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Original article

Attitudes of psychiatric nurses toward restraint interventions in Italian mental health care: Implications for clinical practice

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Abstract. *Background and aim:* The practice of restraint raises a wide range of issues, including technical, clinical, organizational, deontological, ethical, legal, and medico-legal concerns. Clinical practice and numerous studies on the subject suggest that, in general, physical restraint is not effective for the main reasons it is applied. This study aimed to assess nurses' knowledge and training levels regarding the application of restraint tools. *Methods:* An observational, cross-sectional study was conducted among nurses working in mental health facilities using an online questionnaire. The questionnaire, specifically designed for this study, included five main sections: socio-demographic data, attitudes toward physical restraint, and de-escalation approaches among psychiatric nurses. *Results:* A total of 268 psychiatric nurses participated. Most had over six years of experience in mental health, and 80% had received training on physical restraint, primarily during their nursing degree and through post-graduate updates. Conflicting opinions emerged regarding physical restraints as safe tools for preventing skin injuries and the risks associated with their use. Nurses working in 24-hour facilities were more likely to disagree with restraint practices (36.9%), also advocating for constraints to ensure legal protection for both the nurse and the patient. *Conclusions:* Implementing educational programs for healthcare personnel is imperative. These programs should focus on equipping nurses with strategies to minimize the use of restraint and effectively adapt to the anticipated changes in contemporary psychiatry.

Key words: attitude, health, nursing, restraint

Introduction

Violence in the workplace has consistently been a global problem affecting all countries. The true extent of this issue remains unknown, with collected data often representing just the tip of the iceberg. The National Institute for Occupational Safety and Health (NIOSH) defines occupational violence as

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"any physical assault, threatening behavior, or verbal abuse experienced in the workplace" (1). Psychomotor agitation and violent behaviors are common in psychiatric emergencies and mental health departments. To address potential episodes of violence by psychiatric patients, physical restraint practices are frequently employed (2,3). Physical restraint can be defined as a coercive procedure intended to limit the patient's movements to prevent harm to themselves or others, while maintaining necessary treatment and ensuring safety (4). Approximately forty years after the Basaglia Law of 1978—legislation that revolutionized the Italian psychiatric care system by closing large psychiatric hospitals and promoting community-based mental health services (5), the ongoing reliance on physical restraint remains one of the most controversial aspects of contemporary psychiatry (6). The historical evolution of psychiatry highlights a shift in the understanding of mental illness, which has influenced therapeutic approaches. However, to date, there is no consensus on the use of restraint in managing individuals with mental illness (7). Physical restraint is often seen as a remnant of the institutionalized mental hospital culture, associated with a range of negative psychological and physical outcomes. These include long-term effects for those subjected to it, not only in psychiatric settings but also in general healthcare facilities, such as hospitals and residential care homes for the elderly (8). The practice of restraint raises numerous technical, clinical, organizational, ethical, legal, and medico-legal concerns (9). Clinical evidence and extensive research indicate that physical restraint is generally ineffective for the primary purposes it is applied (10). The potential consequences of its use are well-documented in the literature (11,12), with some studies showing significant risks to the patient's quality of life that discourage its application (13). In the United States, research conducted among hospitalized patients and residents in assisted living facilities revealed physical and psychological trauma, including depression, social isolation, functional decline, muscle atrophy, and even fatalities caused by asphyxiation or strangulation. Healthcare workers also reported injuries, such as fractures and eye trauma (14). Another study highlighted the deaths of 26 patients during restraint in Monaco due to issues like strangulation, chest compression, inadequate supervision, and improper use of devices (15). Case reports on patients with mental disorders have also underscored the risk of death from asphyxia when patients are restrained in a prone position (16). Recent studies have identified additional complications observed by nurses in restrained patients, including bruises, edema, pain at restraint sites, fatigue, agitation, anger, thrombosis, and in severe cases, death (17). In addition to these risks, the use of such practices might lead to prolongation of hospitalization times and to potential psychosocial dysfunctions (17). It has been noted that therapeutic relationships could be adversely affected by restrictive interventions as the latter distracted patients from seeking further treatment, thus increasing the risk of non-adherence (18). A study conducted in Australia on detained psychiatric patients and their family's described restraint as a dehumanizing practice that undermines recovery and violates human rights, even when used to manage risks. Participants also reported a lack of interaction and communication between staff and patients (19). Similarly, a study exploring the experiences of inpatients and mental health staff portrayed restraint as a distressing, frightening, and dehumanizing practice. Patients felt a loss of control, while staff experienced reduced job satisfaction (20). However, a common sentiment was that restraint is a "necessary evil" when used as a last resort to ensure safety, highlighting a tension between the desire to minimize restraint and concerns about safety (20). Restraints are also ineffective in preventing behavioral disorders and falls, as shown in studies conducted among elderly residents in semi-residential facilities. These studies indicated an increased risk of falls and fractures in restrained individuals (21). Moreover, as a coercive act against the individual's will, physical restraints violate key ethical principles such as autonomy and undermine constitutional rights safeguarding human freedom and dignity, raising ethical and legal concerns. These issues strongly question the therapeutic value of restraint, prompting widespread efforts to seek alternatives. In 2010, Italy implemented national recommendations to reduce mechanical restraint, leading to a documented decline in its use. For instance, in Emilia-Romagna, restraint

episodes decreased by 62% between 2011 and 2016 (22). A review of the literature emphasizes that adequate and specific training for mental health personnel can enable timely interventions and better management of aggressive behaviors (23). There is a need to hypothesize qualitative improvements for risk situations and to update nurses' professional skills through targeted training programs. Such programs should introduce effective patient management strategies while enhancing communication skills and providing psychological support (24). They should also aim to increase healthcare workers' awareness of their own reactions and emotions when facing violence risks (25,26). Training not only prepares healthcare professionals to handle dangerous situations effectively but also instills confidence in their ability to manage such scenarios (27,28). Studies suggest that education can increase moral sensitivity among psychiatric nurses (29).

De-escalation

The reality of health facilities necessitates the development and implementation of non-coercive intervention strategies as alternatives to traditional methods. The management of patients exhibiting aggressive behavior should prioritize less coercive measures, with physical restraint used strictly as a last resort, only after other methods have failed. Typically, the "cycle of aggression" includes the following phases: trigger, escalation, crisis, recovery, and depression (30). De-escalation refers to a set of non-invasive interventions designed to interrupt the cycle of aggression during the escalation phase. Its purpose is to defuse anger, prevent aggression, and manage violence effectively. A recent conceptual analysis defined de-escalation as "a range of intertwined components provided by staff, including communication, self-regulation, evaluation, actions, and safety maintenance, aimed at extinguishing or reducing aggression/agitation regardless of its cause, while improving the staff-patient relationship by minimizing or eliminating coercion and restriction" (31). The UK National Collaborating Centre for Mental Health (32) identified de-escalation as the primary technique for reducing violence and aggression, thus preventing the need for restrictive interventions. Numerous studies have supported the effectiveness of de-escalation techniques. These studies emphasize the importance of clearly explaining to patients the expected behaviors, their rights, the objectives to be achieved, and the medications to be taken (33). Various approaches to de-escalation have been proposed. For instance, sensory modulation techniques have been suggested as a method to de-escalate and prevent restraint and seclusion, resulting in a 38% reduction in the use of physical restraints and a 46% decrease in the need for forced medication (34). In summary, adequate staff training in managing agitated psychiatric patients, with a focus on verbal de-escalation techniques (including self-control, negotiation, empathy, avoiding provocation, and respecting patients' personal space), can significantly reduce coercive events and promote safer, more appropriate treatments. Additionally, implementing an "open-door" policy in wards has been suggested as a method to reduce aggressive incidents, with its effectiveness demonstrated in a review of the literature (35,36). During the recent online National Conference *"Per una salute mentale di comunità"* ("For Community Mental Health") held on June 25–26, 2021, the Italian Minister of Health highlighted the urgent need to improve alternative approaches. The minister stressed that restraining psychiatric patients with mechanical restraints not only produces negative psychophysical outcomes but also violates fundamental human rights. These considerations were summarized in a draft document and agreement titled *"Overcoming Mechanical Restraint in Mental Health Centers"* (37). Considering these perspectives on physical restraint, this study aimed to analyze psychiatric nurses' attitudes and beliefs regarding restraint practices in nursing care.

Objectives of the study

The purpose of this study was to:

- determine the knowledge and degree of training of mental health workers regarding mechanical restraint, the resulting risks, and the existence of valid alternatives.
- detect knowledge and attitudes towards de-escalation techniques.

Materials and methods

Study design

This study was observational and cross sectional and was conducted by collecting and analyzing the results of a questionnaire administered on-line.

Sample size assessment

In 2021, the Italian Ministry of Health reported that the total number of personnel in public psychiatric operating units was 29,785. Among these, 17.9% were physicians (including psychiatrists and other medical specialists), 6.9% were psychologists, while nursing staff represented the largest professional group (42.9%). Other roles included OTA/OSS personnel (11.6%), professional educators and psychiatric rehabilitation technicians (8.6%), and social workers (4.1%) (38). Using Miller and Brewer's formula (39), with a 95% confidence interval, a sample size and level of statistical significance set at 0.05, the required sample size was calculated as: n = 296.

Data collection

The questionnaire was disseminated through social networks, primarily via the Facebook platform, and targeted nurses employed in all Italian mental health facilities. Nurses working in psychiatric structures across the national territory were invited to participate.

The questionnaire

The questionnaire was specifically designed for the purpose of the study and comprised three main sections.

First section: socio-demographic data

- gender (male or female);
- years of work experience in Italian psychiatric settings, divided into two distinct groups: those who had up to 5 years of work experience and those who had a higher number of years of work experience;
- level of nursing education: if the respondent had a regional diploma, a three-year degree in nursing, a master's degree, or a research doctorate;
- professional role of the participant, i.e. if he or she is: nurse, nursing coordinator or nursing manager;
- the type of psychiatric facility where the professional works, i.e. if it is a care facility operating only during daylight hours (h12) or a facility that operates during all the day (h24);
- whether the participant had ever received training over restraint practices;
- if the participant answered "yes" to the previous item, it was requested if the training took place during basic formation, or professional updates, or in group works.

Second section: Attitudes towards physical restraint

The second section aimed to collect information on the respondents' attitude towards physical restrictions: a total of 12 items were proposed to which the participant had to respond whether they agreed or disagreed. Item proposed were:

Item no.1: I feel that family members have the right to refuse the use of restraints
Item no.2: If I were the patient, I feel I should have the right to refuse or resist when restraints are imposed
Item no.3: I feel guilty placing a patient in restraints
Item no.4: I feel that the main reason that restraints are used is that the hospital is short-staffed
Item no.5 I feel embarrassed when the family enters the room of a patient who is restrained
Item no.6: It makes me feel bad if the patients get more upset after restraints are applied
Item no.7: It makes me feel bad when patients become more disoriented after the restraints have been applied
Item no.8: A patient suffers a loss of dignity when placed in restraints
Item no.9: It is important to apply restraints to assure legal Protection for myself and my hospital
Item no.10: I feel that placing a patient in restraints can decrease nursing care time
Item no.11: I believe that restraints increase the risk of strangulation

Item no.12: I believe that restraints decrease the number of patients' falls

In the third and last section, a total of 19 items were proposed, which focused on the de-escalation attitude in the psychiatric nurses interviewed. For each item a response between "always", "sometimes", and "never" was proposed. Items administered were:

Item no.1: Talk to the patient in a gentle, relaxed, and confident tone
Item no.2: Respond calmly, maintaining a firm attitude <5 years
Item no.3: Offer food, drink and blankets
Item no.4: Be flexible in dialogue
Item no.5 Reserve your own judgment on what the patient should or shouldn't do
Item no.6: Do not seek the confrontation of ideas or reasons, only simple collaborations that calm and strengthen the patient
Item no.7: Use simple language and short sentences, repeating them as many times as needed
Item no.8: Be honest and accurate
Item no.9: I tell the patient when the restraints will be removed
Item no.10: Clearly communicate that the patient is expected to maintain self-control and that staff can help him/her achieve this goal
Item no.11: Paraphrase what the patient says
Item no.12: Reassure the patient that you understand what he is saying
Item no.13: Use open-ended questions
Item no.14: Set boundaries while offering the patient acceptable and realistic opportunities to improve their symptoms
Item no.15: Faced with imminent violence: Warn the patient that violence is not acceptable
Item no.16: Faced with imminent violence: Propose a resolution to any problem through dialogue
Item no.17: Faced with imminent violence: Offer drug treatment
Item no.18: Inform the patient that he will rely on physical restraint if necessary
Item no.19: Consider a demonstration of mild/moderate force in the form of an increase in the number of medical personnel and even security guards ready to act if necessary

Operational timing

From July 2021 to March 2022: drafting of the questionnaire and presentation to the competent Ethics Committee.

From September 2021 to March 2022: administration of the questionnaire to nurses operating in the field of mental health via online links

From March 2022: Analysis of the collected data and related discussions.

Data analysis

All data were collected in an Excel spreadsheet for analysis. The Cronbach's alpha coefficient was calculated for both the second and third sections of the questionnaire to assess the reliability of the responses. Sampling characteristics were summarized and presented as frequencies and percentages.

Ethical consideration

Ethical concerns related to the study were outlined in the presentation accompanying the questionnaire. Participation in the study was entirely free and voluntary, and the act of completing the questionnaire was considered an expression of informed consent. Participants were explicitly informed that their participation was voluntary, and those interested were given the opportunity to review and express their consent. Confidentiality and the anonymity of the collected information were guaranteed in accordance with the principles of the Declaration of Helsinki. The study received approval from the competent Ethics Committee of Bari, Italy, with protocol no. 0071409.

Results

As a representative sample, we aimed to recruit 298 psychiatric nurses. However, a total of 268 psychiatric nurses participated, achieving a response rate of 89.9%. The items related to the second dimension, as respondents' attitudes toward the use of restraints, and the third dimension, like respondents' usage of de-escalation techniques as a preferred approach over

restraints are presented in Appendices I and II, respectively. Based on Cronbach's alpha analysis, the reliability of the data collected for the second dimension was α = .843, while for the third dimension it was α = .926. The socio-demographic characteristics of the respondents are summarized in Table 1. The study included 268 Italian psychiatric nurses who voluntarily agreed to participate. Among the respondents, 183 (68.3%) were women and 85 (31.7%) were men. A total of 246 participants (91.8%) reported having no more than three years of nursing education (regional diplomas or three-year university degrees), and 144 (53.7%) had been employed in psychiatric settings for more than five years. The majority of participants worked in hospital psychiatric wards or therapeutic communities operating 24 hours per day, while 85 (31.7%) were employed in mental health centers or daily centers, working only during daytime hours (12-hour shifts). Regarding training on physical restraint, 225 nurses indicated that they had received such training. Specifically, 22 nurses reported having undergone post-basic updates through training courses, seminars, and conferences (Table 1).

The second section of the questionnaire focused on collecting information regarding respondents' attitudes toward physical restraint (Table 2). From item no. 1 to item no. 9, 78% of nurses reported that they always felt patients' families had the right to refuse the use of restraints. Similarly, 70% of respondents believed that patients themselves always had the right to refuse or resist when restraints were imposed. Additionally, 78% of nurses stated that they felt guilty when practicing restraint and 76% identified hospital understaffing as the main reason restraints were used. 74% thought it was always appropriate to engage with the patient's family in a dedicated room. Furthermore, 75% of nurses indicated that they always felt bad after applying restraints, and 72% believed that restraints caused patients to feel disoriented. 76% agreed that patients always experienced a loss of dignity when subjected to restraint. From a medico-legal perspective, 65% of nurses considered it important to ensure legal protection for both themselves and their workplaces. Conversely, 46% of respondents believed that restraints did not reduce nursing care time. Additionally, 42% stated that restraints could sometimes increase the risk of strangulation, with 39% believing this risk was always present. On the other hand, 70%

Table 1. Sampling characteristics (n=268).

Sampling characteristics	n(%)
Gender	
Female	183(68)
Male	85(32)
Years of work experience in psychiatric settings	
≤5 years	124(46)
>5 years	144(54)
Educational level	
Regional diploma	73(27)
3-year degree	173(64)
Master's degree	21(8)
PhD	1(1)
Psychiatric setting	
H12	85(32)
H24	183(68)
Have you ever received training on the subject of physical restraint?	
Yes	225(84)
No	43(16)
If you answered Yes, what kind of training did you receive? (multiple answers possible)	
Basic formation	203(91)
Professional updates	3(1)
Group works	3(1)
Other situations	16(7)

Table 2. Nurses' attitudes to physical restraint among participants (n=268).

Item no. Answer given	Never n(%)	Sometimes n(%)	Always n(%)
Item no.1	7(3)	42(19)	176(78)
Item no.2	12(5)	55(24)	158(70)
Item no.3	7(3)	43(19)	175(78)
Item no.4	14(6)	41(18)	170(76)
Item no.5	12(5)	47(21)	166(74)
Item no.6	15(7)	41(18)	169(75)
Item no.7	19(8)	44(20)	162(72)
Item no.8	19(8)	35(16)	171(76)
Item no.9	21(9)	57(25)	147(65)
Item no.10	104(46)	67(30)	54(24)
Item no.11	44(20)	94(42)	87(39)
Item no.12	13(6)	54(24)	158(70)

of nurses thought that restraints always reduced the number of patient falls.

The third and final section of the questionnaire included 19 items focusing on the de-escalation attitudes of the psychiatric nurses (Table 3). A majority of respondents (82%) stated that they always spoke to patients in a gentle, relaxed, and confident tone, responding calmly (81%), offering food, drinks, and blankets (64%), and being flexible in dialogue (74%). 62% indicated that they always refrained from passing personal judgment on what the patient should or should not do, while 65% avoided comparing ideas or reasons. Most nurses (76%) reported always using simple language and short sentences, coupled with an honest and accurate approach (74%). Additionally, 69% communicated to the patient when restraints would be removed, while 53% indicated that they consistently maintained self-control to help the patient achieve this goal. When asked about paraphrasing the patient's statements, 35% of nurses reported doing so sometimes, and another 35% reported doing so always. Similarly, 75% indicated they always reassured patients about what they said, while 53% used open-ended questions. 70% stated that they consistently offered patients acceptable and realistic opportunities to improve their perceived symptoms. Regarding responses to imminent violence, 68% of respondents believed it was always important to reassure patients that violence was unacceptable, while 64% consistently proposed resolving issues through dialogue. For offering drug treatment, 46% of nurses reported doing so sometimes, while another 46% did so always. Additionally, 54% of respondents reported that they always informed patients when physical restraint might become necessary. In cases requiring a demonstration of mild or moderate force, 43% indicated doing so sometimes, and another 43% reported always considering an increased presence of medical staff or security personnel prepared to intervene if necessary (Table 3).

Table 3. Psychiatric nurses' attitudes towards using de-escalation techniques in psychiatric patients (n=268).

Item no. Answer given	Never n(%)	Sometimes n(%)	Always n(%)
Item no.1	10(4)	31(14)	184(82)
Item no.2	10(4)	32(14)	183(81)
Item no.3	22(10)	59(26)	144(64)
Item no.4	11(5)	47(21)	167(74)
Item no.5	17(8)	69(31)	139(62)
Item no.6	25(11)	54(24)	146(65)
Item no.7	13(6)	42(19)	170(76)
Item no.8	16(7)	43(19)	166(74)
Item no.9	16(7)	53(24)	156(69)
Item no.10	26(12)	80(36)	119(53)
Item no.11	46(20)	100(35)	79(35)
Item no.12	14(6)	42(19)	169(75)
Item no.13	17(8)	88(39)	120(53)
Item no.14	13(6)	55(24)	157(70)
Item no.15	18(8)	54(24)	153(68)
Item no.16	11(5)	70(31)	144(64)
Item no.17	17(8)	104(46)	104(46)
Item no.18	22(10)	81(36)	122(54)
Item no.19	32(14)	97(43)	96(43)

Discussion

The use of physical restraints is a highly controversial topic that raises increasing concerns due to its negative consequences and its significant impact on the quality of life of those subjected to it, with morbidity and mortality levels that are particularly alarming (40,41). The aim of this study was to assess nurses' knowledge and training levels regarding the application of containment tools, the consequences of their use, the emotions associated with alternative interventions, and the attitudes of these professionals toward de-escalation techniques. The study shows that the majority of participants (54%, n=144) had more than five years of work experience in the mental health field, and 84% (n=225) had received training on physical restraint during their professional careers. This is an important finding, as studies have demonstrated that psychiatric facilities with adequately trained staff tend to report lower frequencies and shorter durations of physical restraint use, along with fewer adverse effects related to this practice (29,42). Supporting this, one study found that education increases the moral sensitivity of psychiatric nurses (43). Negative experiences

related to the use of physical restraints emerged from our study. Most practitioners surveyed reported always or sometimes feeling guilty when restraining a patient (97%, n=218), experiencing unease when patients became angry after restraint was applied (93%, n=210), or when they showed signs of disorientation due to immobilization (92%, n=206). These findings contrast with those of another study, which reported a lack of emotional reactions among nurses (44). Ninety percent (n=204) of participants recognized the importance of using restraints as a means to protect themselves and others in the environment. This aligns with definitions describing restraints as useful tools to ensure patient safety and to protect others from aggressive or disruptive behavior (45). However, only 6% (n=13) did not associate the use of restraints with a reduction in patient falls, which is consistent with a study that found no link between restraint use and a lower frequency of falls (46). The results also highlighted discordance among nurses regarding the risk of strangulation associated with restraint use: 20% (n=44) disagreed with the statement, 39% (n=87) agreed, and 42% (n=94) partially agreed. This confusion persists despite several studies documenting cases of strangulation and protocols recommending that the head of the bed always be inclined at a 30-degree angle to mitigate these risks. Restraint-related deaths have been attributed to various causes, including pulmonary embolism, positional asphyxia, heart failure, suffocation, and strangulation (47). Tragic examples further underscore the risks associated with restraint use, including the cases of Antonia Bernardini (1974), Elena Casetto (2009), and Francesco Mastrogiovanni (2009). These incidents serve as a stark reminder of the ongoing relevance of this issue and the need for alternatives to restraint practices. According to 94% (n=211) of the nurses surveyed, the main reason for restraint use is reduced staffing, indicating a correlation between healthcare personnel shortages and an increase in restrained patients. Similar findings were reported in a study where patients and caregivers emphasized the need for additional staff to reduce reliance on physical restraint (48). Only 3% (n=7) of respondents believed that patients or their relatives do not have the right to refuse the use of restraints. The acquisition of informed consent has a legal foundation in Article 32 of the Italian Constitution, which states: "No one may be obliged to undergo a given medical treatment, except by provision of law." Notably, 94% (n=213) of nurses believed that, in the patient's position, they would have the right to refuse restraints, and 92% (n=206) agreed that restraining a patient deprives them of dignity. The National Bioethics Committee has similarly defined restraints as a "violation of fundamental rights" that is "detrimental to the dignity of the person" (49). Participants expressed overwhelmingly positive attitudes toward verbal de-escalation techniques. 82% (n=184) reported consistently speaking to patients in a polite, relaxed, and confident tone, 81% (n=183) responding calmly while maintaining a firm attitude, and 74% (n=167) demonstrating flexibility in dialogue. 76% (n=170) used simple language and short sentences, repeating them as needed, and 53% (n=120) employed open-ended questions. These de-escalation techniques appear to be critical components of a dynamic process aimed at calming patients while establishing a therapeutic relationship. While building an authentic relationship is essential, 70% (n=157) of nurses reported consistently setting boundaries to maintain social and emotional distance, while offering patients acceptable and realistic opportunities to improve their symptoms. Numerous studies emphasize the importance of clearly explaining expected behaviors, patient rights, treatment goals, and prescribed medications to foster a therapeutic environment (50). In this study, 53% (n=119) of respondents stated they always communicated the expectation that patients maintain self-control and assured them of staff support in achieving this. When faced with impending violence, 68% (n=153) always warned patients that violence was unacceptable, and 64% (n=144) proposed resolving problems through dialogue. Regarding pharmacological treatment, 46% (n=104) reported using medication "always," another 46% (n=104) "sometimes," and only 7.6% (n=17) stated they never resorted to medication. Pharmacological interventions aim to quickly calm patients without excessive sedation, and literature supports the use of low doses alongside communication and environmental adjustments during acute phases (51). Finally, 43.1% (n=97) of nurses reported sometimes using mild or moderate force, such as increasing the presence of medical staff or security personnel,

while 42.7% (n=96) stated they always used this approach when necessary. The recent Italian Law No. 113 of August 14, 2020, addresses the safety of healthcare professionals by requiring healthcare facilities to establish protocols with law enforcement to ensure "timely intervention" in cases of aggression or violence (50).

Limitations

This study has the following limitations. (a) the choice to spread the survey tool online excludes mental health nurses not registered on the social networks in which the survey tool was shared. (b) possible recall biases could be present since, despite the anonymous nature of the questionnaire, being the topic rather delicate, possible reluctance cannot be excluded, which could have led the participants to distort the answers.

Conclusions and Practical Implications

The study revealed conflicting opinions regarding the use of physical restraints as safe tools to prevent injuries and the associated risks of this practice. The lack of emotional reactions among nurses toward the use of restraints was also noted, which is particularly concerning. Ethical reflection among healthcare professionals is crucial for maintaining a compassionate and empathetic attitude, and empathy within the staff is essential for reducing the use of restrictive practices in psychiatric facilities and preventing obstacles in therapeutic relationships. It was observed that patient restraints lead to a reduction in nursing care time, and there was a good awareness of valid alternatives to restraints, alongside a generally favorable attitude toward de-escalation techniques. However, the findings highlight the need to implement educational programs for healthcare personnel. These programs should focus on strategies to avoid the use of restraints and prepare professionals for the anticipated changes in contemporary psychiatry. Furthermore, it is essential to consistently demonstrate the effectiveness of alternative measures and to disseminate these practices to raise awareness and foster sensitivity around this issue. Encouraging open debate on the matter could help move beyond ideologies that perpetuate the use of restraints, which are often regarded as remnants of an outdated institutional model. The goal should be to promote more flexible care environments capable of providing humane and dignified treatment, moving away from practices reminiscent of modernized asylums. The aspiration is to gradually build a system grounded in the belief that "words can be actions." Regardless of the underlying reasons, it is neither ethical nor necessary to dehumanize a patient to achieve therapeutic goals.

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