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Therapeutic physical intervention and direct care behavioral health providers : a project based upon an investigation of direct care behavioral health providers' experiences of therapeutic interventions

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Therapeutic Physical Interventions and Direct Care Behavioral Health Providers

ABSTRACT

The purpose of this quantitative study was to investigate the relationship among the frequency and perceived emotional intensity of therapeutic physical interventions, social support in the work place, and levels of compassion satisfaction/fatigue, burnout, and secondary traumatic stress. This study explored the experiences of direct care behavioral health providers who work with service users in therapeutic milieus across the country. It was hypothesized that as the frequency and emotional intensity of therapeutic physical interventions increased, levels of compassion fatigue, burnout, and secondary traumatic stress would increase. A negative relationship was hypothesized to occur between social support in the work place and levels of compassion fatigue, burnout, and secondary traumatic stress. Data were collected via an online survey that included four different measures that focused on assessing each variable. Analyzed results revealed a negative relationship between the number of therapeutic physical interventions implemented per week and levels of burnout. A negative relationship was also found between social support in the work place and the frequency of emotional intensity during the implementation of therapeutic physical interventions. Additionally, a negative relationship existed between social support in the work place and levels of burnout. These finding are generally in agreement with previous studies and support the need for agency culture and policies to focus on the mental well-being of their employees.

THERAPEUTIC PHYSICAL INTERVENTIONS

AND DIRECT CARE BEHAVIORAL HEALTH PROVIDERS

A project based upon an investigation of direct care behavioral health providers' experiences of therapeutic interventions submitted in partial fulfillment of the requirements for the degree of Master of Social Work

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This thesis is dedicated to all of the direct care behavioral health providers whose passion and tireless effort in this field has been devoted to the positive growth and development of service users as well as advocating for micro and macro-level policies that include and promote the human rights of their colleagues. I hope this research helps agencies to focus their energies on building a culture that endorses the creation and implementation of policies that support the mental welfare and well-being of their direct care employees who work in a notoriously exhausting field.

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CHAPTER I

Introduction

Research on the effects of therapeutic interventions is very often focused on the service user's experience of the event. With the emergence of intersubjectivity as a significant component of the psychodynamic therapeutic process, examining the effects of therapeutic interventions for those who implement and provide care in addition to those who are receiving care. Research into service providers' experiences can be beneficial for settings that use and implement more aversive intervention techniques such as Therapeutic Physical Interventions (TPIs). Bonner, Lowe, Rawcliffe, and Wellman (2002) stated that while the use of restraints and aversive intervention techniques is a highly implemented model of behavioral modification and intervention, very little has been published regarding the perceived effects on service providers.

The purpose of this study is to examine the relationship among (a) the frequency and perceived intensity of TPIs, (b) perceived social support in the work place, (c) service providers' attitudes and beliefs towards the use of TPIs, (d) compassion fatigue (e) burnout, and (f) secondary traumatic stress experienced by direct care service providers who use TPIs in a therapeutic milieu settings.

Social workers in the mental and behavioral health fields view micropractices and macropractices to play an instrumental role in the lives of those we work with. Social workers therefore have the ethical responsibility to be aware of existing policies and protocols regarding the implementation TPIs. This responsibility encompasses the examination of how therapeutic

intervention policies affect direct care service providers, who in turn affect the delivery of treatment for service users. The assessment of direct care service providers' experiences of physical interventions can lead to further examination of how the subjective experiences affect service providers, the workplace environment, quality of service delivery, burnout rates, and the overall impact on the efficacy of the treatment provided in a therapeutic milieu. The results from studying the relationship between TPIs and mental health service providers on a micro-level will serve as a foundation for further research about how subjective experiences and attitudes of direct care mental health service providers impact the delivery of the treatment in a therapeutic milieu setting on a macro-level.

In this study, TPIs are operationally defined as physically laying hands on an identified service user as a means of methodically controlling an aggressive individual. The purpose of using of a therapeutic physical intervention is to restrict service users' movement in order to minimize the risk of injury of service users and/or others in the environment. TPIs can be implemented as a way of "managing a potential or actual aggressive and/or violent behavior" in a therapeutic milieu situation (Mayers, P., Keet, N., Winkler, G. & Fisher, A. J., 2010, p. 61). This intervention is performed "with the ultimate aim of restoring safety in the clinical environment" (Stubbs, B., Leadbetter, D., Paterson, B., Yorston, G., Knight, C., & Davis, S., 2009, p.100). For an intervention to qualify as a TPI in this research study, it must be taught in a physical intervention training provided by the research participant's agency of employment. For the purpose of this study, TPIs include escorts, containments, restraints, holds, and any time service providers need to place hands or go hands on as long as they are implementing physical interventions that fall within the approved training by their agency of employment. TPIs that can be identified as caring gestures that do not attempt to control the movement of a service user

(i.e., hugs, soft touch on the back, holding hands), do not qualify as a TPI for this study. Additionally, mechanical restraints such as straps used to immobilize service users, as well as psychopharmacological methods of controlling a service user's behavior, do not qualify as a TPI for this study.

In this study I examined the experiences of participants who currently employed as direct care mental health service providers within a milieu-based therapeutic setting. A therapeutic milieu is defined as a treatment environment (a) with individuals and groups who have been diagnosed with mental illness, emotional behavioral disorders, and co-occurring developmental disabilities; (b) includes a therapeutic program that is structured by well-defined service components with specific activities being performed by identified staff; (c) takes place for the continuous scheduled hours of operation for the program-more than four hours for a full-day program (Adapted from the State of California, Department of Mental Health, 2011).

Compassion fatigue is defined by the inclusion of two major components, the first is secondary traumatic stress that results from experiencing trauma firsthand and/or hearing about traumatic events that happen to others, and the second is burnout which is "associated with feelings of hopelessness and difficulties in dealing with work" or the ability to be effective in an individual's role (Stamm, 2010, p. 17). Secondary traumatic stress is further characterized by avoidance, numbing, agitation, repetitive and/or pervasive intrusive thoughts, increased arousal; and disruptions of safety, self-trust, self-esteem, and trust in others.

It is important to differentiate compassion fatigue from vicarious trauma. Both compassion fatigue and vicarious trauma include the symptomatic expression of secondary traumatic stress. Vicarious trauma results from a transformation that occurs in the internal belief structures from hearing and learning about traumatic events that happen to other people.

Pearlman and Mac Ian (1995) suggested that an individual's previous defenses that have protected their belief about the world become shattered now that they are more fully aware of "the horrors of people's capacity for cruel behavior against others" (p. 564). Compassion fatigue is differentiated from vicarious trauma in that the secondary traumatic stress symptoms decrease when one is removed from the distressing environment (Harrison & Westwood, 2009).

Research has addressed the effects and implications of vicarious trauma (Devilly, Wright, & Varker, 2009; Pearlman & Mac Ian, 1995), the increasing knowledge about the effects of TPIs on patients (Bonner, et al., 2002; Hejtmanek, 2010; Mayers, et al., 2010), as well as staff's perceptions and attitudes about TPIs (Bigwood & Crowe, 2008; Gelkopf, Roffe, Behrbalk, Melamed, Werbloff, & Bleich, 2009; Stubbs et al., 2009; Suen, Lai, Wong, Chow King, Ho, Kong, Leung, & Wong, 2006). The existing literature on TPIs does not strongly address the subjective experiences or how implementing TPIs affect service providers. The knowledge about how service providers are affected by implementing therapeutic interventions has the potential to affect existing policies as well as the creation of future protocols in therapeutic milieu settings.

CHAPTER II

Literature Review

This chapter addresses important components of TPI use in therapeutic milieus. The impact and effect of TPIs can be examined through a Social Work ethics lens, from the perspective of the service user and service provider, as well as using the theoretical framework of compassion fatigue. The ethical principles of social work guide the creation and implementation of micro and macro level policies in therapeutic milieus and therefore affect the delivery of treatment. This section also reviews existing studies that attempted to examine the experiences, attitudes, and beliefs of both services users and those who provide them care in a therapeutic milieu. Finally, I will use a theoretical approach to discuss how compassion fatigue, secondary traumatic stress, and burnout can have psychological effects on treatment providers.

Ethical Considerations

The code of ethics of the National Association of Social Work (NASW, 2009) states that social workers have an ethical responsibility to clients and colleagues. The ethical principles that make up the NASW code of ethics are not solely confined to those defined as service users. The value of service is the basis for the ethical principle "to help people in need and address social problems" for both clients and colleagues (p. 5). The value of service should always be delivered in a way that "promotes clients' socially responsible self-determination" and "respect [for] the inherent dignity and worth of the person" (p. 5). The concept of respecting a service user's autonomy often times conflicts with the ethical responsibility for social workers and service

providers to limit clients' rights to self-determination if they engage in behavior that poses potential, or actual, risk to themselves and/or others. The intention of this section is to look at the use and effects of TPIs from an ethical perspective. As people dedicated to the ethical delivery of service to our communities, social workers have a responsibility to examine and question if the execution of policies and interventions are positively, and/or negatively, impacting those who work in this field.

Mohr (2010) states that the way staff execute their moral obligation to protect clients from danger posed by themselves and/or others is by restraining them and ultimately putting them at risk anyway. The moral obligation that Mohr is referring to is aptly identified by Gastmans and Milisen (2005) in their discussion about clinical ethics. The authors propose that clinical ethics serves as a moral compass to guide the helping/serving professions. This figurative compass of values and norms is used to create principles on which helping professionals base their code of ethics. The authors go on to explain that "values express what caregivers must aim at in order to attain greater human dignity, norms express concrete rules of behavior that are generally accepted as responsible and adequate for imparting human dignity to caring" (p. 149). The values to which they are referring speak of respect for the dignity of others, respect for autonomy, the promotion of overall well-being, and the promotion of self-reliance or autonomous decision making. The authors cite that often times the use of physical restraints "goes together with a disproportionate infringement of the principle of respect for autonomy" of the service user (p. 151).

Mohr (2010) also identifies autonomy as a guiding principle of ethics in addition to beneficence, maleficence, and justice. Mohr states that the service providers' "ethical duty of beneficence" may often conflict with "a patient's autonomy" (p. 6). The author proposes that a

service user's autonomy is removed by the coercion and threat of physical interventions because a person's right to decide whether or not to comply with a treatment protocol is not based upon his or her own free will and autonomous decision making. Instead, a service user's compliance based upon the assumption that a caregiver has sufficient and appropriate knowledge, and therefore can interpret what is best for the client in the confines of the prescribed and structure and daily living within a therapeutic milieu. The clients inherently lose their voices and sense of agency in this system. Following the same line of thought, Mohr points out that often the least educated staff attend to the daily activities for some of a community's most vulnerable patients. The author argues that service users are often coerced to comply with staff's expectations because society assumes that service providers always know best in the context of care.

The effort to identify alternative de-escalating interventions has resulted in proactive and collaborative methods that ideally prevent the use of TPIs. In a study conducted by Kontio, Välimäki, Putkonen, Kuosmanen, Scott, and Joffe (2010), participants made decisions based upon another person's safety or best interest, rather than a patient's best interest. The decision to prioritize the needs of the milieu over an individual's highlights the ethical conflict that many service providers face when making decisions regarding the execution of TPIs. Kontio et al. used a focus group made up psychiatric nurses and physicians to examine the ethical aspects of nurses' and physicians' perceptions of using physical restraints in a hospital ward, as well as the alternative methods to physical interventions that were employed. The authors found ethical problems present in the hospital ward, such as participants' inability to find alternative interventions to physical restraints, as well as the conflict of taking attention away from the ward to focus on restrained service users. These experiences caused feelings of frustration, guilt, and dread (p. 72). Study participants didn't always feel that viable alternative methods to physical

restraints were available. When asked to identify potential alternatives, they identified (a) the service user as an active participant in developing treatment plans and/or agreement, (b) using the knowledge and familiarity of nurses as a first-step response, (c) changing to a low-stimulus environment, and (4) using the gendered power and authority of male nurses and physicians to pacify patients and prevent power from shifting to patients. Even in identified alternatives, the theme of power and control over service users was present. This research was conducted as a peer focus group with semi-structured open-ended question which allowed for process-oriented responses but it did not permit interpretation about the strength of relationships or the causes of phenomena reported.

Martin, Krieg, Esposito, Stubbe, and Cardona (2008) focused on alternatives to TPIs identified in a study looking at the use of Collaborative Problem Solving as a means of reducing restraints. The authors found the following interventions to affect the systematic reduction of physical interventions for in-patient therapeutic milieus: leadership support of organizational change, the use of data to inform practice, the use of seclusion and restraint prevention tools, inclusion of patients and families, rigorous debriefing after restraints, and workforce development. These identified alternatives take the focus away from power dynamics between staff and service users, and focus on making change within internal structures of the program, and how staff operate within the therapeutic milieu. This particular study focuses exclusively on a hospital inpatient psychiatric unit connected with a prestigious institution that admitted 15 patients at a time. The unit was a structured and contained environment with a presumably higher percentage of trained staff compared to residential homes, juvenile justice settings, and other outpatient settings. The unit employed a total of 72 staff which suggests that the milieu received a lot of support and consistent staff rotations. The high ratio of staff to patients invites

the reader to wonder if this support allows staff to feel less burned out at work. If staff are feeling less burned out, then one could surmise that staff are less reactive and more grounded in moments of potential conflict with patients, thus taking the focus off of power dynamics in the moment. A conflict results when staff are ill-equipped with alternative methods and "they are forced to breach patient autonomy at times when it is unavoidable" (Mohr, 2010, p. 6).

The rights of the service providers should be included in the discussion about social work ethics. The human rights of service users do not exist in a vacuum. Staff have the right to feel safe and to feel appropriately prepared to respond to situations in the work place.

Physical Interventions in Milieu Settings

Service users. The identification of effects, intended outcomes, and efficacy of TPIs is an important topic in mental health services. Hejtmanek (2010) studied how "complex mental health treatment [physical interventions] is simultaneously a violent and an intimate way in which men relate to one another" (p. 668), and can ultimately provide a space for trust and building relational intimacy. Hejtmanek found TPIs in an urban residential setting to serve as a complex form of communication of trust among program residents and direct care staff. Interviews and narratives were used with both residents and staff who worked at a residential facility for adolescent boys (86% African-American) involved with the Department of Child and Family Services. Residents also had a history of being involved in the criminal and foster care systems. The study focused on the experiences of nine direct care staff composed of predominantly African-American males with college degrees, who grew up in the same neighborhood as the residents. Hejtmanek points out the signs of racial/ethnic hierarchy by citing the professional staff as being overwhelmingly European-American women while the direct care staff were predominantly people of color.

Hejtmanek conducted this ethnographic field study over a period of 18 months. She found that staff viewed violent restraints to simultaneously teach lessons to residents while acting as a protective gesture to eliminate behavior that could potentially lead to violence in the world outside of the residence (p. 673). A bond of trust between staff and residents was established through references to the streets, in which staff members were able to communicate commonalities in their social identities with individuals in the program. Program participants indicated they had developed an intimate bond of trust with staff members that had restrained them. Hejtmanek's research is rich in descriptive and anecdotal information; however, her findings lack quantitative empirical data.

Similar to Hejtmanek, Bonner et al. (2002) set out to examine hospital patients' subjective experiences during and after restraints to find out what they identified as helpful and unhelpful during these times. The research team interviewed patients 24 hours after a single restraint, once they had been assessed by hospital nurses for fitness of ability, to give consent and be interviewed. Researchers used a semi-structured interview to ask participants to describe the event (including the physical restraint), antecedents to the incident, their emotional state and what factors they found to be helpful, or unhelpful, during the episode. At the end of the interview they were asked to describe their emotional state, as well as helpful and/or unhelpful factors, after the incident occurred. Unlike Hejtmanke's study, Bonner et al. found that patients reported negative subjective experiences. Patients cited a noisy and unsettling environment, and failed communication from staff to patients, as antecedents to the incident and the restraint. During restraints, patients reported feeling fear, embarrassment, and re-traumatization. Patients who experienced debriefing after restraints reported feeling supported by staff, stating that it

provided them with resolution after the incident, and a better understanding of why they were restrained.

However, some patients reported their feeling of distress to be just as powerful after the restraint as it was before. Additionally, 50% of patients reported that the restraints triggered "distressing memories of earlier traumatic events" (Bonner et al., 2002, p. 472). Due to the small sample size of six patients, the results of this study cannot be generalized. Limitations also include lack of demographic information concerning the type and size of hospital unit, the occupation titles of staff working with identified patients, psychiatric diagnoses (i.e., homogenous or heterogeneous), as well as age, gender, and self-identified race/ethnicity of participants and staff working on the unit.

Mayers et al. (2010) explored the effects of physical interventions among service users who had been hospitalized in a psychiatric hospital in South Africa. Service users consisted of a convenience sample of n=43 and ranged in age from 25-60 years old. Sixty-three percent of participants spoke predominantly Afrikaans. Researchers used a participatory approach through the collective generation of knowledge among service users and providers, who were identified as consult psychiatrists, mental health nurses, nursing auxiliary staff, social workers, and psychologists. The authors extracted themes from focus groups made up of service users who discussed their experiences during the process of TPIs. The authors used results from the focus groups to create surveys and questionnaires designed to obtain quantifiable data. Mayers et al. found noteworthy themes of inadequate communication among providers and users, a violation of rights, and experiences of distress. The findings are important to the information gathering process that can lead to the creation and implementation of appropriate therapeutic interventions. However, the results are not generalizable. The authors note the possibility that a bias was

created inadvertently through the use of service users' peers as interviewers, which could have influenced the responses of other service users. Additionally, no further demographic information was given aside from occupation title.

Service providers. In Hejtmanek's study (2010), the effects of engaging in physical restraints with those they cared for in the residential facility stirred up conflicting feelings for staff members. Direct care staff appeared to grapple with the concept of using physical interventions as a means of teaching program individuals that their behaviors had consequences; whether at the residence or "in the real world" (p. 672). In the same study by Bonner et al. (2002) mentioned previously in the paper, researchers also examined the subjective experiences of the staff during a restraint. Staff reported feelings of distress and discomfort when implementing restraints because they viewed the use of restraints as a last resort and therefore had failed to meet the patients' needs. Planning, communication, and support were viewed to be important in the process leading up to, as well as during, restraints. Sub-components of this included knowing the patient well, planning how to approach the incident, good teamwork, and supporting each other. After restraints, staff reported mirroring the patients' feelings of distress as a result of failures to communicate "between themselves and the patients, and at the failures to meet the patients' needs" (p. 469). After an incident where a staff member was attacked by a patient with a weapon, multiple staff members reported feelings of terror. One staff member stated that they had wet themselves out of fear, and had to stay on the unit for the rest of the day because there were no other trained staff members available in the hospital. The majority of staff found debriefing and reviewing the events soon after an incident to be helpful and supportive. Some also felt that debriefing with patients was important, otherwise there was potential to "end up with a lot of resentment" (p. 470). Ethical issues arose among staff concerning the views that

restraints could be manipulative, coercive, and used for persuasion. Some staff reported that restraints triggered thoughts of previous restraint involvement or re-traumatization.

Gelkopf et al. (2009) surveyed 130 licensed and non-licensed nurses at a mental health center in Israel to assess for staff attitudes, opinions, behaviors, and emotions pertinent to patient restraints. The researchers used a five point likert scale to examine categories related to physical restraints. The first part of the study focused on the attitudes, opinions, and behaviors of nursing staff toward patient restraint. The majority of staff identified the following patient behaviors to justify the use of restraints: attacking someone (94.5%), hitting their head on the wall (87.4%), throwing and breaks things (83.5%), and hitting themselves (82.6%). Goals of restraints were identified as preventing harm to self (97.3%), to limit violent behavior (93.6%) and to avoid harming the environment (90%). Environmental conditions that influenced restraints such as appropriate medication (96.4%), early identification of potential violence (92.7%), more soothing conversations with patients (88.2%) and more personal attention to patients (82.7%) were believed to reduce the likelihood of engaging in restraints. Among the respondents, 49.5% believed that inexperienced nursing staff and a general lack of patience by the ward staff (40.9%) contributed to the use of restraints.

The second half of Gelkpof et al.'s (2009) study focused on the emotions and beliefs of nursing staff toward patient restraints. Staff reported that they believe restraints to calm patients (76.1%), send a message that staff is helpless at containing the unit (41%), over one third of participants thought that patients feel degraded (39.1%) and suffer (37.4%) during restraints. The majority of staff felt pity for the patients (75%) while approximately half of the staff felt frustrated and helpless. Almost all of the staff believed that the patient feels anger towards staff when involved in some part of the process of a physical restraint, and have experiences of fear

(87.9%), sadness (83.3%), degradation (85.8%), and helplessness (80.4%). The staff identified feeling emotions of pity (74.0%), frustration (46.6%), and helplessness (41.9%) when involved in a patient restraint.

Attitudes and beliefs affect how we experience and perceive our surroundings. These findings lead one to wonder how staff's attitudes about aspects involved in their work affect the delivery and implementation of therapeutic goals and treatment. Gelkopf et al. (2009) focused on staff's attitudes and beliefs about TPIs but did not go further into exploring what factors contributed to their beliefs. The study was structured as an objective perspective rather than including staff's personal experiences and how their presence, attitudes, and beliefs contributed to the intersubjective experience of TPIs. The likert scale could not capture emotional and cognitive experiences included in their decision-making process regarding restraint use.

In total, the overall reviewed research does not analyze differences in perceptions based on familial history of discipline and boundary setting, trauma history, familial and community communication styles, race, or gender. Hejtmanek's (2010) study was one of the only articles reviewed that examined and noted the cultural and racial similarities between service users and service providers and the positive effects of TPIs in relation to intimacy development. Bonner et al. (2002) and Mayers et al. (2010) share a major focus on the subjective experiences of service users surrounding physical interventions. Although Gelkopf et al. (2009) examined the emotions felt by nurses during patient restraints, limited data is available about the subjective experience of service providers and how their experiences of implementing TPIs impact their work experience (compassion satisfaction, burnout, secondary traumatic stress, compassion fatigue) and the subsequent implementation of therapeutic treatment.

Compassion Fatigue Theories

Some service users who receive services in therapeutic milieus have experienced and or witnessed trauma. Stamm (2010) states that service providers who work with people who have been exposed to trauma are more likely than their non-trauma focused colleagues to develop symptoms associated with secondary traumatic stress and posttraumatic stress disorder (p. 9). Stamm continues by suggesting that these negative effects can impact service providers' delivery of services and therefore affect the overall efficacy of the organization. Understanding the theories of vicarious trauma and secondary traumatic stress will help in recognizing how working in an environment that uses physical methods to control a person's behavior can potentially lead to experiences of burnout and compassion fatigue. Dunkley and Whelan (2006) highlight the overlapping concepts of compassion fatigue, burnout, secondary traumatic stress, secondary trauma, and vicarious trauma. The authors identify vicarious trauma as a concept coined by McCann and Pearlman (1990) as an internal transformation that occurs within a person as a result from hearing about the traumatic experiences of others. The internal shift can be experienced as a betrayal of trust in the world and can manifest as psychological numbing, emotional distancing, and denial. These traumatic sequelae are in response to therapists' own individual histories and constitution as well as the specific characteristics of the described situation (McCann & Pearlman, 1990, as cited in Dunkley and Whelan, 2006). The authors attempt to underscore the importance of differentiating vicarious trauma from compassion fatigue, which are often mistakenly used interchangeably. Figley (1995, as cited by Dunkley & Whelan, 2006) operationally defines secondary traumatic stress within the overarching concept of compassion fatigue, stating that it results from the situational characteristics that occur when working with those who have experienced distressing events. While secondary traumatic stress

is characterized by external and situational influences, vicarious trauma occurs from the integration of internal characteristics of the counselor (countertransference) and external factors from the situation (McCann & Pearlman, 1990, as cited in Dunkley & Whelan, 2006; Pearlman & Mac Ian, 1995).

Bride, Radey, and Figley (2007) add to the existing discussion of how to operationally define compassion fatigue, secondary traumatic stress, and vicarious trauma. They suggest that compassion fatigue is the more accessible terminology than secondary traumatic stress. Regardless, the authors point out that all three terms are derived from the experience of being negatively impacted as a result of working with traumatized clients. Bride et al. decided to use the term compassion fatigue as an over-arching concept that encompasses these negatively experienced effects.

Exposure to traumatic events through listening to and/or witnessing trauma is correlated with experiencing vicarious trauma. Pearlman and Mac Ian (1995) looked at self-identified trauma therapists with a personal trauma history and trauma therapists without a trauma history. Overall, therapists with a personal trauma history showed greater disruptions in how they experienced themselves, others, and the world, as well as more distress than their peers without a trauma history. The authors found that the newest therapists to the field of trauma experienced the most distress and were also more likely to not receive supervision. Trauma therapists with a personal trauma history who have done long-term and extensive work in the field showed significantly less stress compared to their less experienced counterparts. The authors suggest that more experienced therapists (a) were more likely to receive supervision and consultation and (b) were able to experience healing through their work focusing on their clients' own personal growth and development. Therapists without a trauma history who have done work in the field of

trauma experienced more distress and disruptions in their self-schema (self-esteem, self-intimacy, and self-trust) than their counterparts. The authors suggest that a parabolic effect occurs with disruptions occurring at the beginning and long-term phases of trauma therapists' work experiences. Preliminary exposures to horrific events can be incredibly disruptive and create long-term negative effects from hearing about traumatic events. The authors suggest that the distress that can result over time from working with those who have experienced trauma can solidify or bolster already existing negative schemas that therapists may have about the world and the stories they hear in their practices. The authors found that participants who were experiencing higher levels of distress as a result of listening to trauma in their work as therapists were using their own personal therapies as spaces to discuss the impacts of their trauma work. Based on this finding, the authors suggest that trauma work has the potential to be insidious and pervasive in therapists' lives.

Working with traumatic content can potentially have a negative impact and therefore create significant changes in the beliefs and attitudes of service providers and may result in vicarious trauma or Post Traumatic Stress Disorder (Pearlman & Mac Ian, 1995; Rasmussen, 2005). Pearlman and Mac Ian used the Traumatic Stress Institute Belief Scale (Pearlman, 1996) to measure disrupted cognitive schemas as a measure of vicarious traumatization. Pearlman and Mac Ian also employed the use of the Impact of Events Scale (Horowitz, 1979) to measure and assess avoidant and intrusive signs and symptoms of PTSD as well as the Symptom Checklist-90-Revised (Derogatis, 1977) to measure general levels of distress. Based on the finding that listening to traumatic events can negatively affect therapists, one can speculate about the detrimental impacts on mental health service providers as a result of not having social support or opportunities to debrief and process the traumatic nature of implementing TPIs.

Looking further into the correlational relationship between witnessing/listening to traumatic content and vicarious/secondary trauma will illuminate the effects it has on the therapeutic relationship. Rasmussen (2005) notes that vicarious trauma on the part of the mental health provider contributes to impasses in the therapeutic process. This notion underscores the importance of exploring how TPIs affect levels of distress and vicarious trauma for mental health service users and ultimately impacts the therapeutic process.

Social Support in the Work Place

This study aims to expand upon previous TPI related studies and to examine variables that may potentially be highly correlated with compassion fatigue, secondary traumatic stress, and burnout by looking at variables that may also mitigate these negative experiences. Existing literature suggests that perceived social support is negatively correlated with rates of compassion fatigue (Galek, Flannelly, Greene & Kudler, 2011). Support from family and friends have been found to have the most significance in being a mitigating factor in experiencing burnout and secondary traumatic stress. Galek et al. (2011) studied the effects of social support from family and co-workers for 133 chaplains who work with clients who are affected by trauma and found that as support from family/friends increased, burnout and secondary traumatic stress decreased. Although no statistical significance was found between work place social support and secondary traumatic stress, the relationship between workplace social support and burnout approached significance suggesting that the experience of social support may have some sort of impact on burnout. Baruch-Feldman, Brondolo, Ben-Dayan and Schwartz (2002) found similar results when 211 New York City traffic enforcement agents participated in a study looking at job-satisfaction, social support, and burnout. A negative relationship was found between measures of social support and burnout. The authors found that the types of outcomes depended upon sources

of support. Support from a person's family was found to have a stronger relationship with overall experienced social support than support from co-workers or immediate supervisors.

While Baruch-Feldmen et al (2002) found that support from immediate supervisors was not significantly related with burnout, the analysis showed that the workplace support was positively associated with productivity and satisfaction in the work place. A positively correlated relationship was found to exist between social support and job satisfaction as well as between job satisfaction and productivity. In this study, Baruch-Feldmen et al. examined only the main effects of support and could determine causation between the variables studied.

Some studies have demonstrated that workplace support does not have any mitigating effects on compassion fatigue. When Ross, Altmaier and Russel (1989) studied 169 university counseling center staff, they found no relationship was found among job-related stress, burnout, and social support. The authors did not find evidence of a "buffering effect" from social support when examining the relationship between job-related stress and burnout. They noted that confounding variables such as experiencing high enough levels of stress could be an alternative explanation as to why social support did not serve as a buffer to the effects of burnout or stress.

The inclusion of the workplace environment is essential when looking at the layered experiences of service providers who work in a milieu. Every instance of interaction from a macro level regarding perceived dynamics between supervisors, co-workers, and administration to the micro moments of being intimately engaged in a TPI is incorporated into a service providers overall experience. Assessing which variables play key roles in mental health providers' experiences of working in a milieu that uses the practice of physical interventions can lead to further examination of how these subjective experiences affect individual service providers, which in turn, impacts the workplace environment, quality of service delivery, and the

overall impact on the efficacy of the treatment provided. All of these factors are crucial to how milieu therapy facilities run their programs, hire and train staff, as well as determine workplace protocol and procedures.

CHAPTER III

Methodology

Formulation

This study is a quantitative correlational investigation into how the frequency, perceived intensity, attitudes and opinions towards therapeutic physical interventions as well as perceived social support in the workplace are correlated with levels of secondary traumatic stress, burnout, and compassion fatigue in direct care mental health service providers who work in therapeutic milieus. Within this study there are two hypotheses. Hypothesis #1 is that as the frequency, perceived intensity, and negative attitudes towards therapeutic physical interventions increase, levels of secondary traumatic stress, burnout, and compassion fatigue will increase. Hypothesis #2 is that as the levels of perceived social support in the workplace increase, levels of secondary traumatic stress, burnout, and compassion fatigue will decrease. An online survey questionnaire was used to access the sample. The questionnaire took approximately 25-30 minutes to complete. Responses were imported from the Survey Monkey website into a spreadsheet document for statistical analysis.

Recruitment

Participants self-selected to be in the study and were recruited via non-probability sampling methods of purposive, convenience and snowball sampling techniques. An initial e-mail was sent out to educational collaboratives and day treatment programs in Massachusetts, as well as to residential facilities, hospitals, and therapeutic day schools on the west coast

requesting permission to recruit within the organization for participation in the study (see Appendix A). A colleague who consults with residential facilities across the country, and who is an expert in the field of sexual aggression, assisted in distributing the survey to agencies who met eligibility criteria for a therapeutic milieu. Approval to conduct the survey at identified agencies was granted by the participating agencies. An e-mail explaining the nature of participation and eligibility criterion was sent to the appropriate contacts with the request for it to be disseminated throughout their program. With written permission, e-mail and/or mail flyers were sent to organizations to be posted in areas of congregating such as staff offices and break rooms. All communications, screening questions, recruitment materials, and the survey questionnaire were in English.

Snowball sampling techniques were employed by sending out an initial e-mail to all Smith College School for Social Work students, personal and professional networks, asking for their participation (if applicable) or to pass on the recruiting e-mail to those they believe will meet participation eligibility.

Potential barriers may have prevented direct care service providers from responding to the online survey. Over 50 agencies were contacted to participate in the study and 10 agencies responded with written approval letters to recruit staff members. The 10 agencies employed an aggregate of approximately 100-200 staff that were seemingly eligible to participate. Anecdotal information and personal correspondence with agency administrators points to the possibility that the very traits this study attempted to measure (CS/CF, BO, and Secondary Traumatic Stress (STS)) are the same variables that acted as barriers by preventing potential participants from wanting to spend additional unpaid time at the end of their work day to take the survey. One

participant stated that direct service jobs have "been ranked as both the lowest paying and highest stress job, which is ridiculous." The participant continued on to say that…

> Milieu staff feel under-appreciated and under-supported by administrators. It's really hard to trust an administrative staff who cares more about filling beds and making money than doing good treatment and keeping milieu staff sane and supported.

If more than this one participant felt this way, perhaps a possibility existed for staff that might have made it hard trusting the intentions or purpose of participating in this study at the bequest of higher ranking administrators, if the staff already harbored negative feelings towards their agency's administration.

Participants

The research sample consisted of 49 respondents who were currently employed as direct care mental health service providers within a therapeutic milieu at the time of the study. For the purpose of the study, a therapeutic milieu was defined as a group treatment setting with individuals and groups who have been diagnosed with mental illness, emotional behavioral disorders, and/or co-occurring developmental disabilities. A milieu is an environment that is structured for continuous scheduled hours of operation for the program (more than four hours for a full-day program) (California Department of Mental Health, 2011). A direct care service provider was defined as someone who works in a position that requires them to be active within the milieu for the majority of their shift and working with individuals of any age who require assistance/attention. Participants were at least 18 years of age and had to have been employed by a mental health agency or organization for a minimum of six months. Direct care service providers were not eligible to participate if they were not currently employed or if they were on modified duty/disability as a result of something other than being involved in a therapeutic

physical intervention when the research was conducted. All participants could read and understand English.

Demographic information revealed that the participants were primarily female, White/Caucasian, in their mid twenties to mid thirties and held a degree in higher education. The sample was 28.6% (n=14) male, 71.4% (n=35) female and 12.2% other (n=6). Most of the respondents identified as White/Caucasian (see Table 1). On average respondents were in the 25-34 year old age range (see Table 2). Approximately three-fourths of participants (n=37) either a Bachelor's degree or a Master's Degree (see Table 3). About half of participants (55.1%, n=27) worked in the Northeast region of the United States (see Table 4) and 51% (n=25) of total respondents were employed in a Suburban area (see Table 5). Almost half of the respondents (47%) were made up of floor staff (see Table 6). Participants had primarily been working for 1-3 years (44.9%) and 4-10 years (34.8%) in a direct service position in behavioral health services (see Table 7). An overwhelming majority of respondents worked in agencies that served children (40.8%, n=20) and/or adolescents (93.9%, n=46) (see Table 8). The vast majority of respondents either worked in a residential facility or group home (47.0%, n=23) or in a therapeutic day school (40.8% (n=20) (see Table 9).

Table 1: Participants' Race

Race	Frequency	Percentage†
White/Caucasian	40	81.6%
African or African American	6	14.4%
Other or Multiracial	3	4.0%
TOTAL	49	100%

† Sorted by Percentage

Table 2: Participants' Age group

Age Group	Frequency	Percentage†
18-24	8	16.4%
25-34	35	71.4%
35-44	2	4.1%
45-54	3	6.1%
55+	1	2.0%
TOTAL	49	100%

†Sorted by Percentage

Table 3: Participant Level of Education

Education	Frequency	Percentage†
Bachelor's Degree	28	57.1%
Master's Degree	9	18.4%
High School Diploma/GED	6	12.2%
Missing	3	6.2%
Post Baccalaureate	2	4.1%
Associate Degree	1	2.0%
TOTAL	49	100.%

†Sorted by Percentage

Table 4: Region of US

Region	Frequency	Percentage†
Northeast	27	55.1%
Northwest	17	34.7%
Southwest	4	8.2%
Southeast	1	2.0%
TOTAL	49	100%

†Sorted by Percentage

Table 5: Setting of Agency

Setting	Frequency	Percentage†
Suburban	25	51.0%
Urban	20	40.8%
Rural	4	8.2%
TOTAL	49	100%

†Sorted by Percentage

Table 6: Participant Role

Title	Frequency	Percentage†
Floor Staff	23	47.0%
Instructional Assistant	5	10.3%
Mental Health Counselor	4	8.2%
Social Worker	4	8.2%
Other	3	6.2%
Therapeutic Support Specialist	2	4.1%
Behavior Intervention Specialist	1	2.0%
Behavior Specialist	1	2.0%
Dean of Students	1	2.0%
Direct Care Staff	1	2.0%
Director of Residential	1	2.0%
Para-educator	2	4.0%
Paraprofessional	1	2.0%
TOTAL	49	100%

†Sorted by Percentage

Table 7: Time in Direct Care

Range of Years	Frequency	Percentage
1-3 years	22	44.9%
4-10 years	17	34.8%
Less than 1 year	5	10.2%
11-19 years	3	6.1%
20+ years	1	2.0%
Missing	1	2.0%
TOTAL	49	100%

† Sorted by Percentage

Table 8: Age of Service Users

Age Group	Frequency	Percentage
Children (3-11)	20	40.8%
Adolescents (12-22)	16	93.9%
Adults (23-64)	2	4.1%

Staff in many of the respondents' facilities work with more than one population. In all cases where this was indicated the facilities are those that work with children and adolescents.

Table 9: Type of Agency

Setting	Frequency	Percentage†
Residential Facility or Group Home	23	47.0%
Therapeutic Day School	20	40.8%
Day Treatment/Habilitation	3	6.1%
Hospital-Psychiatric Unit	3	6.1%
TOTAL	49	100%

† Sorted by Percentage

Data Collection

Participants were required to complete a screening questionnaire upon visiting the website to determine eligibility for the study. A list of operational definitions of key terms was provided for participants prior to their viewing the screening questions (see Appendix B). Each eligibility question was set up to redirect participants away from the page if they answered “no” to any of

the first seven questions or "yes" to the last question that pertained to being on modified duty. The questionnaire relied entirely on self-reporting. Participation was voluntary and participants were able to withdraw from the study at any time prior to hitting the "submit" button. Voluntary participation included choosing to not answer any of the questions or not completing the survey.

Instruments. The research questionnaire included 103 questions and was composed of a demographic questionnaire and four surveys: Stamm's (2009) Professional Quality of Life Scale – Version 5 (Pro-QOL); a modified version of Gelkopf et al.'s (2009) Attitudes, Opinions, Behaviors, and Emotions of the Nursing Staff toward Patient Restraint; a modified version of Cohen's (1983) Interpersonal Support Evaluation List (ISEL); and an open ended questionnaire asking about the levels of intensity staff experienced during and after restraints as well as when observing TPIs. The survey contained multiple choice options, likert scale assessment tools, and open-ended questions. The surveys were used individually to measure demographic information, levels of compassion satisfaction or fatigue, burnout, secondary traumatic stress, attitudes toward therapeutic physical interventions, perceived intensity of restraints, and perceived social support within the workplace.

Demographic information. Participants first answered a multiple choice survey (see Appendix C) consisting of descriptive demographic information about age, gender, race, level of education, cumulative years they had worked in direct care, type of therapeutic milieu they currently work in, type of official therapeutic physical intervention training received, and frequency of therapeutic physical interventions they have engaged in during the past six months.

Pro-QOL-5 scale. The Pro-QOL-5 scale (Stamm, 2009) is a standardized assessment tool made up of 30 questions used to measure "the quality one feels in relation to their work as a helper" (Stamm, 2009, p. 8). The questions were used to measure positive and negative effects

of working with people who had experienced trauma and distress. The questions assessed the aggregate of a person's positive and negative work experience and how it affected their overall professional quality of life (see Appendix D). Permission to use and modify this scale for research was posted on the author's website (http://www.proqol.org/Request_Use_Permission_WTRJ.html).

Attitudes and Beliefs Toward Restraints measure. The scale created by Gelkopf et al. (2009) asked participants to reflect upon and rate their beliefs and attitudes towards the use of therapeutic physical interventions (see Appendix E). Permission to use and modify this scale was granted via e-mail correspondence with the author.

Intensity of Emotions scale. I designed a scale that I used to assess the frequency of differing perceived levels of intensity of therapeutic physical interventions. This scale used multiple choice response options to assess the frequency of participants' perceived levels of intensity from being involved in or from watching a therapeutic physical intervention (see Appendix F).

Interpersonal Evaluation Support List. The assessment tool used to measure perceived social support within the staff's agencies was adapted from Cohen and Hoberman's (1983) Interpersonal Evaluation of Support List (see Appendix G). The survey was intended to measure emotional, informational, and tangible support (the latter is also referred to as instrumental support). The questions assessed participants' perceived levels of support within their workplaces. Permission to modify and use this scale was granted via e-mail correspondence with the author's administrative office.

All assessment tools used likert scale scoring. The data were collected and processed by reviewing the finished surveys from Survey Monkey and coded for analysis.

Ethics

Approval was granted by the Smith College School for Social Work's Human Subjects Review Committee (see Appendix H). Participants were presented with a letter of informed consent before proceeding on to the survey questionnaires used in study (please see Appendix I). The informed consent stated the potential risks and benefits of participating in the study as well as the nature of the research. The researcher's e-mail address was provided in the event potential participants had questions. The website link to the questionnaire, hosted by the online site Survey Monkey, was provided in both the e-mail and flyer. To ensure privacy of participants, the online survey website was set up to protect anonymity and strip any identifying digital information (i.e., IP addresses).

Data Analysis

Demographic data were assigned numerical representation to each variable (i.e., Female=1, Male=2, Transgender=3). Most of the demographic data were analyzed using nominal levels of measurement. Whole values, such as number of TPIs used per week, were coded using ratio levels of measurement (i.e., the participant wrote in the actual number).

Attitudes and beliefs likert scale ratings were averaged for each question. Potential responses ranged from 1=Strongly Disagree to 4=Strongly Agree. The averaged scores were interpreted so that an average score of three or higher equaled agreement and an average score of two or lower equaled disagreement with the question. Answers with an average score between two and three were determined to be inconclusive, neither fully in agreement or disagreement.

A bivariate analysis of the data using Pearson's *r* was used to examine the relationship between frequency and perceived intensity of therapeutic physical interventions, perceived social support in the workplace, and each of the identified variables: compassion satisfaction, burnout,

and secondary traumatic stress. Coding, scoring, analysis techniques and directions from Stamm's "The Concise ProQOL Manual" (2010) were used analyze results from the ProQOL-5 survey. The analyzed ProQOL-5 data provided information about the experienced levels of compassion satisfaction and fatigue, burnout and secondary traumatic stress. The ProQOL scoring procedures offered software syntax that created a set of t-scores with a mean=50 and SD=10 for each of the three subscales (Compassion Satisfaction, CS; Burnout, BO; and Secondary Traumatic Stress, STS). This sort of scoring procedure offered a range for each group to which it is applied. Scores less than 43 were considered to be in the low level range and scores above 57 were considered to be in the high level range. The scores were used in a correlational analysis with other variables in the study.

CHAPTER IV

Findings

Results

Analysis of the data resulted in both anticipated outcomes as well as some unexpected findings. The results from this study did not support the first of the original hypotheses. No significant relationship was found among the frequency and perceived intensity of TPIs and levels compassion fatigue, secondary traumatic stress, and burnout. A significant negative relationship was found between burnout and interpersonal support in the workplace; as interpersonal support in the workplace increased, levels of burnout decreased. Additionally, a significant negative relationship was found between intensity of feelings during TPIs and interpersonal support in the workplace; as interpersonal support increased, levels of intensity during TPIs decreased. Compassion satisfaction (CS)/fatigue (CS) scores as a whole were not indicative of noteworthy levels of either CS or CF although the overall scores suggested feelings were closer to fatigue rather than satisfaction. Participants' overall experiences of burnout (BO) were not incredibly high or low; the same was true for secondary traumatic stress (STS). As a group, direct service providers believed that TPIs should be used as a means of keeping the individual, as well as the milieu, physically safe. Direct care service providers held the opinion that TPIs could be reduced significantly if steps were taken to focus on preventative actions by staff, such as verbal de-escalation and identification of triggers for service users. Participants also believed that staff had the potential to increase TPIs if the milieu was understaffed and if there was a general lack of patience or a large proportion of staff were inexperienced. Direct

care service providers demonstrated mixed opinions regarding their perception of how TPIs make service users feed. When it came to evaluating the intensity of emotions, direct care service providers experienced more intense emotions when observing TPIs when compared to their experience during the implementation of TPIs or after having used a TPI. Participants also reported feeling socially supported in their workplaces.

Therapeutic Physical Interventions

Over the past six months the respondents were involved in an average of 2.71 (SD=.898 TPIs per week, range = 1 to 5 TPIs per week) TPIs per week. In addition, respondents observed quite a few TPIs each week (see Table 10). They all received formal training that deals with de-escalation/prevention models that also included instruction on how to perform therapeutic physical interventions by their agency of employment prior to their participation in the study. Nearly all respondents were trained in one of the commercially available methods (see table 11). On the Modified Interpersonal Support Evaluation List (ISEL) the average score was 78.14 (SD=6.56; *Range* = 65 to 94; possible *range* = 26 to 104).

Table 10: Observed Physical Intervention

Range per week	Frequency	Percentage
Never	2	4.1%
1-3 per week	29	59.2%
4-7 per week	9	18.3%
Every Day	2	4.1%
Multiple Times per Day	5	10.2%
Missing	2	4.1%
TOTAL	49	100

Table 11: Training in Therapeutic Physical Interventions

Title	Frequency	Percentage† ††
Crisis Prevention Intervention	19	38.8%
Therapeutic Crisis Intervention	14	28.6%
Right Response	7	14.3%
Professional Assault Crisis Training	4	8.2%
I don't Know	1	2.0%
Other:		
AHIMSA	2	4.1%
Satori Alternatives for Managing Aggression	2	4.1%
PMT	1	2.0%
Menta Method	1	2.0%
TLC-IT	1	2.0%

†Sorted by Percentage

†† Does not equal 100% as three respondents had more than one type of training

Attitudes and Beliefs

Participants' individual responses were averaged to come up with a group response that indicated agreement or disagreement with each section of questions pertaining to their attitudes, beliefs, and opinions about TPIs.

Reasons for TPIs. On average, participants agreed that it was appropriate to use a TPI when service users attack someone, create a brawl in the milieu, and hit their heads on the wall. Participants did not feel that a TPI was an appropriate intervention when service users threaten someone with violence, don't let others sleep, threaten to commit suicide, ask to be restrained, constantly harass staff, or refuse to take their medication. There was no definitive group answer regarding the appropriate use of TPIs if service users throw things and/or hit or break things on purpose, pick a fight with another individual or undress in public (see Table 12).

Table12: Reasons for TPIs

Items	Average †	Standard Deviation
Attack someone	3.75	.488
Physically Harm or attempt to harm themselves	3.59	.497
Create a brawl in the milieu	3.30	.832
Hit their head on the wall	3.02	.762
Throw things and/or break things on purpose	2.45	.627
Pick a fight with another individual	2.36	.718
Undress in public	2.11	.868
Threaten someone with violence	2.00	.682
Don’t let other sleep	2.00	.964
Threaten to commit suicide	1.93	.846
Ask to be retrained	1.50	.665
Constantly harass staff	1.45	.627
Refuse to take their medication	1.32	.601

† Sorted by Average
Note: A score of 1 equals Strongly Disagree. A score of 4 equals Strongly Agree

Goals and meanings of TPIs. Participants felt that TPIs were appropriate to use if they help individuals to avoid harming themselves. Participants agreed overall that TPIs can be used to separate individuals who are fighting, to stop a brawl, and to limit violent behavior. Participants did not think that TPIs should be used as a means of showing individuals that they didn't behave well. As a group, participants' answers were consistent with the previous set of questions in not coming to a conclusive answer regarding the use of TPIs as a means of avoiding property destruction (see Table 13).

Environmental conditions and interventions affecting TPIs. Participants agreed that early identification of potential triggers, soothing conversations, personal attention given to patients, and appropriate medication management were factors that can reduce TPIs (see Table 14 and Table 15).

Table 13: Goals and Meanings for TPIs

Items	Average †	Standard Deviation
To help individuals avoid harming themselves	3.45	.663
To separate individuals who are fighting	3.20	.734
To stop a brawl	3.18	.843
To limit violent behavior	3.09	.895
To avoid property destruction	2.41	.816
To calm an individual	2.27	.817
To show individuals they don't behavior well	1.14	.347
A way to discipline an individual	1.07	.255

† Sorted by Average

Table 14: Environmental Conditions that Reduce TPIs

Items	Average †	Standard Deviation
Potential triggers that lead to violent acts are identified	3.52	.505
Individuals are calmed by soothing conversations	3.09	.640
More personal attention is given to each individual	3.07	.587
The medication treatment is appropriate	3.00	.577
Individuals are given more talk therapy	2.84	.680
If there are more male staff in the milieu	2.12	.739

† Sorted by Average

Table 15: Environmental Conditions that Increase TPIs

Items	Average †	Standard Deviation
If there is a general lack of patience among the staff	3.57	.587
A large proportion of the staff is inexperienced	3.49	.631
The milieu is understaffed	3.32	.674

† Sorted by Average

Emotional impact on the service user. Participants had mixed beliefs about the emotional impact on the service user; whether TPIs are physically dangerous for staff, help calm individuals, harm individuals emotionally, physically dangerous for individuals, perceived as

punishment, make individuals feel degraded, or that individuals suffer during TPIs. The one question that participants demonstrated a collective disagreement with that statement that TPIs show service users that service providers are helpless in containing them (Table 16).

Table 16: Emotional Impact on the Service User

Items	Average †	Standard Deviation
Therapeutic Physical Interventions are physically dangerous for staff	2.84	.680
Therapeutic Physical Interventions calm individuals	2.64	.577
Therapeutic Physical Interventions are physically dangerous for individuals	2.55	.820
Therapeutic Physical Interventions are perceived by the individual as punishment	2.52	.773
Therapeutic Physical Interventions make individual feel degraded	2.29	.774
Therapeutic Physical Interventions harm the individual emotionally	2.26	.658
Individuals suffer due to Therapeutic Physical Intervention	2.12	.697
Therapeutic Physical Interventions show the individual that staff is helpless in containing them	1.65	.529

† Sorted by Average

Service providers' emotions. On average, participants overall denied feeling anger, helplessness, guilt, fear for the individual, appeasement, or satisfaction during TPIs. While participants' averaged scores did not reflect agreement with feeling frustration or pity, they did not collectively disagree either (Table 17).

Perceived service user emotions. Participants agreed that service users felt anger but did not believe that service users experienced joy during TPIs. Average scores regarding feelings of vengeance toward staff, helplessness, sadness, degradation, fear, and appeasement did not fall solidly into agreement or disagreement (Table 18).

Table 17: Service Providers' Emotions

Items	Average †	Standard Deviation
I feel frustration	2.53	.702
I feel pity	2.21	.742
I feel anger	2.00	.690
I feel helplessness	1.98	.672
I feel guilt	1.98	.672
I feel for the individual	1.93	.704
I feel appeasement	1.65	.613
I feel satisfaction	1.51	.592

† Sorted by Average

Table 18: Perceived Service Users' Emotions

Items	Average †	Standard Deviation
They feel anger at staff	3.26	.658
They feel vengeful	2.84	.688
They feel helplessness	2.81	.699
They feel sadness	2.72	.701
They feel degraded	2.47	.702
They feel afraid	2.31	.680
They feel appeasement	2.21	.638
They feel joy	1.83	.594

† Sorted by Average

Desired participation of other service users. On average, participants did not want other service providers to be a part of the decision making process regarding TPIs, debriefing with service users after TPIs, explaining to service users the reason for the use of a TPI, the actual TPI process, or verbal attempts to sooth service providers during TPIs (Table 19 and Table 20).

Table 19: Desired Participation of Other Service Providers for TPIs

Item	Frequency	Percentage
Yes	31	63.3%
No	11	22.4%
Missing	7	14.3%
TOTAL	49	100.00%

† Sorted by Average

Table 20: Participation of Other Service Providers in Certain Areas

Items	Average †	Standard Deviation
The decision making regarding therapeutic physical intervention	1.29	.457
The debriefing procedure after the therapeutic physical intervention	1.26	.445
Explaining to the patient why they needed a therapeutic physical intervention	1.22	.419
The actual therapeutic physical intervention	1.19	.397
Verbal attempts at soothing the patient while in therapeutic physical intervention	1.07	.258

† Sorted by Average

ProQOL

The ProQOL scale was scored with a sample generated *z* score calculation for any given sample, so by definition, the scores are relative to every other person in the sample only. Almost all of respondents (89.8%, *n*=44) scored slightly lower than the mean (range = 45.97 to 47.10) and 10.2% (*n*=5) of respondents' scores were in the higher range compared to their peers for Compassion Satisfaction (*range* = 74.97 to 81.97) (see Appendix J for Table 21). Most respondents scored slightly lower than their peers (89.9%, *n*=44, *range* = 46.01 to 47.64) on the burnout scale (see Appendix J for Table 22). Scores for Secondary Traumatic Stress distribution were similar to burnout scores (see Appendix J for Table 23). The three scales of Compassion Satisfaction, Secondary Traumatic Stress, and Burnout had a strong relationship (see Table 24). While almost all levels of burnout and compassion satisfaction hovered below the mean, one participant's response highlights how stress experienced by working as a direct care service provider in a therapeutic milieu can affect overall satisfaction:

> I am ready to quit as are most of my coworkers. I am glad I took this job. I do feel as though I have more confidence in my ability to manage any situation. That said, it is

incredible [*sic*] stressful and deteriorating my mental health. You get paid minimum wage and are often put in unsafe situations with little support by administrators before and after an event. I love my coworkers but often we just complain together so it isn't very therapeutic. I feel one thing strongly, that the milieu is very understaffed and a lot of situations could be prevented if early warning signs could be addressed but often there is not enough staff and you are simply trying to contain everyone as opposed to provide a supportive environment.

Table 21: CS *t* Score Distribution

Score	Frequency	Percentage
45.97-47.4	44	89.8%
74.97	2	4.1%
81.97	3	6.1%
TOTAL	49	100%

Table 22: BO *t* Score Distribution

Score	Frequency	Percentage
46.01-47.64	44	89.8%
69.17-69.25	2	4.0%
84.61	3	6.1%
TOTAL	49	100%

Table 23: STS *t* Score Distribution

Score	Frequency	Percentage
46.34-47.29	44	2.0%
69.4-69.44	2	4.0%
84.55	3	6.1%
TOTAL	49	100%

Frequency of intense of emotions

Frequency of perceived intensity (none, low, moderate, and high) in relationship to TPIs ranged from not feeling any intensity of emotion at any point in the process to experiencing some form of intense emotions 10 times per week. The frequencies of intense emotions were averaged within each time sub category (during, after, and while observing). These scores were then weighted for further analysis and summed into three scales. The three scales are Intensity of Emotions: During TPIs, After TPIs, and While Observing TPIs. The scales were calculated with a simple formula of ((no intensity*0) + (low intensity*1) + (moderate intensity*2) + (high intensity*3)). This creates a higher scores mean both for more frequent and more intense feelings (see Table 25).

Table 25: Frequency of Intense Emotion

	Mean	Standard Deviation
During	2.73	3.46
After	3.38	4.65
Observing	3.44	5.17

Results from the analysis of experienced intensity of emotions during, after, and observing TPIs showed that participants overall experienced highest levels of intensity of emotions when observing TPIS. Results also showed that intensity of emotions was higher after restraints compared to during restraints (see Table 25). One participant described an increase in adverse reactions after being involved in a TPI:

> In my year and a half there have been about four times that I have had multiple nights of having intrusive thoughts after being in a restraint. Two times I actually needed to use an intervention (music or listening to a book on tape) to be able to fall asleep. During those two times I would also randomly start to have intrusive thoughts during the day and start

to cry. I notice that I get anxiety when I hear verbal altercations or even if I see something like players shoving each other in football after a play on TV. It's a little worse when I've had a restraint within the past few days. Sometimes I'll have to leave the situation because I feel uncomfortable.

Relationships among variables

Initially, there was an unexpected relationship between Compassion Satisfaction (CS) and the number of TPIs seen per week. Once investigated further, there were two respondents whose scores on CS were very high – above 70 in both cases – and the number of TPIs they witnessed was quite low. When they are removed from the analysis as outliers, the analysis appeared to represent the remaining respondents more clearly. The ProQOL variable scales (CS, BO, STS) had a strong relationship (see Table 24). When the relationship between interpersonal support and intensity of emotions was examined, the analyzed data revealed that as interpersonal support goes down, intensity of emotion during TPIs increased. No significant relationships were found between interpersonal support and intensity of emotion both after and observing TPIs. Additionally, when interpersonal support was lower, the variable of BO was higher. A negative relationship was found between burnout and the number of TPIs observed each week (see Table 24). The small sample size did not allow for a regression analysis of the data. The relationship between interpersonal support in the workplace and burnout are significantly correlated as well as the relationship between the intensity of feelings during TPIs and interpersonal support in the workplace (see Table 24).

Open-ended responses reflected the opinions of participants regarding the intention and use of restraints. Some participants' responses contradicted themselves as evidenced by including conditional factors that affect their belief when it is appropriate to use TPIs, such as the age of

the population they were working with. One participant viewed TPIs as serving as both physical and emotional containment for younger service users and felt that TPIs should be used to maintain safety for older service users. Other participants echoed that TPIs should be used explicitly for situations related to physical safety and harm. One participant's response expressed a similar sentiment by stating that TPIs "should be avoided at all reasonable cost and are merely weighed on picking the safest option." However, this same participant considered TPIs to serve as preventative measures and used the analogy of "a parent…scooping [a baby] up before they crawl into a thoroughfare."

Table 24: Correlation Between Key Variables

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress	Interpersonal Support	Intensity of Feelings During TPIs	Intensity of Feelings After TPIs	Intensity of Feelings when Observing TPIs	Frequency of TPIs per week
Compassion Satisfaction								
Burnout	.989**							
Secondary Traumatic Stress	.991**	.999**						
Interpersonal Support	.380*	-.411**	-.205					
Intensity of Feelings During TPIs	-.271	-.251	-.256	-.313*				
Intensity of Feelings After TPIs	-.248	-.232	-,236	-.147	.683**			
Intensity of Feelings when Observing TPIs	-.228	-.216	-.215	-.072	.513**	.832**		
Frequency of TPIs per week	-.062	-.328*	-.353	.036	.197	.150	.132	

* $p < .05$, ** $p < .01$

CHAPTER V

Discussion

The findings for attitudes and beliefs toward TPIs were relatively congruent with those of Gelkopf et al. (2009) when it came to agreeing about reasons and uses for TPIs. However, the use of talk therapy and an increase in male service providers in the milieu received positive and negative responses when asked if they were factors that can reduce TPIs. These particular results deviated from those found in Gelkopf et al.'s study (2009). On average, participants were in agreement that a general lack of patience by service providers, inexperienced staff, and an understaffed milieu will increase the use of TPIs. For approximately 90% of the questions asked about the emotional impact on the service user during TPIS, averaged scores differed from the Gelkopf et al.'s original study. Another interesting finding was that although 63% of participants (n=31) stated that they would like other staff members to be a part of the therapeutic intervention procedure, the averaged scores indicated disagreement with having other staff be a part of the decision making process, the debriefing and explanation process, verbal soothing for the service user, or the actual TPI.

ISEL scores are used to examine the role that social support plays in protecting people from the negative psychological effects of stress. The participants' averaged scores were above the average ISEL scores of the general population (*range of general population* = 32.9 to 34.4, range of *SD* = 4.96 to 5.98) (Steiner, Bigatti, Hernandez, Lydon-Lam, and Johnston, 2010).

However, the difference between scores could be due to using a modified version of the scale and not the original version thus making a valid comparison between the two groups impossible. Another possible explanation for the difference between the study sample and the general population could be that individuals in the direct care behavioral health field understand the importance of social support as a means of self-care.

As predicted, a negative relationship was found among interpersonal support in the workplace and intensity of emotions during TPIs. This relationship supports the theory that interpersonal support can have a buffering effect for potentially traumatic situations. Perhaps with a larger sample size, a stronger relationship could be seen among perceived social support and intensity of emotions both after and observing TPIs. Further research is needed to examine why perceived social support appears to have a stronger relationship with intensity of emotion during TPIs versus after or when observing. One could surmise that service providers generally implement TPIs as a team, thus feeling more support during the TPI. Debriefing, or lack thereof, may also play a role in the perception of interpersonal support in the workplace. Future studies should look into the relationship among intensity of emotion after or from observing TPIs with the debriefing process after TPIs.

Additionally, data analysis revealed a negative relationship among perceived interpersonal social support in the work place and burnout; as support increases, levels of burnout decrease. These results support the theory that interpersonal support can play a mitigating role in occupational stress that leads to burnout (Galek et al., 2011; Baruch-Feldman et al., 2002). Ross et al. (1989) did not find the same relationship between interpersonal support in the workplace and levels of burnout.

Analysis of the data did not support all of the original hypotheses of this study. In fact, the data revealed the opposite effect of what was expected for one relationship to occur; as the number of TPIs per week increased, levels of burnout decreased. Many possibilities exist outside of this study as to the reasons for this relationship. Participants who self-selected to participate in this study may have experienced lower rates of burnout from their jobs, compared to their colleagues who chose not to participate, and therefore felt that they had the time to dedicate to participating in the study. Insight contained in a participant's answer to the open-ended question may reflect the analyzed data; that person stated that "working in this kind of environment is one of the most rewarding experiences…However, I think that it is an extremely difficult job which is not meant for many people." Another participant's response reflected the disparate and seemingly separate feelings about the work done on a micro-level and the experience of working within the context of behavioral health systems:

> I feel there is a major lack of funding for agencies like this and the systems that support our agency (such as CPS). I also feel there is a major lack in positive legislative change. While I feel I do a great job, I also feel hindered in what I can and cannot do. I also feel there is a lack of support for making changes to reduce the use of restraint. I feel there is a lack of resources available to us and others in providing employee support. Despite all this, I feel completely attached to what I do and I know my presence has made a difference.

Perhaps the rewarding feelings about the job overshadow or act as buffers for burnout, compassion fatigue, and secondary traumatic stress.

Another untested theory is that participant biases could have manifested by reporting less symptoms of stress due to protecting their egos and senses of competence. Other unintentional

reporting biases could have occurred due to the presence of secondary traumatic stress symptoms such as numbing and desensitization; an effect of preservation that occurs when working in the field. Perhaps a different reason for the negative relationship between TPIs and burnout occurs because direct care staff feel that TPIs are measurable experiences that allow them to feel productive in their overarching job responsibilities.

One participant suggested that the injury to the service user and service provider during a TPI could possibly have an effect on the emotional and traumatic response of service providers. That person also suggested that a potential difference may occur when looking at unintended injury versus a directed assault on service providers.

The questions did not account for the impacts of racism, sexism, and heterosexism on the levels of compassion satisfaction, burnout, or secondary trauma stress a person may experience from their work. Future research that includes a mixed methods study may better address this with open ended questions regarding the impact of “isms” both interpersonally and structurally within the work environment.

Limitations

The results of this study are not generalizable due to the small sample size. Due to the small sample size, scores for attitudes and beliefs towards TPIs could not illuminate any noteworthy information due to standard deviations being so large. Therefore, opinions towards TPIs did not differ drastically enough to be included in a correlational analysis with other data from the study. Additional limitations exist regarding the quantifiable data about frequency of TPIs as well as the perceived intensity. Based upon open-ended responses, participants appeared to have differing perceptions and understanding of what "intense emotions" were regardless of the operational definitions provided. For some individuals, questionnaire responses did not

match their open-ended responses. Additionally, the survey asked about the frequency of TPIs and neglected to inquire about situations that required de-escalation techniques to be used as well as the frequency in which staff engage in situations that could have potentially resulted in escalated conflict.

Suggestions for future research

Cross, Moore and Ockerby (2010) found that clinical supervision for nurses allowed them to devote time to reflect upon their work and develop a better working relationship with their peers. Nurses stated that they were able to share their experiences and therefore reduce their feelings of isolation. The study revealed that supervision allowed for emotional catharsis, thus permitting the psychological impact of the nurses' work. Possibly education and debriefing can serve as a preventative measure for stress and compassion fatigue, thus simultaneously ameliorating the negative effects of burnout and increasing compassion satisfaction and staff morale (Magyar & Theophilos, 2010; Nachshoni, Knobler, Jaffe, Perez & Yehuda, 2007; Kinzel & Nanson, 2000. Future research is needed into the relationship between burnout and the effects of debriefing after TPIs for direct care staff who work in a therapeutic milieu.

Corrigan, Williams, McCracken, Kommana, Edwards and Brunner (1998) studied clinical staff who worked in state hospitals and wanted to know if staff who have negative attitudes about behavioral treatment therapies are less likely to implement them. While the results of their study did not support this hypothesis, further analysis of their data suggested that the relationship between burnout and attitudes towards behavior therapy was most affected by emotional exhaustion. The authors contended that "staff members who feel emotionally overextended and exhausted by their work are most likely to be pessimistic about behavioral

innovations in their programs" (p. 558). The authors stated that a negative relationship exists between staff who perceive little empathy and assistance from their colleagues and burnout.

Additional research can focus on additional variables that may affect the experiences of direct care staff who work in a therapeutic milieu. Similar to Corrigan et al. (1998), expanded research from the results of this study can examine the connection between frequency and perceived intensity of TPIs and staff attitudes about the use of TPIs. Future studies should also focus on the reflective experiences of service providers who no longer work as direct service providers in a therapeutic milieu. Looking into the perceptions of those who have had the time and distance to reflect upon their experiences may reveal more about the results of this study.

Based on the results from this study in combination with research on the effects of supervision and debriefing, I recommend that agencies examine their existing protocols to find time and space for direct care workers to participate in weekly peer supervision groups. As mentioned previously in the paper, debriefing and group supervision promote a positive working relationship and support among peers (Cross et al., 2010). The experience of group processing and supervised support will lead to feeling supported in the work place and ultimately decrease levels of burnout and reduce the frequency of intense emotions during TPIs.

The experiences of direct care behavioral health service providers are important to social workers who are employed in therapeutic milieus. The role of a social worker encompasses observing and examining the intersectionality of the multiple operating systems that occur within agencies. If we, as social workers, are working towards the well-being of the service users we serve, then we must support our colleagues by working toward policy reform and development that promotes self-care and appropriate measures that serve to prevent and protect against

negative psychological effects that can occur as a result from working in an acute and stressful environment.

The findings from this study will provide insight and direction into future research regarding the impacts of therapeutic physical interventions on the service providers and how both the positive and negative effects impact an individual's experience of their work as well as their work environment.

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Appendix A

Agency Approval Letter Template

AGENCY LETTERHEAD MIGHT BE PLACED HERE

Date

Smith College
School for Social Work
Lilly Hall
Northampton, MA 01063

To Whom It May Concern:

(**Agency or Institution Name**) gives permission for (**Student Name)** to locate his/her research in this agency (institution). We do not have a Human Subjects Review Board and, therefore, request that Smith College School for Social Work's (SSW) Human Subject Review Committee (HSR) perform a review of the research proposed by a (**Student Name**). (**Agency or Institution Name**) will abide by the standards related to the protection of all participants in the research approved by SSW HSR Committee.

Sincerely,

Signature
(**Agency or Institution Director**)
(**Name of program**, if applicable)

Appendix B

Eligibility Screening Questions

Eligibility Questions	Yes	No
Are you 18 years of age or older?		●
Are you currently employed as a direct care worker (floor staff)?	●	●
Have you been employed at your current work place for six months or more?	●	●
Do you work in a therapeutic milieu?	●	●
Have you received formal training to perform therapeutic physical interventions from your current place of employment?	●	●
Have you used a therapeutic physical intervention in the past six months?		
Are you currently on disability or modified duty NOT related to being involved in a therapeutic physical intervention?	●	●

[Skip Logic: If answer "no," to any of the first six questions or "yes," to the last question, they are taken to the following message:]

Thank you for your interest in this study. Unfortunately, you are not eligible to participate. If you have any questions about this study or eligibility criteria, please contact the researcher at rvoit@smith.edu.

Appendix C

Demographic Questionnaire

1. Age:

- ● 18-24 years old
- ● 25-34 years old
- ● 35-44 years old
- ● 45-54 years old
- ● 55+ years old

Other (please specify)

2. Gender:

- ● Female
- ● Male
- ● Transgender

Other (please specify)

3. Race/Ethnicity (Check all that apply):

- ☐ African or African American
- ☐ Afro-Caribbean
- ☐ American Indian
- ☐ Chicano
- ☐ East Asian
- ☐ Latino-Central American
- ☐ Latino-South American
- ☐ Middle Eastern
- ☐ Pacific Islander
- ☐ Puerto Rican
- ☐ Southeast Asian
- ☐ White/Caucasian

Other (please specify)

4. Highest level of education completed:

- ● Associate's Degree
- ● Bachelor's Degree
- ● Doctoral Degree
- ● High School Diploma/GED
- ● Master's Degree
- ● Post Baccalaureate
- ● Did not complete high school

Other (please specify)

5. Educational plans (Check all that may apply):

- ☐ Associate's Degree
- ☐ Bachelor's Degree
- ☐ High School Diploma/GED
- ☐ PhD, MD
- ☐ Post Baccalaureate
- ☐ Master's Degree
- ☐ Don’t have any plan to continue my education

6. Region of U.S. you currently work in:

- ● Northeast
- ● Northwest
- ● Southeast
- ● Southwest
- ● Midwest

7. The agency I work at is located in a (please choose the answer that best fits):

- ● Rural location
- ● Suburban location
- ● Urban location
- ● Remote location

8. Role:

- ● Day Care/Habilitation Worker
- ● Floor Staff (Dorm/Residence)
- ● Instructional Assistant
- ● Mental Health Counselor
- ● Nurse
- ● Psychologist
- ● Psychiatrist/Doctor
- ● Social Worker
- ● Teacher

Paraprofessional or Other (please specify)

9. Type of agency/organization you are employed at:

- Day Treatment/Habilitation Program
- Hospital-Psychiatric Unit
- Residential Facility (includes group homes)
- Rehabilitation correctional facility
- Therapeutic Day School

Other (please specify)

10. Length of time at your agency of employment:

- Less than 1 year
- 1-3 years
- 4-10 years
- 11-19 years
- 20+ years

Other (please specify)

11. Length of time working in a direct care/floor staff position in mental health/behavioral health services:

- Less than 1 year
- 1-3 years
- 4-10 years
- 11-19 years
- 20+ years

Other (please specify)

12. Over the past 6 months, estimate an average number of times PER WEEK you were involved in therapeutic physical interventions:

13. Type of therapeutic physical intervention training received (check all that may apply):

- ☐ Crisis Prevention Intervention (CPI)
- ☐ Collaborative Problem Solving
- ☐ Mandt System
- ☐ PREVENT
- ☐ Professional Assault Crisis Training (ProAct)
- ☐ Right Response
- ☐ Therapeutic Crisis Intervention (TCI)
- ☐ I don't know

Other (please specify)

14. How often do you observe a therapeutic physical intervention being conducted? (Please select the answer that fits most often.)

- ● Never
- ● 1-3 per week
- ● 4-7 per week
- ● Every day
- ● Multiple times per day

15. Age of population you work with (check all that may apply):

- ☐ Children (3-11 years old)
- ☐ Adolescents (12-22 years old)
- ☐ Adults (23-64 years old)
- ☐ Elders (65+ years old)

16. Gender of population you work with:

- ☐ Mostly male
- ☐ Mostly female
- ☐ Mostly transgender
- ☐ About equal ratio male: transgender: female
- ☐ About equal ratio male : female
- ☐ About equal ratio male : transgender
- ☐ About equal ratio female : transgender

17. Race/ethnicity of population you work with (according to census bureau categories): Please check all that may apply

- ☐ American Indian or Alaska Native
- ☐ Asian Indian
- ☐ Black, African American
- ☐ Chinese
- ☐ Guamanian or Chamorro
- ☐ Filipino
- ☐ Japanese
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Other Asian (Hmong, Laotian, Thai, Pakistani, Cambodian, etc.)
- ☐ Other Pacific Islander (Fijian, Tongan, etc.)
- ☐ Other race (please specify) _____

Appendix D

Pro-QOL 5 Scale

Professional Quality of Life Scale (ProQOL): Compassion Satisfaction and Compassion Fatigue (ProQOL)

When you help people you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

In the past 30 days...

	Never	Rarely	Sometimes	Often	Very Often
I am happy.	●	●	●	●	●
I am preoccupied with more than one person I help.	●	●	●	●	●
I get satisfaction from being able to help people.	●	●	●	●	●
I feel connected to others.	●	●	●	●	●
I jump or am startled by unexpected sounds.	●	●	●	●	●
I feel invigorated after working with those I help.	●	●	●	●	●
I find it difficult to separate my personal life from my life as a helper.	●	●	●	●	●
I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.	●	●	●	●	●

	Never	Rarely	Sometimes	Often	Very Often
I think that I might have been affected by the traumatic stress of those I help.	●	●	●	●	●
I feel trapped by my job as a helper.	●	●	●	●	●
Because of my helping, I have felt "on edge" about various things.	●	●	●	●	●
I like my work as a helper.	●	●	●	●	●
I feel depressed because of the traumatic experiences of the people I help.	●	●	●	●	●
I feel as though I am experiencing the trauma of someone I have helped.	●	●	●	●	●
I have beliefs that sustain me.	●	●	●	●	●
I am pleased with how I am able to keep up with helping techniques and protocols.	●	●	●	●	●
I am the person I always wanted to be.	●	●	●	●	●
My work makes me feel satisfied.	●	●	●	●	●
I feel worn out because of my work as a helper.	●	●	●	●	●
I have happy thoughts and feelings about those I help and how I could help	●	●	●	●	●

	Never	Rarely	Sometimes	Often	Very Often
them.					
I feel overwhelmed because my case work load seems endless.	●	●	●	●	●
I believe I can make a difference through my work.	●	●	●	●	●
I avoid certain activities or situations because they remind me of frightening experiences of the people I help.	●	●	●	●	●
I am proud of what I can do to help.	●	●	●	●	●
As a result of my helping, I have intrusive, frightening thoughts.	●	●	●	●	●
I feel "bogged down" by the system.	●	●	●	●	●
I have thoughts that I am a "success" as a helper.	●	●	●	●	●
I can't recall important parts of my work with trauma victims.	●	●	●	●	●
I am a very caring person.	●	●	●	●	●
I am happy that I chose to do this work.	●	●	●	●	●

Appendix E

Attitudes and Beliefs toward TPIs

MEASURES OF ATTITUDES/BELIEFS TOWARDS THERAPEUTIC PHYSICAL INTERVENTIONS

Restraint Questionnaire : Gelkopf et al., (2009). Attitudes, Opinions, Behaviors, and Emotions of the Nursing Staff toward Patient Restraint. *Issues in Mental Health Nursing*, 30:758–763. Used with permission from author.

The term "individual" is used in the following questions to refer to patients, residents, clients, students, and other service users.

1. **Please mark how much you agree with the following statements: I believe it is appropriate to implement a therapeutic physical intervention for an individual when they…**

	Strongly Disagree	Disagree	Agree	Strongly Agree
Attack someone	●	●	●	●
Hit their head on the wall	●	●	●	●
Throw and/or break things on purpose	●	●	●	●
Physically harm or attempt to harm themselves	●	●	●	●
Ask to be restrained	●	●	●	●
Threaten someone with violence	●	●	●	●
Pick a fight with another individual	●	●	●	●
Undress in public	●	●	●	●
Create a brawl in the milieu	●	●	●	●
Don't let others sleep	●	●	●	●
Constantly harass staff	●	●	●	●

	Strongly Disagree	Disagree	Agree	Strongly Agree
Refuse to take their medication	●	●	●	●
Threaten to commit suicide	●	●	●	●

2. Please mark how much you agree with the following statements: A reason for performing a therapeutic physical intervention for individuals is...

	Strongly Disagree	Disagree	Agree	Strongly Agree
To help individuals avoid harming themselves	●	●	●	●
To limit violent behavior	●	●	●	●
To avoid property destruction	●	●	●	●
To calm an individual	●	●	●	●
To separate individuals who are fighting	●	●	●	●
To stop a brawl	●	●	●	●
To show individuals they didn't behave well	●	●	●	●
A way to discipline an individual	●	●	●	●

3. Please mark how much you agree with the following statements: Therapeutic physical interventions can be REDUCED significantly if...

	Strongly Disagree	Disagree	Agree	Strongly Agree
The medication treatment is appropriate	●	●	●	●
Potential triggers that lead to violent acts are identified	●	●	●	●
Individuals are calmed by soothing conversations	●	●	●	●
Individuals are given more talk therapy	●	●	●	●
More personal attention is given to each individual	●	●	●	●
If there are more male staff in the milieu	●	●	●	●

4. Please mark how much you agree with the following statements: Therapeutic physical interventions will INCREASE significantly if...

	Strongly Disagree	Disagree	Agree	Strongly Agree
The milieu is understaffed	●	●	●	●
A large proportion of the staff is inexperienced	●	●	●	●
If there is a general lack of patience among the staff	●	●	●	●

5. Please mark how much you agree with the following statements:

	Strongly Disagree	Disagree	Agree	Strongly Agree
Therapeutic physical interventions calm individuals	●	●	●	●
Therapeutic physical interventions show the individual that staff is helpless in containing them	●	●	●	●
Therapeutic physical interventions make individuals feel degraded	●	●	●	●
Individuals suffer due to the therapeutic physical intervention	●	●	●	●
Therapeutic physical interventions harm the individuals emotionally	●	●	●	●
Therapeutic physical interventions are perceived by the individual as punishment	●	●	●	●
Therapeutic physical interventions are physically dangerous for individuals	●	●	●	●

	Strongly Disagree	Disagree	Agree	Strongly Agree
Therapeutic physical interventions are physically dangerous for staff	●	●	●	●

6. Please mark how you feel when you see an individual that is involved in a therapeutic physical intervention

	Strongly Disagree	Disagree	Agree	Strongly Agree
I feel pity	●	●	●	●
I feel frustration	●	●	●	●
I feel helplessness	●	●	●	●
I feel appeasement	●	●	●	●
I feel guilt	●	●	●	●
I feel anger	●	●	●	●
I feel fearful for the individual	●	●	●	●
I feel satisfaction	●	●	●	●

7. Please mark how you perceive an individual to feel when you see them involved in a therapeutic physical intervention

	Strongly Disagree	Disagree	Agree	Strongly Agree
They feel anger at the staff	●	●	●	●
They feel afraid of the staff	●	●	●	●
They feel degraded	●	●	●	●
They feel sadness	●	●	●	●
They feel helplessness	●	●	●	●

	Strongly Disagree	Disagree	Agree	Strongly Agree
They feel vengeful	●	●	●	●
They feel appeasement	●	●	●	●
They feel joy	●	●	●	●

8. Would you like other staff members (i.e. teachers, unit supervisor, clinician, program administrators, etc.) to be part of the therapeutic physical intervention procedure?

● Yes ● No

9. In your opinion, what part of the procedure would you like other staff members to be a part of?

I would like other staff members to be part of...

	Yes	No
The debriefing procedure after a therapeutic physical intervention	●	●
Verbal attempts at soothing the patient while in a therapeutic physical intervention	●	●
Explaining to the patient why they needed a therapeutic physical intervention	●	●
The actual therapeutic physical intervention procedure	●	●
The decision making regarding therapeutic physical interventions	●	●

Appendix F

Intensity of Emotions Scale

Intensity of Therapeutic Physical Interventions

Over the past 6 months, estimate an average number of times PER WEEK…

1. …you experienced NO feelings of intensity WHILE implementing therapeutic physical interventions?

NO INTENSITY: No negative experiences or thoughts surrounding therapeutic physical interventions.

2. …you have you experienced LOW levels of intensity WHILE implementing therapeutic physical interventions?

Low: Experiences of distress and or negative emotions. These experiences will typically go away by the end of the event.

3. …you experienced MODERATE levels of intensity WHILE implementing therapeutic physical interventions?

Moderate: Experiences of distress, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. These experiences from the event usually go away by the end of the day.

4. … you experienced HIGH levels of intensity WHILE implementing therapeutic physical interventions?

High: Experiences of distress, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. These experiences from the even last longer than a few days.

5. … you experienced NO feelings of intensity AFTER implementing therapeutic physical interventions?

NO INTENSITY: No negative experiences or thoughts surrounding therapeutic physical interventions.

6. …you experienced LOW levels of intensity AFTER implementing therapeutic physical interventions?

Low: Experiences of distress and or negative emotions. These experiences will typically go away by the end of the event.

7. … you experienced MODERATE levels of intensity AFTER implementing therapeutic physical interventions?

Moderate: Experiences of distress, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. These experiences from the event usually go away by the end of the day.

8. …you experienced HIGH levels of intensity AFTER implementing therapeutic physical interventions?

High: Experiences of distress, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. These experiences from the even last longer than a few days.

9. … you experienced NO feelings of intensity from WATCHING therapeutic physical interventions?

NO INTENSITY: No negative experiences or thoughts surrounding therapeutic physical interventions.

10. …you experienced LOW levels of intensity from WATCHING therapeutic physical interventions?

Low: Experiences of distress and or negative emotions. These experiences will typically go away by the end of the event.

11. … you experienced MODERATE levels of intensity from WATCHING therapeutic physical interventions?

Moderate: Experiences of distress, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. These experiences from the event usually go away by the end of the day.

12. … you experienced HIGH levels of intensity from WATCHING therapeutic physical interventions?

High: Experiences of distress, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event. These experiences from the even last longer than a few days.

Appendix G

Modified Interpersonal Evaluation of Support List*

*Adapted from Interpersonal Support Evaluation List (ISEL), (Cohen, 1983) with permission from author.

1. Please mark how much you agree with the following statements: At My Work...

	Strongly Disagree	Disagree	Agree	Strongly Agree
There are several people I could turn to who could help solve a problem.	●	●	●	●
Most of my co-workers are more interesting than I am.	●	●	●	●
There is at least one person who takes pride in my accomplishments.	●	●	●	●
There is no one that I feel comfortable with talking about work-related issues.	●	●	●	●
Most people think highly of me.	●	●	●	●
I feel like I'm not always included by my co-workers.	●	●	●	●
There is really no one who can give me an objective view of how I'm handling my work.	●	●	●	●
There are several different people I enjoy spending time with.	●	●	●	●

	Strongly Disagree	Disagree	Agree	Strongly Agree
I think that my co-workers feel that I'm not very good at helping with work-related issues.	●	●	●	●
If I wanted to go out to a meal I would have a hard time finding someone to go with me.	●	●	●	●
I feel that here is no one I can share concerns about my work with.	●	●	●	●
If I were sick, I could easily find someone to help cover my shift.	●	●	●	●
There is someone I can turn to for advice about handling work-related problems.	●	●	●	●
I am as good at doing things as most other people.	●	●	●	●
When I need suggestions on how to deal with a work-related problem, I know someone I can turn to.	●	●	●	●
People do not have much confidence in me.	●	●	●	●
Most people do not enjoy the same things that I do.	●	●	●	●

	Strongly Disagree	Disagree	Agree	Strongly Agree
There is someone I could turn to for advice about making career plans or changing my job.	●	●	●	●
I often don't get invited to do things with others.	●	●	●	●
Most of my co-workers are more successful at making changes in their lives than I am.	●	●	●	●
No one I know would do something to recognize my birthday.	●	●	●	●
If a family crisis arose, it would be difficult to find someone who could cover my shift for me.	●	●	●	●
I am closer to my co-workers than my friends are to theirs.	●	●	●	●
There is at least one person I know whose advice I really trust.	●	●	●	●
I have a hard time keeping pace with my co-workers.	●	●	●	●
If I needed to take a "mental health day", I could easily find someone to cover my shift	●	●	●	●

Appendix H

Human Subjects Review Committee Approval Letter

School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

February 6, 2012

Rebecca Voit

Dear Becca,

The requested revisions to your Human Subjects Review application have been reviewed and are approved. Nice work with the changes. In addition the amendments you requested are also approved and make good sense to me.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck on your research project and I look forward to hearing what you find!

Sincerely,

David L. Burton, M.S.W., Ph.D.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

Appendix I

Participant Informed Consent

Dear Participant,

My name is Rebecca Voit and I am a second year Master's student at Smith College School for Social Work. I am working on a study that involves researching therapeutic physical interventions (non-mechanical restraints, containments, holds, escorts, hands on, etc.) when used in a therapeutic group setting. The purpose is to examine experiences of service providers that occur as a result of using therapeutic physical interventions. This study will focus exclusively on direct care mental health service providers (floor staff). The data gathered from this research will be used for a Master's in Social Work (MSW) thesis and possible future publications or presentations.

Your participation will include filling out a survey about your general experiences working in a mental health setting, as well as questions that focus on your experience using therapeutic physical interventions. Additional questions will be asked regarding demographic information (i.e., age, race/ethnicity, education level, etc.). This should take approximately 25-30 minutes. All information will remain anonymous. In order to be eligible, you must be at least 18 years of age and currently employed as direct care workers in a mental health therapeutic group setting for a minimum of six months at an agency or organization. Direct care work that qualifies for the study is defined as working in a group setting (such as a school, residential facility, day treatment program, hospital unit, rehabilitation correctional facility, etc.) for the most of your shift. You need to have received formal training to use therapeutic physical interventions provided by your agency of employment prior to your participation in the study. If you have not used a therapeutic physical intervention in the past six months then you are not eligible to participate in this study. If you are not currently employed, or are on disability/modified duty that is a result from something other than an injury from a therapeutic physical intervention, you are not eligible to participate in this study. Participants must be able to read and understand English as well as have access to an internet connected computer that's available in a space that ensures privacy.

Although the research process is intended to be relatively non-invasive it is possible that participation in this research has the potential to elicit negative emotional responses in some participants that may linger after the survey experience is complete. In case you experience any negative emotions at any point in the process and want to talk more about this, please see the referral list included at the end of this letter.

An important benefit of participating is the knowledge that your participation is adding to important research that will ultimately provide information and shed empirical light on the subject of the use of therapeutic physical interventions and their effects. Participation may experience feelings of validation and acknowledgement of your experiences. Compensation will not be provided for participating in this study.

Your participation in this study will be kept anonymous. Questions asking about personal information will appear but will not include identifying information such as your name or agency

of employment. It is important to not identify any service users that you work with in the course of this study. Those who will have access to the data from this study include myself, my research advisor, and the college's statistician will sign a confidentiality agreement if they view any data that contains identifying information. In publications or presentations, the data will be presented as a whole and when brief illustrative quotes or vignettes are used, they will be carefully disguised. All data from questionnaires will be kept in a secure location for a period of three years as required by Federal guidelines and that data stored electronically will be protected. Should I need the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Participation in the study is voluntary, you may withdraw from the study at any time during the data collection process, and you may refuse to answer any question without penalty. Due to the anonymity of this study, it is impossible for your data to be withdrawn even if you choose to withdraw or not complete the research study as your contributions cannot be separated from the total group process.

If you have any additional questions, have any concerns about your rights or about any aspect of the study, you are encouraged to e-mail me [redacted] or call the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CHECKING "I AGREE" YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Rebecca Voit, MSW Candidate
Smith College School for Social Work
[redacted]

Thank you for your participation in this research study.

Please print a copy of this for your records.

Resources for Referrals

Suicide Prevention & Crisis Hotlines
1-(800)-273-8255
TTY: 1-(800)-799-4889

www.TherapyMatcher.org
(617) 720-2828 or (800) 242-9794
info@therapymatcher.org

King County Crisis Line of Washington State
1-(877)-427-4747 or (206)-461-3222
TTY/TDD (206)-461-3219

NASW
*Massachusetts Chapter

*Washington Chapter
www.helpstartshere.org

Appendix J

Frequency Distribution Tables

Table U: CS T Score Distribution

Score	Frequency	Percentage
45.97	1	2.0%
46.05	1	2.0%
46.2	1	2.0%
46.42	3	6.1%
46.46	1	2.0%
46.5	2	4.1%
46.54	2	4.1%
46.57	2	4.1%
46.61	4	8.2%
46.65	3	6.1%
46.69	3	6.1%
46.72	3	6.1%
46.76	2	4.1%
46.8	4	8.2%
46.84	1	2.0%
46.91	2	4.1%
46.95	3	6.1%
46.99	3	6.1%
47.02	2	4.1%
47.1	1	2.0%
74.97	2	4.1%
81.97	3	6.1%
TOTAL	49	100%

Table V: BO T Score Distribution

Score	Frequency	Percentage
46.01	2	4.1%
46.09	1	2.0%
46.17	2	4.1%
46.25	2	4.1%
46.33	4	8.2%
46.42	2	4.1%
46.5	2	4.1%
46.58	4	8.2%
46.66	1	2.0%
46.74	2	4.1%
46.82	2	4.1%
46.9	4	8.2%
46.98	2	4.1%
47.07	4	8.2%
47.15	2	4.1%
47.23	2	4.1%
47.31	1	2.0%
47.39	2	4.1%
47.55	1	2.0%
47.64	2	4.1%
69.17	1	2.0%
69.25	1	2.0%
84.61	3	6.1%
TOTAL	49	100%

Table W: STS T Score Distribution

Score	Frequency	Percentage
46.34	1	2.0%
46.42	3	6.1%
46.46	4	8.2%
46.5	1	2.0%
46.54	4	8.2%
46.58	2	4.1%
46.62	1	2.0%
46.7	1	2.0%
46.74	4	8.2%
46.78	3	6.1%
46.82	4	8.2%
46.86	3	6.1%
46.9	1	2.0%
46.98	3	6.1%
47.02	3	6.1%
47.05	2	4.1%
47.09	1	2.0%
47.17	1	2.0%
47.21	1	2.0%
47.29	1	2.0%
69.4	1	2.0%
69.44	1	2.0%
84.55	3	6.1%
TOTAL	49	100%