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Ruth A. Muellejans
Heart Work: Meaning Making, RTF
Workers, and Physical Restraints

ABSTRACT

The purpose of this study was to explore the individual experiences of Residential Treatment Facility (RTF) workers utilizing physical restraints as an intervention with children, specifically looking at potential impact of these experiences, as well as the subsequent meaning making process. This exploratory study employed phenomenological qualitative methods of in-depth interviewing with six participants, creating a space through which these individuals were able to share their personal and collective narratives of working in RTFs. The data gathered through the phenomenological interview process displayed five salient and unanimous themes amongst the participants: the significance of their motivation for becoming a RTF worker, the uniqueness of each worker's experience, the importance of balancing the personal with the professional, the range of dynamic roles of RTF workers, and hope as the main factor in generating motivation and sustainability. Not only does this research study begin to shed light upon the significantly understudied and undervalued experiences of RTF workers, but it also created a space through which these individuals were able to have their voices heard and reflect upon the meaning this work has had in their lives in a way they had not previously experienced.

**HEART WORK: MEANING MAKING, RTF WORKERS, AND PHYSICAL
RESTRAINTS**

A project based upon an investigation of residential treatment facility workers' meaning making processes in regards to the utilizations of physical restraints as interventions submitted in partial fulfillment of the requirements for the degree of Master of Social Work.

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2013

ACKNOWLEDGEMENTS

This thesis could not have been completed without the assistance and support of many individuals whose contributions are greatly acknowledged and appreciated.

I wish to dedicate this thesis to all residential treatment facility direct care workers, for their tireless dedication and unrelenting compassion, and without whose devotion and hard work the positive growth and healing that takes place in RTFs would not be possible. My hope is that this research is meaningful on a personal level for direct care workers, as well as spurs agencies to reassess the needs of their workers and provide greater care and support for these individuals.

I also want to thank my thesis advisor, Joshua Miller, whose unconditional support, encouragement, and passion has made this project possible. Thank you for providing me with such a wonderful “holding environment” throughout this entire process, and for our cross-country Skype dates at all hours of the day and night. You have not only been an amazing advisor and mentor, but a true friend in every sense of the word, and for this I am eternally thankful.

I wish to thank my family for their unwavering love, support, humor, and delicious food, which has been the backbone of this thesis. I want to give special recognition to my father, Arnd, who has been one of the dedicated direct care workers for over two decades and is a constant inspiration to me. To my mother, Julie, whose passion for the creative process, the beauty of life, and unfaltering faith in me has carried me through this journey. To my sister, Sarah, who always made time to chat with me, despite the time difference, and listened to my half formed ideas as I dreamed up my thesis. And to my brother, Gavriel, whose never ending video clips of songs he was learning on the piano and saxophone brought me such joy and made it possible for me to rejuvenate during the depths of my research.

To all of my wonderful friends, without whose love, support, and venting sessions the completion of this project would not have been possible. Thank you, Melissa, for sharing in the laughter, tears, frustrations, and successes of “the thesis.”

A very special thank you to the girls of Parkwood. It is truly because of you that this thesis came to fruition. You have been, and continue to be, my inspiration for becoming a social worker, and have been such a driving force for me in pursuing my goals over the past few years. Wherever you are in life, I hope that you know what a deep and meaningful impact you have made in my life. Thank you.

À mon flamant amoureux- merci de tout mon coeur.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	ii
TABLE OF CONTENTS	iii
CHAPTER	
I INTRODUCTION	1
II LITERATURE REVIEW	6
III METHODOLOGY	18
IV FINDINGS	24
V DISCUSSION	44
REFERENCES	53
APPENDICES	
Appendix A: Human Subject Review Approval	56
Appendix B: Informed Consent Form	57
Appendix C: Referral Sources	59
Appendix D: Screening Questions	60
Appendix E: Demographic Questions	61
Appendix F: Initial Open-Ended Interview Questions	62

CHAPTER I

Introduction

“There can be no greater revelation of a society’s soul than the way in which it treats its children.” Nelson Mandela

6:30am: First shift. Two staff enter the house and begin their shift. Complete a sharps count (cooking knives, all utensils, scissors, pencil sharpeners, nail clippers, tweezers, etc.). Prep morning meds for the kids who take them. Go upstairs and get a rundown from the night staff. The house is still quiet with the slumber of the 10 children in their beds. A few of the older girls are already up, getting dressed, eating breakfast, taking their meds; their high schools begin earlier than the elementary schools. It’s time to get everyone else up, maybe this morning everyone will get up and do their morning routines without a problem and no one will refuse to go to school. The night staff help start the morning off and do the first round of wakeups, then they leave, hopefully to get some well-deserved rest. The younger children are full of energy, it’s hard to keep the house calm and make sure everyone eats and gets to school on time. After much coaxing and patience, all the girls except for one have made it out of the house by 8:45am. No amount of positive reinforcement, encouragement, or even the last resort of bribing, makes the final girl change her mind and agree to go to school. Supervisors are informed and the school is notified. The rest of the day is split between household chores, preparing for afternoon groups, going to meetings (school, social workers, etc.), some of the girls have medical and dental

appointments during the day, and one has a court date. The one girl who stayed home is encouraged to do homework and help out around the house; one staff has to stay with her all day.

2pm: Second shift. Three staff enter and begin their shift. Complete a sharps count (cooking knives, all utensils, scissors, pencil sharpeners, nail clippers, tweezers, etc.). Prep afternoon meds for the kids who take them, prep afternoon snack, change and fold laundry, prep for dinner, prep for groups. The older girls who take buses start coming home and staff begin to leave to pickup from the other schools. All have to be searched with a metal detector upon arrival home. The kids come home and are full of energy, some have had good days, others have struggled; the first hour is chaos trying to settle everyone down and begin afternoon routines of showering, snacks, group, homework, cooking dinner, and fun activities for those on high enough behavioral levels. If the house is settled enough the two morning staff leave and end their shifts; if the kids are not calm and settled the morning staff stays as long as needed. The kids have to be watched at all times, except when using the bathroom, and staff has to maintain a 3:1 kids to staff ratio.

Dinner begins around 5pm, a few of the girls begin arguing with each other, two of them run around the house and refuse to join everyone for dinner. One of the older girls becomes upset when staff sets a verbal limit with her, asking her to please use respectful language at the table. She begins swearing and yelling at staff; she had a really hard day in school. The plate of food flies out of her hands and cascades down the staff closest to her. She gets up from the table and begins pushing the table and forcefully throwing the chairs around. Staff attempt to calm her down and give several positive reinforcements and options for separating herself from the group, but to no avail. The other kids are becoming agitated, some are getting triggered and begin acting out themselves, yelling at the girl who is upset and beginning to run around the house without

supervision. Two staff secure the girl who is being unsafe (holding onto her arms and using verbal de-escalation techniques), the other staff attempts to remove the remaining kids from the dining room, bringing them into the living room to begin their evening routines and finish homework; most follow the instructions but two of them refuse to leave the dining room and continue to watch the scenario unfold.

The girl becomes more triggered when staff place hands on her to secure her and keep her safe (she has a trauma history which staff are aware of, but she is becoming physically violent with the table and chairs, and threw a plate at one of the staff; maintaining safety for everyone is a must and this is following agency protocol). She begins kicking staff and trying to punch them, after multiple verbal warnings to stop so that staff would be able to work with her to deescalate and let go of her, she continues to escalate. This ultimately results in a physical restraint and the anxiety and stress levels of all parties involved are exponentially high. The girl is eventually able to de-escalate and is released from the hold. By now it is past bedtime and staff hurry to assist in the completion of bedtime routines and, after much cajoling, finally get everyone in bed. Staff read bedtime stories to the little ones and then it is lights out. Then begins the nightly duties of cleaning the house, doing laundry, prepping breakfast for the morning, and a myriad of reports for each child, as well as for the restraint that occurred. Supervisors are left messages with the daily rundowns. Staff then sit in the hallways, monitoring all of the bedrooms until the night staff arrive.

11pm: Third shift. Two staff enter and begin their shift. Complete a sharps count (cooking knives, all utensils, scissors, pencil sharpeners, nail clippers, tweezers, etc.). Day staff give night staff the daily rundown; this was a good night-there was only one restraint. Day staff leave to end their shift, hopefully getting some rest before coming back in tomorrow.

This is a small glimpse into one day in one Residential Treatment Facility (RTF). Imagine being these RTF workers, day in and day out, 365 days a year, rain or shine, through snow days and summer vacations, when the kids are sick and you are sick, being the parent, caretaker, cook, housekeeper, playmate, confidant, homework helper, disciplinarian- embodying all of these roles multiple times throughout the day while training to foster and sustain a positive relationship with the kids, a relationship that is already so tenuous and fraught with challenges due to you not being the actual parent and the seemingly endless histories of trauma, abuse, and insecure attachments that these kids carry (Strout, 2010).

Historically, much research and attention has been given to the children in the RTFs who are subject to physical restraints as an intervention used in crisis situations in which the child is gauged to be unsafe towards him/herself or others (Mohr, 2010), which will be discussed in more depth within the following literature review. But what about the RTF workers who are utilizing physical restraints, often on a daily basis and multiple times per day? What impact has this had on them? How have they coped with the perpetual high stress levels and chaos that their jobs consist of? How have they come to understand the work that they do and what meaning have they made from their identities as RTF workers? How can we, as social workers and as a society, better take care of the direct care workers who are protecting and devoting their lives to this very vulnerable population?

It takes a special type of person to be able to be a RTF worker and to give of oneself so thoroughly and completely; this line of work is simultaneously unbelievably rewarding and relentlessly unforgiving. For many children, this is the last stop in a long line of foster homes, being bounced around from family to family, often times suffering perpetual abuse and neglect along the way. And the RTF workers are tasked with providing a safe and healthy environment

for the children in which they can begin to rebuild positive attachments, learn how to tolerate seemingly unbearable emotions, sustain positive relationships with their peers and with adults, and develop appropriate and healthy coping skills; attempting to repair the damage that has been done and the hurt that has been inflicted. This is no small feat, and it becomes even more challenging when agencies are short staffed and overworked, inhibiting their abilities to support the direct care staff in the ways that they need.

Through the sharing of six personal accounts from RTF workers, a shared narrative has begun to form, and a window is being opened through which to begin to understand the individual and collective experiences of being a RTF worker, as well as the personal impact of this work and the meaning making process that has subsequently followed. The strong and powerful voices of these six RTF workers tell the stories of their experiences in this line of work and having to utilize physical restraints, sharing the trials and tribulations of building and maintain such complex and meaningful relationships under a myriad of stressful, heartbreaking, and challenging situations.

CHAPTER II

Literature Review

“Often in loco parentis as well as in a therapeutic relationship, the professional [staff member] finds himself in the space between the child and the institution in a way which might be compared to the mother’s position between the child and society.” (Hartnup, 1986, p.42)

The relationship between child and Residential Treatment Facility (RTF) worker is a complex, multifaceted one, encompassing multitudes of emotional attachments and challenges, which have the potential to become much more complicated when physical restraints are utilized as an intervention. The role of the RTF worker is intense and encompassing in nature, in the sense that it integrates parental functions, therapeutic functions, social functions, and social control activities (Moses, 2000, p.477). Thus, it is essential for the emotional, mental, and physical well-being of both the child and the RTF worker to explore and understand the impact that utilizing physical restraint interventions has on the RTF worker and the subsequent meaning making process of these experiences.

RTFs serving children and youth provide integrated behavioral, emotional, and mental health wrap-around services for children and youth who are unable to live with biological or foster families for a variety of reasons, including being victims of abuse and neglect, and many are in the custody of the state. RTFs are essentially group home living environments aimed at

providing the treatment and care needed for building positive coping skills, developing and implementing appropriate behaviors, and fostering healthy relationships, with the ultimate goal of being able to reintegrate into a typical living situation, ideally reunification with a family member if possible. There is a propensity of literature addressing the concern about increases in physical restraints in RTFs, including the impacts on the children, as well as suggesting alternative methods to reduce and potentially eliminate physical restraints. However, to my knowledge, little to no research has been conducted on the impact that utilizing physical restraints has on the RTF worker. This chapter addresses important components of physical restraints and explores the experiences and meanings that this intervention holds for RTF workers. I will be examining the utilizations of physical restraints and the impacts on the clients, and the therapeutic utility of physical restraints, as well as the relatively recent resistance towards employing this form of intervention and the ethical considerations that arise. This section will also discuss the impact this intervention has on care providers in general using a theoretical approach to explore issues of vicarious traumatization and compassion fatigue. Additionally, the implications that enacting this intervention can have on individual meaning making for the RTF worker will be explored through the lens of personal narrative and discourse analysis.

Physical Restraints: Usage and Impact

Physical restraints are interventions intended to be used as safety measures designed to protect both clients and staff in situations where it is ascertained that clients are an imminent danger to themselves or to others (Mohr, 2010). This begs the question of what constitutes ‘imminent danger’ and how is ‘safety’ of client and of staff determined? Irving (2002) engages in a discourse around this issue in a study conducted examining the use of physical restraints in

an acute hospital setting. Irving (2002) details the complex power dynamics that are in-play when determining when to utilize physical restraints, specifically highlighting the determinant factor of ‘inability to self govern’ being based upon “hierarchical observation, normalizing judgments and ritualized examination” (p.411). While this methodological way of determining whether or not to utilize physical restraints can be beneficial in the maintaining of safety, it also serves to increase the degrees of separation in understanding and recognizing what Mohr (2001) decries as “an aversive intervention involving a physical assault on the child’s body” (p.31). However, this also serves to place staff in the undesirable role of having being called upon to make these determination and themselves engage in an “aversive intervention,” an actuality that has not been given adequate, if any, consideration in much of the literature.

While numerous studies cite the adverse effects of utilizing physical restraints as a form of intervention (Day, 2002; Irving, 2002; Mohr, 2001, 2010; Strout, 2010), these forms of restraints continue to be utilized with concerning frequency. Leidy et al. (2006) document the number of physical restraints that occurred in a RTF for female adolescents in an exploratory study. Over the course of about 3 years, 155 out of 415 adolescent females were involved in 1,059 physical restraints (Leidy, 2006, p.343), a number indicated as extremely high. Miller, Hunt, and Georges (2006) posit that one of the reasons for the sustained high number of physical restraints is due to the fact that RTFs are increasingly replacing psychiatric hospitals as placements for children with less acute conditions, however who still exhibit aggressive behaviors both self-directed and towards others, thus increasing the utilization of physical restraints.

Need for Decrease in Physical Restraints

There has been a slew of research over the past few decades critically assessing physical restraint data and the need for a decrease in the frequency of the use of this intervention. Miller et al. (2006) expound upon the need for a reduction in the use of physical restraints, citing potentially harmful consequences to clients, such as reinforcing the use of aggressive behaviors as a coping skill, ethical issues of clinical and therapeutic efficacy, potential for humiliation, causing retraumatization, and the misuse of physical restraints as a form of discipline (p. 202). The study that was then conducted by Miller et al. (2006) sought to determine whether or not implementations of external interventions (a restraint reduction committee) geared towards the actual RTF agencies would help in the decrease of physical restraints. Overall, there was a 59% decrease in restraints at the facility being studied over an almost 3 year span; however the researchers were unable to conduct follow-up studies. This study is informative in showing the great need for a decrease in the use of restraints and makes it obvious as to the negative impact on clients, however does not expound upon worker impact.

This method of introducing alternative interventions and implementing changes within RTF agencies themselves seems to be a common theme in the literature. According to national law, the use of physical restraints is only to be used in emergency situations for the purpose of physical safety; this law was established through the efforts of advocacy organizations and published research, which documented a shocking number of deaths associated with the physical restraint intervention (Crosland et al., 2008, p.401). However, many RTFs continued to report high numbers of physical restraints, prompting Crosland et al. (2008) to devise a study to determine the efficacy of implementing staff training programs on reducing the use of physical restraints in RTFs for foster children. The study results showed a decrease in the frequency and

use of physical restraints upon implementation of specific training programs for RTF staff. However, this study was unable to control for other external variables that may have contributed to the decrease in physical restraints. Crosland et al. (2008) cite the need for reducing this intervention due to the fact that there have been a significant number of client deaths and while this is a harrowing truth it does not address additional important factors for advocating for the reduction of physical restraints, specifically the impact on the RTF workers.

Therapeutic Utility of Physical Restraints: Clients and Staff

Physical restraints have been used over the years as a form of therapeutic intervention, however there is very little evidence that demonstrated the actual therapeutic values of this intervention; in fact much of the literature posits that physical restraints have negative therapeutic consequences. Strout (2010) conducted a study to determine the impacts of being physically restrained on actual clients, through a discussion of prior literature and data, as well as actual patient accounts describing this experience. The patterns that were found detailed a significant negative psychological impact (i.e. feelings of anger, fear, dehumanization, powerlessness, humiliation, violation, etc.), retraumatization, feelings of being subjected to unethical, punitive, and abusive practices, as well as a “broken spirit,” which clients described as feelings of hopelessness and helplessness (Strout, 2010, p. 423). Although this study specifically focuses on therapeutic implications for clients, it briefly addresses negative impacts that using physical restraints has on nurses and other staff working in facilities that use this intervention. Strout (2010) mentions that psychological consequences have been documented related to the use of physical restraints, specifically distress, anger, anxiety, and retraumatization, as well as ethical conflicts between maintaining/controlling safety and behaviors and the therapeutic values of many helping professions (p. 417). Unfortunately, this is only briefly mentioned in this study

and does not go into detail about long-term impacts on the workers. Likewise, Evan, Wood, and Lambert (2002) discuss the need for physical restraint minimization, citing qualitative studies that demonstrate significant negative impacts on the individuals restrained and their families, however they neglect to include the implications for the care providers utilizing these interventions.

Within the past few decades there has been some research conducted that posits that there are positive therapeutic aspects of physical restraints, citing attachment theory and the idea of creating a holding environment as justifications for continuing physical restraint interventions (Bath,1994; Sourander et al., 1996). Day (2002) discusses the controversy surrounding the use of physical restraints as an intervention and critiques the justification that restraints are therapeutic for the child based upon attachment theory, arguing that there is minimal empirical evidence to suggest that restraints create a holding environment for the child and foster a closer client-care provider relationship, as postulated by prior research (p.273). Rather, significant attention needs to be given to the potential violation of trust that occurs between the staff and client when a physical intervention is used, and the repercussions that this then has on the therapeutic alliance and relationship.

Mohr, Mahon, & Noone (1998) further challenge the therapeutic utility of restraints and provide empirical evidence that demonstrates the negative consequences that this intervention has on clients. Through qualitative data collected about children in institutional and hospital settings where physical restraints were employed, Mohr, Mahon, & Noone (1998) identified highly reoccurring themes of client-experienced vicarious trauma, staff alienation, and direct trauma (p.99). Special attention was also given to the environment in which physical restraints are often used, many times being highly stressful and anxiety provoking, for staff as well as

clients, thus increasing the potential for abuse through the use of physical interventions to occur due to increased negative countertransference amongst staff towards clients (Mohr, Mahon, & Noone, 1998, p.101). This occurrence has significant impact on therapeutic relationships and provides further evidence to suggest that physical restraints are harmful to both parties involved.

In another qualitative study, Mayers, Keet, Winkler & Flisher (2010) sought to gauge the perceptions and experiences of mental health service users who experienced interventions including restraint, seclusion, and sedation. The main themes that were extracted from the data were issues of inadequate communication between service providers and users, a sense of violation of rights, and an overall experience of distress. Mayers et al. further address the need for the respect of the human rights of the service users and provide further evidence to challenge the therapeutic utility of restraints. However, the missing component of this research is the perspective of the service providers and the impact that utilizing physical restraints may have on their human rights and feelings of distress. The role of the service providers appears to be frequently neglected, which is especially concerning due to the fact that they are employed by agencies/institutions that are requiring them to utilize physical restraints. The implications of inhabiting this position, where one is being required to physically control another individual, can certainly be constituted as an ethical violation of human rights and cause for distress, let alone questionable in a therapeutic sense, and deserves further exploration.

Vicarious Traumatization

Themes of trauma and retraumatization consistently appear within the literature in relation to the efficacy and therapeutic implications of physical restraints, specifically with regards to how traumatic events, such as physical restraint interventions, can impact the therapeutic alliances and relationships between staff and clients. Many youth are placed in

residential treatment facilities through the court and social welfare agencies and present with histories of trauma (Leidy, 2006, p.342), thus increasing the potential for physical restraint interventions to be re-traumatizing. While trauma theory has been applied to the clients experiencing this physical intervention, it is important to apply this framework to the staff, as well, with special attentions given to the impacts of primary traumatization, vicarious traumatization, and compassion fatigue.

RTF workers may experience primary traumatization when involved in a physical restraint, due to circumstances in which a worker is assaulted by a child, or even threatened. This may be experienced as a traumatic event for the RTF worker, possibly even re-traumatizing if said worker has experienced other traumatic events in the past. Additionally, McCann and Pearlman (1990) expound upon the occurrence of vicarious traumatization in those who serve as caregivers for individuals who have experienced trauma and been victimized, stating “therapists who work with victims may find their cognitive schemas and imagery system of memory (Paivio, 1986) altered or disrupted by long-term exposure to the traumatic experiences of their victim clients” (p. 132). Not only does this experience apply to therapists, but to RTF workers, as well, whose inhabitation of multiple roles increases the potential for bearing witness to the trauma of their clients and thus the experience of vicarious traumatization.

Furthermore, it is prudent to assess the impact that physical restraints have on RTF workers due to the risk of secondary traumatic stress, also referred to as compassion fatigue, a type of trauma that can occur in the caregivers of those who have directly experienced psychological trauma, in which the caregivers (i.e. RTF staff) may themselves become indirect victims of the trauma (Bride & Figley, 2009, p.316). Bride, Radey, and Figley (2007) describe compassion fatigue as “the natural and consequent behaviors and emotions resulting from

knowing about a traumatizing event experienced by a significant other—the stress resulting from helping or wanting to help a traumatized or suffering person” (p.155). Those who work in RTFs are daily presented with suffering, and often feelings of helplessness may arise, especially when working with children who have extensive trauma histories. To then have to use physical restraints as an intervention has the potential to make an even greater impact on RTF workers, especially in regards to disruptions or alterations in their cognitive schemas. Bride, Radey, and Figley (2007) further suggest that those

“experiencing compassion fatigue are believed to be at higher risk to make poor professional judgments such as misdiagnosis, poor treatment planning, or abuse of clients...[and] the first step in preventing or ameliorating compassion fatigue is to recognize the signs and symptoms of its emergence” (p.156).

It is crucial to address this in relation to RTF workers, the individuals who are “in the trenches” day in and day out, working with individuals who have most likely experienced trauma throughout their lives, and to assess the impact that utilizing physical restraints has on this population of direct-care workers.

Meaning Making

“Personal meaning is a fundamental dimension of personhood, and there can be no understanding of human illness or suffering without taking it into account—Eric Cassell (as quoted in Strong, 2002, p.475).” The ways in which people ascribe meaning to experiences shapes their beliefs and understandings of themselves and the world. As such, the meaning that is given to traumatic or upsetting experiences is particularly significant in the creation of individuals’ lived stories. Strong (2002) discusses the idea that creating and paying homage to the narrative of suffering exposes the individual and collective meanings that people use to understand and respond to the suffering and to one another. The values and meanings that are

attributed to an individual's lived story often times shape the way every subsequent similar situation is viewed and understood, often times serving to solidify the beliefs and meanings that have been internalized.

Mackay and Bluck (2010) further discuss meaning making in memories, specifically in the context of hospice workers' memories of death-related and low point life experiences. Mackay and Bluck (2010) explore how the subjective perceptions of traumatic experiences often "challenge the validity of an individual's worldview and spur such a search for meaning" (p. 717), at times perhaps even invalidating an individual's worldview belief, cause questioning about the benevolence of the world, and deepening the awareness of how little control an individual actually has in life. Park (2008) further addressed the impact that a traumatic event has on an individual's worldview and the meaning making process that occurs in the aftermath, explaining,

"individuals have a set of basic global beliefs and goals from which they derive a sense of purpose or meaning in life; this is their global meaning system. When confronted with a potential stressor, individuals assign some meaning to that event (appraised meaning). The extent to which this appraised meaning is discrepant with their global meaning system determines the extent to which they experience distress. Distress initiates "meaning making" efforts to bring global and situational meanings into alignment. This meaning making is assumed to lead to changes in situational meaning (assimilation), or, more rarely, to changes in global meaning (accommodation)" (p. 971).

Thus, it seems prudent to take into consideration and explore the meaning making process that RTF workers undergo after engaging in physical restraints, especially when they are precipitated by aggressive behaviors or threatening situations. It is crucial in understanding the impact that

utilizing physical restraints has on RTF workers, especially in how RTF workers perceive themselves, the world, and their subsequent work with children in a RTF capacity. Exploring the interaction with these potentially stressful and traumatic experiences, as well as the narrative process of reconstructing meaning, can have significant implications for understanding the complex relationship between child and RTF worker and raise provoke dialogue surrounding the therapeutic utility of specific interventions.

As demonstrated throughout this review of literature, there is significant and replicable data to suggest the negative therapeutic impacts of physical restraints on clients, thus leading into research that posits the need for reduction of physical restraints. While there is some research that alludes to possible positive therapeutic impacts through the use of restraints, specifically in terms of attachment theory and creating holding environments, this research is somewhat out-of-date and no current research supporting these hypotheses has been found to-date in the research collection for this study. As seen in the literature, most of the research surrounding physical restraints, in and out of RTF settings, focuses on the impact on the client and does not address the staff, specifically RTF workers. This signifies an immense need for research to be conducted on the impacts on RTF workers, which will perhaps add to the literature addressing agency strategy and training implementations focused on reducing physical restraint interventions.

In addition to the substantiated research exploring the negative outcomes for children experiencing physical restraints in contrast to the paucity of research exploring impact of physical restraints on the RTF worker, including the very real vulnerability that is present for RTF workers in experiencing various traumatic and fatigue responses, exploring the meaning making process that occurs for RTF workers is paramount to understanding the complexities of the work and the need for further research. As such, an in depth exploration of the ways in which

experiences of utilizing physical restraints as an intervention and how they are subsequently understood and impact RTF workers is essential.

CHAPTER III

Methodology

The purpose of this research study is to explore the experience of residential treatment facility workers who utilize physical restraints as a form of intervention with children and the meaning that they ascribe to this experience. This study specifically takes into account the mental, emotional, and physical well-being of the RTF workers and provides a space for the exploration of how values, beliefs, and worldviews may or may not have been affected by the utilization of this specific intervention. Much of the research to date that addresses the use of physical restraints as an intervention is quantitative in nature and emphasizes the impact of physical restraints on clients (Leidy, 2006; Mohr, Mahon, & Noone, 1998; Strout, 2010), as opposed to the ways in which this affects RTF workers. Through this study I hope to create a space in which RTF workers can share their experiences and reflect upon the potential significance and meaning that this has had for them personally.

Study Design and Sampling

This study was a qualitative exploratory investigation that employed non-probability purposive sampling from various RTFs located in the San Francisco Bay Area, utilizing an inductive framework as a means of informing various theoretical frameworks. This study was designed to be exploratory in nature in order to examine the experiences of RTF workers in the particular setting of RTFs that utilize physical restraints as an intervention, with a focus on the

individual's meaning making as a consequence of these experiences. This specific formulation further enabled the gathering of data that was rich in material and allowed for in-depth description and analysis of this material.

The data for this study was gathered through in-depth interviews, utilizing a phenomenological approach that emphasized the individual narrative, experience, and meaning making processes. Through the course of these interviews I gathered both demographic data including age, race, gender, current work status, and length of employment in RTF (Appendix E) and qualitative data, utilizing a phenomenological interview structure comprised of three sections: 1) life history 2) contemporary experience and 3) reflection on meaning (Appendix F). Through the use of a qualitative research design I was able to gather more comprehensive and in-depth information, as well as have the opportunity to work directly with the participants in the study.

Recruitment Process

This study employed a snowball sampling recruitment process, which began with my contacting individuals who I knew who worked at or had connections to RTFs and whom I knew met the sample criteria. These individuals then reached out to other RTF workers, assessed their interest in participating in my study, and secured contact information through which the individuals gave permission to be contacted. The potential participants were then contacted via phone in order to explain the study, invite their participation, and determine level of interest and eligibility. Each participant was asked screening questions to determine eligibility; the eligibility criteria were as follows:

1. Are you 18 years or older?
2. Do you speak English?

3. Are you currently working in a Residential Treatment Facility (RTF) for children and/or youth or have you within the past 2 years in the San Francisco Bay Area?
4. Does the RTF where you work/worked utilize physical restraints?
5. Have you been involved in physical restraints throughout your work at the RTF?
6. Does the RTF where you work/worked utilize other forms of restraints other than physical restraints (e.g., mechanical restraints, chemical restraints)?

If potential participants answered “no” to any question except for question 6, it was explained to them that they were ineligible for the study. If “yes” was answered to question 6 their ineligibility was also explained, as this study focused solely on physical restraints in which RTF workers’ bodies were being utilized as a means of restraint and intervention. Answering “yes” to questions 1-5 was necessary in order to participate in the study and if this was the case then interview dates and times were scheduled with potential participants. Prior to beginning the interview, participants were provided with an informed consent form, which I explained and discussed with them in detail (Appendix B). The informed consent form explained the nature of the study, the expectations of the participants, and the potential risks involved in participating, as well as provided a referral list of support services that participants were invited to access if desired. The participants either agreed to the informed consent, in which case we proceeded forward with the interview, or they had the option to decline participation in the study. In an effort to achieve diversity this study was open to anyone who met the basic criteria outline above, however I recognize that requiring participants to be English-speaking limited the diversity of the study; this was a necessary exclusion for the integrity and validity of this study as I do not have fluency in other languages.

Data Collection Methods and Analysis

The data for this study was collected through in-depth interviews, guided by a specific qualitative interviewing structure. Irving Seidman (2006) describes a method of qualitative interviewing which he terms “phenomenological interviewing,” essentially a technique which combines life-history and in-depth interviewing (p.15). This method employs primarily open-ended questioning, building upon the participants’ responses to the questions, and ultimately creating an opportunity for the participant to reconstruct his/her experience and explore the meaning that he/she has attributed to it. Additionally, this method relies on a relationship that develops between the researcher and participant, resulting in an evolving, co-constructed conversation. The interviews were approximately an hour and a half and divided into three sections: life history (specifically experiences that led to becoming a RTF worker), contemporary experience, and reflection on meaning. Each interview section consisted of a few opening questions, however the content of each interview was very much dependent on the participant and the personal development in material and meaning, as well as the relationship that was formed with the interviewer. Each interview was tape-recorded and had full data transcription, in order to allow for thorough data collection and full analysis of the data.

When planning the implementation of my study and the methods of data collection and analysis, it was prudent to explore the ways in which biases or omissions could potentially affect my study. For example, it was important to note specific demographic trends that were prevalent throughout the data, such as race, gender, age, etc. As I used snowball sampling as a method of data collection, there were biases in terms of who was referred and recommended to the study. While I attempted to minimize biases and omissions, it was impossible to completely eliminate them, as my sample size was small, relied upon referrals from the participants themselves, and was gathered from one specific region.

The information and data that I gathered through the interviews was analyzed and shared using multiple techniques. I created profiles for the participants whom I interviewed and incorporated these segments as a way to share the interview data. From the original interview transcriptions, shorter narratives encapsulating the main passages of interest were selected and incorporated into the findings chapter, providing a powerful way to understand the meaning that the participants have come to give these experiences. I also identified salient themes that were simultaneously identified by the participants and were present throughout the interviews, determined the connections, and then provided analysis and commentary based upon these findings. This method of data gathering, analysis, and sharing allowed myself, as the researcher, and as well will hopefully enable the reader, to gain a deeper understanding and appreciation of the intricacies of RTF workers' experiences, while also providing a lens through which to further awareness of how powerful personal, social, and organizational contexts are within these experiences.

Ethics

As with any research study and design, ethical considerations need to be taken into account. One of the ethical issues that I attended to in the design and implementation of my study was a need to pay attention to the population from which I gathered my data, in order to assess who was being excluded and included from the study (i.e. race, gender, age, geographic location, etc.) and the implications this may have for the outcomes and conclusions of the study in terms of being able to generalize the results and account for the validity of the study. Another ethical consideration is my bias in relation to this research study. I have a personal relationship to this subject matter, as I have previously worked in a residential program, and needed to be mindful of my own hypotheses and emotions that arose throughout this process, doing my best to ensure

that my “self” did not interfere with the methodology of the study. Special consideration and attention was also given to the sensitive and potentially emotionally challenging nature of the interviews that I conducted and the information that I gathered from participants. Participants were informed of this prior to beginning the study and were provided with community resources to access if additional support was needed.

CHAPTER IV

Findings

"I interview because I am interested in other people's stories...stories are a way of knowing.... Every word that people use in telling their stories is a microcosm of their consciousness.... At the very heart of what it means to be human is the ability of people to symbolize their experiences through language. To understand human behavior means to understand the use of language.... At the root of in-depth interviewing is an interest in understanding the experience of other people and the meaning they make of that experience." (Seidman, 2006, p.7)

Through the use of Irving Seidman's phenomenological method of in-depth qualitative interviewing, I have been able to more intimately and thoroughly explore the experiences and meaning making processes of six individuals who have worked in RTFs and utilized physical restraints as an intervention in their work. Rather than framing my findings as results, as my research study is exploratory in nature, I will be exploring and analyzing specific themes, similarities of experience, and individual meaning making. Through the sharing of my participants' stories and experiences, beginning with myself and now with the reader, insight and understanding can be gained of the innermost workings, insights, and deep strength that permeate the intensely complex role of being a RTF worker. The main themes that will be explored in the following chapter include: motivation for becoming a RTF worker, uniqueness of

experience, balancing the personal vs. the professional, dynamic roles of RTF workers, and hope as the main factor in motivation and sustainability.

Introduction to Participants

Six individual RTF workers were interviewed for the purpose of this research study. Brief introductions to the participants are as follows, as they will be appearing throughout the entirety of this chapter.

JAY- 25-year-old white male who was a RTF worker for 2 years and recently transitioned to a position involving more educational coordination rather than direct care RTF work. Jay recalls an experience in college that precipitated his desire to work with youth in a RTF, stating

“We had a charity organization in college that encouraged inner city kids to join wrestling teams. [I was a wrestler in college] and all the wrestlers in college helped. I enjoyed working with inner city youth, which is who I ended up working with in the facility, that kind of motivated me in my interest in kids.”

MARY- 26-year-old white female who was a RTF worker for 2 years and recently began a graduate program in social work. Mary recalls her time as a RTF worker with overwhelming fondness, despite the daily chaos and stress that seems to come along with the territory. Mary reflects,

“I always use the term ‘I miss [RTF].’ I miss working there, and not to say I miss restraints, but I believe [RTF] did wonderful service. I saw progress and I saw kids make progress and that’s pretty cool, these are kids who have been to hell and back, so... I miss the work, I believe [RTF] will always hold a special place for me, the staff is so loving and I hope kids know they are all caring and cared for...”

STAN- 40-year-old black male who has been a RTF worker for 17 years. While over the years Stan has taken on additional administrative duties, he remains adamant in continuing as a direct

care worker, as that is where his heart truly is. Stan shares that his experience of long-term RTF work and the growth that has happened for him personally, professionally, and the growth he has witnessed within the residential world itself. Attitude and perspective play a big role in being able to maintain a sense of stability and positivity in this field. Stan recalls an interaction with a supervisor some years ago, which helped shape his view on challenging situations,

“Over the years I worked in one of the RTFs that was a locked facility. One night I went to help out and it was completely crazy. Six or seven restraints happened that night; the staff was stressing out, and afterwards they were in halls doing paper work. I was talking to my supervisor and I said ‘oh my god it was a horrible night.’ This guy told me ‘look down the hallway, are all the kids in beds asleep?’ I said yeah. Then he said ‘all the staff and everyone are ok, right?’ I nodded yes. ‘Then you had a good night.’ And he was right, it was a good night, and this has stuck with me, you feel me?”

AMY- 27-year-old white female who was a RTF worker for 4 years and recently began a graduate program in social work. Amy knew that she wanted to go into the mental health field prior to becoming a RTF worker, and this experience further solidified her passion for this work. When asked what she envisions her career path to be in the future, Amy states,

“I definitely want to work with kids. I would love a school-based job, helping with education, consulting with teachers, helping them understand kids’ behavioral and educational needs. I’m also looking at clinician positions in other residential programs. So few people are willing to do work with kids in residential and I’m thinking maybe I have a few more years in me, despite some of craziness and my not wanting to do restraints. I’m thinking as a clinician, perhaps...I want to work with kids and families, so I might end up back there, but in a different role with a different perspective.”

TREVOR- 38-year-old black male who was a RTF worker for 4 years and then transitioned into the position of dean of students at a college prep charter school. As Trevor shares his story and experiences, the care and empathy that he has for all of the kids that he worked with became unmistakably evident and showed through in his understanding of and reactions to various situations. Trevor describes having to do home visits with the kids in the RTF, stating

“that stuff was sad too, man, doing home visits that was the worst part of job for me, taking a kid to a home from which they’ve been removed and now the visit has to be monitored by me... I don’t know these people and here I am coming into their house, bringing their child and basically setting the terms on which this interaction can happen... that was the worst, that was worse than the restraining...”

KATIE- 25-year-old white female who was a RTF worker for 3 years and recently began a graduate program in social work. Katie reflects upon the uniqueness of being a RTF worker and the meaning that it continues to have in her life, stating,

“It wasn’t until I had some separation from it and began grad school that I was really able to look back on it and realize what an enormous impact it had on me...the pure stress and almost constant anxiety that was present...you don’t realize what a toll that takes on you until afterwards. But also all the good parts of the work too, and there really were so many...taking the kids to a basketball game and watching their faces light up, trying to do everything in your power to give them as many happy and loving childhood memories as you possibly can...and I carry those kids with me, they are my motivation for doing the work I do...”

THEMES

“I Wanted to Help”

Each interview participant expressed nearly identical motivation for initially becoming a RTF worker, noting both a desire to help and to work with children. Additionally, three out of the six participants reported undergraduate backgrounds in psychology and mental health related fields, while the other three reported various social sciences and liberal arts backgrounds, including sociology, anthropology, and criminal justice studies. Within this expressed desire to enter the helping professions as a direct care worker, a sub-theme arose, across the board, of extremely minimal knowledge about what the work of an RFT would entail prior to applying to and being hired for the position. Each participant's story is unique and comprised of different events which transpired in their lives, yet all ultimately converged on the same path and became RTF workers. Stan describes his early life and the multiple paths that he took to becoming a RTF worker, explaining:

“I was a military child and traveled around a lot when I was younger...later I got interested in this field and did some work while in the military myself with the Special Olympics while I was in basic training and at that point I felt that I wanted to work with kids in some capacity...After the military I wanted to get into the law enforcement field and I applied to several different agencies and chose highway patrol, and I passed that test and I was proceeding along with that. And my cousin was working at a group home facility and one Saturday morning I decided to stop by to visit and ended up spending a good eight hours there. At that point I wanted to look into it to see what it was all about. I applied and was hired shortly thereafter...I had a few friends growing up that I know now were in group homes but we didn't really know what a group home was but being young kids we'd see them running around, never see parents...we kind of assumed it was some kind of place that they lived in, but we didn't really put

two and two together. It is really funny all these years later working in a group home, saying that's where these cats were living at, they were living in a group home; it was funny at that point. We knew they were not in jail but couldn't put our fingers on it back then, we didn't really trip on it to be honest, just when I got the job I was like so this is where these guys were probably living, we never really asked questions...For me, I was drawn to this work just for the fact that I was working with the kids and I had this feeling in my heart that I want to keep people out of jail as opposed putting them in jail...I got some information from my cousin and went the following week and applied. I was hired right away and have been there ever since..."

In contrast, Mary grew up on the East Coast and completed her undergraduate degree at a college in Virginia, pursuing both education and psychology. Mary identifies a deeply rooted desire to help others and credits her education in psychology, and the subsequent years of being a RTF worker, as pivotal markers along her journey to ultimately becoming a social worker. She describes her process of entering the RTF world, explaining:

"After college I was looking for jobs and determined I didn't want to do teaching, I wanted to go more into the therapy realm. I've had experience myself with therapy and that for me was a really positive experience and I'm open about that... and so for me I was like how can I combine knowledge of this field and kids and teaching and also find a job. I was on the hunt, had just graduated in May and had a good connection and wanted to move, I don't know exactly how I found the RTF, either online or word of mouth, either way I loved the concept of it, so I applied and had a job within a month after I graduated which was amazing..."

While both Stan and Mary entered the field of residential work through different routes, both share an underlying, simple desire of wanting to help, of feeling drawn to giving of the self and being in service for one of the most vulnerable populations where there is no shortage of need.

“You Don’t Know Until You Know”

While it may be said of most new experiences in life that one does not and cannot fully understand and “know” until having been immersed in it and experience it first hand, this seems to be more acutely true with the role of RTF worker. The intensity and complete integration of self into the work appears to create a secret language of sorts that is only truly communicable with other RTF workers. This experience is so unique and unlike any other that it creates both a bond between RTF workers, as well as a separation from those on the outside who can never fully “know” what it is like to inhabit this role in such a way that one lives, eats, breathes RTF until it seeps out of one’s pores. As one of the participants, Trevor, puts it,

“You really can’t talk to people about it, and you hear this in other professions like ours, like with ER nurses, people in a mainstream gig will never understand what it is like to work in a residential group home with a kid who is just losing it and you are trying to figure out how to calm them down, just working in a place that is always so unpredictable...”

All participants reflected upon the uniqueness of the experience, reporting that above all it was unlike any work or world in which they had ever been engaged. Most notably, all participants reported initial feelings of heightened anxiety, fear, and stress, specifically in relation to the almost perpetual chaos of the environment and the frequency of engaging in physical restraints. While in time most found the intensity of these feelings and stress levels abating, five of the six participants expressed that they also needed to desensitize and compartmentalize the experience of working in a RTF and frequently utilizing physical restraints

in order to minimize the negative effects of their emotional and physical reactions on their ability to do the work. One of the participants, Jay, describes his initial reaction to beginning work in a RTF, as follows:

“I think we had basic training, they teach us how to restrain. At first it was a little bit shocking at the amount and frequency at which I might have to restrain kids...I had been a bouncer and bartender before so grabbing people was not that foreign to me but I guess I had separated that from the professional experience of doing it at day time with kids...it felt foreign to me and I remember the first time I was there seeing the restraints it seemed very odd to me...I don't think I've ever told anyone this, my initial thought was “I don't know if I can do this,” because kids were screaming and yelling and it was such high anxiety and I thought “wow I can't do this on a daily basis.” I had felt the same way riding around with police when I first thought I was going to go into law enforcement “oh man I don't know if I can get used to this,” but sadly enough I did get used to it... I think your first restraint you just feel a little bit anxious a little adrenalin, some worry and some good feelings, personally, I like some of those feelings. I think over time it slows and you just become more and more used to it, so you get to a point where when kids are starting to hit you and you used to become anxious, but now you are used to it and you become used to grabbing a kid or attaching to a restraint, its just part of your daily duties...”

Jay's reflections on his initiation into the role of RTF worker mirror the experiences of the additional participants, specifically in regards to the anxiety and feelings of self-doubt; surface level doubt about choosing to become a RTF worker and deeper doubting of one's personal ability. Another participant, Amy, describes her first physical restraint and how it is only upon reflection that she has begun to realize the impact it has had on her and the ways in which she compartmentalized as a self-protective coping skill. Amy recalls,

“The first restraint I did I switched in for another staff. They always tried to have new staff switching into a restraint that was already occurring. I had only been there three weeks and I remember that was my first experience. He was a really big kid and my hands shaking, I was really hot and sweating. I remember one of the staff gave me medical gloves to wear because it was so slippery with the sweat and hard to keep the hold. I could feel adrenaline pumping through me, such a physical reaction, and my heart was racing. Prior to switching in, what I vividly remember was the fact that the kid had slapped one of the staff in face and her face was very red and she ran out crying...I felt supported afterwards, but I was anxious throughout it...I remember it taking a while for my body to re-regulate itself, my shortness of breath, sweating, heart pounding, the physical sensations...I was there for four years and worked way up as supervisor and went down to averaging maybe two restraints a day. It had become more common to me and I did not have the intense physical response. There were still certain situations where a kid was very violent with themselves or with another staff member and I would still feel that adrenaline, especially if I was particularly worried about my safety. I never got completely used to it but it got easier...still there were outlier moments where you just felt really raw...”

Both Jay and Amy describe the experience of becoming desensitized over time due to the regularity of engaging in physical restraints and the need to somehow detach from the intensity of this intervention in order to continue to perform the complex roles of RTF worker during and after the occurrence of the physical restraint. Although the act of detaching and having a desensitized reaction to this intensely emotional intervention may dominate many of the experiences of RTF workers, Amy poignantly asserts that there remain moments of rawness, as evidenced by her earlier statement. Continuing to reflect upon her time as a RTF worker, Amy emphasizes that it is only in retrospect that she has begun to realize how intense the work was

and the deep impact that being a RTF worker has had in her life. She recalls that there were times when she would return home after a long, draining day and would cry to her boyfriend, but states,

"I didn't understand how intense it was at the time, and now that I am out of working in residential in such an intense way and not involved in any restraints, I think back and I don't know how I did that everyday. I feel almost more emotional and PTSD-ish about it now that I've had time to process it. I feel like being in it I had to compartmentalize and distance myself because I don't think I would have been able to sustain it and it isn't until after that it has hit me in such an emotional way. I think to myself all the time, "I don't know how I did that every day," its almost like I had moments where I'd come home and breakdown but on an average day I got kicked, bit, hit and it was normal, and now I think back and I don't think I'd be able to do it again..."

The not knowing until actually experiencing what it means to be a RTF worker may be one of the most intense shocks to the system. As discussed throughout the literature review, there is a great deal of research and discourse surrounding the impact of living in a RTF and being involved in physical restraints as being retraumatizing for the child, however there is little exploration of the impact of this on the RTF worker. Each participant reported feeling unprepared and taken aback by what being a RTF worker entailed, specifically in regards to physically restraining children and four out of six participants noted that in reflecting back they realized they had to desensitize and separate themselves from their emotional reactions in order to tolerate the chaotic environment and the physical restraints. Katie reflects upon this stating,

"I think I wonder too, though, sometimes when we are into a traumatic experience of having to physically restrain a child, to be forced into that role of controlling, to have to do that, that's not a pleasant experience and its upsetting and sticks with you. I think sometimes when we have those experiences

desensitized doesn't mean that you don't care, but maybe that its just too much to have to hold onto all those feelings about it, so you separate yourself from it, you just do it, you have to, you know, but if we are constantly emotionally present all the time in all that's going on, it can be exhausting and overwhelming.”

“I Am Only Human”

“I've found myself in situations thinking I know I should not be trying to deescalate this kid because maybe I'm the one who set limits, or the kid tried to bite me and I'm angry, but no one is there to relieve you, and you know nothing good will come of this for me or kid...some days depends on my mood, if I am more or less able to be affected by kids, I'm only human, feelings arise...”

(Amy)

“Hell yes there were times when I was mad, angry when restraining a kid...I always reminded myself this is someone's child, I don't care what has happened, I don't want to put the through anything else...yeah you are pissed off, but you need to remember this is your job...” (Stan)

“It gets forgotten, that we are people too and that this is upsetting and sometimes it is hard to just brush it off and act like it hasn't upset you...or made you angry...a kid punches you square in the face because they are mad at you...Its not easy to always remember the overarching reasons for why you do this work and always be able to separate the kid from the behavior in the moment...”

(Katie)

The struggle that the participants are describing above is indicative of the nature of RTF work and the chaos and turmoil that is present both in the external environment of the RTF and in the internal landscape of the RTF worker. As indicated throughout the extensive interviews

and research, this sometimes conflicting battle between personal sense of self and professional sense of self is not often talked about amongst RTF workers or within the context of supervision. Most times the professional sense of self and intensity of the purpose and meaning behind going into this line of direct care work supersede personal reactions. However, there remain times of heightened emotional turmoil and chaos within the RTF and the worker in which it is very challenging to override the instinctual responses to working with an extremely frustrating or physically assaultive child. Trevor shares the intensity of such an experience and candidly describes the moment where the personal self overrides the professional self, as follows:

“The biggest effects for me would be the fear of retraumatizing the kid, a kid who has suffered physical abuse and is already triggered and lonely, in a place they don’t want to be, and then you end up attaching to and restraining that kid...you have to be really thoughtful about it...Remembering that you are a person too, that’s part of the process of it, because they want you to act like a machine sometimes and act like it doesn’t affect you...It’s hard, don’t get me wrong. There are points when you are just so frustrated and pissed and a kid keeps on acting out and escalating and you are like “it’s done now, you have a minute to get your ass moved or it’s done.” I’ve definitely had that train of thought, and then it just escalates into a restraint...I don’t know, sometimes I think it was the right thing to do, sometimes my emotions get the better of me and at that moment it’s about what my need is, as opposed to what the kid’s need is...”

Trevor is tapping into what each of the participants indicated throughout the interviews and their reflections upon their roles as RTF workers. The physical component that comes along with working in a RTF and restraining children on a frequent basis causes a variety of intense and different emotions to arise. The physical aspect, in the heat of the moment of chaos and

threat of, or actualized, violence, can turn into a power struggle between child and RTF worker, with layers of needing to manage the behavior while simultaneously feeling personally attacked, angry, or retaliatory, not to mention self-protective. Workers had to grapple with perpetual physical injuries, some minor and some more severe that each participant reported, ranging from bruises to being kicked and punched, to scratches, to being bitten and spit on, as well as a broken hand, torn meniscus, and fractured ankle, all of which at times can be challenging to not take personally. For some of the participants, this struggle between personal self and professional self was indirectly addressed through the protocol of being able to ask to switch out with another staff member or expressing the need to take a few minutes space. Unfortunately, as is many times the case with RTFs, there is often understaffing and, as Amy states above, sometimes there are simply not enough staff on hand to help deescalate the situation for both the child and the staff. Additionally, while supervision and debriefing aided in supporting RTF workers in managing complexly stressful and unpredictable situations, attention was rarely, if ever, given to the RTF worker's sense of self and in understanding and exploring the deeply personal reactions that arose during physical restraints.

“I Am Your Everything”

“It’s so different being a residential worker, it’s so unlike anything I’ve ever done or been. You basically live and breathe the kids day in and day out...as much as you are their family, they become your family...In all my time working at the RTF I spent more time with the kids and other staff than with my own friends and family...you know that they need you and that there is no one else, you can’t just call out sick on a kid, there are no snow days, no holidays off...you are their parent, caretaker, playmate, housekeeper, cook, disciplinarian...you get all of their love and all of their hate and you still show up day in and day out...and yet there remains the boundaries of showing

affection to them, things like hugging, that normally would be fine, but these kids have trauma histories and there are rules that are in place...and yet you represent everything to them...and they want to jump on you and hug you and you have to kindly disengage...but there are no qualms about putting hands on a kid if they are unsafe or escalated and need to be restrained...it is such a weird role to have, so much of everything all at once...it is hard, it is hard to contain all of that in one person all the time...regularly going from cooking and eating dinner together, to restraining a kid, to tucking them in bed and reading them a bedtime story...I can't think of anything else like it..." - Katie

The above excerpt from Katie poignantly describes the multiple complex and dynamic roles that are inhabited by RTF workers, roles that are often in tension with one another and create an internal sense of conflict. This, again, is something that one cannot be prepared for until being in the thick of it and actually experiencing the slipping into and out of all of these roles multiple times on a daily basis. Each participant expressed the intensity in which the work is all consuming and the challenge in negotiating how to keep all of these roles in one person. Katie also addresses the issue of specific boundaries that are in place, further adding to the unique challenges of being a RTF worker. All of the participants reported agency protocols about showing affection towards the children, including no hugging, no touching other than what is absolutely necessary or in the context of a physical restraint, no hand holding (regarding younger children), and any other "typical" caretaker affectionate behavior. The reasoning behind these rules is related to the unfortunate fact that most of the children have significant trauma histories, and have suffered from physical, emotional, or sexual abuse.

Additionally, it is important to model appropriate and safe behavior with the children and provide an environment in which they are safe and can re-regulate themselves. Part of this is setting boundaries between staff and children in order to help them reincorporate appropriate and

safe behaviors with adults. Yet there remains the challenge of being a caretaker in all senses of the word while also having to adhere to professional boundaries in place that often prohibit the engagement in typical demonstrations of love and affection, such as hugging. RTF workers are essentially surrogate parents, yet inhabit this liminal space in which they are expected and trained to utilize physical force when needed, however they are also the ones who read bedtime stories, tuck the children into bed at night, and are the first faces they see in the morning. This is a remarkably unique and challenging role to inhabit and there is no way to avoid the emotionally charged situation that this creates.

While a parent fulfills multiple roles and transitions between loving caretaker to disciplinarian to house keeper, for instance, the powerful bond that exists between parent and child, and thus (in most case) the subsequent unconditional love, is not replicable within the RTF worker and child relationship. Unfortunately, most children in a RTF have experienced many failed parent-child relationships (in various forms, whether biological parents, foster homes, kinship arrangements, etc.) and this can result in struggles with forming healthy attachments due to a proven pattern of the significant people in their lives leaving them or mistreating them. Additionally, the high turnover rate of RTF workers almost seems to predict that the children are the constant within the RTF and there is a seemingly endless cycle of worker after worker, staying for a brief time and then moving on. This, perhaps, may impact the child's ability or desire to become close with a RTF worker, due to the belief and fear that they will be leaving. This seemingly inevitable situation only adds to the intensity and ambivalence of the relationship between RTF worker and child, as well as the challenges of inhabiting multitudes of roles.

Both Jay and Stan shared personal experiences of specific situations in which they utilized physical restraints, further demonstrating the complexities and challenges of having such

a multifaceted and sometimes seemingly contradictory role. Jay reflects that while he believes the children he worked with felt predominantly safe around him, there were times that he acknowledges where his judgment was clouded and perhaps the best decisions were not made. As he continues to share his experiences, Jay taps into the deeply personal aspects of being a RTF worker and how difficult it can be to have such conflicting emotions and at the same time fulfill roles that may be in conflict with one another and with the RTF worker's internal processes moment to moment. Jay explains,

“At times I feel guilty or bad. I haven’t been fearful, I’ve had kids come up to me with a knife and I don’t get nervous or anxious, but more looking back and feeling guilty or bad about what happened afterwards...”

Feelings of guilt or self-doubt are common in the aftermath of a particularly intense and triggering event, specifically with the utilization of physical restraints where the RTF worker is engaged in such a power dynamic with the child. Jay continues on to share a situation that resulted in a physical restraint, an incident that years later still compels feelings of doubt, uncertainty, and twinges of guilt, triggering internal questions of "what could I have done differently?" and "did my emotions get in the way of being helpful and therapeutic?" Jay describes a scenario in which he individually physically restrained a 16-year-old male who was physically larger than him and classified as "high level" in regards to behavioral, emotional, and mental health needs.

"Basically, the restraint went down outside in the rain and staff watched me restrain, I expected them to help me, I should have been more adamant about them helping me in hindsight, but he wasn’t known to be assaultive but started hitting me and I slipped and lost balance while he head butted me and I just had to make a decision. I don’t know how much was up to me, my fight or flight kicked in and I flipped to put my hips into him so he didn’t land on me I landed

on him and he hit his head pretty hard...thank god everything ended up ok, he got cut and an ambulance came and there was lots of blood. I guess overall I shouldn't have put myself into that situation and I guess no matter what even if he is ok it shouldn't have happened. I mean he is 16 years old, the situation I probably put him in was traumatic for me but also traumatic for him...I think no matter how tough he tried to act it could have been very traumatic for him so I toil with that in myself, and that's just one of a few...I wasn't able to process with him after like I wanted to...There was an instance where he said negative things to me about it, I think he was acting really tough and getting in my face about it and I looked at his hand and it was just shaking...so I could see how much it impacted him...I think he was trying to save face, there was almost like a handshake later in class, like 'we cool', and he was in my P.E. class and never acted out in class, I think he was worried about what would happen..."

Stan also identifies feelings of self-doubt and guilt when recounting specific instances characterized by particularly high levels of crisis and ponders ways in which physical restraints and the potential for retraumatizing the children can be avoided. He states,

"My relationships with the kids are what matters and are so important, I also think my relationships help limit the restraints...These kids had experienced so much trauma and I built it in my mind to have a safe place for them and not have it be retraumatizing...I remember this one kid, he'd act so big and tough and be in a restraint, and then ask to go to his room afterwards. I remember going in and checking on him and he was in the corner of his bed facing the wall and shaking terribly. I don't want anybody to feel that way. I felt horrible. And so I tailored my efforts for him and always made sure to go see if he was ok...and then there was the look of relief on his face and he would smile and want a hug..."

“You Can, Therefore I Hope”

“It's the children the world almost breaks who grow up to save it.”

Frank Warren

Despite the challenges and stress, despite being kicked, bitten, and spit on, despite living and working in a world that is incomprehensible to the average person, despite having to frequently physically restrain children, despite knowing that for many the RTF was the last stop along the line of many traumas and hurts, despite all of this, what is it that keeps these individuals engaged in this line of work, coming back day after day and continuing to put their blood, sweat, tears, and hearts into this work? One word: HOPE.

This is not the half-hearted, fleeting thought of hope, the “oh well, tomorrow has got to be better” kind of hope. This hope is a deeply rooted, unshakeable belief in the true abilities of the children to heal and grow, to overcome obstacle and break the barriers that have been set up for them for so long; a belief that permeates the very core of these RTF workers, and it is what always remains, no matter how hard and heartbreaking the days or weeks have been. And it is not an unfounded hope, either. It resonates within the progress and healing that is seen and actualized within the children, and fostered through the care and environment provided by the RTF workers.

Hope can be one of the most elusive beliefs to cling to at times, and often the RTF workers are not only holding onto hope as a motivating factor for the dedication to the work and the children, but also holding onto hope for the children themselves when they have seemingly given up. Katie poignantly reflects upon the need to carry the hope for the children at times when they are unable to on their own:

“I remember this one Saturday, two of the younger girls were being picked up by their workers and going to an “adoption party,” what an odd concept...and I

helped them get dressed and they wanted to wear pretty dresses and we did their hair and they were so excited...these were girls who had been in and out of so many foster homes at such a young age, and that day they were so excited and so full of hope...and they came back later that day, no families had been interested in them, they came in and you could see the hurt on their faces, the disappointment...soon after they began acting out and picking fights, tantruming and throwing things, becoming physically assaultive towards themselves and towards staff and ended up in restraints...in that moment we had to open ourselves up to take in all the hurt and pain they were feeling and hold the hope for them that this was not how the story ended and that while they were feeling hopeless we remained hopeful despite everything and that wouldn't change...we needed to show them this..."

Coupled with the hope is the very real healing and progress that the children make, time and time again. Both Stan and Trevor vividly recount numerous stories of children working their way through the RTF program and graduating, finding permanent families and flourishing. Stories of encountering former clients years later and hearing them tell with pride the accomplishments that they have made and the hardships they have overcome, stories of voicemails thanking them for believing in them and for helping them through such a tough time years ago. As Stan recounts these stories, the pride in his voice can be heard as he talks of the many children he has worked with throughout his 17 years in the residential world,

"Progress and hope is what keeps me going, it would be crazy if I left now and I have no desire to. I do some administrative work but I am still doing direct care, I spend all my time with the kids, that's where my heart is. I want to be on duty with the staff and the kids, I am a sort of daddy to them all, to a lot of people, and I tell you it has made me one hell of a daddy to my own guys...I got a few more years left in me for sure."

As demonstrated through the sharing of experiences of the six participants, even though each individual has a unique and singular set of circumstances that led to becoming and being a RTF worker and the subsequent meaning making processes and personal impacts, there are significant commonalities across all participants that provide important insight into the world of RTF workers. The themes highlighted throughout this chapter- motivation for becoming a RTF worker, uniqueness of experience, balancing the personal vs. the professional, dynamic roles of RTF workers, and hope as the main factor in motivation and sustainability- saturated the personal and collective narratives of the six individual RTF workers and the more universal conceptualization of the RTF worker. The uniqueness of the intensity and complexity of being a RTF worker is undeniable, however the deeply rooted belief and power of hope and healing, as well as undying faith in the potential of the children, and being a part of the actual progress being made, provides transcendent meaning for these six individuals. Despite the times of crisis and stress, as well as heart-wrenching sadness that at times permeates all aspects of this work, the journeys that these six individuals experienced have been, and continue to be, deeply impactful. The power and process of individual meaning making has provided a context through which to heal and to understand a purpose in their own individual suffering as a part of the work that they do in helping to heal and ease the pain of the many wounded children of the world.

CHAPTER V

Discussion

“Working in residential impacted my worldview and drove me into social work. There is this way of hope and belief that people can change and seeing that in actuality, not just with the kids, but seeing that parents, guardians and family members could change too- bearing witness to that was life changing.” (Amy)

The objective of this qualitative study was to explore the experiences of RTF workers who utilize physical restraints as an intervention and the meaning ascribed to these experiences. Through the interviewing of RTF workers as a means of understanding their experiences, personal and collective narratives, and how they have come to embody this aspect of their lives, the meaning making process and the effect of being a RTF worker in this capacity can be seen and explored. As this was an exploratory study, it was structured with an openness devoid of attempting to prove a specific hypothesis, rather evolving from curiosity and the desire to understand and pay homage to the experiences of RTF workers and the meaning that this role has held, or continues to hold, in their lives. As the study progressed and I engaged in further interviews, the complexities of the role of RTF worker became more apparent and it became evident that the individual and collective meaning making for the six participants encompassed not only the utilization of physical restraints, but also the inhabitation of the multifaceted role of being a RTF worker.

Key Findings

As understood through the findings, the meaning making process and the long-lasting implications of being a RTF worker is unique to each individual; however there appears to be a collective meaning, as well. Strong (2002) explores the poetic aspects of the meaning making process, including ways of sharing, retelling, and re-integrating impactful life experiences, specifically in regards to suffering and illness. While the participants in this study expressed the stress, difficulty, and suffering (understood both on a physical level and more existentially) of utilizing physical restraints and working in an environment characterized by continuous high levels of intensity and the ways in which this has shaped and given meaning to their lives, it appears that there was also a significantly positive meaning derived from these experiences which has been incorporated into the individual personhood of each participant.

Each participant expressed, undoubtedly, that despite the negative and stressful aspects of being a RTF worker, the hope and belief in progress and healing for the children in the programs provided an internal map for their drive to continue to pursue work in the helping professions, specifically with children and youth, albeit in different capacities. Amy eloquently expresses in the above quote a sentiment and belief that was shared by all of the participants- working as a RTF worker in all of its complexities, including being required to utilize physical restraints, was a life changing experience. It is significant to note, however, that for an experience that has been so impactful, even to the point of shifting worldviews, each participant came to the realization that this was an experience that they had never actually processed out loud nor reflected upon in depth prior to engaging in the interview session.

Thus, in exploring this trend of limited prior reflection upon the impact and meaning of the experience of being a RTF worker, the dialogue that each participant engage in throughout

the interview can be viewed as an additional layer of the meaning making process. The telling and retelling of an experience is significant in the process of giving meaning to a particular life event and to increasing insight and understanding in one's life; especially with challenging experiences this can be a healing and reparative process, an ability to reconstruct a narrative of strength and personal significance. John Shotter (1993) explores the construction of reality, social life, and meaning through language and through the retelling of stories, events, and memories. He additionally proposes that,

“perhaps our task in coming to a grasp of the nature of human understanding is . . . to re-voice processes that have become de-voiced and abstracted from their proper habitats, to see or re-envision them in their living contexts” (1996, p. 13).

The process of interviewing participants, utilizing a phenomenological method, inevitably provided a space through which individuals were able to re-voice experiences and processes that had thus far remained seemingly voiceless. As Jay states,

“I haven't really thought about how intense this work was or talked about it with anyone since...I'm realizing as we talk now that it has stayed with me and has influenced my views of the world and the work that I do...This has really been an important part of my life...”

An additional aspect of the meaning making process for the participants, and in exploring the significance of being a RTF worker in their personal and professional lives, were the discourses around contemplating the efficacy of utilizing physical restraints as an intervention. The issues that arose regarding utilization of physical restraints with children encompass ethical dilemmas, personal feelings of guilt in regards to fear of retraumatizing the children, and feelings of helplessness in being able to envision an alternative intervention, specifically given the high

level of behavioral, emotional, and mental health needs of the children. Amy poignantly captures this dilemma that seems to be so distinctly present in the consciousness of RTF workers, stating,

“As much as I understand kids die in restraints all the time, and I hated doing it, there were times when I didn’t know how else to keep them safe other than by putting hands on them. I don’t think that it can be an either or situation in thinking about whether restraints should be used or not, but I wish they didn’t have to be. The place I worked at had a restraint reduction initiative, but at the end of the day there were still kids that needed to be restrained. . . I wish I knew but I don’t have answer for better alternative.”

Based upon the findings of this study, it appears that the exploration and value of the meaning making which RTF workers ascribe to their experiences in residential settings utilizing physical restraints with children is significant, impacting not only their personal sense of self and worldview, but additionally the work that they continue to do, whether as RTF workers or in other environments. In reflection, all participants expressed a deeper understanding of the personal impact that working in a RTF has had, however for all but one participant this was in retrospect, rather than while currently being a RTF worker. This begs the contemplation of potential for positive impact for both RTF worker, and the subsequent direct care work that is done with the children, if the exploration and discussion of the meaning making process was addressed earlier on within the context of the actual work.

As both the researcher and a former RTF worker myself, I discovered my own meaning making process throughout the implementation of this study. Through personal disclosure of my time as a RTF worker to the participants, positive rapport was immediately created and an unspoken understanding was felt within the room, directly tying into the universal theme of “you don’t know until you know.” Moreover, I found this process of phenomenological interviewing

to be an insightful and reparative process for myself in reflecting upon my experiences as a RTF worker, the impact this work has had on me, and my own meaning making process. I found that in bearing witness to the stories of my participants and truly listening to their continual process of giving meaning to their experiences, I was able to reflect upon ways in which I had conceptualized and somewhat limited my remembering of being a RTF worker.

Specifically through the overarching theme of hope as being the sustaining force in RTF work and in determining continuation on in helping professions, I was able to reconnect with the hope that I had for the children that I worked with in the RTF, which had at times been overshadowed by the stress and chaos of the behaviors and environment. I found that I was able to discover and connect with a sense of equilibrium and peace around being a RTF worker, with all the intricacies that it entailed, and found an ability to simultaneously hold on to both the positive and negative aspects of this time in my life. Conducting and participating in these six interviews provided me with the space that I had not had prior to this, in both my professional and personal lives, to really reflect upon my experience, how it has impacted me, and how I have come to understand this time in my life. At the same time, a parallel process was occurring for my participants by virtue of the fact that each one reflected in surprise that they had never taken the time, nor had it given to them, in which to reflect upon their lives as RTF workers and the complexities of this experience. In this way, the meaning making process proved to be multifaceted; a process that does not necessarily resolve in completion, but rather continues to evolve with different understanding through time, space, and experience.

Limitations

Due to the small sample size of this study, the results are not generalizable in a traditional sense to the larger population of RTF workers as a whole. However, phenomenological

interviewing is more focused on the constructed process of meaning making, which inherently extrapolates meaning for the researcher and, subsequently, the reader, rather than attempting to make generalizable claims applicable to entire group. While the participants within this study shared common beliefs and salient themes were identified, the findings are unable to be viewed as definitively significant. Additionally, due to nature of participant recruitment being through snowball sampling, there is limited variation amongst RTFs that were represented, due to both the geographic location of the sample and the fact that a few of the participants worked at the same RTFs. Furthermore, while each interview was structured with the same groups and sub-groups of questions, space was intentionally left for participants to have more autonomy within the interview, thus resulting in unique but not standardized or replicable interviews.

Implications and Future Research

This study has implications for the field of social work in numerous ways. The RTFs in which the study participants worked included social workers as part of the treatment team. Social workers are therefore involved with both the children who are living in the RTF and receiving treatment, as well as the direct care workers who essentially provide a surrogate family for the children. Understanding and being aware of the challenges associated with being a RTF worker, as well as addressing the complex issues that arise, is essential in providing the best possible care for children in RTFs.

Social workers have a unique opportunity to be a pivotal force in increasing awareness of the intricacies of working in the residential field and creating a space to address the ethical considerations of both utilizing physical restraints as an intervention as well as emphasizing the deeply impactful result this may have on the RTF workers themselves. Additionally, it is

imperative to increase and support self-care amongst RTF workers, a process in which it would be beneficial to include social workers, specifically those working in conjunction with the RTF workers. One of the similarities that arose between participants in this study was the retrospective realization that during the time that they were actively working in a RTF they became desensitized to the stress and traumatic experiences, as well as compartmentalized the negative and troubling aspects of the work as a means of self-protection. This is a larger issue that is not just the responsibility of the field of social work to address, but society as a whole, and more specifically through policy change.

RTF workers are predominantly young adults typically hired directly out of college and with minimal experience working with children who have high levels of behavioral, emotional, and mental health needs (Weaver, 2007). Stan, an anomaly due to being 40 years old and working in a RTF, addressed this throughout his interview, describing the RTF workers he hired and trained as "just kids themselves...they have no idea what they are getting into." Furthermore, Stan explained that oftentimes his role included not only caring for the children but the staff, as well. This is incredibly significant when considering implications this has regarding ways in which the field of social work can become increasingly supportive towards RTF workers. It is vastly important for social workers to view the support and care of RTF workers as part and parcel of their responsibility. Specifically when viewing this responsibility through a capacity building approach, through social workers investing in RTF workers, they are ultimately investing in the children inhabiting the RTFs. As discussed previously, RTFs are often the last stop in a long line of unsuccessful placements for children with significant behavioral, emotional, and mental health needs, as well as significant trauma histories. The RTF workers subsequently end up being parental figures for the children who have had untrustworthy parents

or caregivers, thus the challenges are immense and the stakes are high for helping these children to develop trust in adults. As such, it would seem obvious that we, as a society, would provide the utmost care, support, and training for the direct care workers who are acting as surrogate families and taking care of these children day in and day out, 365 days a year. However, RTF workers are more often than not overworked, underpaid, and inadequately supported; fulfilling roles and providing care in ways that most who are not involved in the RTF world cannot even imagine.

It is imperative for future research to address this discrepancy between the significance and importance of being a direct care worker for such a vulnerable population, and yet not having one's individual personhood and relationship to this work being taken into consideration, valued, and supported. Perhaps if additional studies were conducted in a similar vein as this study, but on a larger scale, the results would be more significant and therefore have definitive implications on the field of residential work. Current research on the experiences of RTF workers, utilizing physical restraints as an intervention within the context of their daily responsibilities and roles, is significantly lacking. Further research should address this for the benefit of the RTF workers and the children in RTFs, as well as to invest in building the capacity of RTF workers to serve these children and to support policy changes that can be made for the betterment of social services provided to vulnerable populations.

Funding for social services has historically been minimal and is often one of the first areas to be cut when economic challenges arise. Unfortunately, this appears to have significance in the importance, or lack thereof, that is placed upon addressing the needs of RTF workers and supporting research studies that explore the needs of this population. As mentioned previously, there are numerous restraint reduction initiatives that are being promoted, however there does not

yet appear to be a viable replacement option that will be significantly beneficial for RTF workers and the children they are working with who are in need of skilled interventions to address high levels of behavioral, emotional, and mental health needs. As such, the need to have trained workers to restrain children will, in all likelihood, never completely disappear. Further research should focus on studying, developing, and implementing alternative strengths-based interventions to utilize with children who are many times significantly dysregulated in multiple domains of functioning. On an even more radical level, I suggest revisiting and reassessing the RTF model as a whole and truly determine if it is functioning in a holistic and healthy manner that is both positively benefiting the population it is serving, as well as promoting the well-being and emotional, mental, and physical health of the caregivers who are dedicating themselves to this work.

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Appendix A

Human Subjects Review Approval Letter



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

February 6, 2013

Ruth Muellejans

Dear Ruth,

Thank you for making all the requested changes to your Human Subjects Review application. Your project is now approved by the Human Subjects Review Committee.

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 with your study.

Sincerely,

A handwritten signature in blue ink that reads 'Marsha Kline Pruett /PhD'.

Marsha Kline Pruett, M.S., Ph.D., M.S.L.
Vice Chair, Human Subjects Review Committee

CC: Josh Miller, Research Advisor

Appendix B

Informed Consent Form

Dear Participant,

My name is Ruth Muellejans and I am completing my Masters degree in Social Work (MSW) at Smith College School for Social Work. I am in my final year of graduate school and I am conducting research for my thesis, exploring the experiences of residential treatment facility workers who utilize physical restraints as a form of intervention with children and the meaning that they ascribe to this, specifically with regards to their mental, emotional, and physical well-being. The results from this study will be used for my thesis and may also be used for presentations and publications in the future.

I would like to invite you to participate in my study, which is completely voluntary in nature. You are eligible for participation in this study if you are 18 years or older, speak English, work or have worked within the past 2 years at a residential treatment facility (RTF) for children that utilizes physical restraints in the San Francisco Bay Area, you have engaged in these physical restraints at the RTF, and the RTF does not utilize other forms of restraints (specifically chemical or mechanical). Your participation would consist of an approximately 2-3 hour long interview with me, during which I will be asking you personal background questions and about your experiences working in residential treatment facilities (RTFs) where physical restraints were utilized and exploring the personal meaning that this has had for you. I will be audio taping the interview for my research purposes and I will personally be reviewing and transcribing the interview.

Participation in this study may bring up difficult and possibly upsetting feelings due to the sensitivity of the material that will be discussed, as I will be asking you to reflect upon your experiences utilizing physical restraints. If you find that you would like additional support at any point during or after the interview process, I am providing you with a referral list of resources that you can access in the community for support at your convenience.

Additionally, it is important for you to understand that as an individual completing my Masters degree in Social Work, I am a mandated reporter, meaning that I am obligated to report any information that is relayed to me regarding the abuse or neglect of a client that is brought to my knowledge.

Although there is no financial compensation for your participation in this study, your participation will provide you with the opportunity to reflect upon your experiences working in a RTF and share your own personal and unique story. It is my hope that telling your story and reflecting upon your experiences will be meaningful for you. It is also my hope that your participation will inspire further research into the impact of physical restraints on RTF workers, as this is an area that has yet to be thoroughly explored, as well as encourage the implementation of alternative interventions.

The utmost precautions will be taken to ensure your confidentiality throughout this study. All identifiable information will be removed and will not be included in the final presentation of the research. I will personally be conducting the interviews, reviewing the audiotapes, and analyzing the data. My research advisor will have access to the data only after identifiable information has been removed. If this research is included in presentations or publications, the data will be presented as a whole and any illustrative quotes or vignettes will be carefully disguised. All data, including audio tapes, transcriptions, and interview notes, will be kept in a secure location for three years, as required by the Federal guidelines and data that is stored electronically will be encrypted and password protected. If materials are needed beyond three years, they will remain in a secure location and will be destroyed when no longer needed.

Your participation in this study is voluntary. If you choose to participate, you may withdraw at any point during or after the interview process, and up until March 1, 2013, at which point all materials pertaining to you will immediately be destroyed. You may decline to answer any questions throughout the interview. If you have any concerns or questions about your rights or about any aspect of the study, please feel free to contact me at [email address] or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (xxx) xxx-xxxx. Please keep a copy of this informed consent form for your personal records.

Thank you for your time and interest in my research study.

Sincerely,
Ruth Muellejans
MSW Candidate, Smith College School for Social Work

YOUR SIGNATURE INDICATES THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Participant Signature _____ Date _____

Researcher Signature _____ Date _____

Appendix C

Referral Sources

1. **Mental Health Association of San Francisco:** Non-profit organization that provides referrals for mental health services and counseling around the Bay Area

Mental Health Association of San Francisco
870 Market Street, Suite 928
San Francisco, California 94102
Telephone: (415) 421-2926
Fax: (415) 421-2928

Email: info@mha-sf.org

Hours: 9:00 a.m. to 5:00 p.m. Monday through Friday

2. **Therapy Network:** Non-profit organization of psychotherapists, providing free, confidential referrals for mental health services throughout San Francisco, The East Bay, and Marin County

San Francisco: (415) 323-5519

East Bay: (510) 898-6012

Marin: (415) 578-0408

3. **Psychological Services Network:** Organization providing individual, couples, and family therapy for children, teenagers, and adults; training clinic for the California School of Professional Psychology

Psychological Services Center
1730 Franklin St. Suite 212 Oakland
Telephone: (510) 628-9065

Hours: M-Th 9am-8:30pm F 9am-4:30pm No drop-in services

If further referral assistance is needed, please do not hesitate to contact me at [email address].

Appendix D

Screening Questions

1. Are you 18 years old or older?
Yes
No
2. Do you speak English?
Yes
No
3. Are you currently working in a Residential Treatment Facility (RTF) for children and/or youth, or have you within the past 2 years in the San Francisco Bay Area?
Yes
No
4. Does the RTF where you work/worked utilize physical restraints?
Yes
No
5. Have you been involved in physical restraints throughout your work at the RTF?
Yes
No
6. Does the RTF where you work/worked utilize other forms of restraints other than physical restraints (e.g. mechanical restraints, chemical restraints)?
Yes
No

Appendix E

Demographic Questions

1. What is your age?
2. What is your gender?
3. What would you identify as your race and/or ethnicity?
4. Are you currently working in a RTF? If you previously worked in a RTF how long ago was this?
5. How long have you/did you work in a RTF?

Appendix F

Initial Open-Ended Interview Questions

Part I: Life History

1. Can you tell me a little bit about yourself, who you are, where you are from, a bit about the life course that led you to residential work?
2. How did you come to work in a RTF?

Part II: Contemporary Experience

1. What does/did your work in a RTF entail?
2. Can you describe what it has been like for you working at a RTF (currently or in the past)?
3. What experiences have you had utilizing physical restraints? Can you share a vignette?

Part III: Reflection on Meaning

1. Given why you decided to become a RTF worker and given what you have said about your work now (or at a RTF previously), how do you feel about the role of being a RTF worker utilizing physical restraints in your life?
2. What sense of meaning does this hold for you?
3. Has your experience as an RTF worker influenced your personal values and sense of self as a professional?
4. What are your future plans, either as a RTF worker or in your larger career trajectory? Have your experiences and the meaning that they hold for you influenced these plans?