

The effect of psychoeducation given to psychiatry nurses on level of knowledge, attitudes, and practices regarding physical restraint: A randomized controlled study

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Abstract

Purpose: This study aims to determine the effect of psychoeducation, given to nurses working in a psychiatry clinic, on level of knowledge, attitudes, and practices regarding physical restraint.

Design and Methods: This study was conducted with a randomized-controlled-study design. A total of 111 nurses were recruited and randomly assigned to experimental (n = 53) and control (n = 58) groups. The experimental group received psychoeducation, while no intervention was applied to the control group. This study was conducted in a psychiatric hospital located in the Eastern Anatolia of Turkey. A Descriptive Form and the Levels of Knowledge, Attitudes, and Practices of Nurses Regarding Physical Restraints Questionnaire were used to collect data.

Findings: Statistically significant differences were found between the pretest and posttest total mean scores on the level of knowledge ($P = .000$), attitudes ($P = .000$), and practices ($P = .000$) of the nurses in the control group and the study group.

Practice Implications: An increase in the level of knowledge and positive improvement in attitudes and practices were observed in the nurses who received psychoeducation. Providing nurses with psychoeducation on physical restraint can positively contribute to improving their level of knowledge and to eliminating their negative attitudes and practices on this subject.

KEYWORDS

attitude, knowledge, nurse, physical, professional practice, psychiatric nursing, restraint

1 | INTRODUCTION

For patients suffering from chronic mental disorders, there are many methods available to control their risky behaviors and to provide for their security and the security of staff, including isolation, mechanical restraint, chemical restraint, and physical restraint.¹⁻³ One of these methods, physical restraint, is applied to prevent an individual's freedom of movement by fastening a physical or mechanical device onto an individual against their.^{4,5} Although the negative physical and psychosocial effects of physical restraints have been well-documented, they still continue to be

widely used.⁶ The frequency use of physical restraint in psychiatry clinics in England, China, Australia, and Turkey is 12%, 51.3%, 31%, and 23.9%, respectively. Physical restraint methods vary from one country to another.⁷⁻¹⁰ According to the regulations set by the Ministry of Health in Turkey, physical restraint can only be applied upon order of a physician, informed consent must be obtained by the patients and their relatives, and the period for which the patient may remain in the restraint is limited to 24 hours. Studies conducted in Turkey have, however, found that nurses applied physical restraint without first obtaining approval by a physician and that they experienced problems during applications.¹¹⁻¹³

Physical restraint is generally used to prevent patients from harming themselves and the people around them and to calm the patient.¹⁴ A study by Okanlı et al,¹⁵ reported that 85% of the nurses used physical restraint to prevent aggressive behaviors of patients. Although physical restraint is considered to be for the sake of patients, it can cause many physiological and psychological complications, including blood circulation impairment, aspiration, difficulty in breathing, physical injury, humiliation, anger, and even death.^{14,16} The use of physical restraint continues to be a controversial ethical issue, as it negatively affects a patient's autonomy and respectability. A study by Okanlı et al,¹⁵ showed that 39.5% of psychiatry patients felt very sad and felt as if they were being punished, and 80.6% stated that their needs were not met during restraint. Physical restraint not only negatively affects patients, but nurses as well. A study by Çelik et al,¹⁷ found that nurses experienced an ethical dilemma and felt sad, guilty, distress, discomfort and ashamed when they had to apply this method of restraint.

The fundamental responsibility of health personnel is to protect and improve the health and security of the patient for whose care and treatment they are responsible. To this end, psychiatry nurses play a key role in terms of applying physical restraint and preventing complications. In general, in-service trainings are given to psychiatric nurses for physical restraint. Although many trainings have been regulated for nurses many of the studies carried out in Turkey and around the world have shown that nurses' level of knowledge regarding the application of physical restraint and its complications was low and that they experienced ethical problems when applying it.¹⁶⁻¹⁸ A study performed in 2016 found that psychiatry nurses' level of knowledge of physical restraint was low, and the implementations of physical restraint were negative.¹⁵ Positive interpersonal interaction and good communication were recognized as preventative approaches in avoiding restraint. The perception of patients by health personnel (perceiving patients as dangerous, aggressive, difficult to deal with) affects the use of physical restraint. The health personnel, who are faced with an aggressive, dangerous patient, feel fear and threat. This prevents health personnel from finding alternative ways other than physical restraint. In the studies conducted, it is suggested to increase the ability of nurses to communicate effectively with the patient and to develop empathy ability in reducing physical detection.^{5,19} The researchers have prepared a psychoeducation program that includes the effects of physical restraint use on the patient and health personnel, anger-violence management, empathy, and therapeutic communication techniques.

This study aims to determine the effect of psychoeducation given to nurses working in psychiatric hospitals on the knowledge level, attitudes, and practices regarding physical restraint.

The following hypotheses were developed for the study.

H1 *Psychoeducation given to nurses working in psychiatry clinics increases their knowledge level regarding physical restraint.*

H2 *Psychoeducation given to nurses working in psychiatry clinics effects attitudes positively towards physical restraint.*

H3 *Psychoeducation given to nurses working in psychiatry clinics positive development the practices of physical restraint.*

2 | METHODS

2.1 | Design

A randomized-controlled study design was used for this study.

2.2 | Participants

Participants met the following exclusion criteria; had not been working in a psychiatry clinic for at least 6 months, had not applied physical restraint at least once and who not agreed to participate in the study. This study was conducted in a psychiatric hospital located in the Eastern Anatolia of Turkey (Elazığ Mental Health and Diseases Hospital) between March 2017 and May 2018. The study was conducted in one of the eight active Mental Health and Diseases Hospital in Turkey. The hospital was selected randomly considering its socioeconomic level, closeness to the city center, and the number of psychiatric nurses that were registered in that hospital. The hospital is located in a large area. There are 12 clinics in total. It serves patients in 18 provinces. Clinics are positioned as a separate building.

2.2.1 | Sample size

To identify nurses who were experiencing physical restraint, the researchers contacted 250 of the 278 nurses working in the psychiatric hospital. During the interviews, 200 nurses were identified as experiencing physical restraint. Of these, 50 nurses met the exclusion criteria. Thus, 150 nurses were included in our study sample. The sample size included minimal 106 (53 experimental, 53 control) with a statistical power of 90%, and confidence interval of 0.95 using the data of Bowers et al,¹⁹ with the PASS 11 program. The study sample was composed of a total of 126 patients (63 control and 63 experimental groups) who met the eligibility criteria. However, for various reasons (pregnancy, holiday, not complete test etc.) during the application process, 15 participants left the control and experimental group. The study was completed with 111 nurses (53 in the experimental group and 58 in the control group; Figure 1).

2.2.2 | Randomization

There are 12 psychiatric clinics in a psychiatric hospital. To have homogeneous control and experimental groups in the study, a table was prepared with the names of clinics and numbered from 1 to 12 assigned to a group using a random table of numbers. The numbers were written on opaque cards and selected by a foreigner. Single-numbered clinics were the control group and double numbered clinics were determined as experimental group. The nurses working in six psychiatry clinics were the

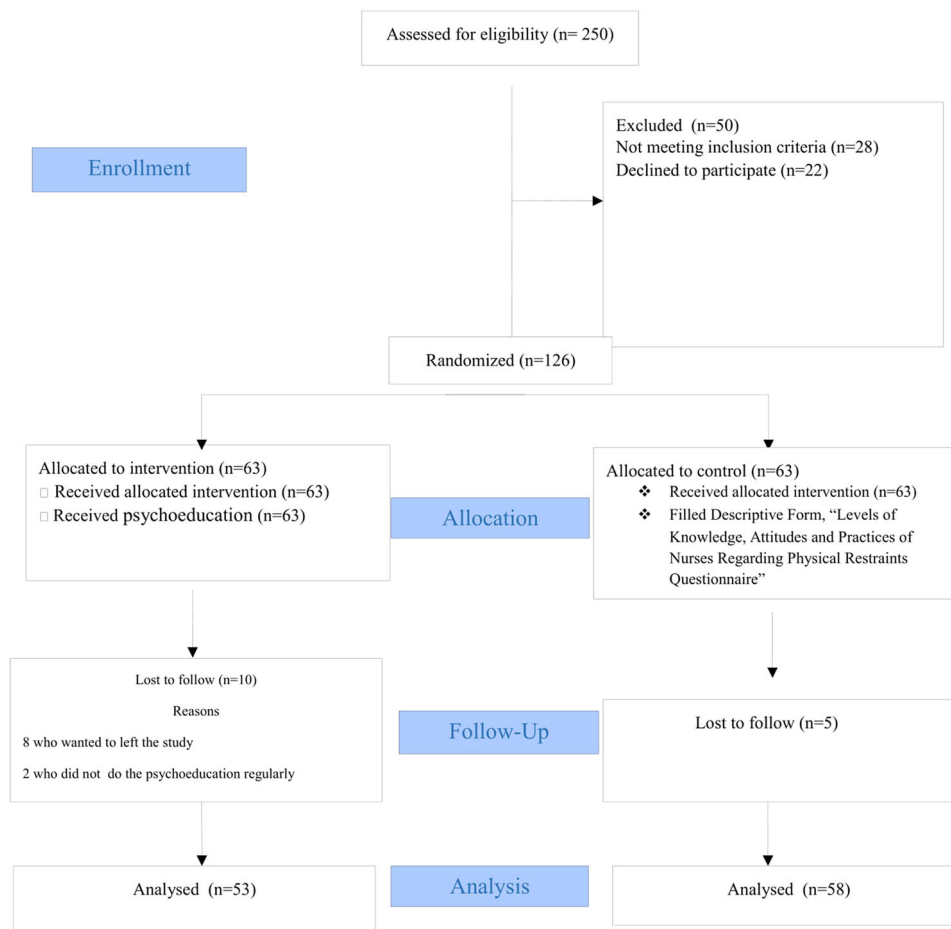


FIGURE 1 Consort flow diagram of eligibility and enrolment study participants [Color figure can be viewed at wileyonlinelibrary.com]

control group, and the nurses working in six psychiatry clinics formed the experimental group. Listed and numbered names of nurses in the control and experimental group. And then selected with using a computer-aided simple random sampling method. Psychiatry clinics are located in different buildings and away from each other within the hospital. Nurses in the clinic do not go outside the clinic, including food. Therefore, it is not possible for the nurses to share with each other and nurses in the control and experimental group to be affected from each other.

2.3 | Measures

A Descriptive Form and the Levels of Knowledge, Attitudes, and Practices of Nurses Regarding Physical Restraints Questionnaire were used to collect data.

2.3.1 | Descriptive form

The descriptive form included five questions regarding the socio-demographical characteristics of the nurses (eg age, gender, level of education, marital status, and a number of years employed).

2.3.2 | Levels of knowledge, attitudes, and practices of nurses regarding physical restraints questionnaire

This scale was prepared by Janelli et al²⁰ and developed by Suen LKP. The Turkish validity and reliability study of the questionnaire was carried out by Kaya et al.¹² The scale consists of three subscales: knowledge level, attitudes, and practices. Scores on the subscales of knowledge, attitudes, and practices vary between 0 to 11, 12 to 48 and 14 to 42, respectively. The Cronbach's alpha coefficient for the original scale total score's ranges between 0.88 and 0.90. For the present study, the Cronbach's alpha internal consistency coefficient was found to be 0.89.

2.4 | Data collection

The data (pretest) were collected Descriptive Form, and Levels of Knowledge, Attitudes, and Practices of Nurses Regarding Physical Restraints Questionnaire to the control group and the experimental group. Upon completion of the applications, Levels of Knowledge, Attitudes, and Practices of Nurses Regarding Physical Restraints Questionnaire' was applied again to the control group and the experimental group in the posttest. The data (pretest-posttest) were

collected by the fourth researcher through face to face interviews. It took approximately 20 minutes for the nurses to complete the forms.

2.5 | Nursing intervention

2.5.1 | Psychoeducation

Psychoeducation is a term used for describing cognitive, behavioral, and psychosocial treatment approaches. It aims to provide information and support and to introduce coping skills. It covers all processes applied to develop targeted behaviors in individuals.⁵ Furthermore, psychoeducation focuses on individual strengths, concentrating on the present and future, instead of on the past. Psychoeducation programs are presented in a variety of formats and can be offered for an hour or a day, or on a weekly, monthly or annual basis.^{5,21} Primary, secondary, and tertiary preventive health care services can be administered psychoeducation. Coping with stress, strengthening interfamily processes, and raising awareness about social problems are among the primary preventions targeted by psychoeducation.^{5,22} Secondary prevention includes determination of the problem, helping to reach a solution to the problem, and providing support, while tertiary prevention includes acquiring better coping skills and rehabilitation to overcome problems.^{22,23} Psychoeducation can also be performed to develop emotional support, change negative attitudes and beliefs, explain opinions about a topic, improve problem-solving skills, and deal with a crisis.

2.5.2 | Experimental group

Psychoeducation was applied to the experimental group for once a week for 6 weeks (12 sessions) with group-based sessions. No other psychoeducation with similar content (individual or group) was offered to the participants of this study during the research. The experimental group was provided with group psychoeducation for 6 weeks. The psychoeducation program was based on specifically prepared to address the level of knowledge, attitudes, and practices regarding physical restraint use of the nurses. In addition, psychoeducation includes the effects of use of physical restraint on patient and health personnel, anger-violence management, empathy, and therapeutic communication techniques.

The training was conducted by the fourth researcher in the education room in the hospital with group-based sessions. Each week, two 40 to 45 minutes sessions were organized. Details of the sessions constituting the psychoeducation program applied to the experimental group were as follows.

2.5.3 | Session 1,2

After meeting the nurses, information about the research was provided. The researchers then administered the pretest and answered the nurses' questions. Next, the nurses were instructed on the different therapeutic communication techniques, and videos and role-play were used to demonstrate effective communication techniques used in patient-nurse communication.

2.5.4 | Session 3,4

Practice procedures for physical restraint, on whom it can be applied, and the physical and mental effects of the practice on patients were presented according to the regulations put forth by the Ministry of Health. Following the instruction, any questions the nurses had were answered.

2.5.5 | Session 5,6

The experiences nurses had with patients during physical restraint applications were discussed. Methods other than physical restraint were identified, and the issues to consider and how to provide care to patients during physical restraint were explained.

2.5.6 | Session 7,8

Nurses were shown videos explaining how to use empathy to better understand patients. Stress management methods were presented in a practical manner. For repetition, the nurses were assigned homework related to the material presented.

2.5.7 | Session 9,10

Anger management methods were presented to the nurses via videos and practical instruction. For repetition, the nurses were assigned homework related to the material presented.

2.5.8 | Session 11,12

The nurses provided their feedback about the effectiveness of the education program. Previous and newly learned information was compared and discussed through a question/answer session. After administering a posttest to the participating nurses, they were given booklets related to psychoeducation.

2.5.9 | Control group

No intervention was applied to the control group. No other psychoeducation with similar content (individual or group) was offered to the participants of this study during the research.

2.6 | Data analyze

The SPSS 22.0 software package was used to assess the data. Regarding the assessment of the data, percentage, arithmetic mean, and standard deviation were used for distributions of participants in the experimental and control groups based on their descriptive characteristics, the chi-square test was used to compare control variables among in the control and experimental groups. While dependent-samples *t* test was conducted to compare the pre- and posttest mean scores of the scale, the independent-samples *t* test was used for comparison of mean scores of the scale among patients in the control and experimental groups, the

analysis will help prove the hypothesis regarding the efficiency of this training in both groups. The strength of association was expressed as odds ratios with 95% confidence interval. Cronbach's alpha was used to assess the internal consistency of the scales. The level of significance was set at $P < .05$.

2.7 | Ethical considerations

Legal permission was obtained from the Ethics Committee of University Health Sciences to carry out the study on January 17th, 2017 (IRB: 2017/2-8; Clinical Trial Acknowledgement Number is: REF/2019/03/024706). Participating nurses were informed about the aim of the study, and any questions they had regarding the study were answered. Furthermore, the nurses were informed that their personal information would be kept confidential and not be used for any other purposes than those directly related to the study and that they had the right to withdraw from the study at any time they wished.

In compliance with the ethical principles of Informed Approval Form, Volunteering and Confidentiality regarding the protection of individual rights, an informed consent form confirming the participants' voluntary participation and the promise to keep all data collected from them confidential was received from all participants. Following the research, the participants constituting the control group were given an educational booklet.

3 | RESULTS

3.1 | Comparison of control and experimental group in terms of descriptive characteristics

Of the nurses in the control group, 42% (24) were between the ages of 26 and 33, 72.0% (42) were female, 64.0% (37) had completed a license program, 79.0% (46) were married, 53.0% (31) had been working for 12 to 17 years. Of the nurses in the experimental group, 40% (21) were between the ages of 26 and 33, 70.0% (37) were female, 64.0% (34) had completed a license program, 79.0% (42) were married, 52.0% (28) had been working for 12 to 17 years. The control and experimental group nurses were homogeneous in terms of descriptive characteristics ($P > .05$, Table 1).

3.2 | Comparison of pretest and posttest scores on the level of knowledge, attitudes, and practices regarding physical restraint in the control group

The control group's pretest total mean score on the *Level of Knowledge Regarding the Use of Physical Restraint* subscale of the questionnaire was 6.67 ± 1.26 , while their posttest mean score was 6.67 ± 1.08 , the results of which indicated no statistically significant difference between them ($P = .113$). The level of knowledge of the control group nurses regarding physical restraint was found to be moderate. Among the nurses, 87% stated that physical restraint must

TABLE 1 Characteristics of the participants (n = 116)

Variable	Control group		Experimental group		Test value and P
	n (58)	%	n (53)	%	
Age groups					
18-25	7	12.0	8	15.0	$X^2 = 1.682$ $P = .142$
26-33	24	42.0	21	40.0	
34-41	20	33.0	17	32.0	
42-49	4	7.0	5	9.0	
50-57	3	6.0	2	4.0	
Gender					
Male	16	28.0	16	30.0	$X^2 = 1.336$ $P = .288$
Female	42	72.0	37	70.0	
Educational level					
High School	13	23.0	11	21.0	$X^2 = 2.382$ $P = .334$
License program	37	64.0	34	64.0	
License program and above	8	13.0	8	15.0	
Marital status					
Married	46	79.0	42	79.0	$X^2 = 1.782$ $P = .171$
Single	12	21.0	11	21.0	
Working year in psychiatric clinic					
0-5, y	10	17.0	10	19.0	$X^2 = 2.317$ $P = .137$
6-11, y	17	30.0	15	29.0	
12-17, y	31	53.0	28	52.0	

be performed by professionals, 95% stated that informed approval must be received from families, 97% stated that restraint must be loosened once every 2 hours, and 96% stated that type, time and reason for use of restraint must be noted by the nurse (Table 2).

The control group's pretest total mean score on the *Attitudes Regarding the Use of Physical Restraint* subscale was 28.35 ± 3.62 , while their posttest mean score was 28.40 ± 4.08 , the results of which indicated no significant difference between them ($P = .720$). Of the nurses in the control group, 65% stated that the family of the patient had the right to object to the use of restraint, 40% felt guilty when applying restraint, 81% said that patients suffered disorientation from the restraint, and 70% stated increased choking risk in patients who were placed under restraint.

The control group's pretest total mean score on the *Practices Regarding the Use of Physical Restraint* subscale was 22.05 ± 1.52 , while their posttest mean score was 23.00 ± 2.17 , the results of which indicated no significant difference between them ($P = .632$). The control group nurses' practices regarding physical restraint were found to be moderate. Of the nurses in the control group, 91% had attempted different initiatives before settling on physical restraint, 95% had checked patients once every 2 hours to see if they were in the right position, 95% explained to the patient why they used restraint, 90% told the patient when the restraint would be removed, and 92% frequently checked whether the restraint had opened.

According to the intragroup comparison of the scale mean score of nurses in the control group, a statistically significant difference was not found among the pretest and posttest ($P > .05$). The scale total and subscales mean score did not change as significantly in the control group.

3.3 | Comparison of pretest and posttest scores on the level of knowledge, attitudes and practices regarding physical restraint in the experimental group

The experimental group's pretest total mean score on the *Level of Knowledge Regarding Physical Restraint* subscale was 6.98 ± 2.03 , while their posttest mean score was 9.24 ± 1.56 , the results of which indicated a statistically significant difference between them ($P < .05$). In other words, the level of knowledge of the nurses in the

experimental group had increased according to their posttest scores. Of the nurses in the experimental group, 85% stated in the pretest that restraint must be applied by professionals, while this rate rose to 95% of the nurses in the posttest; 50% stated in the pretest that patients had the right to object to the use of restraint, while this rate rose to 70% in the posttest; and finally, 70% stated in the pretest that restraint could result in the death of the patient, while this rate rose to 90% in the posttest (Table 2).

The experimental group's pretest total mean score on the *Attitudes Regarding Physical Restraint* subscale was 27.02 ± 2.13 , while their posttest total mean score was 32.09 ± 1.23 , the results of which indicated a statistically significant difference between them ($P < .05$). Of the nurses in the study group, 20% stated in the pretest that family members had the right to reject the use of restraint, while this rate rose to 55% in the posttest; 40% expressed in the pretest that they felt guilty when applying restraint, and this rate remained the same (55%) in the posttest; and finally, 80% stated that patients suffered disorientation from the restraint, and this rate increased to 90% in the posttest.

The experimental group's pretest total mean score on *Practices Regarding Physical Restraint* subscale was 21.56 ± 1.67 , while their posttest total mean score was 30.09 ± 3.49 , the results of which indicated a statistically significant difference between them ($P < .001$). In other words, the practices of the nurses in the experimental group underwent positive development from the pretest to the posttest. Of the nurses in the experimental group, 81% reported in the pretest that they used different methods before applying restraint, while this rate rose to 90% in the posttest; 70% reported in the pretest that they applied restraint only after being charged to do so by a physician, while this rate increased to 90% in the posttest; 90% stated in the pretest that they explained to the patient why they applied physical restraint, while this rate rose to 97% in the posttest; 90% reported in the pretest that they informed the patient about when the physical restraint would be removed, while this rate increased to 95% in the posttest; and finally, 95% stated in the pretest that they frequently checked to see whether the restraint had opened, but this rate dropped to 75% in the posttest (Table 2).

According to the intragroup comparison of the scale mean score of nurses in the study group, a statistically significant difference was

TABLE 2 Pretest and posttest scores of the control group and experimental group on level of knowledge, attitudes, and practices regarding physical restraint use

	Level of knowledge (0-11)		Attitudes (12-48)		Practices (14-42)	
	Pretest	Posttest	Pretest	Posttest	Pretest	Posttest
Control group	6.67 ± 1.26	6.67 ± 1.08	28.35 ± 3.62	28.40 ± 4.08	22.05 ± 1.52	23.00 ± 2.17
Test value	$T = 0.126$		$T = 1.237$		$T = 0.895$	
P value	.113		.720		.632	
Experimental group	6.98 ± 2.03	9.24 ± 1.56	27.02 ± 2.13	32.09 ± 1.23	21.56 ± 1.67	30.09 ± 3.49
Test value	$T = 2.003$		$T = 1.234$		$T = 0.651$	
P value	.001*		.000*		.003*	

*The significance level was accepted as $P < .05$.

found among the pretest and posttest. ($P < .05$). The scale total and subscales mean score changed at the end of psychoeducation as significantly in the experimental group.

3.4 | Comparison of pretest and posttest scores on the level of knowledge, attitudes, and practices regarding physical restraint in the control and experimental group

No statistically significant difference was found between the pretest total mean score of the nurses in the control and experimental groups on their levels of knowledge ($P = .081$), attitudes ($P = .145$), and practices ($P = .320$) subscales of the questionnaire.

A statistically significant difference was, however, found in the posttest total mean scores of the control group and the experimental group on the level of knowledge ($P = .000$), attitudes ($P = .000$), and practices ($P = .000$) subscales. The level of knowledge regarding physical restraint of the nurses in the experimental group increased more than that of the nurses in the control group, and the attitudes and practices of the nurses in the experimental group were observed to have developed in a positive manner (Table 3).

4 | DISCUSSION

This study was conducted to determine the effect of psychoeducation given to nurses working in psychiatry clinics on the level of knowledge, attitudes, and practices regarding the use of physical restraint are discussed in line with the literature.

In the comparison between the experimental group and the control group in this study, the difference between the mean scale scores in posttest was found to be significant. The experimental group's mean scale and subscales scores in the posttest were found to increase significantly in relation to the control group. According to the comparison with the mean pretest-posttest scores in the intragroup comparisons, a significant difference was found between the experimental group's scale and the subscales mean scores. The results supported our hypotheses that psychoeducation given to nurses working in psychiatry clinics increases their knowledge level regarding physical restraint, effects attitudes negatively contribute to improving the practices of physical restraint. Nurses knowledge about restraint and their underlying attitudes toward physical

restraint use should be identified because knowledge and attitudes can affect practices.

An increase in knowledge in the posttest, as compared to the pretest, was observed in their statements indicating that they understood that physical restraint must be applied by physicians, patients have the right to object to physical restraint, and restraints can cause problems. Psychoeducation programs that instruct nurses on the application rules governing physical restraint, complications that may occur in patients, and subjects related to the ethical dimensions of physical restraint application can positively contribute to improving the level of knowledge of nurses. A study by Blair et al,²¹ stated that staff education is effective in decreasing physical restraint. In a systematic review conducted by Goulet et al,²² it was reported that psychoeducation provided positively affect the application and decrease the frequency of physical restraint applications. Wilson et al,⁵ stated that nurses can decrease their physical restraint practices by increasing their positive communication with the patient, empathizing and changing the physical environment.

An increase in attitude was indicated by the experimental group nurses' statements citing that family members had the right to reject restraint, that the nurses felt guilty when applying restraint, and patients suffered from disorientation after restraint. Wilson et al,⁵ emphasized that physical determination of patients and nurses had a negative effect on the mental health of the patients and the nurses wanted to reduce the physical detection. A study by Kaya et al,¹² conducted with nurses found similar sentiments. These results can be attributed to the fact that the psychoeducation program provided nurses the opportunity to relate their experiences using physical restraint, offering positive recommendations regarding these experiences, and taught them how to cope with stress, anger management methods, and empathy. According to Ye et al,²³ the education provided to staff working in a psychiatric clinic was effective in terms of decreasing physical restraint frequency and complications related to restraint Eskandari and Abdullah implementing an educational program which can influence the knowledge and attitude of nurses can minimize the use of physical restraint in hospitals.⁴

An increase in practices was indicated by the experimental group nurses' statements citing that before applying physical restraint, different methods should be tried, restraint can only be applied after obtaining permission from a physician, patients must be told why physical restraint is being used and when the physical restraint would

TABLE 3 Comparison of pretest and posttest scores of the nurses in the control group and experimental group on level of knowledge, attitudes, and practices regarding physical restraint

	Level of knowledge		Attitudes		Practices	
	Pretest	Posttest	Pretest	Posttest	Practice	Posttest
Control group	6.67 ± 1.26	6.67 ± 1.08	28.35 ± 3.62	28.02 ± 4.08	22.05 ± 1.52	22.00 ± 2.17
Experimental group	6.98 ± 2.03	9.24 ± 1.56	27.02 ± 2.13	32.09 ± 1.23	21.56 ± 1.67	30.09 ± 3.49
Test value	$T = 1.102$	$T = 0.987$	$T = 0.536$	$T = 1.205$	$T = 2.105$	$T = 0.784$
P value	.081*	.000*	.145*	.000*	.320*	.000*

*The significance level was accepted as $P < .05$.

be removed, and frequent checks of whether the restraint is opened must be made. These results confirm the efficacy of psychoeducation on the use of physical restraint. According to a study by Huang et al,²⁴ the nurses were more likely to apply alternative methods to that of a physical restraint (communication therapeutic environment) as their level of knowledge increased, and their attitudes toward restraint underwent a positive change, which had a positive effect on their practices. In fact, many alternatives can be considered before using restraints, such as improving the ward environment, providing light music to ease the patients' anxiety, providing companionship and supervision, evaluating the effects of sedatives and analgesics in a timely manner and meeting patients' reasonable demands.²⁵ Educators and/or head nurses should introduce alternatives to the nursing staff and encourage the use of these alternatives; doing so may help improve the nurses' attitudes regarding physical restraint. The greater the nurses' knowledge, the more positive the attitude and the better the practice would be. Bowers et al,¹⁹ found that nurses had important duties in decreasing physical restraint practice, nurses could have effective communication with patients, get empathy training and develop positive relationships with patients and develop alternative methods other than physical restraint.

5 | LIMITATIONS

The psychoeducation program was provided only for a limited period of time. In addition, the posttests evaluation was conducted only once and the long term effects of education were not assessed.

6 | CONCLUSION AND SUGGESTIONS

No significant differences were observed in the level of knowledge, attitudes, and practices regarding the use of physical restraint in the control group, whereas, for the experimental group, which was provided psychoeducation, their level of knowledge increased and their attitude and practices regarding the use of physical restraint underwent positive improvements.

IMPLICATIONS FOR PRACTICE

The application of physical restraint is universally fear and anxiety for patients. Practices to reduce physical restraint are a universal goal. In many countries, psychiatric nurses are provided with training to reduce physical restraint practices. What makes our work different from other training is not only to reduce the physical restraint practice, but also to use therapeutic communication techniques, empathy, and anger-violence control. Psychoeducation used in this study will be useful in larger sample groups and for longer-term implementation.

Our study highlights the fact that the psychoeducation applied in this study has been shown to be beneficial in terms of increasing the

knowledge levels of nurses on the use of physical restraint and of improving negative attitudes and improper practices. Moreover, the psychoeducation applied in this study can serve as a reliable guide for psychiatry nurses in other countries.

RELEVANCE STATEMENT

The application of physical restraint to psychiatric patients is decreasing thanks to the training given to nurses. Psychoeducation given to psychiatric nurses leads patients to feel better and to make patients less hurt by practicing physical restraint.

CONFLICT OF INTERESTS

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

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