it that way since they had no choice, but I still get chills every time I think back on that day" (girl, 12 years old).

### 3.9 | Comprehensive understanding

Based on the participants' narratives, the naïve understanding and the themes of structural analysis, it became clear that feeling forced hurts. The meaning of restraint was interpreted as "powerlessness when facing threats, leading to despair and loss of faith in the adults involved, healthcare professionals as well as parents" (see Table 1 and Figure 1). Powerlessness can be elucidated based on Foucault's analysis of power as interpreted by Hörnqvist.[36] He describes how the exercise of power includes both a certain degree of coercion and a certain form of voluntariness: coercion on the part of the superiors and a certain form of voluntariness on the part of the subordinates. Power is everywhere, and every social relationship is a power relationship. Power is not something one has in isolation; rather, power lies in the power relationship between one person and another or between one group and another, and is due to differences in social position, gender, age, knowledge, experience, etc. Strengths are structured in different ways and vary depending on whether the superiority depends on, for example, finances, physical strength, or institutional support. A balance of power may not completely determine what actions are to be performed, but each balance of power, however structured, affects to some extent what is done. Exercising one's dominance in a balance of power involves getting someone else to actively participate in the processes that consolidate their own subordination. Based on Foucault's ideas about power and power relations, children could be defined as subordinate when receiving healthcare.[36] However, the participating children did not convey voluntary subordination, but about trying to make their voices heard and offering resistance. The adults and the child were therefore on a collision course, in which the child was overpowered. This could be compared to the discouragement experienced, as described by Halldórsdóttir and Hamrin,[41] when uncaring is present and the healthcare professional is perceived as indifferent to the patient as a person.

## 4 | DISCUSSION

The findings showed that being restrained had a great impact on the studied children and young people, leaving them feeling powerless. They had lost faith in the adults involved in the healthcare procedure. This powerlessness was represented by feeling physically limited and by being held, against their will, by both caregivers and their parents; by fighting for one's life to get loose and by discovering that then more adults would come and hold one's arms, legs, and/or head. Although it is contrary to the obligation to protect the child and the child's rights,[1] restraint occurs in various healthcare procedures.[20,42–45]

The UNCRC[1] and the government of Sweden[46] are clear that all people have the right to physical integrity and protection against forced physical intervention. In a study by Lombart et al.,[20] the child's health and best interests were presented as justifications for restraint, which, from this perspective, may be seen as consistent with the UNCRC principle of the best interests of the child.[1] Here the child perspective is based on the adult view of what is best for the child. This means that the adult, aided by their own experiences and knowledge from their own upbringing, education, profession, family, etc., tries to understand the child's situation and judge what is best for the child.[47] However, from the child's perspective, the situation might have been evaluated differently. In the study by Lombart et al.,[20] the participating nurses were well aware that restraint is complicated ethically as well as in relation to legislation. It made them feel guilty. At the same time, they felt compelled to perform the procedure because it was part of their expertise and competence to perform prescribed procedures. Based on how Hörnqvist[36] interpreted Foucault's thoughts on power, the nurses' actions can be explained by the imbalance in the healthcare context, where professional knowledge and competence confer power. It is also possible that the nurses felt compelled to perform the prescribed examinations and treatment because they were subordinate to the physician.

Being held against their will during various procedures was found to cause agitation, anxiety, and stress in children.[42] Fear and anxiety are barriers to participation,[48] and a higher degree of participation increases children's consent to planned care.[49] When children are excluded and not involved, they begin to imagine things, become more isolated, and are left alone with their fears. Adopting a child's perspective increases the chances of being able to involve the child. With preparation and age-appropriate information, the child's conditions for participation and control over the situation increase.[45,50] The degree to which a child can be involved must be assessed by the person responsible for care and treatment in each individual case, which means that knowledge of the child's perspective and previous experiences is a prerequisite for the best possible care.[8,11] When children gain increased knowledge and control, the balance of power in the power relationship between the adult and child can also change, but it could also be the case that the child, in exchange for being involved, finds her/himself facing a certain degree of coercion to consent to planned care.[36]

The present results also showed that restraint and powerlessness created memories and deep scars that affected children for a long time, perhaps a lifetime. Restrictive holding of children during various healthcare procedures increases the risk of trauma, which makes it even more difficult to carry out procedures in the future.[26,45] Sørensen et al.[45] described an 11-year-old girl who after a bad experience developed severe needle phobia, refused recommended treatment and did not trust her mother to give her injections. Similar results emerged in this study, indicating that being restrained can result in healthcare avoidance later in life.[44]

Powerlessness meant feeling invisible and not listened to. Children need to be listened to and allowed to participate.[45] A prerequisite for feeling secure in the healthcare situation and for trusting healthcare professionals was described by children themselves as being seen as an individual, listened to, and taken seriously.[50] Likewise, in a study by Sahlberg,[8] nurses emphasized the importance of children feeling safe in the healthcare situation, but stated that time pressure affected the children's opportunities to speak. Under time pressure, the nurses perceived the parents as important in helping their children to communicate with the care staff. This became especially important when the children were afraid and unwilling to participate. When procedures still needed to be performed, the nurses said that it could be useful to hold the child.[8] Bray et al.[42] found that parents also saw restraint as something expected and acceptable. By not letting the child speak and express their perspective, the child's power over their own situation is diminished.[47] This consolidates the child's subordinate position in the power relationships between adult and child and between nurse and patient.[36] There is then the risk that the nurse might be perceived as indifferent to the child as a person[41]; parents observed this when healthcare professionals displayed an impersonal attitude toward their child when restraining them for a medical procedure,[51] leading to discouragement as the result of uncaring. If the nurse is instead perceived as genuinely concerned, the child would feel empowered.[41]

## 5 | LIMITATIONS

The phenomenological hermeneutical method of interpretation was able to help bring about awareness of alternative understandings of restraint, which is reported as commonly used in pediatric care. However, the transferability of the present findings is limited. First, the secondary analysis of qualitative data is subject to certain limitations,[40] and as some of the data analyzed were collected long ago, practices might have changed in favor of including children more in decision-making. When comparing the recently collected data with the earlier narrated experiences of feeling forced, however, the narratives confirmed each other. It seems likely that the meaning of feeling forced as it appears here can give insight into how children experience restraint in current practice, although more and deeper insight into the phenomenon is required. Second, the sample contained more girls than boys and was therefore not gender equal. Notably, however, one person's experience can never be said to be the same as another's, so the findings of qualitative research cannot be generalized.[28] Furthermore, according to Ricœur,[52] there is never only one meaning, and not just one probable interpretation, so the internal consistency and plausibility of the interpretation in relation to competing interpretations should be considered. For instance, Leibring and Anderzén-Carlsson[23] reported that children found restraint supportive when they were fearful in relation to their cancer treatment. Circumstances always influence how we experience a situation, and the fact that several participants in this study experienced fear related to medical procedures might have colored their experiences. Also, in two of the included studies, the participating children were offered cinema tickets for participation; this might have influenced their willingness to participate but was not deemed to have influenced *how* they described their experiences. Furthermore, the participants described feeling forced, as a part of their healthcare experiences although this was not specifically asked about.

Furthermore, the data sampling might have had impact on the data analyzed. In interviews, a story is created in interaction between the interviewer and the interviewee. The fact that the interviewer is involved in co-creating the story might therefore influence what is told. In written narratives, it is possible to tell stories without interference and produce an autonomous text.[28] However, since the short written narratives were anonymously collected, follow-up questions to gain clarification were impossible.

The present authors were all experienced in pediatric nursing but had varying levels of experience in qualitative analysis. This could be a limitation as well as a strength: being naïve when trying to understand another person's experiences might make one open minded, which, according to Lindseth and Norberg,[35] is desirable for analysis. Throughout the analysis, the research team had extensive discussions, returned repeatedly to the transcribed narrative, and reflected on their findings in relation to other research findings and theories, which, according to Lindseth and Norberg,[35] is necessary to broaden one's understanding of a phenomenon.

## 6 | CONCLUSION

This study highlights that children might experience hurt when being forced to undergo healthcare procedures and that being restrained might mean suffering in children, not just temporarily, but through long-lasting memories influencing their future healthcare contacts. Restraint meant powerlessness, hindering the children from taking part in decision-making about their own healthcare examinations and treatments. These findings call for action to support children's self-determination, participation, and integrity in healthcare. As research on how children experience restraint in healthcare is limited, the phenomenon merits further investigation with respect to children's own perspectives under different circumstances.

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