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Treatment Providers' Perspectives on Restraints and Seclusion for Children in Psychiatric Facilities

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Walden University

College of Social and Behavioral Sciences

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Calpurnia Okwuone

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Walden University
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Abstract

Treatment Providers' Perspectives on Restraints and Seclusion for Children in Psychiatric Facilities

by

Calpurnia Okwuone

M.S., Walden University, 2015

M.S., University of Phoenix, 2011

B.A., University of Kansas, 2007

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

School of Psychology

Walden University

February 2021

Abstract

The use of restraints and seclusions in psychiatric treatment facilities for children and adolescents has caused major disputes in the healthcare field. Treatment providers determine the need to implement a restraint or seclusion depending on their perceptions of the situation and their responsibility to abide by the rules and regulations of the facility. The purpose of this research was to gain a deep understanding of how treatment providers are affected prior to, during, and following the use of a restraint or seclusion with a child or adolescent patient. Attribution theory was the theoretical framework used to examine this phenomenon. Data were gathered from in-depth interviews through the process of purposive sampling of 8 treatment providers from child/adolescent psychiatric treatment facilities in a large Midwestern city. Written documentation from the interviews was hand coded using interpretative phenomenological analysis to determine patterns and themes. Treatment providers shared a variety of experiences, including emotional and physiological reactions toward restraint use, relying on familiarity with patients to assist with reacting appropriately to challenging situations, questioning their ability to incorporate proper techniques and procedures, experiencing struggles with power and control, developing relationships and support, and debriefing. Data from this study could lead to positive social change as the experiences shared by participants provide knowledge and insight into the complexities of the intervention process and could assist child/adolescent facilities with developing alternative actions during crises that do not involve restraints or seclusions but rather coping techniques to assist with a reduction in aggressive behavior.

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Chapter 1: Introduction to the Study

Introduction

The term *crisis procedure* can be used to represent many situations in various fields of work. In the mental health field, restraints and seclusions are two of the most well-known interventions used during a crisis (Green-Hennessy & Hennessy, 2015, p. 547). These intensive procedures have been known to cause both negative and positive outcomes for the patient, but little is known about the effects on the individuals implementing the procedure. How are these individuals impacted by using these crisis procedures? What are the perceptions of these individuals regarding the overall effectiveness of these interventions for patients? Answers to these questions may provide valuable insight for prevention and treatment of problematic reactions during escalated situations in mental health. Moreover, the same answers would further the understanding of the safety and comfort of treatment providers implementing these procedures.

In most child/adolescent psychiatric facilities, seclusions and restraints are used to manage a patient's behavior (Brophy et al, 2016). Tremmery et al. (2015) identified seclusions and restraints as reactive procedures often used when treatment providers are out of options in reducing aggressive behavior of a child/adolescent patient. These intrusive procedures have been associated with significant problems in the mental health field, including potential for injury not only to the patient but also the individual initiating the restraint (Tremmery et al., 2015). Additionally, there exists a risk of psychological issues for the child/adolescent patients, and the adults implementing these procedures. Researchers have found restraints and seclusions on children and adolescents can cause

traumatizing effects, but there is lack of research into the psychological and physiological effects on the adults implementing these procedures (Green-Hennessy & Hennessy, 2015; Muir-Cochrane, Oster, & Gerace, 2014; Tremmery et al., 2015). In addition, there is a lack of evidence of therapeutic benefit in using restraints and seclusions on children and adolescents in psychiatric facilities (Muir-Cochrane et al., 2014). Researchers have shown children/adolescents are not learning positive behavioral alternatives, which may cause their behaviors to remain the same (Huefner & Vollmer, 2014; Muir-Cochrane et al., 2014; Valenkamp, Delaney, & Verheij, 2014). Moreover, the use of restraints and seclusions introduces the problem of the control factor. Jacob, Seshadri, Srinath, Girimaji, and Vijay-Sagar (2014) stated there is an increased risk with the use of restraints and seclusions as such procedures could become normalized over time because the procedures function as a temporary solution for the occurrence of the disruptive behavior. Continued use of restraints and seclusions considerably heightens the risk for abuse (Jacob et al., 2014).

In this study, I sought to develop an understanding of treatment providers' experiences prior to, during, and following the use of a restraint or seclusion with a child/adolescent patient. I analyzed responses provided by participants through interviews to discover themes and patterns from the various experiences shared, invoking the theoretical implications of attribution theory (Andrews, 2017). The need for this research derives from a deficiency in the literature on the implementation of restraints and seclusions on children and adolescents from the perspective of treatment providers. Obtaining feedback regarding the experiences of implementing restraints and seclusions

from the treatment providers' perspectives allows for a reevaluation of crisis procedures in psychiatric facilities. The results of this study may contribute to positive social change through treatment provider feedback assisting psychiatric treatment centers in developing alternative strategies to deescalate a child/adolescent patient displaying signs of aggression.

Chapter 1 provides an outline of the importance of this research along with a discussion of the key components of the study. Chapter 1 includes the (a) background, (b) problem statement, (c) purpose of the study, (d) research questions, (e) theoretical framework, (f) nature of the study, (g) definitions, (h) assumptions, (i) scope and delimitations, (j) limitations, and (k) significance of the study. The chapter concludes with a summary.

Background

Green-Hennessy and Hennessy (2015) stated that many child/adolescent patient facilities require improvement in crisis intervention. There are several treatment approaches for children/adolescents displaying aggressive behavior; however, most treatment providers in these facilities continue to react with the most restrictive intervention involving a restraint/seclusion without using alternative approaches that may be beneficial to both the client and the treatment provider (Andrews, 2017; Green-Hennessy & Hennessy, 2015). Crisis procedures, such as restraints and seclusions, used in psychiatric treatment facilities for children/adolescents between the ages of 3 and 18 in the United States continue to garner much attention from the federal government and Congress regarding practice of less restrictive methods of interventions on clients

(Simonsen, Sugai, Freeman, Kern, & Hampton, 2014). Ross, Campbell, and Dyer, (2014) stated that the Mental Health Act (MHA, 2014) defines *restraint* as a restrictive intervention relying on external controls to limit movement or responses of an individual. *Seclusion*, according to the MHA, is defined as the confinement of an individual at any given time of day alone in a room or area for which there is no exit (Ross et al., 2014).

In the late 1970s, restraints and seclusions were identified as an "embarrassing reality" (Madan et al., 2014, p. 1273) for the psychiatric field. Many psychiatric treatment facilities claim that the involuntary placement of a child/adolescent psychiatric client in an empty room has been found to be an effective strategy in decreasing high levels of agitation and preventing injury. Nonetheless, a belief has evolved that treatment providers are unable to treat children/adolescents who display aggressive behaviors without the implementation of physical interventions.

Ross et al. (2014) stated that 12,000 episodes of restraints and seclusions on children/adolescents in psychiatric facilities occur annually in the United States; therefore, approximately 33 restraints and seclusions are implemented daily. Implemented in 2000, the Children's Health Act (CHA) Section 3207 is directly related to restraints and seclusions (Ross et al., 2014). Section 3207 requires any health care facility receiving federal funding to protect patients against physical or mental abuse or corporal punishment, specifies the circumstances under which restraints and seclusions may be used, and lists requirements for staff training on restraints, seclusions, and alternative methods (Ross et al., 2014).

According to many professional organizations, various offices of each state, and laws of the federal government, circumstances in which restraints and seclusions should be implemented consist solely of maintaining safety when proactive interventions do not work, when less intrusive methods such as verbal deescalation are unsuccessful, and when the behavior of the child/adolescent presents an imminent danger or serious injury to themselves or others (Kirwan & Coyne, 2017). An ongoing clinical, ethical, and legal debate surrounding the use of restraints and seclusions on children/adolescents in psychiatric treatment facilities has mainly focused on the physical and psychological effects commonly associated with its use (Kirwan & Coyne, 2017). Kirwan and Coyne (2017) listed such physical and psychological effects to include severe injury, death, panic attacks, and posttraumatic stress, resulting in facilities across the United States to seek reduction in these coercive measures.

Studies have shown that, in practice, the motivation behind the use of restraints and seclusions is often found to go against recommendations (Furre et al., 2014; Pogge, Pappalardo, Buccolo, & Harvey, 2014). Due to these findings, questions have been raised regarding treatment providers' decisions in determining the use of these procedures. The gaps in the literature I sought to address with this study are the experiences of treatment providers when implementing restraints and/or seclusions on a child/adolescent patient, and their thought process prior to, during, and following these procedures. Researchers have conducted similar studies that have contributed to the understanding of the attitudes and knowledge of treatment providers working with children/adolescents in psychiatric facilities who exhibit aggressive behaviors (Shechory-Bitton & Raipurkar, 2015), but

more studies are needed to have a better understanding of treatment providers' experiences. Shechory-Bitton and Raipurkar (2015) examined attitudes toward the use of physical restraint among staff who were working in residential facilities for children/adolescents and the relationship between these attitudes, their knowledge, and coping strategies for dealing with stressful situations, such as these restrictive procedures. Shechory-Bitton and Raipurkar, however, did not articulate the thought processes and attitudes of staff prior to and during the implementation of a restraint or seclusion. These researchers placed emphasis on the staff members' coping style in stressful situations and how their coping style correlated with the crisis intervention method used by the facility. Denison (2016) focused on the current attitudes and knowledge toward the use of restraint and seclusion by staff members on children/adolescents and did not explain the experiences these staff members had prior to and during the restraint and seclusion procedures.

Given the evidence of research on treatment provider opinions and attitudes toward the use of restraints and seclusions on children/adolescents (Denison, 2016; Furre et al., 2014; Shechory & Raipurkar, 2015), I sought to expand on prior research to develop a better understanding of treatment provider experiences prior to, during, and following the implementation of a restraint/seclusion on a child/adolescent, to determine how they might be affected. Results of this research may assist in improving the overall culture of the mental health field by providing further insight regarding strategies and techniques to assist in decreasing the number of physical interventions used on children/adolescents in psychiatric facilities.

Problem Statement

Many researchers have addressed the use of restraint and seclusions on children/adolescents residing in psychiatric treatment facilities (Caldwell et al., 2014; Scott, Duke, Scott & Dean, 2014). Nevertheless, the published studies have not addressed the experiences of treatment providers who engage in these physical interventions to develop a better understanding of their thought processes prior to, during, and following the use of restraints and seclusions (Denison, 2016; Furre et al., 2014). The average age range of patients in psychiatric treatment facilities that provide services to children and adolescents is 3–18 (Shechory & Raipurkar, 2015). The amount of data collected focusing on treatment providers' perspectives when implementing restraints and seclusions on children/adolescents between the ages of 3 and 18 is low in any given study (Minjarez-Estenson, 2016; Pogge et al., 2014; Shechory & Raipurkar, 2015).

The specific problem is that while treatment providers' attitudes toward the use of restraints and seclusions are known, researchers have not explored the phenomenon of treatment providers' experiences leading up to, during, and following the use of these procedures (Green-Hennessy & Hennessy, 2015; Jacob et al., 2014; Tremmery et al., 2015). There is a need for an increased understanding regarding the experiences of treatment providers prior to, during, and following the implementation of a restraint or seclusion in child/adolescent treatment facilities. This knowledge could provide insight into the effectiveness of these interventions. Minjarez-Estenson (2016) stated that many facilities make clear that restraints and seclusions are intended only after less restrictive alternatives have been implemented but shown to be ineffective. Obtaining a better

understanding from the perspective of the treatment providers regarding their experiences prior to, during, and following the use of a restraint or seclusion may assist with a change in culture and in leaders' outlooks on the use of these procedures, possibly leading to organizational change.

Purpose of the Study

The purpose of this phenomenological study was to gain a deep understanding of how treatment providers are affected prior to, during, and following the use of a restraint or seclusion on children/adolescents in psychiatric treatment facilities. Previous research is focused mainly on how child/adolescent patients are affected by the use of physical interventions (Scott, Duke, Scott & Dean, 2014), strategies on how to reduce the use of restraints and seclusions (Felver et al., 2017), and treatment providers thoughts and opinions of the effectiveness of physical interventions (Pollastri, Lieberman, Boldt & Ablon, 2016). What is not discussed in the literature are how treatment providers are affected prior to, during, and following the intervention process. According to Green-Hennessy and Hennessy (2015), little research has focused on the treatment providers perspective of implementing a restraint or seclusion. Specifically, it would be of great benefit to researchers and consumers/providers in the mental health field to understand treatment providers experiences leading up to, during, and following the use of these procedures. From these shared experiences, knowledge and insight can be provided for organizations to begin discussing alternative ways in which problematic behaviors can be addressed to reduce the use of physical interventions.

Research Questions

Based on the identified problem and the formulated purpose, the research questions guiding this study were as follows:

RQ1: How do treatment providers make meaning of their experiences when they use restraints or seclusions on children/adolescents?

a. How do treatment providers talk about what they are experiencing before implementation of a restraint or seclusion?
b. How do treatment providers talk about what they are experiencing during implementation of a restraint or seclusion?
c. How do treatment providers talk about their experience following implementation of a restraint or seclusion?

Theoretical Framework

The theoretical framework for this research study was derived from Fritz Heider's attribution theory (Heider, 1958). This theory contributes to the understanding of the thought processes and experiences of treatment providers prior to, during, and following the implementation of a restraint or seclusion on children/adolescents. In this section, I discuss the main principles and assertions of attribution theory, including the theory's appropriateness as the theoretical framework in this study.

Attribution theory focuses on individuals' interpretations of events and how these interpretations relate to their thinking and behavior (Heider, 1958). According to Heider (1958), people try to determine why people do what they do. An individual who seeks to understand why another individual displayed a type of behavior may attribute one or

more causes to that behavior. Heider believed there are two different types of attributions: internal and external. An internal attribution is the assumption that an individual is behaving a certain way due to their attitude, character, or personality. An external attribution is an assumption that an individual is behaving a certain way due to situational or environmental features.

Green-Hennessy and Hennessy (2015) stated that treatment providers' attributions regarding the challenging behavior of physical and verbal aggression from a child/adolescent patient shape their response or reaction. The importance of understanding the meaning of a behavior for a child/adolescent is significant to developing an appropriate intervention (Green-Hennessy & Hennessy, 2015). According to Green-Hennessy and Hennessy, treatment providers often neglect to analyze the meaning behind the behavior once the behavior is observed or identified, which in turn can be problematic and possibly result in an inaccurate interpretation of the behavior's purpose. Attribution theory is appropriate and a relevant component of the theoretical framework for this study because this theory applies to the meaning a treatment provider makes regarding the behavior of a child/adolescent patient, warranting the use of a restraint or seclusion. A further discussion of attribution theory and its application to this study is provided in Chapter 2.

Nature of the Study

The selected approach for this study was qualitative with a phenomenological research paradigm. The qualitative approach consists of research collected based on subjectivity (Taylor, Bogdan, & DeVault, 2016). Qualitative research is mostly

comprised of interviews involving open-ended questions and observations. According to Taylor et al. (2016), within qualitative research, individuals are interviewed with questions that pertain to their own experiences and feelings concerning a phenomenon, as opposed to quantitative research in which the subjects are asked to describe their experiences in categorical dimensions.

The focus for researchers who use phenomenological research is the commonalities all participants possess when experiencing a certain phenomenon. These researchers must seek to understand the common experiences of the participants to develop a deeper understanding of the features of the phenomenon (Taylor et al., 2016). The decision to implement the phenomenological approach to this study derived from Smith, Flowers, and Larkin's (2009) method of interpretative phenomenological analysis (IPA). IPA is a qualitative approach that focuses on how individuals make sense of their experiences. In following this approach, a researcher is required to collect detailed, reflective, first-person experiences from participants.

IPA (Smith et al., 2009) provided a conventional, phenomenologically focused approach to the interpretation of these experiences. IPA was selected for this study because the methodological principles of interpretative phenomenology align with the purpose of the study (i.e., to gain a deep understanding of how treatment providers are affected prior to, during, and following the use of a restraint or seclusion). Using IPA, I provided thick descriptions of the experiences of implementing a restraint or seclusion on a child/adolescent.

Participants for this study must have had experience implementing restraints or seclusions during crisis situations on at least three separate occasions. The chosen number of times a participant experienced participation in physical interventions is essential to obtain substantial and rich data from participants who can make identifiable comparisons of their experiences (Denison, 2016). According to Denison (2016), the level of expertise is enhanced by the accumulation of restraints or seclusions implemented by a treatment provider. Certain behavioral cues with the accumulation of experience may correlate with the way a restraint or seclusion is implemented. Participants in this study were able to compare their first experience with their second and third, identifying differences and similarities in their thought processes and responses prior to, during, and after these interventions.

The number of participants chosen to examine the perspectives and beliefs of treatment providers who have experienced the implementation of a restraint or seclusion on children/adolescents in psychiatric facilities in a large Midwestern city was eight. The number of participants chosen for this research was substantive enough to identify themes and patterns within the data. Interview transcripts of the participants were analyzed from audio-recorded files of the interviews. Smith et al. (2009) provided five stages of IPA data analysis consisting of (a) read and reread the transcript (b) document emerging theme titles, (c) analyze and place data in theoretical order, (d) produce a table of themes ordered coherently, and (e) write up and final statement outlining the meanings inherent in the participants' experiences.

Definitions

The following terms and concepts are significant to the foundation of the current study.

Aggression: Involves injuring others, attacking, or threatening others with mental and/or physical violence, including bullying, arguing, fighting, displaying short-tempered behavior, disobedient and unruly behavior, and irritability (Faay, Valenkamp, & Nijman, 2017, p. 43).

Attribution: A concept in social psychology that addresses the processes by which individuals explain the causes of behavior and events (Green-Hennessy & Hennessy, 2015).

Challenging behavior: Behaviors that may cause direct harm to an individual, cause harm to other people, or reduce an individual's access to community resources. Challenging behaviors may include self-injury, physical aggression, or property damage (Shechory-Bitton & Raipurkar, 2015).

Children's Health Act (CHA): In effect since 2000, this legislation focused on increasing research and treatment of health issues in children (Ross et al., 2014, p. 610). Some issues the CHA sought to address were the increase in the number of children with autism, asthma, epilepsy, and additional health conditions. Section 3207 addresses the use of restraints and seclusions on children/adolescents.

Crisis procedure: A developed plan put in place when a crisis or emergency situation arises that is not able to be deescalated through normal preventive actions (Scott et al., 2014).

Mental Health Act (MHA): Introduced in 1983 and revised in 2007, the MHA provides standards health care professionals must abide regarding the treatment of individuals with a mental disorder (Ross et al., p. 44). Mental health providers must follow the guidelines of the MHA to determine when an individual can be admitted to a hospital against their will, when treatment can be given against their will, and what safeguards are put in place to ensure the patient's rights are being protected.

National Association of State Mental Health Program Directors: An organization that works with states, federal partners, and stakeholders to promote wellness, recovery, and resiliency for individuals with mental health conditions along with individuals who possess co-occurring mental health and substance abuse related disorders across all age groups, cultures, and economic backgrounds (Muskett, 2014, p. 51). The organization is referenced in this study regarding the organization's six core strategies based on trauma-informed care.

Physical restraint: A personal restriction that inhibits or reduces the ability of an individual from moving their torso, arms, legs, or head freely. The term *physical restraint* does not include physical escorts. *Physical escort* is a temporary touching or holding of the hand, wrist, arm, shoulder, or back to prompt an individual who is displaying disruptive and aggressive behaviors to walk to a safe location away from others (Pogge et al., 2014).

Seclusion: The involuntary confinement of an individual alone in a room or area they are physically prohibited from exiting. This does not include a *timeout*, which is a behavior management technique that is part of an approved program and involves the

supervised separation of the individual in a nonlocked setting, implemented for the purpose of calming (Yurtbasi, Melvin, & Gordon, 2016, p. 261).

Trauma-informed care: An approach to engage individuals with a history of trauma in recognizing the presence of trauma symptoms and acknowledge the role trauma has played in their life (Muskett, 2014).

Assumptions

I assumed that participants would answer questions in this study honestly given that anonymity and confidentiality would be preserved. Additionally, I assumed that each participant would provide enough information during the interview to achieve saturation to address the research question presented in this study. Because the topic of interventions may be sensitive for some participants, I sought to develop a safe and empathic atmosphere during the interview, allowing participants to feel comfortable sharing their personal thoughts and feelings. I also emphasized to participants that they were volunteers and could withdraw from the study at any time with no ramifications.

Scope and Delimitations

This study was designed to address the gap in the research regarding treatment providers' experiences prior to, during, and following the implementation of a restraint or seclusion on a child/adolescent in a psychiatric treatment facility. The scope of this study, therefore, was delimited to treatment providers who have had three or more experiences implementing restraints and seclusions on children/adolescents. This study excluded treatment providers who have had fewer than three experiences or no experience implementing restraints and seclusions on children/adolescents. These individuals were

excluded because they do not represent the core focus of the study, and their experiences may be different from the experiences of treatment providers who have had three or more experiences implementing restraints and seclusions on children/adolescents. The number of participants selected for this study was eight, which was decided based on similar qualitative studies indicating this sample size to be sufficient for rich data collection (Merriam & Tisdell, 2015; Vaismoradi et al., 2016).

In this study, transferability was achieved using purposive sampling. This method of subjective sampling allows the reading audience to form a connection relating parts of the study and their own personal experiences (Merriam & Tisdell, 2015). Nonclinical staff and treatment providers who did not meet the research criterion did not fall within the scope of this study. This information, however, may still hold value to those who seek data to develop an understanding of the phenomenon being studied. Purposive sampling may generate more comprehensive findings than any other method of sampling. Should readers and other individuals not involved in this study be able to relate to the results of the study with their own experiences and find meaning in the data collected, then this study meets the criterion of transferability.

Two theories were considered for this study; however, I determined they were not a good fit for the study as neither theory aligned with the goal of the research study, which was to develop an understanding of the experiences of treatment providers prior to, during, and following the use of a physical restraint or seclusion on a child/adolescent patient. Social ecology theory was the first theory that was considered for this study. The social ecology theory combines culture, institutional contexts correlated with

relationships in the human environment, and psychology (Houston, 2017). The objective of this theory is to examine the interactions of human relationships amongst various types of activity. This theory does not align with the current study because the focus was on interactions and relationships between treatment providers and child/adolescent patients, whereas, the focus of this study was to understand how treatment providers are affected prior to, during, and following the use of a restraint or seclusion on child/adolescents in psychiatric treatment facilities.

The second theory I considered using for this study was the social constructivism theory. Amineh and Asl (2015) stated social constructivism is based on three assumptions consisting of learning, reality, and knowledge. The social constructivism theory focuses on constructing knowledge based on the understanding of the context and culture of society. If this research were focused on examining how treatment providers develop knowledge of a child/adolescent's behavior based on the interactions with the child/adolescent patients, social constructivism theory would have been a good theory to use. The purpose of this study, however, was not to examine the interactions between the treatment provider and the child/adolescent patient but rather to develop an understanding of how treatment providers are affected prior to, during, and following the use of a restraint or seclusion on child/adolescents in psychiatric treatment facilities.

Limitations

This study was limited to participants with experience implementing restraints or seclusions during crisis situations on at least three separate occasions. The location of the study was limited to a selected region in a large Midwestern city. If the location of the

study were broadened to other regions, there is a possibility this study might produce additional results. Qualitative research is known to lack generalizability; however, this limitation can be compensated by the number of details revealed through the interviews (McCusker & Gunaydin, 2015). Due to the lack of qualitative studies regarding this phenomenon, this valuable information could be integrated into more successful treatment strategies moving forward. Additional qualitative research, however, is still needed in this area.

Another limitation of this study involved biases that may influence the research outcome. As a former treatment provider who has worked in psychiatric facilities with children/adolescents and experienced the implementation of a restraint and seclusion, I possess biases that may have impacted my process of data analysis. Smith et al. (2009) stress that a researcher must adjust their mind frame to prepare for new knowledge by minimizing any thoughts and beliefs held previously when using the IPA approach. This process of adjustment is known as bracketing (Woods, Macklin, & Lewis, 2016). Bracketing my experiences helped me identify my bias or preconceptions regarding the implementation of restraints and seclusions on children/adolescents. The process of bracketing led to a more self-critical and reflective approach, which enhanced my active listening skills and helped me remain open to the experiences and perspectives of the participants. I kept a reflective journal in which I documented my subjective reflections of the data. The journal included my observations as well as the perceptions, understandings, opinions, and reactions I had toward the data as I completed the process of data analysis.

Significance

This qualitative IPA study is unique because it addresses the phenomenon of seclusions and restraints on children/adolescents with a distinct focus on the experiences of implementing these procedures from the perspective of the treatment providers. The exploration of treatment providers' perspectives prior to, during, and following the implementation of restraints and seclusions on children/adolescents can be important to society, producing social change as most studies regarding physical interventions on children/adolescents are centered on the experience of the child/adolescent as opposed to the individual implementing the procedure (Caldwell et al., 2014; Muir-Cochrane et al., 2014; Scott et al., 2014). This research may contribute to filling the gap in the literature, allowing for a better understanding regarding the perspective of treatment providers prior to, during, and following the implementation of restraints and seclusions on children/adolescents. Examining perspectives of treatment providers through one-on-one interviews sheds light on what is not being addressed in child/adolescent psychiatric facilities to improve the use of less intrusive interventions. Through these shared experiences, organizations can begin to discuss and develop strategies to decrease the overall use of physical interventions in these psychiatric facilities.

The potential findings of this study may lead to positive social change as the data collected throughout the interviews may uncover patterns and themes that pertain to other aspects of child/adolescent physical interventions. The patterns and themes discovered in the data may aid individuals who oversee/supervise psychiatric facilities for children/adolescents in developing alternative actions for treatment providers to

implement that do not include physical interventions and instead involve implementing various coping techniques that will ease the aggressive behavior of the child/adolescent.

Information gathered from participants in this study may lead to more implementation of safe, ethically sound, and consistent aggression management in child/adolescent psychiatric facilities. In addition to the reduction in aggression, the therapeutic milieu of these facilities may increase, allowing the patients to progress in meeting their treatment goals. Green-Hennessy and Hennessy (2015) stated that nationally a variety of treatment providers struggle with improving seclusion and restraint practices in their domains of care. Working together with one another to implement performance improvement programs addressing restraint/seclusion implementation and offering alternative methods is a powerful mechanism for change and thus provides a valuable lesson for community mental health care providers.

Summary

As the researcher for this study, I explored research surrounding the implementation of restraints and seclusions on children/adolescents, acknowledging the lack of data pertaining to the experiences of treatment providers who implement these procedures (Jacob et al., 2014; Tremmery et al., 2015). The gap in the literature addressed through this study is the lived experiences of treatment providers prior to, during, and following the implementation of a restraint/seclusion on a child/adolescent (Caldwell et al., 2014; Timbo et al., 2016). The purpose of the current phenomenological study was to explore the experiences of treatment providers prior to, during, and following the use of restraints or seclusions on children/adolescents in psychiatric

treatment facilities. The theoretical framework for this study was based on Heider's (1958) attribution theory that focuses on individual interpretations of events and how this relates to thinking and behavior. The results of this study may contribute to positive social change as the patterns and themes discovered within the data may assist child/adolescent facilities in developing alternative actions that do not include physical interventions and instead involve implementing various coping techniques that will ease the aggressive behavior of children/adolescents.

In Chapter 2, I provide a literature review to further explain the research problem. In addition to an extended discussion of the theoretical framework, the literature review includes the literature search strategy and the body of evidence explored by previous researchers regarding the use of restraints and seclusions used on children and adolescents in psychiatric facilities, with the mention of relevant constructs such as aggression, trauma-informed care, and cultural change within the mental health community.

Chapter 2: Literature Review

Introduction

Crisis procedures, such as restraints and seclusions used in psychiatric treatment facilities for children and adolescents in the United States, have long been a controversial topic for the mental health field (Ross et al., 2014). Much of the controversy surrounds the consequences or results of these physical procedures as they can cause considerable human suffering, including death, for children and adolescents receiving care, along with injuries for clinical staff providing the care. Clinical, ethical, and legal debate has increased with the awareness of the controversial nature of the use of restraints and seclusion on children/adolescents (Muir-Cochrane et al., 2014). This debate has resulted in an international movement toward reducing coercive measures in child/adolescent psychiatric facilities, culminating in changes to international recommendations and legislation.

The New York Office of Mental Health conducted research and found that the United States is lacking in comparison to international facilities in areas of taking initiative to reduce seclusions and restraints in child/adolescent psychiatric hospitals (Wisdom, Wenger, Robertson, Van Bramer, & Sederer, 2015). The purpose of the current study was to gain a deep understanding of how treatment providers are affected prior to, during, and following the use of a restraint or seclusion on children/adolescents in psychiatric treatment facilities. Green-Hennessy and Hennessy (2015) stated that obtaining further data from the perspectives of the staff or treatment providers engaging in restraints or seclusions with children/adolescents would assist in furthering the

initiative to reevaluate these invasive strategies used in a crisis. Gathering data from the perspectives of the treatment providers may assist in developing less intrusive and physical interventions, thus improving the overall therapeutic outcome for clients (Green-Hennessy & Hennessy, 2015). A significant percentage of the literature reflects the negative impact of the use of restraints and seclusions globally on children and adolescents across various populations in psychiatric facilities, but I examined the experiences of treatment providers who have used restraints and seclusions on children/adolescents to understand how they are affected when using these procedures (Caldwell et al., 2014; Scott et al., 2014; Timbo et al., 2016).

In the following chapter, I provide an overview of the search strategy for the review of the extant literature. In addition, the theoretical framework associated with the variables of interest is highlighted. Next, I present an exhaustive literature review of the body of evidence for restraints and seclusions used on children and adolescents in psychiatric facilities and relevant constructs. The chapter concludes with an overview of the various gaps in the literature related to the variables of interest, placing emphasis on the critical nature of such research for the mental health field.

Literature Search Strategy

The search strategies implemented in this literature review were comprehensive; filters were chosen to exclusively focus on peer-reviewed journals, books, and government documents derived from multiple databases. The primary database search engines included: PsycINFO, PsycARTICLES, MEDLINE, SocINDEX, Education Resources Information Center, Science Direct, CINAHL, and ProQuest, EBSCOhost,

Plus with Full Text. Key terms used included *aggression, restraint, seclusion, psychiatric treatment facility, physical interventions, crisis procedures, children, adolescents, staff, challenging behavior, attribution, trauma-informed care, training,* and *alternative methods*. Multiple combinations of search terms were used to begin the search. Those documents that presented sound and compelling arguments on the topic of the implementation of restraints and seclusions on children/adolescents determined the articles selected for review. A date range of 2014–2018 was used to select empirical literature assisting in yielding a range of population parameters (e.g., sample sizes, effect sizes, analysis type) providing a scientific scope to the current study. The information provided in this chapter was analyzed from a plethora of literature outlining research questions, summarizing methodology, sample size, research design, findings, and future research recommendations. Additionally, search parameters dating back to the early-to-mid 20th century were referenced to collect material associated with theoretical perspectives, thus providing a historical timetable linking certain theories to the variables of interest.

Theoretical Foundation

The search for relevant literature specifically on the implementation of restraints and seclusions and how it affects the treatment provider was challenging in that most researchers have focused on the consequences of these interventions on children/adolescents as opposed to how the individual implementing the intervention may be affected (Scott et al., 2014; Timbo et al., 2016). In the following theoretical review, emphasis is placed on the attribution theory (Heider, 1958), as this theory assists in

building an understanding of how treatment providers implementing restraints and seclusions on children/adolescents reach the decision of reacting to a specific behavior displayed by a child/adolescent with these physical interventions.

During the mid-20th century, Fritz Heider (1958) conducted research on causal attribution, proposing the idea that the intentions, attitudes, and drives of human behavior are caused by forces either within or beyond the immediate control of individuals. Heider's attribution theory focuses on individuals' interpretations of events and how this relates to their thinking and behavior. According to Heider (1958), an individual who seeks to understand why another individual displayed a type of behavior may attribute one or more causes to that behavior. Heider suggested that humans are instinctively inclined to explain the reason for certain actions as a means of validating behavior. Heider proposed two different types of attributions: internal (interpersonal) and external. An internal attribution is the assumption that an individual is behaving in a certain way due to their attitude, character, or personality. An external attribution is an assumption that an individual is behaving a certain way due to an incident that occurred within the current situation.

Current research indicates attributions for treatment providers working in psychiatric facilities with children/adolescents are associated with reducing helping behavior and increasing anger (Faay et al., 2017; Furre et al., 2017). Challenging behavior displayed by children in psychiatric facilities is a major source of stress for treatment providers (Faay et al., 2017; Furre et al., 2017). Vassilopoulos, Brouzos, and Andreou (2015) stated an important factor in managing challenging behaviors is

competency and knowledge of how to redirect the child/adolescent without the use of physical interventions. The attributions displayed by treatment providers resulting in increased anger are due to a lack of understanding regarding the purpose the behavior serves for the child/adolescent (Vassilopoulos et al., 2015). Vassilopoulos et al. (2015) determined an increased need for treatment providers to be trained in the areas of applying appropriate behavior principles in a structured and systematic way, altering their approach and attributions toward challenging behaviors displayed by children/adolescents.

Interpersonal (Internal) Attribution

Heider (1958) suggested two different types of attribution, one being interpersonal attribution also known as internal attribution. Interpersonal attribution suggests that an inference is made by an individual based on their internal characteristics, such as personality or attitude. Recent research highlights the importance of treatment providers' attributions in influencing their responses to challenging behaviors (Fraser, Archambault, & Parent, 2016; Furre et al., 2017). Vassilopoulos et al. (2015) argued that the type of causal attributions made by an individual will relate to future helping behavior. Treatment providers who develop attributions of challenging behaviors displayed by children/adolescents to be internal and under control are more likely to experience anger toward the child/adolescent and less likely to offer support (Vassilopoulos et al., 2015). This attribution is based on the inference that the child/adolescent possesses the knowledge and ability to control the disruptive behaviors (Vassilopoulos et al., 2015).

External Attribution

External attribution is the second type of attribution suggested by Heider (1958), who believed the explanation or interpretation of behavior is the situation that a person is experiencing in the moment. Researchers specify that the responses of treatment providers to challenging/aggressive behaviors are intricately connected to their attributions regarding the behavior; therefore, the treatment providers' beliefs as to why a child/adolescent displays challenging behavior would be expected to relate to their response to that child (Maris & Hoorens, 2014; Vassilopoulos et al., 2015). External attributions are considered more positive as the behaviors of the child/adolescent are often understood by the treatment provider and handled in a less invasive manner (Maris & Hoorens, 2014). Overall, the attribution theory explains how individuals perceive behavior and develop beliefs about these behaviors, creating their own personal perspectives attaching meaning to the behavior (Maris & Hoorens, 2014). This theory provides the framework for the current research question in which I sought to explore how treatment providers make meaning of their experiences when they use restraints or seclusions on children/adolescents, attaching meaning to the behavior and reasoning behind the treatment providers use of the physical intervention.

Literature Review Related to Key Variables and/or Concepts

The following section is a discussion of the variables of physical interventions important to the present study. In this literature review, I examine the current knowledge regarding children who display aggressive behavior in treatment facilities, the struggles experienced by treatment providers who implement physical interventions, and the

interventions that have shown promising results. Specifically, this review covers practices in reviewing behavior incident data, explores the use of positive behavior supports, and examines various interventions that treatment providers use with and without success.

Interpretative Phenomenological Analysis

The most appropriate methodology to explore the experiences of implementing restraints and seclusions on children/adolescents from the perspective of the treatment provider is phenomenology. The focus of phenomenological research is the commonalities all participants possess when experiencing a certain phenomenon and gathering knowledge about the meaning participants give to the experience (Abayomi, 2017). As discussed in the previous chapter, the choice of implementing the phenomenological approach stems from Smith et al.'s (2009) method of IPA. Researchers who successfully use IPA capture and reflect on the principal claims and concerns of the research participants. Additionally, such a researcher offers an interpretation of the material provided by participants grounded in their experiences.

Researchers typically use IPA when they want to explore common experiences of participants to develop a deeper understanding of the features of the phenomenon (Abayomi, 2017). The process of data analysis in this approach entails going through the data, reviewing the various interviews of participants, and keeping attentive to certain quotes, statements or sentences that assist in providing an understanding of how the participants experienced the phenomenon (Abayomi, 2017). From these statements, the researcher determines the themes or patterns present. The interpretative phenomenological approach best fit my research question as I sought to determine how

each individual makes meaning of experiencing the same phenomenon (restraints/seclusions).

Child/Adolescent Aggressive Behavior

According to Tremmery et al. (2014), aggressive and violent behavior is becoming more common in psychiatric settings particularly for those treating children and adolescents. In child/adolescent psychiatric settings, minors have been found to be less able than adults who reside in psychiatric facilities, to inhibit their aggressive behaviors. This may contribute to a higher occurrence of aggressive behaviors that may pose a treatment challenge for the staff involved. Aggressive behavior can be examined from many different perspectives as this is a complex phenomenon; the meaning of aggressive behavior can be interpreted in many ways, and from various perspectives such as biological, social, psychological, and cultural (Langone, Luiselli, Galving & Hamill, 2014). Due to the complexity of aggressive behavior, there exist many inconsistencies when the term is used in the clinical environment. Research has shown that the perception of how aggressive behavior is defined can vary between care and cultural settings as aggression is an extremely emotive topic which is open to subjective interpretations, perspectives, and understandings (Ebesutani, Kim, & Young, 2014; Langone, 2014). Muir-Cochrane et al. (2014) in their research regarding child/adolescent aggressive behavior discovered common factors contributing to the display of these behaviors which include, witnessing aggressive behavior, being subject to abusive behavior by a parent/adult, and parental attitudes displaying favor toward violence. Additionally, according to these researchers there exist psychiatric disorders that could be

related to aggression in children/adolescents such as conduct disorder, substance abuse disorders, impulse control disorder, oppositional defiant disorder, and autism. Overall psychological components in which children/adolescents' struggle with the regulation of emotions has been found by researchers to be connected to child/adolescent aggression (Gallant, Snyder, & Von der Embse, 2014; Muir-Cochrane, Oster, & Gerace, 2014).

Jacob et al. (2014) believe that in most child/adolescent psychiatric facilities shortcomings are displayed in the clinical skills of treatment providers. These researchers believe treatment providers lack skills such as the ability to remain objective and calm in aggressive situations which may further contribute to the escalation in aggressive behavior. Additionally, researchers have found certain variables of interaction or lack thereof from the treatment provider may also contribute to aggressive behavior (Van Gink et al., 2017). Berg et al. (2013), sought to examine the predictors of aggression and restraint of children/adolescents within psychiatric facilities from the perspective of staff in four European countries (Belgium, Finland, the Netherlands, and the United Kingdom). The researchers used an explorative research approach conducting qualitative interviews to develop a better understanding of staff's perception of contributing factors that lead to child/adolescent aggressive behavior. Staff members from different professional backgrounds were interviewed for the study. Fifty-eight staff members participated in the study of whom 43 were staff who worked directly with the adolescents daily (social workers, educators, support workers, and RNs). Based on the data collected from the interviews, facility staff reported that aggressive behavior has been seen to escalate into a major aggressive incident when there is a violation of psychological or

physical space. Most participants identified negative childhood experiences as the underlying cause for the adolescent acts of aggression. Berg et al. concluded that challenging behaviors can oftentimes be minimized if the treatment provider develops a better understanding of the antecedents of aggression, likely resulting in the management of aggression by other means aside from restraint and seclusions. This study supports pre-existing research findings that developing an understanding of antecedents to aggression has been found to decrease aggression in other clinical populations. Limitations to this study can be found in the lack of knowledge staff held regarding a patient's background and history of abuse. Additionally, further research should include careful examination of the events leading to aggression, and factors leading to decreased or increased incidents of aggression and its subsequent management.

Scott et al. (2014) stressed the importance of a cross-cultural examination from the perspective of staff regarding behaviors displayed within psychiatric settings as the information obtained will enhance the knowledge base in child/adolescent clinical settings. Additionally, obtaining information from the perspective of the staff (treatment provider) may contribute to the development and implementation of best practices in crisis situations. Providing the treatment provider's perspective may also assist with ensuring client-focused practices and safe aggression management is achieved (Pollastri, Lieberman, Boldt, & Ablon, 2016, p. 189). Oostermeijer, Nieuwenhuijzen, Van de Ven, Popma, and Jansen (2016) addressed the lack of staff knowledge in implementing positive programming strategies to decrease aggressive behavior in children/adolescents within treatment facilities. These researchers found a lack of planned activities in an

unstructured treatment setting may also contribute to conflict between patients thus provoking acts of aggression.

Faay et al. (2017) conducted a study analyzing 575 violent incident report forms from a child/adolescent psychiatric facility with the goal of detecting and categorizing early warning signs of aggressive behavior within child/adolescent psychiatric treatment centers. These researchers discovered 1087 warning signs which were categorized into 16 different schemes. The top three warning signs of aggressive behavior in children/adolescents detected by the researchers were restlessness, not listening, and anger. Results of this study indicate that restlessness in the child/adolescent leads to an increase in tension, resulting in a more severe display of agitated behavior which then leads to aggression. The above study provides new knowledge and insight into the precursors of aggressive behavior from children/adolescents in a psychiatric setting. Obtaining a better understanding of the warning signs prior to the display of aggressive behavior exhibited by children/adolescents allows researchers to recommend a more structured way for treatment providers to conduct a risk assessment of the patient to ensure the implementation of safe, ethically sound, and more consistent aggression management in clinical psychiatric practices (Faay et al., 2017). Limitations to this study, however, may be found in the data as the data was retrieved from another study in which the collection of warning signs was not the main focus. This limited the amount of warning signs seen in the incident reports to an overall 53.8% in which 42.6% of the data reviewed displayed no warning signs. Additionally, the researchers used only one source of input which is the Proactive Monitoring of Aggression in Children Tool; had

additional research tools been used more warning signs may have been uncovered. Given these limitations, the researchers concluded that future researchers should continue to focus on the exploration of aggressive behavior and possible warning signs as this may contribute to a more thorough understanding for treatment providers of aggressive behavior displayed by children/adolescents within psychiatric facilities (Faay et al., 2017).

Implementing Restraints and Seclusions

For most child/adolescent psychiatric treatment facilities restraints and seclusions are implemented as an intervention of last resort (LeBel, Huckshorn, & Caldwell, 2014; Wilson, Rouse, Rae, & Ray, 2018). According to research the standard guidelines within most child/adolescent treatment facilities state that the treatment provider should only use restraints and seclusions if necessary to protect the child or any other individuals in the environment from immediate or imminent risk of harm, and additionally to prevent the child from absconding (Andrassy, 2016; Gansel & Leze, 2015; Wilson et al., 2018). Many child/adolescent treatment facilities follow the guidelines set forth by the U.S. Department of Education and Substance Abuse Mental Health Services Administration (Marx & Baker, 2017, p. 23). Together the Department of Education and Substance Abuse Mental Health Services Administration identified 15 principles that should be followed not only by states and local school districts but also mental health facilities providing services to children and other stakeholders. A summary of the 15 principles provided by Marx and Baker (2017) is listed below:

1. Every effort should be made to prevent the need for the use of restraint and seclusion.

2. Mechanical restraints should never be used to restrict a child's movement. Drugs or medication should not be used to control behavior unless authorized by a licensed physician or qualified health professional.

3. Unless a child's behavior poses an imminent danger of serious physical harm to self or others physical restraint and seclusion are not to be used.

4. Policies restricting the use of restraint and seclusion should apply to all children.

5. All behavioral interventions must be consistent with the child's rights to be treated with dignity and free from abuse.

6. Restraints or seclusions should never be used as punishment, discipline, a means of intimidation or retaliation, or as a convenience.

7. Restraints or seclusions should never be used to restrict a child's breathing.

8. In a situation where there is repeated use of a restraint or seclusion on an individual child, a revision of strategies currently in place should occur to address the dangerous behavior. Staff must consider the implementation of positive behavioral strategies.

9. Behavioral strategies to address dangerous behavior resulting in the use of restraint or seclusion should address the underlying cause or purpose of the dangerous behavior.

10. Staff, teachers, and other personnel should be trained regularly regarding the appropriate use of alternative interventions to restraints and seclusions.

11. All restraints and seclusions must be monitored continuously and carefully to ensure appropriateness and safety.

12. Parents should be informed of the policies on restraints and seclusions.

13. Parents should be notified as soon as possible when a restraint or seclusion is used on their child.

14. Policies on restraints and seclusions should be reviewed regularly and updated as appropriate.

15. The use of a restraint or seclusion on a child should always be documented in writing. (Marx & Baker, 2017, p. 23)

These guidelines make it clear that seclusions and restraints are only intended to be used after less restrictive alternatives have been considered, attempted, and shown to be ineffective (Marx & Baker, 2017, p. 26).

According to Deveau and Leitch (2015), growing evidence has found that clients perceive staff as using physical interventions to “punish” or “control” the child/adolescent. Pogge et al. (2014) stated that researchers continue to find evidence illustrating the non-violent disruptive behavior of the client as the most common precursor to the implementation of a restraint or seclusion. Such behavior includes a child who talks incessantly during a therapeutic group or a child who loudly and frequently interrupts the flow of the group with derogatory comments or inappropriate noises. Findings such as these raise questions regarding the decisions by treatment providers who

make the determination to use restraints and seclusions. Additionally, questions are raised regarding the potential for seclusions and restraints to be used inappropriately and inconsistently with the intervention principles set forth by the facility (Andrassy, 2016, p. 146).

Seckman et al. (2017) have shown through quantitative research involving registered nurses working in child/adolescent psychiatric facilities that the implementation of seclusions and restraints has resulted in feelings of safety and reassurance for the client in that being placed in a seclusion or restraint relieves distress caused by interpersonal stress. Additionally, through the research conducted by Seckman et al. (2017), seclusions were found to be considered an important factor in safeguarding the therapeutic environment; finding that removing children/adolescents who are unable to be controlled can be a benefit for the other children within the unit as the removal of the child/adolescent minimizes the risk of eliciting distress in other patients. Paterson, Bennet, and Bradley (2014) stated quantitative studies conducted by Deveau and McGill (2013), Flynn (2012), Williams and Grossett (2011), and Rimland (2011) have displayed widely contrasting rates of the use of restraints and seclusions within adolescent psychiatric hospitals. The cause of these differences remains unclear and researchers do not know if they can be determined in the assessment of patient populations or setting characteristics. Huefner and Vollmer (2014) found client characteristics associated with restraints and seclusions within child/adolescent facilities include younger males between the ages of 8-15 and early stage of admission. External factors may include the organizational culture such as staff's ability to tolerate aggressive behavior, staff's beliefs

regarding the therapeutic benefits of restraints and seclusions, and whether the treatment facility itself places emphasis on therapeutic outcomes (Deveau & Leitch, 2015, p. 589). Additionally, staff training has been found to be a major factor in significantly contributing to physical intervention practices.

According to Allen, de Nesnera, Barrnett, and Moreau (2014), confidence displayed by treatment providers in managing aggressive behaviors using less restrictive management options are found to be a key factor in an organization's ability to provide proper care and meet therapeutic goals. Many researchers have argued that the use of restraints and seclusions are harmful and traumatic and that the use of these interventions on clients maintains the violence the interventions intend to control (Brophy, Roper, Hamilton, Tellez & McSherry, 2016; Duxbury, 2015; Gansel & Leze, 2015). According to Brophy et al., (2016) the use of seclusions and restraints on children/adolescents was found to be both non-therapeutic and re-traumatizing, thus increasing the risk of physical and emotional injury for both clients and treatment providers. A qualitative study conducted by Caldwell et al. (2014), explored the experiences of restraints and seclusions from the perspective of children/adolescents from three different treatment facilities across a 10-year span. These researchers discovered that children/adolescents associate restraints with fear and anger. Both the children/adolescents and treatment providers identified post-restraint emotions that had negative lingering effects. Anger was the most identified emotion among children after a restraint was received. These findings appear contrary to research suggesting restraints reduce agitation in children as the results show that restraints make children more agitated. These researchers additionally interviewed

staff across the 10-year period in which staff reported that they perceived noncompliance as an immediate cause for the use of a restraint or seclusion. It was agreed by the children who were interviewed that they were restrained for not following the rules as opposed to endangering the safety of themselves or others. According to the interviews, a large portion of the staff saw the implementation of these procedures to be routine stating the implementation of restraints and seclusions is a "necessary evil" to protect staff and children. Caldwell et al. reported noncompliance should not be used as justification for the implementation of a restraint or seclusion as these circumstances do not fit the "imminent danger" rationale declared by most facilities regulating the use of restraint and seclusions for children within these institutions. The study conducted by Caldwell et al. suggests the need for further understanding of the discrepancy between vulnerability and power among children and staff. This study brought to fruition many important patterns and themes that require further investigation. A limitation to this study is that it focused on gaining the perspective of the child/adolescent and their experiences of enduring a restraint or seclusion. While treatment providers were interviewed, further examination of treatment provider's thought processes prior to, during, and following the implementation of a restraint or seclusion would provide additional insight in developing alternative strategies to the use of physical interventions.

Madan et al. (2014) stated additional research is needed regarding the implementation of physical restraint and seclusion on children/adolescents from the experience of treatment providers. These researchers believe continued research is urgently needed on this topic to assist in building awareness regarding the excessive use

of restraints and seclusions on the child/adolescent population. By pushing the study of this topic forward, researchers may create a sense of challenges, emotionality, humanity, and professionalism causing a breakthrough in changing the culture of child/adolescent mental health facilities regarding the use of physical interventions. Eimear, Candice, and Adam (2014) stated efforts have been made in the United States to reduce seclusions with some success using a range of strategies which involved intensive training for all treatment providers and clinical staff. Although efforts and improvements were made, there were still approximately 150 major injuries that occurred after a child has been restrained or secluded. Therefore, improvement in these facilities in reducing the invasive procedures of restraints and seclusions is needed to improve the overall mental health culture.

Pressure from advocates, families, policymakers, and government agencies to reduce the use of seclusion and restraints in psychiatric treatment facilities for children and adolescents has increased in the past several years as many states have authorized legislation and executed initiatives aimed towards preventing or carefully governing the use of seclusion and restraint in these facilities (Simonsen et al., 2014, p. 319). Shechory-Bitton and Raipurkar (2015) stated treatment providers may exhibit indirect violence through lack of competency and use of inadequate procedures causing a failure to adhere to the guidelines of the workplace. Langone et al. (2014) discovered through interviews with treatment providers that experiences when implementing a seclusion or a restraint on a child/adolescent can be dehumanizing. Langone et al. (2014) questioned the use of indirect power of a treatment provider when engaging in a physical restraint or seclusion.

The researchers found that violence and aggression increase for both client and staff when a seclusion or a restraint is practiced wherein the staff member may indirectly assert his or her power over the child/adolescent to deescalate the situation. This research conducted by Langone et al. (2014) was however focused solely on children/adolescents with developmental disabilities; specifically, children/adolescents with autism. This research does not include children/adolescents who possess mental health disorders (i.e., depression, anxiety, impulse control, etc.). Van Loan, Gage, and Cullen (2015) believe the change that needs to occur must begin at the top of the hierarchy with organizations modeling nonviolent and noncoercive management practices toward staff. Without the collaborated dedication of all individuals within an organization striving to reach the same goal of decreasing the use of restraints and seclusion, change will not occur.

Trauma-Informed Care

Within recent years, various regulatory agencies and professional groups such as the Association of Child and Adolescent Psychiatric Nurses, American Psychiatric Association, and Centers for Medicare and Medicaid Services created a specific set of guidelines for child/adolescent psychiatric facilities to follow to reduce the use of restraints and seclusions (Azeem et al., 2015, p. 181). These guidelines are focused on a more trauma-informed environment in which the restrictive interventions are only to be used in the most extreme situations when a client displays an imminent risk of harm to themselves or others. Boel-Studt (2017) stated all aspects of the mental health field must become trauma-informed as those psychiatric facilities within the United States that push

for trauma-informed care work towards eliminating any behaviors and policies that may cause harm or traumatize staff and clients.

Recently, much concern has been brought to the forefront by government agencies and policymakers regarding the negative impact from the implementation of restraints and seclusions on children/adolescents. Evidence-based studies of various recommended strategies to reduce restraints and seclusions have been limited (Cullen et al., 2015; Pollastri et al., 2016; Valenkamp et al., 2014). The introduction of trauma-informed awareness within psychiatric facilities has brought about specific prevention principles that assist the treatment provider in the avoidance of engaging in physical interventions (Muskett, 2014). According to collaborative research conducted on the use of trauma-informed care in many child/adolescent psychiatric environments, treatment providers are being retrained in the use of preventative measures to include: awareness of the client's traumatic past, developing and implementing a safety plan, use of comfort rooms, approaches used to deescalate a severe behavioral situation prior to the use of a restraint or seclusion (Watson, Thorburn, Everett, & Fisher, 2014).

Bryson et al. (2017) discovered positive results of trauma-informed techniques were achieved quickly and sustained over a long period, therefore indicating that more facilities specializing in child and adolescent mental health must work towards further reduction and eventual elimination of restraints and seclusions as best practice in escalated situations. Azeem et al. (2015) conducted a study with the purpose of determining the effectiveness of the National Association of State Mental Health Program Directors six core strategies based on trauma-informed care to aid in the

reduction of restraints and seclusions for child/adolescent clients. The hospital staff obtained continuous training on these six core strategies between March 2005 and March 2007. The six strategies considered essential for restraint reduction include:

1. Leadership focused on changing the cultural environment, developing a plan, and involving all stakeholders.
2. Facilities collect data on seclusion and restraint use and use the data to review with staff and evaluate incidents.
3. Creating a therapeutic environment centered around recovery and trauma-informed care, individualized treatment planning and responding to clients' needs.
4. Use of tools available to reduce seclusions and restraints such as physical environment, de-escalation plans, and other assessment tools.
5. Involvement of consumers in a variety of aspects of the organization's efforts to reduce restraints.
6. Consistent use of debriefing tools used to analyze instances of seclusions and restraints and to lessen the adverse effects of these occurrences. (Azeem et al., 2015, p. 180)

Researchers discovered a downward trend in restraints and seclusions within the facility after the implementation of the trauma-informed treatment.

Recommendation based on the findings of this study suggest that treatment providers therapeutically communicate with the client as this allows for identification of triggers and warning signs that may assist in preventing a crisis procedure from occurring

(Azeem et al., 2015, p. 180). Limitations, however, can be found within the research as Azeem et al. (2015) stated a second study was being conducted on the girls' unit that focused on a dialectical behavior therapy initiative that could have inadvertently caused the researchers' efforts to implement the six core strategies to be biased. Additionally, a longer baseline of data was not available before this study was implemented although the researchers believe the data they collected from their study is another step forward in validating the effectiveness of the six core strategies on the reduction of restraints and seclusions in inpatient psychiatric facilities for children/adolescents.

Denison (2016) found through research that the debriefing process following the implementation of a restraint or seclusion assists in effectively reducing the rate of physical interventions used within child/adolescent psychiatric treatment facilities. The debriefing process includes the treatment provider and the client developing an understanding of what occurred before, during, and after the use of a restraint or seclusion. Ling, Cleverley, and Perivolaris (2015) examined debriefing data to develop a better understanding of the experiences of inpatients before, during, and after a restraint. Fifty-five clients were provided with a Restraint Event Client-Patient Debriefing and Comments Form. Factors that were assessed within the debriefing included the emotional support needed for the client and staff. Additionally, the root cause of the incident was analyzed through problem-solving strategies consisting of identifying what went wrong, what could have been done differently, and how the treatment provider could assist the client in avoiding similar incidents in the future. The researchers discovered that loss of autonomy and related anger, conflict with staff and other clients, as well as unmet needs

were some mutual factors that precipitated the use of a restraint or seclusion. Most clients reported that there exists a need for increased communication with staff as this could have prevented many physical interventions.

Limitations to this study can be found in the instrument used within this study as the Restraint Event Client-Patient Debriefing and Comments Form does not allow clients to specify whether they were physically or chemically restrained, or secluded. This lack of information does not allow the researchers to understand which type of restraint the client experienced unless the client mentions the intervention on the debriefing form. Ling et al. (2015) stated that findings within past research suggest the perception of clients varies regarding different types of restraints. Therefore, the possibility exists that the findings within the above research study may have been different if the debriefing forms were analyzed based on which restraint each client experienced. An additional limitation to the study is that the completion of the debriefing form required a significant amount of attention to complete the entire document. Ling et al. (2015) revealed that some staff would write on the behalf of a client, therefore it is unclear what type of impact this may have had toward client's responses. The researchers admitted that the study was biased toward participants as the data collected were mostly from clients who displayed the ability and motivation to complete the form whereas those who possessed language barriers were less likely to complete the form without the assistance of a clinician.

The researchers found overall that emphasis is placed on the importance of consistent one-to-one communication with clients and staff prior to the escalation of

clients' behavior. The restraint incidents described in the study display an example of missed opportunities for staff to connect with the client, therefore causing the client to feel angry and unheard. Through the debriefing process, both clients and staff were able to improve their awareness of the restraint and seclusion experience. Bryson et al., (2017) stated that debriefing strategies are used to lessen the impact of traumatization and re-traumatization to the client and treatment provider.

Cultural Change

Researchers have argued that there exists a significant need for cultural change throughout child/adolescent psychiatric organizations. Bonnell, Alatishe, and Hofner (2014) concluded the change needs to be focused on the elimination of seclusions and the reduction of restraints as the implementation of these procedures may indicate systems' failure in managerial and clinical practices. Although the total need to eliminate restraints within these facilities is ideal, this may not be feasible as there may exist situations in which proactive calming techniques such as verbal interventions may not work. Should the treatment provider fail to decrease severely aggressive behavior exhibited by a child/adolescent, he or she must take the necessary precautions to ensure the safety of the child exhibiting the behavior as well as those around them (Yurtbasi et al., 2016). According to Noyola, Sorgi, Alday, and Reidler (2014), quality mental health care requires time, resources, and space to allow treatment providers to deliver proper treatment to meet the unique needs of the client, however, holistically throughout the United States such entities are not sufficiently dispersed throughout all child/adolescent psychiatric facilities to practice client-focused mental health care.

Previous research suggests a change in policy and procedure within child/adolescent psychiatric facilities can initiate a reduction in the frequency and duration of restraints and seclusions (Langone et al., 2014). Some researchers have argued that policy and procedure changes must be coupled with a cultural shift otherwise change may not occur (Andrassy, 2016; Felver et al., 2017; Kimball, Jolivette, & Sprague, 2017). Jungfer et al. (2014) suggested attitude and culture change may be most helpful within facilities in which treatment providers have become accustomed to the use of restraints and seclusions believing these physical procedures to be necessary and therapeutic.

To approach treatment providers within child/adolescent psychiatric facilities with automatic restrictions on the use of restraints and seclusions could cause these individuals to feel unsafe and resentful towards management. Denison (2016) believes that changing the staff's attitudes and perspectives towards the use of these crisis procedures through education and provisions of alternative strategies may allow staff to feel more comfortable with the overall change in the work environment. Holmes, Stokes, and Gathright (2014) found that attempts made to reduce the use of restraints and seclusions due to the response of managerial or legislative demands may backfire in that treatment providers may find alternative methods in which the use of these physical procedures may continue to be implemented. These researchers state managerial directives to reduce seclusions and restraints may unintentionally dismiss staff's concerns for their own safety and the safety of those on the unit. Therefore, the support of managerial staff is crucial to the success of reducing restraint and seclusion initiatives. Furre et al. (2014)

recommended further qualitative research incorporating interviews with staff which might assist in providing insight regarding the changes in practice, culture, and attitudes that may be helpful with the reduction of restraints and seclusions.

Summary and Conclusions

Despite the numerous debates surrounding the use of restraints and seclusions on children/adolescents in psychiatric facilities, this chapter signifies the limitation of qualitative research regarding treatment providers' experiences leading up to, during, and following the implementation of these physical interventions. Obtaining a perspective from those individuals implementing these procedures is a relevant construct in developing new strategies that avoid these invasive procedures thus improving the overall culture of the mental health field. Additionally, the treatment provider's perspective can contribute to the development and implementation of good practices in conflict situations thus assisting in ensuring patient-centered and safe management of aggression (Oostermeijer et al., 2016).

The existing literature on restraints and seclusions does not exemplify a body of knowledge in which clinicians are able to justify the use of this practice. Further, clinicians, parents, and researchers continue to express the need to better understand the efficacy of physical restraint and seclusion as well as alternatives to their use. To understand the complex phenomenon of physical restraint and seclusions this study must be driven by clear theoretical and methodological strategies. With the use of the theoretical lens of attribution theory, I sought to increase the understanding of how treatment providers interpret certain behavior.

The literature review indicated a large amount of discrepancy amongst the general population of treatment providers about the proper use of restraint and seclusions on children and adolescents. As such, this discrepancy may lead to further misuse of these invasive procedures, possibly injuring both the client and treatment provider. An investigation into specifically how treatment providers perceive a situation that may lead to the use of a restraint or seclusion along with what they experience during the implementation of a restraint or seclusion is essential in informing the readers' understanding of the present study.

While much of the literature published so far on this topic is informative from the standpoint of what the client's perspective is when experiencing a restraint or seclusion, there is very little in the way of describing the perspective of the staff or treatment provider engaged in these procedures. Much of the research to this point has been quantitative in nature and as such has not been able to directly look at from where certain perceptions may arise, and how these perceptions may be influenced by the child's behavior. There is a variety of research that looks at what perceptions exist, but until researchers start to look at where those perceptions come from, child/adolescent psychiatric facilities will not be able to effectively develop intervention strategies that may be less invasive and harmful for both client and staff.

Chapter 3 discusses the methodology that was used for the current study. In addition, a detailed overview of the population is provided as well as sampling procedures and processes specific to recruitment, participation, and data collection. Further discussed is the plan for data analysis provided in an outline for the interviews

given in the current study and a discussion of potential threats to the validity and reliability of the research. Finally, ethical considerations and measures taken to prevent ethical conflict within the current study are discussed.

Chapter 3: Research Method

Introduction

The purpose of the current phenomenological study was to gain a deep understanding of how treatment providers are affected prior to, during, and following the use of a restraint or seclusion on children/adolescents in psychiatric treatment facilities. Chapter 3 includes a discussion of my methodological plan, a detailed description of the research design, and my role in the research process. A rationale for the chosen research design is discussed as well as the reasoning for the selected population for participant selection. I also provide details discussing data collection and analysis. The chapter concludes with a discussion on identifying issues of trustworthiness, which includes ethical considerations relevant to the study.

Research Design and Rationale

The central phenomenon I sought to explore was the experiences of treatment providers prior to, during, and following the use of restraints or seclusions on children/adolescents in psychiatric treatment facilities. Based on the identified problem and the formulated purpose, the research questions for this study were the following:

RQ1: How do treatment providers make meaning of their experiences when they use restraints or seclusions on children/adolescents?

a. How do treatment providers talk about what they are experiencing before implementation of a restraint or seclusion?

b. How do treatment providers talk about what they are experiencing during implementation of a restraint or seclusion?

c. How do treatment providers talk about their experience following implementation of a restraint or seclusion?

Qualitative research provides an in-depth understanding of subjective experiences and perceptions of individuals or groups of individuals regarding a specific phenomenon (Taylor et al., 2016). Qualitative research was appropriate for this study as this research method focuses on collecting in-depth data, subjectivity, and the naturalism and interpretivism associated with the objectives and purpose of the study (Merriam & Tisdell, 2015). Qualitative research was used to direct the audience toward the goal of understanding a phenomenon using tools that may produce comprehensive and thorough information that would otherwise not be discovered through standardized instruments frequently used in quantitative research (Taylor et al., 2016). Qualitative research methods use open-ended tools for data collection; therefore, researchers who use these methods often interact with individuals who may provide different answers and explanations of the experience of a phenomenon according to their perspective. Quantitative research lacks the intimacy, depth, and variety of responses that can be obtained using the qualitative approach (Merriam & Tisdell, 2015).

Qualitative research includes several research approaches, such as ethnography, phenomenology, case study, biography, narrative (hermeneutics), grounded theory, and action science (McCusker & Gunaydin, 2015). Among these approaches, I chose the phenomenological approach due to its dependence on thick descriptions of the phenomenon being studied (Willis et al., 2016). I examined the phenomenon of treatment providers in child/adolescent psychiatric treatment facilities who have experienced the

implementation of a physical restraint or seclusion on a child/adolescent patient. By exploring and gaining an understanding of treatment providers' experiences, discoveries made from themes and patterns in the data may contribute to improvement in crisis management methods not only for the specific facilities where the study was conducted, but for other child/adolescent treatment facilities nationwide.

I used Smith et al.'s (2009) phenomenological design approach known as IPA. IPA is a well-known methodological framework in qualitative research involving a thorough, detailed examination of personal experiences focused on individual perceptions of the experienced phenomena; the researcher plays an active role in the data collection process. The researcher attempts to understand the participants' perspectives while also interpreting the results, seeking to identify if there exists more to the phenomenological experiences than what is comprehended and shared by the participants.

The other qualitative research designs mentioned above (case study, grounded theory, ethnography, etc.) were not appropriate for this study because these methods do not align with the study's purpose. Case study research was not the strongest form of research, although the focus of the research was exploratory. Case studies are known for examining personal interactions and relationships in an influential manner (Tumele, 2015). Because I sought to examine a phenomenon and obtain views from the treatment providers on their experiences with restraints and seclusions, a case study design did not align with the comprehensiveness of using multiple sources of data as seen in most case studies.

Although grounded theory research provides significant knowledge for qualitative research, this research method was not adequate for the current study. The goal of researchers using a grounded theory design is to produce a new theory in the study area that derives from the data findings (Glaser, 2016). That was not the goal of this research study; therefore, grounded theory research methods were not appropriate for this study.

Biographical research was not chosen as the research method for this study as this form of research is solely focused on one participant (Kaźmierska, 2014). Obtaining data would be difficult if this method were used, as the experiences of one individual may not necessarily apply to all other individuals who experience implementing restraints and seclusions with children/adolescents. Ethnographic research is mainly limited to a certain geographical setting, which can cause difficulty in comparing the findings of this research to other geographic areas (Glaser, 2016). Additionally, ethnographic research engages not only in qualitative but quantitative research methods, which in this particular study may diminish the personal approach of the study.

Role of the Researcher

When using IPA (Smith et al., 2009), the researcher is perceived as the instrument of data collection. As the researcher in this qualitative study, I am the main instrument of data collection, analysis, and interpretation. As the primary data collection tool, I gathered, recorded, and analyzed data, and I reported the findings. Vaismoradi, Jones, Turunen, and Snelgrove (2016) stated that if researchers play the role as the main instrument of data collection, it is necessary that they recognize any preconceived thoughts regarding the phenomenon of the study.

My role as the researcher using IPA (Smith et al., 2009) involved observation and learning from each participant's experience. My role consisted of actively listening and developing an understanding of each participant's experience involving the use of a restraint or seclusion on a child/adolescent patient. Through my role as the researcher, I sought to deeply understand the meanings participants found in describing their experiences as well as the meanings I found based on their descriptions.

I had no personal or professional relationships with any participants for this study; I had no power over them. My level of education and title as a researcher might generate feelings of power and inequality with participants. To control these perceptions, participants were informed prior to signing informed consent that they were able to withdraw their participation at any time with no consequences.

As the researcher, it was important for me to divulge my experience with the phenomenon under study, as this may potentially bring about researcher bias if not monitored continuously. From the years 2013–2016, I worked in a psychiatric treatment facility for children and adolescents in a specific county in the state of Kansas. During my employment, I worked as a youth and family specialist; my position consisted of personally interacting with patients to provide leadership, teaching, role modeling, correction, boundary setting, life skills, communication, and interpersonal relationship skills. While in this position, I experienced implementing restraints and seclusions several times with children/adolescents ranging from ages 5–18. My experience working as a youth and family specialist may offer both similar and different perspectives as those

treatment providers who were participants in this study. This study took place in a different city and state from where I was employed.

When using IPA (Smith et al., 2009), researchers must adjust their mind frame to prepare for new knowledge provided from the participants' responses (Abayomi, 2017). As the researcher begins to adjust, this allows for the opportunity to actively listen to participants describe their experiences of the phenomenon. Abayomi (2017) described IPA as possessing an interpretative component; therefore, any assumptions I had regarding how others experience restraints and seclusions must be acknowledged. However, I must be open and understanding of the experiences described to me by participants. Using IPA, my role as the researcher was to approach the study from a contemplative and analytical standpoint. Adopting this approach was necessary to manage any researcher biases, as I exhibited firm attention and presence, acknowledging but setting aside any previously held assumptions regarding the phenomenon.

Methodology

Participant Selection Logic

The sample size of participants for this study was eight treatment providers. The parameters I set for participant selection included experience engaging in a restraint or seclusion with a child/adolescent patient on three separate occasions. Merriam and Tisdell (2015) stated the number of study participants is not definitive within any study, but the goal of this study was to obtain a sample size adequate to reach data saturation to develop an understanding of the characteristics of the phenomenon being studied. According to Willis et al. (2016), qualitative researchers tend to work with smaller

sample sizes. The average sample size recommended by Merriam and Tisdell (2015) is between five and 25 participants; other researchers recommend a range between three and 10 participants for a phenomenological study (Abayomi, 2017; Vaismoradi et al., 2016; Willis et al., 2016). As this study was based on distinctive criteria of a group of individuals who have experienced the same phenomenon, a sample size of eight was selected.

The target sample size was determined by data saturation, which I attempted through purposive sampling (Merriam & Tisdell, 2015). The concept of purposive sampling is to select certain individuals and locations due to their ability to elicit pertinent information to answer the research question or studied phenomena. Therefore, in this research study, purposive sampling techniques were used to detect participants who have worked directly with children/adolescents and have experienced the implementation of a restraint or seclusion on a child/adolescent in the facility where they are employed on three or more occasions. I used the snowball technique when I was unable to obtain data saturation through purposive sampling (Merriam & Tisdell, 2015). The snowball technique consists of using existing participants to recruit more individuals from among their colleagues.

This study was conducted in a selected region in a large Midwestern city. This region was chosen due to the proximity to my area of residence. There are five psychiatric treatment facilities that focus on the treatment of children ages 3–18 in the selected region. Once I received IRB and facility permission, I requested via email that flyers be posted in those facilities who had granted permission for me to recruit

employees on their campus, indicating the central purpose of my study along with my contact information for participation and recruitment (see Appendix A). Each potential participant who contacted me received an overview of the purpose of the study as well as a prescreening (see Appendix B for prescreening questions) to make sure they met the research criteria: (a) experience of implementing three or more restraints or seclusions on a child/adolescent patient on three separate occasions; (b) willingness to speak English throughout the interview; and (c) willingness to complete the interview in person, by phone, or via Skype/Zoom. After the screening, informed consent and confidentiality were outlined as well as participant protection from potential harm. The prescreening and overview of the study process lasted 15–20 minutes. For those participants who met the research criteria, I began to schedule time slots for one-on-one interviews lasting 1 to 2 hours with a debriefing period included in that time. Once each interview was completed, each participant was provided a crisis line number to contact if they experienced any stress or emotional discomfort from the interview process.

Instrumentation

Vaismoradi et al. (2016) stated the researcher is considered the primary data collection instrument in most qualitative studies, therefore, my role as the researcher was crucial to the study, as I was responsible for recruitment, data collection, data analysis, and dissemination of findings. As the primary data collection instrument, I aimed to ask questions that were open-ended and allowed the participant to choose the depth and direction of their responses. To prepare for the interviews I created an interview protocol which consisted of a list of semistructured questions (see Appendix C) used as a guide to

elicit detailed responses. Prior to the use of the protocol, I had the questions reviewed by professionals (dissertation chair and methodologist) to determine whether the questions were appropriate for the study.

I performed sample interviews to practice prior to conducting this study. Two sample interviews were given to former colleagues of mine who possess the same criteria as those recruited for the actual study. These two practice interviews were conducted to ensure the questions within the interview protocol promoted a positive interaction, allowed the flow of the conversation to keep going, and motivated the participants to talk about their experiences. After completing the practice interviews, I asked for feedback from my colleagues regarding how they thought the questions and interview protocol as a whole would work. Within the feedback I sought to determine whether the questions were clear or confusing, and obtained insight into their thinking process of working through their responses to the questions. This feedback was then shared with my methodologist for review prior to conducting the real interviews with selected participants.

As the primary instrument for data collection, minor changes occurred during the research process that required adaptation and a quick response, particularly when the participants provided unexpected or uncommon responses. Vaismoradi et al. (2016) stated the role the researcher plays as the primary instrument for data collection in a qualitative study allows for increased development of understanding through verbal and nonverbal communication, ability to instantly process data, recap and obtain clarification

of response, review responses for correct interpretation and accuracy with participants, and delve into uncommon responses participants may provide.

Each interview began with an explanation of the purpose of the study, and an informal discussion preparing the participant to discuss their personal experiences, while also allowing the participant to feel more at ease in the interview environment. The protocol involved informing the participants of the importance of understanding their experiences, and reassuring participants not to feel limited in their responses, and that follow-up questions would be asked to better understand their experiences. Participants were asked questions such as, how their day is going, how long they have been working for the facility, what his or her position is at the facility, and whether this is the first time working in a child/adolescent psychiatric facility. These questions were listed in the interview protocol and led to further in-depth questions regarding participants experiences with implementing restraints and seclusions on child/adolescent patients (see Appendix C for full protocol).

All interviews were audio recorded using a digital recorder and transcribed verbatim by a professional transcriptionist. The use of a digital recorder allowed me to repeatedly review the interviews to assist in analyzing the transcripts. The transcriptionist was required to sign a confidentiality agreement before beginning the transcription process. On the typed transcript participants' names were not used; rather, numbers were assigned to each study participant for privacy protection and to maintain confidentiality.

Procedures for Recruitment, Participation, and Data Collection

The purpose of this research study was to develop an understanding of treatment providers' experiences prior to, during, and following the implementation of a restraint/seclusion on a child/adolescent. The first criterion for participation in this study was treatment providers working in child/adolescent psychiatric facilities who were willing to be interviewed in person, over the phone, or via Skype/Zoom. The other criteria were that participants must have engaged in a restraint or seclusion with a child/adolescent patient on at least three separate occasions and were willing to speak English throughout the interview. Potential participants were recruited by the posting of flyers throughout the facilities (see Appendix A) as well as by word of mouth. Because I was interested in only treatment providers who have worked directly with the children/adolescents, administrative assistants, information technology, human resources and recruiting, and accountants were not considered for an interview. To adhere to the theoretical framework of IPA (Smith et al., 2009) purposive sampling was used to select participants in this study.

Participants were recruited from five different facilities in a selected region of a large Midwestern city. I first sent an email to the director/CEO of the organizations explaining my study and requesting that he or she distribute my research flyers within their facility to recruit participants for the study (see Appendix A). My goal was to recruit 8-10 participants. In addition to purposive sampling I used the snowball technique to gain participants. Participants were asked during the debriefing portion of the interview if they knew any co-workers who fit the research criteria and who might be interested in

participating in the study. Participants who were able to identify other potential participants were requested to share information regarding the research with these individuals and provide them with my contact information to become a participant in the study.

Individuals who met all requirements and wished to be a part of the study were sent the documentation on informed consent for review via email. The informed consent document included the central purpose of the study, ensured confidentiality of the participant, listed any potential risks that might come about within the interview, and the expected benefits of the study for each participant. Prior to any participant signing the consent form, I consulted with each individual via phone to determine if he or she had any additional questions or comments regarding the study. I then discussed availability and scheduled a time and place for the interview. Voluntary participation was indicated in the consent form. By signing the informed consent form, participants were indicating that they acknowledged and understood the procedures and intent of the study.

Data were collected using face to face, phone, or Skype/Zoom semistructured interviews. The private location of the face-to-face interviews varied based on the request and availability of the participant. I coordinated with each participant to discuss his or her preferred time and/or location of the interview, while also remaining cognizant of parameters surrounding confidentiality in public settings. As the central tool of the study, I was responsible for the data collection which was done through the interviews. I used my protocol of interview questions that were reviewed by my committee to ease the

process of data collection. Data collection for participants was limited to one interview, approximately one to two hours long.

Participants were informed that the interview was recorded for data collection and analysis in the subsequent stages of the study. Each participant was informed that the recordings were only to be used by this researcher, the transcriptionist (who signed a confidentiality agreement), and the research committee (chair, methodologist, university research reviewer) for data analysis and would not be accessible to any other party. Anyone on the committee may request data at any time.

The target sample size was determined by data saturation. Due to the inability to obtain data saturation from purposive sampling I used snowball sampling to recruit more participants until data saturation was reached. Data saturation was achieved with 8 participants when no new data emerged. The interview process concluded with a debriefing. Upon completion of the interview, the participant was informed that he or she would be contacted for member checking once I had reached the data analysis stage of the study (McCusker & Gunaydin, 2015). The process of member checking helped with obtaining feedback from the participant regarding accuracy of the transcribed information from the data provided during the interview. The member checking process took approximately thirty minutes for each participant.

Data Analysis Plan

I did not use a qualitative data analysis software as this interpretative study was reliant on my interpretative mind and personal analysis of themes and patterns within the data. Through the use of a qualitative data analysis software, interview transcripts would

be labeled and organized in a way that prevented my exploration and discovery of the data's essence (Woods, Macklin, & Lewis, 2016). Smith et al. (2009) stated researchers who use IPA seek to be with and resonate with the data. Qualitative data analysis software can cause a divide between the researcher and the data preventing the researcher from connecting with the experiences described in the interviews.

Smith et al. (2009) provided five stages of IPA data analysis consisting of: (a) read and reread the transcript closely to become familiar as possible with the recollection of the experience, (b) document emerging theme titles; (c) analyze and place data in theoretical order, (d) produce a table of themes ordered coherently, (e) write up and descriptions outlining the meanings inherent in the participant's experience; these five stages for IPA data analysis were used repetitively during this study. Although these stages provided a structure for the research data analysis, I was not bound to apply these five stages in the exact order listed above.

During the initial stage of analyzing data using IPA, I read and listened to each transcript and audio recording several times. Smith et al. (2009) stated the repetitive reading of the transcript and listening of the recordings supports the emergence of keywords or phrases repeated in the participant's responses. Identifying these keywords and phrases assisted with condensing the words/sentences in the transcript. The repetitive process during this initial stage allowed for the possibility of new understandings to develop each time the transcripts were read and recordings heard. While reading and listening to the transcripts and audio recordings I took descriptive notes of any thoughts or comments displaying significance.

The next stage consisted of looking for and documenting emerging theme titles. During this stage, the researcher tries to make sense of the connections between emerging themes (Smith et al., 2009). As the researcher, I transformed initial notes into concise phrases to capture the essential quality of what was found in the text. Emerging themes revealed in the data were then placed in analytical and theoretical order.

As I began to compile the themes and makes sense of connections, some themes were altered for better alignment with the descriptions that came from the participants. During the next stage I created a table of themes which were ordered coherently. The final stage of IPA (Smith et al., 2009) consists of the write-up and descriptions outlining the meanings inherent in the participant's experiences. I provided a narrative account of thick descriptions supported by participants' own words during their telling of their experiences.

Issues of Trustworthiness

Trustworthiness can be increased in research by displaying credibility, transferability, dependability, and confirmability (McCusker & Gunaydin, 2015). Credibility applies to the exactness of the research findings exhibiting the actual experiences or perceptions of the participants (McCusker & Gunaydin, 2015). According to Morse (2015), different strategies have been used to establish credibility within research. The strategies are known as member checking, triangulation, peer briefing, and reflexivity. To ensure the credibility of the research I chose the strategy of member checking. Member checking consisted of checking in with the participants via email and

providing them with a full transcript of their interview for which they made suggestions and sent back, possibly increasing the credibility of the results (Morse, 2015).

The process of transferability in qualitative research is attained when the research audience can make an association between their personal experiences and parts of the study (McCusker & Gunaydin, 2015). The process of transferability was increased within this study through my presentation of a full description of the methodological procedures and context of the research (i.e., setting, background, framework, nature of the study). From this description, the audience and future researchers may obtain the necessary amount of information regarding the context of the research allowing them to make similarities to other contexts of their lives (Abayomi, 2017). Should readers of this study find meaning in the results and be able to link the results to their own experiences, transferability criterion has been met.

Dependability is perceived as the degree to which the research findings can be deemed repeatable or replicable by other researchers (McCusker & Gunaydin, 2015). Once I received IRB and facility permission, I documented specific information throughout each stage of data collection and analysis. This documentation process was known as an audit trail (Merriam & Tisdell, 2015). By maintaining an audit trail throughout the research process dependability may be increased as the documented information allows other researchers access to my process of decision-making according to the actions taken throughout the progression of the research (Merriam & Tisdell, 2015).

To achieve confirmability within this research study I chose to use the strategies of reflexivity, triangulation, and the audit trail. Through the process of triangulation different resources were used throughout the research to compile and produce results. The resources that I used in this study consisted of audio recorded interviews, transcripts, notes, and a reflexive journal (Morse, 2015). I used the strategy of reflexivity by keeping a reflexive journal in which I documented my subjective reflections of the data. The journal included my observations as well as the perceptions, understandings, opinions, and reactions I had toward the data as I completed the process of data analysis (Woods et al., 2016).

The audit trail and reflexive journal display confirmability by providing information on how data was gathered, analyzed, and recorded. Additionally, the reflexive journal provides a collection of my thoughts and observations throughout the research. Notes were taken after each interview regarding my observations of the participants' responses that may have improved the quality of information provided during the interview. Additional themes were created from the information documented in my reflexive journal as this journal was perceived as an added source of data to be used in the process of data analysis.

Ethical Procedures

For this study to occur permission was first obtained from the IRB at Walden University (IRB approval 01-16-20-0417264). Once I received IRB approval from Walden University, I sent an email to each facility addressed to the CEO/Director explaining the nature of the study and requesting they distribute or post my research

flyers in their facility so that potential participants might contact me directly. The flyers indicated the central purpose of my study and included my contact information for participation and recruitment (see Appendix A). Prior to any potential participant signing a consent form, I consulted with each individual before the interview began to determine if he or she had any additional questions or comments regarding the study. The consent forms are essential for ethical research as each participant must be cognizant of the purpose and nature of the study. Voluntary participation is indicated in the consent form. By signing the informed consent form, participants were indicating that they acknowledged and understood the procedures and intent of the study.

There were minimal risks involved in this study. When implementing a study using human participants there may be a slight chance of emotional and psychological distress, due to the nature of the topic being discussed. If any participants were to have become emotionally or psychologically distressed during the interview process, I would have immediately stopped the interview and made certain the participant was provided with a toll-free number to speak with a licensed mental health professional.

I took into consideration those participants who did not feel comfortable voicing their opinion about their experiences of implementing restraints and seclusions for fear of retaliation from the CEO or head of the facility. This concern was addressed during the recruitment process over the phone as potential participants were given an overview of the study in which confidentiality was stressed and maintained. Any participant who initially agreed to be a part of the study but then refused to participate once the study began or withdrew early could leave the study with no penalty. Prior to beginning the

interview process, each participant was informed that there would be no penalization against them should he or she choose to withdraw from participation in the study at any time. Data collected from participants who chose to withdraw would be eliminated from the data analysis.

I have never worked in psychiatric treatment facilities for children/adolescents in the selected region of this Midwestern city, and therefore have no relationship with any participants from any of the study organizations in this county. Prior to recruitment, I had no previous encounters with employees at the five facilities or those who were referred by snowball sampling. There were no power differentials as I am in no position to have any sway over any potential participants.

Data collected from participants was handled as confidential, however, because I know the identities of the participants, the data is not anonymous. All personal information provided by the participants such as names and gender have been protected under confidentiality. The process I used to protect participants' confidentiality involved the assignment of different numbers to mask identities. These numbers were used during data analysis and upon the presentation of research findings. Audio recordings, written transcripts, notes, and my reflective journal were stored and locked in a file cabinet located in my home for which I am the only person with the key. The raw data collected was not shared with any party, other than myself, the transcriptionist, and my dissertation committee. My plan to disseminate the research results is through publishing my study in a psychiatric journal to target the specific psychiatric/behavioral population of children and adolescents. Additionally, I plan to present my study and its findings to facilities

from which I recruited participants. Community stakeholders who should hear about my research results include psychiatric youth care workers, therapists, nurses, psychologists, and psychiatrists.

Summary

In this chapter I provided the rationale for using the qualitative research method and explained why interpretative phenomenological analysis was appropriate for this study as IPA aligns with the research question. Choosing IPA as the approach to this study allowed me to obtain an understanding of the experiences of participants with complexity and detail of their accounts of the phenomenon (Park & Park, 2016). I described my procedures for recruitment, participation criteria, length of interviews, data collection and analysis procedures, and issues of trustworthiness. In describing issues of trustworthiness, I explained my process of establishing credibility, transferability, dependability, and confirmability by doing member checks, keeping a reflexive journal, and maintaining an audit trail. I have clarified that I used these techniques to reduce research biases and inaccurate interpretations as well as to engage in effective data collection and analysis. Additionally, I described any ethical issues addressed to ensure participants protection. I made every effort to ensure there was no harm caused to participants. Participants were reminded that they were free to withdraw from the study at any time with no consequences. A presentation of the data analysis and results is discussed in detail in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this interpretive phenomenological study was to describe and develop an understanding of treatment providers' lived experiences prior to, during, and following the use of a restraint or seclusion on children/adolescents in psychiatric treatment facilities. In this chapter, I provide the results of data collection through open-ended interview questions, demographic information on participants, and procedures used for conducting interviews. The research questions for this study were the following:

RQ1: How do treatment providers make meaning of their experiences when they use restraints or seclusions on children/adolescents?

a. How do treatment providers talk about what they are experiencing before implementation of a restraint or seclusion?

b. How do treatment providers talk about what they are experiencing during implementation of a restraint or seclusion?

c. How do treatment providers talk about their experience following implementation of a restraint or seclusion?

In this chapter, I present data from interviews with eight treatment providers who have implemented restraints or seclusions on a child/adolescent in a psychiatric treatment facility. Additionally, provided in this chapter are details regarding setting, data collection, and data analysis. Further sections in this chapter relate to evidence of trustworthiness, such as transferability, dependability, and confirmability, along with results of the study.

Setting

Once I received IRB approval (01-16-20-0417264), I reached out via email and phone to two CEOs and three directors of five psychiatric treatment facilities in a selected region in a large Midwestern city, specializing in psychiatric treatment for children and adolescents to explain the study in detail. I made a request to each director and CEO to email them flyers to print and/or hand out to treatment providers or to post in areas treatment providers had access to. The first participant for the study was unable to meet for the face-to-face interview. Due to this dilemma, I submitted a request for a change in procedures allowing interviews to be conducted in-person but also via Skype/Zoom or over the phone. I received approval for this change in procedures on April 3, 2019. The approval number for the study remained the same.

I used purposive sampling and the snowball technique to obtain participants for this study (Merriam & Tisdell, 2015). I interviewed a total of eight participants. Three participants were obtained through flyers at the facilities. The other five participants were obtained by using the snowball technique in which I offered those participants who had already been recruited the option of extending the invitation to participate in this study to other potential candidates. Through the process of purposive sampling, all participants were given a prescreening interview over the phone to ensure they met the research criteria. A total of 10 potential participants were given a prescreening interview. One potential candidate revealed they had only been involved in one restraint and no seclusions, disqualifying them from being eligible to continue with the interview process. A potential candidate revealed that they had witnessed three restraints and two

seclusions; however, they were not directly involved in the interventions, making them an ineligible participant. I interviewed a total of four participants face to face. Three participants were interviewed via Skype and Zoom (online video meeting services), and one participant was interviewed over the phone.

Demographics

Participants in the study were eight treatment providers in a selected region in a large Midwestern city. All participants signed the informed consent form prior to the interview. All participants met the necessary criteria for participation: (a) experience of implementing three or more restraints or seclusions on a child/adolescent patient on three separate occasions and (b) willing to speak English throughout the interview. Five participants were women, and three participants were men. The majority of participants were mental health technicians (n = 3), the rest were nurses (n = 2), unit supervisor (n = 1), a mental health counselor (n = 1), and a family and youth specialist (n = 1). The average number of restraints experienced by participants was four, and the average number of seclusions experienced by participants was three.

Table 1

Participant Demographics

Participant	Gender	Position	# of restraints	# of seclusions
1	Female	Mental health tech	5	6
2	Female	Mental health tech	3	4
3	Female	Nurse	3	2
4	Male	Mental health counselor	5	3
5	Female	Family and youth specialist	6	4
6	Male	Mental health tech	4	3
7	Male	Unit supervisor	5	3
8	Female	Nurse	3	1

Data Collection

Interview data were collected from eight treatment providers over the course of 10 months in a large Midwestern city. Data collection occurred between April 17, 2019, and February 26, 2020. Four interviews were held face to face at local coffee shops and bakeries. Three interviews were held via the Internet using Skype or Zoom on my computer in the privacy of my home, and one interview was held over the phone. I allotted 1–2 hours for collecting interview data; however, the actual interview times ranged from 51–72 minutes. Participants who I met with face to face or via Skype/Zoom received a phone call prior to the interview to review informed consent and discuss any questions they had regarding the study before the interview. No follow-up interviews took place; however, I did reach out to five of the eight participants via email requesting clarification regarding details of certain statements made in the interview. This did not require a follow-up phone call as the requested information was minor and easily explainable through email taking no more than 5 minutes.

A digital recorder was used to record the interviews. Each participant was notified prior to beginning the interview that I might be taking notes and there might be slight pauses in between questions due to note taking. For those participants I met with face to face and through Sykpe/Zoom, I wrote down noticeable changes in body language and facial expressions as participants described their perceptions and lived experiences of implementing a restraint or seclusion on a child/adolescent. For the participant I spoke to by phone, I wrote down noticeable changes in tone as they described their experiences. I kept a reflexive journal throughout the interviews and data analysis process to record my own meanings, reactions, and experiences of gathering and analyzing data. I used this reflexive journal to bracket my experiences so I was able to focus on describing the experiences of the participants. In accordance with the procedures outlined in Chapter 3, I collected data using the questions from the interview protocol to assist in guiding the interview (see Appendix C for full interview protocol). Questions asked included:

1. Please think back to your first experience when you had to implement a restraint.
    a. Tell me what it was like for you prior to the use of the intervention.
    b. Tell me what it was like for you during the implementation of the intervention.
2. Thinking back on those times when you used a restraint or seclusion tell me about a time when it was difficult for you.
3. What is it like for you after implementing a restraint or seclusion?
4. Tell me about the support you get when using a restraint or seclusion.

Although I followed the interview protocol during each interview, clarification was needed regarding participants' experiences, meanings, and perspectives they shared regarding the phenomenon of implementing interventions on children and adolescents. Therefore, follow-up questions were also asked, as anticipated, such as, "What do you mean by X?" or "What was going through your mind when X?"

Once the interviews were completed, a professional transcriptionist transcribed the interviews in a timely manner. Once the interviews were transcribed, each participant was sent a copy of the transcript through email. I received emails from all participants once they had read the copy of the transcript to inform me that the transcript was documented correctly and to share any feedback. This is a method of member checking, a strategy used to authenticate participants' responses (Morse, 2015). There were no variations from my original data collection plan. No unusual circumstances occurred during data collection.

Data Analysis

The research data were analyzed using the phenomenological approach consistent with the IPA approach. Each transcript and recording were read and listened to on five separate occasions. I recorded notes on the transcripts while reflecting on the experience of the interview. The type of notes taken included notes that pertained to mannerisms, body language, and tone of voice exhibited by participants when explaining their experiences. Additionally, I took notes indicating repeated information provided by the participant. In reviewing the notes, I searched for similarities and differences. These notes were used as I reviewed the data, rereading transcripts and listening to recordings.

For example, while I listened to each interview, participants discussed their emotional reactions during their experiences with implementing interventions. I took notes of each participant discussing their emotional reaction prior to, during, and following the described experience of a restraint or seclusion and listed each emotion described. The emotional reactions reported by the participants when implementing these interventions led to the development of emergent themes, including fear, annoyance, anxiety, anger, and stress. These emergent themes are discussed later in this chapter.

I analyzed the data by hand and did not use computer software for any data analysis. The choice to not use computer software to analyze data was made because I wanted to ensure I was fully immersed in the data and able to discover various themes and patterns without assistance. Once I listened to the recordings and repeatedly read the transcripts, statements made by participants that indicated significance were highlighted. By applying the steps from Smith et al. (2009), I identified and categorized themes based on similarities. Then I created a descriptive label for each theme. Beneath each label was a quote from participants' experiences, using their own words to describe the theme. I created a table for each transcript used to develop growing themes (see Table 2).

Four superordinate themes and 16 emergent themes resulted from analysis of participant data. The four superordinate themes were (a) emotional reactions, (b) warning signs and triggers, (c) process of intervention, and (d) organizational culture. Emergent themes were created initially, and superordinate themes were formed after this initial analysis of the data. Emergent themes included frustration, fear, anger, nervousness, annoyance, remorse, stress, relief, antecedents of behavior, knowing the patient, proper

techniques and procedures, physiological reactions, power and control, communication and relationships, trust and support, and debriefing and processing. Table 2 displays how the four superordinate and 16 emergent themes are linked. No discrepant cases were identified in this study.

Table 2

Superordinate and Emergent Themes

Superordinate themes	Emergent themes	Participants	Sample statements
Emotional reactions	Frustration Fear Anger Nervousness and anxiety Annoyance Remorse Stress Relief	P1, P2, P4, P6	"I felt like I went through a wave of emotions during the intervention. At first, I was nervous and somewhat annoyed because I had to restrain him, and then while restraining him things began to feel calm. Then the patient would get worked up again, which stressed me out." "It was a little stressful in the beginning you know especially because he was resisting. I felt sorry for him because I knew the kid, and I knew he didn't want to be restrained so I felt bad because I couldn't let him go free, because then I wouldn't know what would happen. But after when it was all said and done he was calm, and I was relieved that he didn't have to be chemically restrained." "At times I could feel myself getting frustrated knowing that I will have to intervene at some point because the patient was not calming down. Sometimes if you are the person that is trying to deescalate the situation you become the target and they start insulting you, spitting on you, and throwing things at you which is bound to make you feel some type of anger." "My first experience with a restraint I was scared. I was dreading the thought of having to intervene physically with the patient. I was questioning whether I could do it, and whether I could do it right."
Warning signs and triggers	Knowing the patient Antecedents of behavior	P2, P7, P4	"He was upset because we told him he needed to go to his room to cool down, he refused becoming increasingly angry and began making more racial comments toward staff. He then began pushing items that were on the table in front of him on the floor. He was instructed once more to go to his room and replied by saying "ya'll are gonna have to make me go". At this point he had to be physically escorted to his room using basic intervention techniques." "The patient began acting out in his room by tearing his shirt and tying it around his neck. Myself and another staff entered the room when he began displaying self-harming behavior. We attempted to verbally deescalate the patient, but we were not successful, and he thought that we were going to physically hurt him so, he made aggressive advances towards us. At this time the patient had to be physically restrained." "I caught the patient attempting to carve his gang set into a chair in the day room with his pencil. When I approached him and questioned him he became angry, saying that I was disrespecting him. When I told him he would receive a consequence for defacing facility furniture, he attempted to punch me. I immediately moved to place him in a restraint and my coworker removed the remaining patients from the floor."

table continues

Superordinate themes	Emergent themes	Participants	Sample statements
Process of intervention	Proper techniques and procedures Physiological reactions	P2, P5, P3	"It had only been about 7 or 8 minutes but I was hoping the restraint wouldn't go on any longer because I could feel the tension in my muscles the way I had him in the hold and it was starting to hurt." "If you do the technique properly you will be fine, so it wasn't that difficult because she couldn't move much; but I have been in restraints where I have been so focused on trying to remember the hold that the patient got free and that was not fun." "Sometimes it's like a guessing game because you're not sure if you're doing it right but you have them secured, but when you're thinking about your hand placements and if you're hurting them, or if they can get free. It could be one simple mistake like your hand is facing down when it should be facing up and they could get out of the hold."
Organizational culture	Power and control Communication and relationships Trust and support Debriefing and processing	P4, P1, P6	"It's almost as if they become too prideful and that gets in the way of handling the situation more effectively. Those are the interventions that get on my nerves, the ones that happen because of staff." "For the restraints I described to you earlier, I almost always had support. With the seclusions support is not really needed. There is always one other person there to support you also the nurses jump in sometimes if you are short staffed so the nurses may oftentimes assist with a restraint if three people are needed for a three person hold or if you know we need the rest of the kids off the unit while another kid is being placed in a restraint." "I mean really there's not enough time to debrief and process what just happened because we have to maintain patient to staff ratio so I kind of do a type of self-debriefing and play the incident over again in my head and think about if I did everything right."

The superordinate and emergent themes described above assisted with supporting my analysis of the data. In the following sections of this chapter, lived experiences of the participants for each of the four superordinate themes, as developed in the creation of the emergent themes, are described.

Emotional Reactions

Emotional reactions to the experience of interventions presented similarities amongst participants. All eight participants discussed a variety of emotions they encountered regarding their experiences prior to, during, and following the

implementation of a restraint or seclusion on a child/adolescent patient. All participants described moments of experiencing frustration, fear, anger, nervousness, annoyance, remorse, stress, and relief.

Frustration

Frustration was described by all eight participants as an emotional reaction experienced by some prior to, some during, and some following the implementation of a restraint or seclusion on a child/adolescent patient. Four of the eight participants described experiencing frustration prior to the implementation of an intervention, once they had had exposure to prior situations that required a restraint or seclusion. Participant 2 described experiencing frustration due to the behavior of the patient prior to the implementation of an intervention: "I was faced with a situation where the patient was making an unreasonable request and being extremely disrespectful toward me. I was feeling frustrated knowing that at some point I would have to intervene because he wasn't calming down."

Participant 4 also expressed frustration toward a patient's behavior prior to intervening regarding the impact the behavior could have on the other patients on the unit stating:

> Once you have experience with interventions you're not so on edge when a patient starts to have behaviors. It's more frustrating than anything else because it disrupts the flow of the unit. I get frustrated because all the other kids who have done nothing wrong have to be cleared from the area and sometimes when one kid

> is exhibiting behaviors, then that can set off a chain of behaviors from the other kids on the unit.

Three participants expressed experiencing frustration during the intervention. For these three participants, their experiences of frustration were related to the challenging behavior of a patient worsening during the implementation of a restraint. Participant 7 stated:

> I had him in a hold, myself and another staff, and he continued to try to punch and kick, but the hold was secure. He then proceeded to spit and try to scratch my arms. I was feeling frustrated because he wasn't calming down and his behavior continued to escalate. Normally once they are secured in a hold, knowing that they can't move they calm down within a few minutes, but this particular patient increased his behaviors once he was in the hold.

Participant 6 expressed experiencing frustration after the implementation of an intervention due to the inability of being able to recognize the reason for the behavior of the patient. Participant 6 stated:

> Before the intervention she was having a good day. She had participated in several activities and seemed to be enjoying herself. After she was restrained, I felt frustrated because I could not figure out what had caused her to change up her mood and start becoming aggressive with the staff.

Participants described experiencing frustration due to the acknowledgement that the use of less restrictive strategies were proving to be ineffective in decreasing the

behavior of a patient, which resulted in the realization that a more extreme intervention needed to be implemented. Participant 1 described:

> I was more irritated because I've dealt with him several times in having to seclude him. So in my mind I was just like "not again" you know I tried to talk to him and tell him to you know stop, you know go to a different group if you don't want to be part of the group we can do something in a different group, but he continued on you know, so before he was secluded I was just like more in my mind like "here we go again" and just more irritated than anything else.

Fear

Six participants expressed experiencing fear during the first time they implemented an intervention. Each described fear prior to the intervention of not knowing what to do, as well as fear of being hurt if they did not intervene. Two participants described fears of harming the patient when implementing a restraint. For example, Participant 4 expressed:

> I'm a big guy and this kid was like a petite 15-year-old girl. It's not easy being my size and having to restrain teenage girls. I was so scared that I was going to hurt her when I had her arms in the hold. If I'm being honest, because it was my first restraint and it was a female patient, I wasn't securing the hold too tightly because I was afraid, I would hurt her, or she would bruise. I wish restraining the female patients was something that I never had to do but I know that it's necessary for the safety of the patient and others around.

Participants discussed how their experience of fear was mostly caused by a sense of uncertainty regarding what would or should happen next and how long they would be restraining the patient. Participant 5 whose first experience with an intervention was a seclusion, described being scared of the seclusion turning into a restraint. Participant 5 stated:

> We told the patient to go to the seclusion room because she was disturbing the rest of the patients on the floor. She complied with the directive and I walked her to the seclusion room. I was the staff assigned to monitor her and it was my first time dealing with aggressive behaviors from a patient. When she was in the seclusion room her behavior escalated. She started kicking at the door, calling me names, and screaming at the top of her lungs. I was so scared that I would have to go in there and restrain her.

Anger

Participants shared how they experienced anger prior to, during, and following the implementation of a restraint or seclusion. Three participants described experiencing anger toward the patient for having to intervene. These participants described similar situations in which they felt they were being provoked by the patient to engage in a physical intervention. For example, Participant 1 described a situation in which she experienced anger toward a patient prior to the intervention:

> It was like she was just trying to challenge me because I was staff, like she was trying to get one over on me because I had not worked with her before. She was speaking aggressively for no reason like she wanted to start a fight and it was

> making me angry. I am not there to fight with children and teenagers, I am there to do my job, and she was trying to get under my skin.

Anger was not only expressed toward patients, as two participants described experiencing anger toward their coworkers for the language and tone used to speak to the patients. These participants expressed that the language and quality of their interactions with the patients elicited a negative trigger that led to the display of aggression which eventually resulted in an intervention. For example, Participant 7 explained:

> I was running a group and my coworker told one of the patients to pay attention but it was the tone in how he was speaking to the kid you know that caught my attention and it caught the attention of the patients on the unit. So of course, the kid he was talking to began to ignore him, and because there is this sense of power and control that certain staff want to have, my coworker immediately began barking commands at this kid to put away what he was doing and pay attention. I started to get angry with my coworker because I knew this kid, and I knew that raising your voice at him is just a trigger for him to begin acting out. My coworker didn't back down and the kid started getting physically aggressive, so we had to restrain him. I was so pissed because the entire situation could have been avoided.

Nervousness and Anxiety

All eight participants described experiences of nervousness or anxiety during various occasions for which they had to implement a restraint or seclusion on a child/adolescent patient. Nervousness was described in almost all participants first

experience with an intervention. Some participants experienced anxiety over the decision to intervene, while others experienced anxiety over the decision to stop the intervention. Three participants described experiencing a mental debate regarding whether to proceed with the intervention. They expressed that these debates caused more anxiety as they were distracting and caused much distress. For example, Participant 4 explained:

> It was my first time having to deal with a patient displaying aggression and it was a new patient at that, so you know I didn't have any background really as to why they were admitted. He just refused to listen to my directive and I'm already nervous because I was in front of all the other patients and he is telling me "no I'm not doing that shit" and saying things like "fuck off." When he started throwing stuff was when I started having like a mental dialogue with myself thinking "what should I do?" and "can I still keep him calm?", "should I intervene?" I even had thoughts like "I wish I could walk away." I was so nervous about how to handle the situation.

Determining when to release the patient and stop the intervention was the main cause of experiencing nervousness for four participants. These participants described how during the process of a physical intervention they had to monitor the amount of resistance from the patient by the tension in their muscles. Additionally, three of these four participants described situations in which another staff was involved in the intervention and therefore the decision to release the patient from the hold had to be a joint decision. These participants explained that although a patient was showing signs that they were calm, due to the intensity of the intervention and the high levels of anxiety, these

participants expressed still being “on edge” which made it difficult to immediately disengage due to the calming behavior of the patient. Participant 3 provided the following description:

> Even before the intervention I was on edge, but my anxiety level started rising when I had to physically intervene and put the patient in a restraint. As he continued to struggle it just made me even more nervous and the anxiety doesn’t die down just because the patient is calm. That’s what makes it harder to make a decision to release them from the hold because I was still feeling anxious due to the intensity of how the restraint began.

The uncertainty of knowing or the inability to predict the trajectory of how a patient may react or behave when he/she is already in a heighten state of aggression was a concern expressed by a majority of participants which lead them each to experience anxiety. Participant 8 explained:

> You literally don’t know what’s going to happen, the situation could go either way, it can escalate, or by continuously talking to the patient they may be able to calm down; it’s just hard to tell but your emotions are running high from beginning to end.

Annoyance

Six of the eight participants expressed experiencing annoyance when describing their experiences. Two participants described being annoyed by patients who were placed in seclusion due to what they explained as “unnecessary behaviors.” Participant 1 described experiencing annoyance toward a patient who was known for having to be

restrained or secluded at least once a day. In her description she expressed belief that this particular patient found humor in being secluded which caused her to feel annoyed. Her description is as follows:

> It was like he knew what to do to work himself up to the point where he didn't have to get restrained but knew that he would be separated from the rest of the group, and to be honest I think he enjoyed it. When you do like a seclusion you normally don't really need another staff to help you escort the patient to the isolated room. So this kid I mean all I would do is just you know like slightly tap his arm and you know say "okay we're going to the quiet room" or the seclusion room and he'll go in there and I'll stand outside the room and he'll like say stuff, try to trigger me, try to get me upset. I found it annoying because his behavior was unnecessary and pointless. Umm but because he's in the room he can say whatever he wants to say and then eventually he gets bored and he calms down. But seclusions are never as intense as restraints they're more annoying than anything else because it's just the kid like well, when its teenagers it's just them talking and just trying to rile you up.

All six participants described their experiences of annoyance based on the belief that the patient's defiant behavior was occurring because they simply wanted to "piss off" staff. Participants stated that they attempted to avoid reinforcing the behavior in order to prevent an intervention from occurring. Participants expressed that they do not enjoy engaging in interventions if there is no need and feel annoyed when patients try to taunt

them to elicit a negative reaction. Participant 7 expressed his experience of annoyance and described how he tries his best to avoid an intervention:

> I don't think they understand like we really don't want to have to do this. It's annoying because we truly want to do whatever we can to not have to put our hands on them, but I can't walk away this is my job, and it's like they know that, it's like they can tell we are trying not to react because the moment we do they get what they were looking for.

Remorse

Participants described experiencing remorse in some situations that required interventions, particularly in situations when they knew the patient was upset about something unrelated to anything that occurred on the unit. A majority of participants felt like they were faced with a dilemma regarding how to best interact with the patient without escalating the challenging behavior. Participants expressed that having the knowledge of why the behavior is occurring caused them to interact with the patient differently than if the behavior was unprovoked. Participant 4 discussed the difficulty of having to restrain a patient who recently returned from a family therapy session that did not go well:

> I felt sorry for him you know? Like everyone could tell that he was in a bad mood because his session didn't go well, so when he started throwing chairs it wasn't directed towards anyone and I understood what triggered the behavior, but he still had to be restrained. During the restraint I didn't know whether to comfort him, because that could reinforce the behavior and he was already mad. It wasn't a

> long restraint but it's like you're unsure of what to do after the restraint. Like do you talk to him about what happened and risk triggering the behavior all over again?

More than one participant described experiencing remorse after intervening with a patient. Three participants described thinking back over the incident after the intervention was over and feeling empathy for the patient. For example, Participant 8 described,

> When the restraint was over, I kept going over it in my head how it started and wondering if we could have handled the situation a different way. I think in this situation because the patient is not normally aggressive and because the nurses and staff on the unit knew why she was upset; she could have been approached differently to where there was no need for an intervention. I think when the time came for her to be restrained, I'm sure it was hard for her because in a way it's like we took away her freedom and opportunity to be upset about what she was going through. She began crying when we restrained her, and you could tell that she was hurting emotionally which is what caused her to act the way she was acting. I felt so sad for her.

Stress

All eight participants shared moments of experiencing stress prior to, during, and following the implementation of an intervention. A majority of participants described experiencing stress upon completion of an intervention due to the uncertainty that the patient may or may not begin to engage in problematic behaviors once more. Participant 2 described that she felt as if she had to be very careful around the patient because he/she

may easily become angry or upset, this resulted in continued stress for the participant throughout her shift:

> I felt like my mind was still in intervention mode like I was continuously watching and checking in on the patient in case there was a reoccurrence of the behavior. I felt like this for the rest of my shift. It was so stressful and hard to focus on the other patients on the unit.

Some participants expressed that engaging in physical interventions with patients was the most stressful part of their position. Participants explained that they would hope to avoid engaging in any interventions if they could but for the safety of the other patients and staff on the unit, they understood that physically intervening is a necessary action that must be taken at times. Participant 1 stated:

> During my first year as a mental health tech I was exposed to many interventions, restraints, and seclusions, but I was never directly involved. My second year is when I experienced my first restraint. Engaging in a physical restraint is never comfortable and most times this was the part of my job that caused me to stress out the most. I understand that I have to do it to keep everyone on the unit safe but it's still an uneasy thing for me to do.

Participant 6 expressed similar emotional reactions as participant 1 regarding experiencing stress and comfortability stating:

> Although physical interventions are needed, they are still used as a last resort. Intervening can cause so much stress for everyone on the unit because it stops everything. Most of us will do mostly anything to avoid restraining a patient

> because no one wants to be in those complicated holds, and they are so uncomfortable.

Relief

Three participants described experiencing relief after engaging in an intervention. Some participants provided descriptions of their first experiences after implementing an intervention, as feeling as if there was a huge load or weight lifted off their mind. These participants shared similar worries and concerns regarding their ability to implement an intervention correctly and expressed extreme relief upon completion of the intervention as well as a boost in self-confidence. For example, Participant 8 described:

> As a nurse I am not prone to engaging in as many interventions as the mental health techs and supervisors on the floor, but there are times when we have to assist with interventions if it becomes too out of control. My first time having to intervene was so nerve racking but once I got through it, I felt a huge amount of relief that the incident was over. I also thought "Wow that was it? Ok I can do this again if I have to." It was like I felt more sure about myself if I ever had to be in a situation like that again.

One participant described experiencing relief that lasted until he had arrived home from the facility and was able to process his part in the intervention. Participant 4 described an incident in which he was engaged in a restraint and uncertain if the restraint would require more staff to become involved as the patient's aggression continued to escalate while in the hold. Participant 4 explained:

> It was me and another staff and we had the patient on the ground. I had his arms and my coworker had his legs but this kid I mean he was irate. He would not calm down for nothing. I wasn't sure what was going to happen, and we didn't want him to get a shot and if we had to call for more staff, I was sure he would go crazy, I mean he was strong and could of possibly broken loose. I kept talking to him you know like distracting him, talking about whatever, just to get him to calm down and thankfully it worked, man I was so relieved because that incident could have wound up going a different way.

Emotional reaction is the first superordinate theme from the participants' reflections, and the emergent themes of frustration, fear, anger, nervousness/anxiety, annoyance, remorse, stress, and relief reveal emotional reactions as a lived experience encountered by treatment providers prior to, during and following the implementation of a restraint or seclusion.

Warning Signs and Triggers

Several participants discussed being aware and cognizant of warning signs and triggers exhibited by patients particularly those with whom they had worked before. Participants expressed that understanding what may trigger a patient assisted them with strategies on how to prevent or prepare for an intervention. Warning signs and triggers is the second superordinate theme in these findings, and is comprised of the emergent themes of, knowing the patient, and antecedents of behavior.

Knowing the Patient

Participants discussed that knowing the patients and what to look for regarding their behaviors allows for the opportunity to engage in non-restrictive interventions such as verbal de-escalation in hopes to avoid engaging in a restraint or seclusion. Most participants referenced their method of observation on facial readings of patients that represented cues for which a patient may become aggressive leading to a possible intervention. Participants discussed certain signs that they look for in patients who are having trouble controlling their problematic behaviors, which allows them to signal to their coworkers that there may be a need for assistance and the possibility of a potential intervention. Participant 3 described:

> For patients who have been to the facility more than once it's easy to spot the warning signs like agitation, speaking aggressively, or displaying non-compliant behavior. I look at their facial expressions, pay attention to their tone of voice and how they are moving or interacting with other patients and staff on the unit. Sometimes if it's a patient who I am not too familiar with I have to question whether it looks like they are moving towards me to hit me or are they open to speaking with me. That's when I have to make the decision of should I move closer and talk to the patient or prepare for an intervention.

Participant 7 described his experience as "taking a chance" when observing and recognizing the signs of potential problematic behaviors when it came to patients with whom he was familiar. He described how he would challenge these patients based on their therapeutic relationship. Participant 7 explained:

> If I'm being honest, with some patients particularly the male adolescent patients that I had established relationships with, I would sometimes challenge them when they would make verbal threats by getting in their face and telling them to "go ahead." It's not like I was trying to intimidate them and I know it's not proper procedure and it was a risk, but I also knew that given our relationship, knowing what triggers them and what to look out for like tension in their body, or if their fists were clenched, or they were pacing, raising their voices I could tell when they weren't to the point of requiring an intervention. But don't get me wrong it's me taking a chance and sometimes it doesn't work and leads to either a restraint or seclusion.

Antecedents of Behavior

In addition to knowing the patient, the second emergent theme that participants expressed in describing warning signs and triggers was antecedents of behavior. Each participant described antecedents of behavior that occurred prior to engaging in an intervention with a patient. The antecedents described typically consisted of a patient being given a directive by a staff, lack of attention, teasing/bullying from other patients, or engagement in unlikable tasks or activities. These antecedents were followed by negative behaviors directed toward the participant or other staff that led to the implementation of an intervention. Behaviors such as, insulting staff, peer name calling/teasing, property destruction, aggressive speech, ignoring/non-compliance, throwing objects, and self-harm were followed by the antecedents. Most participants experienced the same or similar antecedents during their first encounter with an

intervention. All eight participants described experiencing aggressive speech and the throwing of objects when providing detailed descriptions of what occurred prior to engaging in some interventions. Three participants described being insulted by a patient which caused further escalation when they attempted to redirect and calm the patient down. Participant 1 described how a patient became so worked up that she was not able to control the level of escalation of her behavior regardless of being told to calm down:

> It was like she had the urge to become more self-destructive, like she couldn't control her behavior to prevent the intervention from happening. She kept calling me names like any curse word in the book you name it, she was saying it, till it escalated to a point that required intervening.

Several participants expressed beliefs that patients engaged in negative behaviors to intentionally instigate an intervention as a way of getting attention no matter if the attention was negative. These participants expressed beliefs that patients who sought attention through the experience of an intervention did so as a sense of control. Participant 5 described a patient who would continuously self-harm causing staff to intervene on several occasions:

> We had to physically restrain her because she was self-harming and right after we released her from the hold and left her room, she began self-harming again. She knew what would happen, that we would have to intervene again, we eventually had to put her on a one to one because we couldn't keep intervening.

Similar to Participant 5, Participant 7 stated:

> He continued to get in my face and speak aggressively. He started throwing chairs and flipping tables, so I had to intervene for the safety of others. There was no reason for his behavioral outburst, he does this almost every other day, almost like he's showing off and I think he tries to engage in aggressive behaviors because he knows he will get restrained to gain the attention he was seeking.

Disagreements between patients on the unit was an antecedent described by participants that did not occur often however, in most cases this antecedent would lead to the use of a physical intervention. Participants explained that although for the most part the patients get along with each other, there are times when bullying can occur which leads to an intervention. For example, Participant 4 described an incident in which the antecedent that lead to the restraint involved a patient who was being made fun of:

> At dinner time the patient was sitting at a table across from peers who had been picking on her. She then proceeded to get up from the table and throw her food tray at her peers. We had to call a security procedure to break up the fight and restrain the two patients because they had become physically aggressive with one another. Once they were safely restrained by staff they were escorted to their rooms.

Patients given a directive by staff was a reoccurring antecedent described by all participants when providing details of incidents that lead to an intervention. Most participants described situations in which non-compliance to the directive would lead to aggressive speech or insults to staff, which would then be followed by physical aggression or property destruction. Participant 2 described a situation in which a chain of

events occurred that eventually led to a physical restraint that later turned into a seclusion:

> The patient was instructed to hang up the phone immediately. He decided to ignore staff and continued his phone conversation. So, he was clearly ignoring staff, and then he became verbally aggressive when staff approached him directly and instructed him to hang up the phone. At this time, I instructed the rest of the kids on the unit to go to their rooms. Once the rest of the patients were in their rooms, I walked to the nurse's station and began to attempt to physically remove the phone from the patient's hand. When I attempted to grab the phone, the patient used the phone to hit me. At this time my coworker, myself and the manager on the unit attempted to physically remove the kid from the area. He then attempted to run from us. So, myself and my coworker applied restraints and were able to successfully bring the patient down to the ground in a position that safely secured his arms and legs. We held him in this position for about 5-7 minutes. Once the patient deescalated his physically aggressive behavior, we slowly removed ourselves from restraining him and told him that he needed to go to his room. The patient then began acting out in his room by banging on his door and yelling threatening comments to staff. I escorted him to the isolation room, and he remained in locked isolation for approximately two hours due to the physical and verbally aggressive gestures and comments he was making.

Warning signs and triggers was the second superordinate theme in this research, and the emergent themes of knowing the patient and antecedents of behavior show how

participants identified problematic behaviors and the cause for these behaviors. Participants used their knowledge and history of working with a patient to navigate their interactions with those who displayed problematic behaviors and were also able to identify the precursor for these behaviors, which helped determine the appropriate intervention.

Process of Intervention

A majority of participants shared that the process of engaging in an intervention was the most intense part of their job. Process of intervention is the third superordinate theme that was developed from interviews with participants. The emergent themes of following proper techniques and procedures, and physiological reactions, emanated from the experiences that were shared and analyzed.

Proper Techniques and Procedures

A major concern for all participants when describing their experiences during an intervention was following procedures and "getting it right." Participants described experiencing issues with focus, recall, accuracy, and self-doubt when engaging in the intervention process. Each participant, during their first encounter with an intervention, experienced concern regarding implementing the proper technique and following the procedures correctly, particularly during a restraint. Many participants described how they attempted to remain focused on following procedures and using the proper technique, however stressed the difficulty in doing so given the intense atmosphere and the fact that they were experiencing a range of emotions. Participant 5 described:

> Everything happens so fast, and for my first restraint it was like a whirlwind, it was hard to focus on whether I was following the procedure and implementing the proper technique because the kid was struggling to get free and all I'm trying to do is keep him from doing that, but obviously I still had to keep focus and make sure my hand placements were accurate. It's kind of nerve racking because you're not really sure you're doing it right, but the other staff involved were so focused on their own holds that they didn't redirect me or tell me I was doing anything wrong.

Three participants described concerns about following proper techniques and procedures due to fear as to what might occur should they end a restraint too soon. Participants described experiences of self-doubt in making the determination whether to continue the intervention or release the patient. This experience was described as stressful for participants as they expressed that they wanted to ensure the continued safety of the patient and other individuals on the unit. Participant 7 stated:

> It's a judgment call really, most of the time I just want to release them and walk away, but you have to think about what would happen if you released them at the wrong time, what they might do, so it's important to follow procedure and proper protocol.

Attempting to recall which techniques to use and the appropriate hand placements were concerns expressed by all participants. A majority of participants described difficulty in maintaining focus in the present moment as they were mentally trying to remember what procedure comes next and to ensure accuracy in the movements so as not

to accidently release the patient or cause injury to themselves and to the patient. Participant 4 described his experience regarding ensuring proper techniques and procedures during a restraint:

> During the restraint I tried to focus on the proper techniques and escorting procedures we are trained on. I remember trying to recall our training and thinking were my hands in the correct placement. This was my first restraint, so I was more worried about my hand placement and if I was doing the escort correctly more so than anything else. I just kept having thoughts like "am I doing this right?"

Participant 7 expressed:

> I believe it's something that requires repetition in order to do it correctly without having to be in your thoughts while trying to focus on the hold, but I don't want to gain this experience through continued practice on patients!

Several participants described concern and difficulty with securing the intervention, explaining that certain techniques and holds were more difficult than others and oftentimes left participants feeling tense, exhausted, and even injured afterwards. Participant 6 described:

> I have experienced a couple of injuries during a restraint. Sometimes when you're in a hold your instinct is to maneuver in a way that may be more effective and secure, but you have to follow procedure and only do the techniques that have been approved. One time I got hurt because I was trying to put a patient in a hold where I grab around the patients legs, this hold required two people and my

> coworker had the upper torso but I couldn't get the legs to secure so I was trying to make my body go in a way that it couldn't and stretching my arms around this kids legs and I was kicked in the face it was just a hot mess.

Physiological Reactions

In addition to proper techniques and procedures, the second theme that emerged from participants experiences with the process of interventions was physiological reactions. Although participants described experiencing an array of feelings and emotions prior to, during, and after engaging in interventions, a majority of participants also experienced physiological reactions to these incidents. Physiological reactions such as, adrenaline, tension, and exhaustion were described by most participants. Most participants described how these physiological reactions lasted throughout the intervention. Six participants described experiencing adrenaline from beginning to end when describing situations involving interventions. Participant 3 stated, "I could feel my adrenaline going for most of the time I was involved in the intervention." Participants associated their rise in adrenaline to being nervous, anxious, or even scared. Participant 5 described:

> I mean I don't know what causes it but maybe it was because I was nervous. It's like the environment sort of tenses up and you are unsure how the patient is going to react to the next thing that comes out of your mouth because he's already angry and could snap at any moment so I just felt on edge and my heart was racing.

The decision to intervene for a majority of participants was associated with the rise in adrenaline and experiencing muscle tension prior to the intervention. Participants

described how the physiological reactions impacted their behavior as well as their interaction with the patient. Three staff related their body's reaction to problematic behavior exhibited by a patient as "my body's way of telling me when it's the right time to intervene." Many participants explained that their rise in adrenaline was a key factor in helping them throughout the intervention process. Three participants described how some behaviors exhibited by participants can be unpredictable and therefore at times when they could feel their adrenaline rising, they would feel an urge to respond. Participants described that in some situations this "urge" may have caused them to respond too early escalating the situation which then may have led to an intervention. Participant 2 explained:

> I mean although he wasn't throwing anything or had not yet physically harmed anyone, he had the phone in his hand as if he was going to hurt anyone who came near him. He also made verbal threats. I was already nervous because I wasn't sure what he was trying to do with the phone still in his hand. My adrenaline was going and I wanted to prevent something bad from happening if he were to use the phone as a weapon so I made the first advance to try to remove it from his hand which made him even more angry. I guess continuing to talk to him while keeping our distance could have worked but how long could that have gone on? I mean he was not following our directives and we clearly told him to do something and he ignored us and became irate.

Experiences of tension and exhaustion were described by participants during a physical restraint. Six participants described experiencing tension in their muscles while involved in a restraint that required several different techniques. Participant 6 stated:

> At this time I placed the patient in a restraint by grabbing a hold of his arms and placing them in a secure hold behind his back. I dropped him to the floor and while on the floor he began banging his head aggressively on the floor. My heart was racing so fast I was so scared he would end up with a head injury. Another staff came and held his head in a stationary position to stop the patient from injuring himself. When the staff tried to position his head, the patient tried to bite him. Things were so intense, and I still had to secure his arms and keep him from hurting his head. I could feel my muscles straining because this kid would not let up he was trying everything he could to get free. It was a mess, we put what's called a spit hood over the patient's head so he wouldn't try to bite or spit at us. Another staff then secured a hold of his legs and eventually we were able to carry him to his room but by the end I was done. I was so sore and exhausted.

Some participants attributed the physical exhaustion to the rise in adrenaline and the position in which they were holding the patient in a restraint explaining that both muscle tension and high adrenaline levels lead to feelings of exhaustion after the intervention. Participant 1 described:

> I'm a small person so putting these kids in restraints can be difficult for me especially if it's an adolescent. It's like my body is aching the entire time because I have to tense my muscles to keep the patient in the hold. If they become calm

> your muscles relax but your adrenaline is still going so your fully alert if they become aggressive again which sometimes they do and then my muscles tense back up. It's very tiring, the continuous adrenaline and tension in securing the hold is physically exhausting.

The emergent themes of proper techniques and procedures and physiological reactions comprised the third superordinate theme of process of interventions. Engaging in the intervention process challenged many participants to recall what they learned through their training in order to implement proper techniques and procedures while also experiencing heightened states of physiological reactions.

Organizational Culture

The fourth and final superordinate theme is organizational culture. The factors that impact the perceptions and attitudes of employees in their organization was related by participants as essential in how each facility operates. Power and control was an emergent theme, and participants shared how some treatment providers who tried to exert their power or control over patients created a situation which led to the implementation of a restraint or seclusion. Communication and relationships was a second emergent theme, and statements about the importance of developing therapeutic relationships with patients as well as the importance of regular one-to-one communication between treatment provider and patient were given by participants. Trust and support was the third emergent theme as participants shared the importance of ensuring effective trust and support with patients and between each other. Some participants also shared experiences of an absence of support from their coworkers and supervisors within their organizations. Debriefing

and processing was the fourth emergent theme, and participants shared how they oftentimes lacked the opportunity to discuss their feelings, reactions, and circumstances surrounding their restraint experience due to the organizational demands of unit coverage.

Power and Control

Power and control was described by study participants as a central component of the overall organizational culture. Participants discussed observing numerous power struggles between their coworkers and patients. Participants described feeling as if some staff displayed an exertion of power and control when interacting with patients who were not necessarily engaging in problematic behaviors. For example, Participant 2 described how her coworker gave an unnecessary ultimatum to a patient causing the patient to become agitated, which escalated into more negative behaviors that eventually led to a restraint:

> It wasn't the kid's fault, I mean yeah he was being a little stubborn but it wasn't like he was out of control, I didn't even think it would lead to an intervention, but my coworker, he wouldn't let up he had to add more fuel to the fire by telling the patient that because he isn't following directions that he wouldn't be allowed to go to the gym with the rest of the unit later that night. It wasn't his call to make but he did and that set the kid off. I felt like the restraint could have been avoided if my coworker would have worked with the patient instead of making a final decision without talking with the supervisor.

Two participants described experiencing an imbalance of power and control with male patients. Participants expressed the difficulty of working with certain patients who lack

respect for women in a position of authority making it hard for them to do their job effectively. Participant 5 described:

> He had been making sexually inappropriate comments to me. When I instructed the patient that he needed to go to his room, he became agitated and stated, "I'm not going to listen to you because you're a woman." I had to call for a male staff member to come and assist with the patient. It's frustrating because I feel like to him he got one over on me because I had to call for help, like I had lost control of the situation or was scared to handle it on my own, which I wasn't but I know that it probably seemed like that to him.

Three participants discussed how important tone and overall staff demeanor must be taken into consideration when interacting with patients. Participant 5 stated:

> I feel like some staff don't even bother to take time and figure out what's going on. It's sad because you see this happen almost daily. Some staff are quick to react and go straight to an intervention if a patient isn't doing what they're told. Protocol is to first try to verbally deescalate but I feel like that gets lost for some when they are more focused on the behavior instead of the reason for the behavior.

Communication and Relationships

Like the emergent theme of power and control, communication and relationships developed as an emergent theme in the overall organizational culture that treatment providers attribute to their perceptions and attitudes when working with child/adolescent patients. Participants described the development of therapeutic relationships with patients

and commented on certain staff members having had “favorite patients” on their unit. Participants discussed the difficulty of having to engage in interventions with patients with whom they felt they had developed a bond and attempting to mend that relationship after an intervention. Participant 4 described:

> I knew that it would be a little difficult after restraining him for me to regain his trust, but I tried to talk to him anyway, away from the rest of the kids on the unit. I tried to reassure him you know that I know it was uncomfortable and upsetting for him to be restrained, but that no one wanted to restrain him, it’s that we had to. I tried to explain that my role as his staff is there to support him and work with him to help him get better. I was like “you think I want to have you on the floor like that? No!” I let him know that I want him to feel safe and supported.

Six participants identified rapport building as an important factor in working with child/adolescent patients, stressing the importance of using consistent communication and building a relationship in order for patients to effectively communicate their feelings and any hardships they may be experiencing. Participant 4 described a situation in which he was able to avoid an intervention due to his relationship with a patient and expressing understanding of problematic behaviors displayed by the patient:

> He was verbally aggressive and pretty angry, but I knew it wasn’t directed at me. I asked him if I could speak with him in his room because he was clearly agitated. He complied although he was still pacing back and forth in his room, but we were able to talk, and he calmed down.

Several participants discussed experiencing a conflict in their role as a treatment provider when patients with whom they had established therapeutic relationships would display behaviors that required an intervention. Participants described their role as conflicting due to the importance of their job duties to provide security and ensure the safety of themselves and those on the unit as well as providing support and establishing a good therapeutic relationship with the patients. A majority of participants rationalized their reason for intervening as "following protocol and procedure" and it being "the right thing to do for everyone's safety." Participant 3 described:

> It's tough because I know he worked so hard in his treatment and everything that he worked for was diminished in an instant just to ensure his safety. That's what gets to me when we have to do interventions with these patients because while your implementing the intervention, you're also thinking about all the stuff that you worked on with the patient and because they're children and teens they can't separate the fact that we have to do our job and intervene when necessary. All they interpret is that we put our hands on them or we're punishing them and there goes that bond.

Participants reflected and discussed how their experiences with restraints and seclusions severed many therapeutic relationships developed with the patients because they identified the safety of themselves, the patient, and others as top priority above all else and many patients did not understand this logic. Participant 6 described:

> At the end of the day I can't worry about it. Even if he feels like he can't trust me anymore I can't be phased by that. I have to make sure that I'm protecting all

> parties involved, meaning myself, the patient, and everyone else on the unit. So I can't be worried about having to restrain him because I'm doing my job and I'm doing what's necessary even if he stops talking to me afterwards.

Participants described that there is no time to be concerned about the relationship established with the patient when risk and safety are the main concerns. Participant 6 described:

> It doesn't matter to me because I'm not thinking about that (how the patient is feeling). I'm only thinking about protecting the patients and everyone else on the unit from this patient who is acting out. So if we have to intervene and even restrain them then that's what I'm going to do. Whether they want to speak to me afterwards, that's on them.

Trust and Support

Participants described the importance of supporting patients throughout their time at the facility, as well as ensuring they are supporting their coworkers. Participants expressed that although they would have to engage in interventions at times with patients, they still sought to ensure that patients understood that they are also there to support and help improve their treatment.

Three participants discussed establishing trust and support as fundamental factors towards a patient's treatment. These participants expressed that providing consistent support would lead to positive progression for the patient during their stay at the facility. Participant 7 expressed the importance of providing continued support even when patients are making verbal threats:

> Sometimes I may be threatened or called derogatory names by patients, but that doesn't mean I have to stoop to their level. I attempt to pull them aside once they have calmed down to talk to them about why they are behaving that way. I feel like this builds trust and most patients who are being verbally aggressive I feel are really crying out for help so most times I don't give a negative reaction when this happens.

Not only is providing support to the patients a role that was stressed by a majority of the participants, but many participants also stressed the importance of supporting and receiving support from their coworkers. Participant 4 described an experience in which he felt unsupported by his coworkers when faced with a situation that lead to an intervention.

> It was only me and another worker on the unit but this patient's behaviors were escalating fast so I had to intervene but my coworker just got up and got the other patients out of the way and didn't come try to help me get the kid calm. I had to holler for my supervisor whose door was shut and finally I got some help. I didn't have any support, not from the nurses who were also watching, and I know they don't intervene unless they have to, but you could tell I needed more help and they just watched.

A majority of participants however, described that they have received support through most of their encounters with interventions and expressed gratitude towards their coworkers for helping them in situations that lead to interventions and even those that did not. Participant 5 described:

> The support from staff is extremely needed and is available when physically restraining a patient. In this field you must be able to trust that staff will react appropriately and respond accordingly if other staff needs assistance. I have never felt unsupported in a physical restraint. However, there are instances where staff could have intervened sooner, or they chose to not intervene at all. In those cases, this might escalate the patient more especially if the staff restraining the patient is the staff member the patient is angry with.

Debriefing and Processing

Several participants described difficulty in finding time to debrief and process after engaging in an intervention due to organizational demands. Participants discussed how the lack of ability to debrief causes staff to feel "burnt out" which can lead to a stressful work environment. Three participants described feeling as if their own needs were dismissed by supervisors and coworkers due to the need for continuous coverage on the unit floor. Participant 4 described:

> Just like we have to prioritize safety and risk over everything else, our ability to process what happened falls to the bottom of the list because we are needed to fall back in line and expected to pick up where we left off with the rest of the patients before the intervention occurred, almost like pretending nothing happened. The only time we really get to process is after work or during supervision but then supervision doesn't happen that much either so you just kind of have to swallow your emotions and get back to work.

Participants described how the culture of the unit or the facility in general can be perceived as stressful due to the inability to process feelings and emotions that may have occurred during an intervention. Participant 2 explained:

> I think it would be beneficial if we were allowed to debrief after an intervention, especially a restraint. Being able to process what just happened is important and we never have time to do it because we're always worried about having enough coverage. I mean some restraints can be really intense, and when you're on the floor in a hold for a long time, it's important for your body to have a break too.

Three participants discussed the difficulty of engaging in an intervention and resuming their work with the patients immediately after. Participant 6 described that he oftentimes struggles with "getting himself together" after he has been involved in an intervention he stated:

> Man it's like they (supervisors) want you to just get back to work after you've been practically attacked, spit on, scratched and everything else. I swear I almost lost it on one of the patients, but I know that I have to keep my emotions reserved because it could cause other patients to escalate. So, it's like I immediately have to get myself together and keep my composure. Sometimes though these feelings carry over into my personal life because I don't get the opportunity to process what happened at work.

Organizational culture was the fourth superordinate theme, and participants provided rich descriptions of how the structure and culture of their organizations affected their perceptions and attitudes associated with their interactions with the child/adolescent

patients. The emergent themes of power and control, communication and relationships, trust and support, and debriefing and processing shows how treatment providers adapt and operate within their organizations. Additionally, the four emergent themes show how the culture of each organization impacts the participants perception and how they make meaning of their experiences on the unit floor.

Evidence of Trustworthiness

Trustworthiness can be increased in research by displaying credibility, transferability, dependability, and confirmability. Credibility applies to the exactness of the research findings exhibiting the actual experiences or perceptions of the participants (McCusker & Gunaydin, 2015). As noted previously, the process of member checking was used to establish credibility. Through the process of member checking I sent full transcripts of each interview to the participants' individual email addresses, requesting that they review the transcripts and make suggestions or contact me if the information transcribed appeared to be inaccurate from what was described. All eight participants emailed me once they had received and read the transcripts, informing me that the data transcribed was accurate and there was no need for any changes.

Transferability was achieved by providing rich descriptive data and through the process of purposive sampling. This process of transferability allows the audience and future researchers to obtain the necessary amount of information regarding the context of the research, therefore allowing them to make similarities to other contexts of their lives (Abayomi, 2017). All eight participants met the criteria to participate in this study. I began to reach saturation by the sixth interview, however I proceeded to interview two

more participants to determine if any new data would surface; no new data was found from these two interviews. To obtain data saturation and thick descriptions of the phenomenon being studied, qualitative research is the best method of choice. This method is used to direct the audience toward the goal of understanding a phenomenon, using tools that may produce comprehensive and thorough information which would otherwise not be discovered through standardized instruments frequently used in quantitative research (Taylor et al., 2016). Detailed information was obtained from the experiences of eight participants who I interviewed. In adherence with the guidelines of IPA, each transcript was read and reread multiple times a day for a two-week period. This allowed me to become more familiar with the data (Smith et al., 2009). After reading and rereading the transcripts for those two weeks, the transcripts were revisited six times during my process of data analysis. Dependability was addressed by providing rich detailed descriptions and I maintained an audit trail documenting specific information through each stage of data collection and analysis.

Confirmability was achieved within this study through reflexivity, triangulation, and the audit trail (Morse, 2015). Detailed descriptions of how data were collected, recorded, and analyzed were provided. I kept a reflexive journal through which I documented my subjective reflections of the data. This journal included my observations as well as perceptions, understandings, opinions, and reactions I had toward the data as I completed the process of data analysis. Information documented in my reflexive journal assisted me in the identification of themes.

Results

The purpose of this interpretative phenomenological analysis was to increase my understanding of the lived experiences and perceptions of restraints and seclusions from the treatment provider's perspective. Descriptions of the lived experiences of eight treatment providers were collected and interpreted for research purposes. From the descriptions of the lived experiences provided by the eight participants I obtained further insight into the question that guided this research. The research question was: How do treatment providers make meaning of their experiences when they use restraints or seclusions on children/adolescents? Results of the data gathered indicate that participants have varied experiences. Most treatment providers participating in this study shared similar emotional responses to their experiences. Additionally, participants also provided detailed descriptions of how their emotions and cognitive reactions affect how they make meaning of and respond to problematic behavior. Participants discussed how their perceived causal explanations for patients exhibiting challenging behavior affected their emotional response and how they experienced the intervention.

Treatment providers' descriptions of implementing restraints and seclusions varied. All participants provided similar experiences during their first encounter with an intervention however, each participant's descriptions once they had had experience were mixed. Participant 1 stated, "I definitely don't get shook up anymore, like I'm prepared for it umm like once you've done it one time you kind of like prepare yourself for the next time." Participant 3 said, "Honestly it's still stressful and a little scary, even though it's not my first time it still feels that way." Participant 6 asserted,

> Once I have the patient in the hold I'm fine because I'm comfortable with implementing a restraint. I think honestly what I still have trouble with is the situations that lead up to the restraint because you just never know what direction the situation may go so for me I'm always anxious during the beginning.

Participant 4 described, "It came more naturally and instinctively to intervene when necessary. Once I had three or four restraints or situations when I had to seclude patients in the isolation room I felt more comfortable with my own judgment."

The data revealed that some treatment providers rarely processed the personal impact restraints and seclusions may have on them. It seemed that treatment providers' lived experiences of implementing restraints and seclusions provided insight into how some treatment providers are able to acknowledge the emotional impact interventions may have on them whereas others may minimize the emotional impact, prioritizing the safety of the patients and others over their own emotional well-being.

The treatment providers asserted similarities regarding their descriptions of warning signs and triggers exhibited by patients prior to engaging in an intervention. Insulting staff, teasing other peers, property destruction, aggressive speech, non-compliance, throwing objects, and self-harm were common antecedents of behavior identified by participants. Each participant described their lived experiences of observed problematic behaviors exhibited by patients which lead to the need for an intervention. For example, Participant 4 said,

> Once he was in his room, he continued to be verbally aggressive toward staff and peers. When he was asked to stop yelling, he got in my face and attempted to push

> me out of his way, I grabbed his arms and placed him in a two-armed escorted hold.

Participant 2 stated, “The patient made aggressive advances towards us, at this time the patient had to be physically restrained.” Participant 6 commented, “He started throwing things in his room, cursing and punching the walls so the unit manager asked that I escort him to the isolation room.”

All the participants in this study described experiencing physiological reactions when explaining their encounters with interventions. Participants described experiencing the physiological reactions of adrenaline, tension, and exhaustion at different moments during their encounters with restraints and seclusions. For most participants, the physiological reactions occurred sequentially with adrenaline being the first physiological response experienced by the participant when faced with a patient who is exhibiting problematic behaviors. For example, Participant 7 said,

> It’s like I could feel my adrenaline rising as he continued to raise his voice…I had him in a restraint and still felt on edge, my heart was racing and my muscles were strained from the hold….this was the longest I had been in a hold, when he was finally released my arms were so sore and I was exhausted.

Following procedure and ensuring the use of proper technique during interventions was an experience shared by all participants that involved concerns of accuracy as well as feelings of self-doubt. Participants made it clear from their described experiences that “getting it right” involved focus and proper recall however, each participant described difficulties with this task. For example, Participant 3 stated,

> Trying to focus on the proper technique while I have this patient who is screaming at the top of their lungs and flailing their arms and legs everywhere was hard especially when my main priority is to make sure that they're safe so I had to try and concentrate on the hold and make sure that I'm doing it right and that they aren't able to get an arm or leg free to hit or kick me.

This was similar to what Participant 4 described,

> My stress level was on ten and they kept trying to escape the hold so I'm trying to make sure I'm doing it right but it's hard to keep focused because I was also trying to prevent them from getting hurt and making sure they didn't hurt me.

Each participant was able to describe moments in which they questioned themselves and the procedure they used to intervene in certain problematic situations, although no participants mentioned receiving any negative feedback from their coworkers regarding how they handled the intervention. The most concern expressed by participants was centered around accuracy and recall. Their facial expressions as they reflected upon past interventions used presented as if there was still some self-doubt regarding the proper use of techniques and procedures especially when recalling their first encounter with an intervention.

Participants described observing their coworkers attempting to assert their power over patients by ordering consequences if the display of a problematic behavior is not ceased, instead of trying to understand the reason behind the behavior. All participants described their role as a treatment provider as ensuring patients are supported throughout their treatment process. Participants described the development of therapeutic

relationships with the patients and how engaging in an intervention can have a negative impact on this relationship. For example, Participant 6 described,

> I mean it's like we have many hats when we're on the unit floor but making sure that everyone is safe is the most important role we play as staff. So, when I restrained him of course he's going to be mad at me, but I can't think about that in the moment. Sometimes though when I have to intervene with a patient who has come so far and made a lot of progress, I can't help but think "well there goes all that work out the window."

All participants described the process of debriefing after an intervention as a concept that is lacking in the overall culture of their facilities. While each participant described having to fill out an incident report regarding the intervention, most participants expressed that incident reports are completed at the end of their shift. Participants explained that the need for the appropriate staff to patient ratio prohibits them from debriefing and processing interventions that have just occurred. All participants expressed the need for debriefing, stressing that reviewing the events that have just occurred during an intervention and evaluating their decisions and actions taken would be very helpful and allow them to think back over the incident to determine if they have done everything they should have done or if they could have handled the situation differently. Participant 5 described her thoughts on debriefing stating,

> I think it's absolutely necessary but when can we find the time? We are expected to be back on the floor with the other patients so there's no one who can "tap in" and provide coverage while we debrief with a supervisor or coworker. It's kind of

stressful cause from my experience I'm always a little shaken up after an intervention.

Summary

The purpose of this study was to understand and describe how treatment providers make meaning of their lived experiences of implementing restraints and seclusions on children/adolescent patients. Semi-structured interviews were conducted to obtain a description of the perceptions and experiences of eight treatment providers. The descriptions provided from the interviews produced meaningful accounts from treatment providers regarding their experiences of engaging in interventions. In this chapter, details regarding data collection, analysis, and interpretation were provided, along with the procedures I applied through IPA. I used purposive sampling to recruit eight participants from which data were collected. Results of the data analysis from the transcribed interviews were provided and four superordinate themes, along with 16 emergent themes were discovered. Chapter 5 will consist of an interpretation of findings, limitations of the study, and recommendations. The chapter ends with a section on implications for social change, and study conclusions.

Chapter 5: Interpretation, Recommendations, Conclusion

Introduction

This study was designed to gain a deeper understanding of the lived experiences of treatment providers who have engaged in restraints and seclusions with child/adolescent patients. I examined how treatment providers described and made meaning of their experiences engaging in these interventions. A minimal amount of research exists that focuses on treatment providers' perspectives when implementing restraints and seclusions on children/adolescents. While treatment providers' attitudes toward the use of restraints and seclusions are known, the exploration of treatment providers' experiences leading up to, during, and following the use of these procedures has gone unaddressed. This study was organized according to the methodological principles of IPA. My objective was to provide an understanding of the lived experiences of treatment providers prior to, during, and following the implementation of a restraint or seclusion on a child/adolescent patient. Additionally, I sought to add to the existing literature on treatment providers' experiences of engaging in physical interventions. Through IPA, the data collected assisted in the improvement of understanding this phenomenon and providing new knowledge and insights regarding the intervention process, emotional reactions toward interventions, triggers and warning signs, and organizational culture.

Interpretation of the Findings

The findings from this interpretative phenomenological study developed from thick descriptions of in-depth interviews with treatment providers who shared their lived

experiences of engaging in restraints and seclusions with child/adolescent patients. Four superordinate themes, including emotional reactions, warning signs and triggers, process of interventions, and organizational culture derived from the emergent themes formed from the interviews with the participants. These findings are compared to existing literature and theory to supplement the interpretation of the results. The findings are discussed and organized below by superordinate theme. Each discussion includes connections to the literature as well as my own reflections as the researcher.

Superordinate Theme 1: Emotional Reactions

The findings of participants experiencing strong emotional reactions centered on their descriptions of situations in which they had to intervene verbally or physically. The focus on emotional reactions was not surprising to me given the described intensity of the incidents and observation of emotions portrayed on the faces of participants as they recalled and described the events that transpired during their experiences with interventions. Participants described eight key emotions that influenced their perceptions and experiences throughout the intervention process: (a) frustration, (b) fear, (c) anger, (d) nervousness/anxiety, (e) annoyance, (f) remorse/sadness, (g) stress, and (h) relief. As mentioned in Chapter 2, challenging behavior displayed by children in psychiatric facilities is a major source of stress for treatment providers (Faay et al., 2017; Furre et al., 2017). In support of this research, participants shared experiences of not only undergoing mental stress but physical stress when working with child/adolescent patients.

In relation to the types of behavior that elicited emotional reactions, displays of self-harm were expressed by participants as the most difficult behavior to intervene due

to the patient's repetition of the self-harming act. Participants shared that these situations caused them to experience an array of emotions due to uncertainty whether the patient would resume the behavior upon completion of the intervention. Many participants described that after engaging in an intervention in which a patient self-harmed, minutes later the patient would again begin engaging in self-harming behavior causing another intervention, which was typically a restraint. These interventions, as explained by participants, caused them to experience continued negative emotional reactions, such as frustration, annoyance, fear, anxiety, and stress. This finding supports Berg et al.'s (2013) research, in which interviews with staff revealed the process of intervening during self-harming behavior evoked strong emotions due to the challenges of these interventions.

Participants described experiences in which verbal aggression often intensified their emotions. Verbal aggression, as described by participants, was elicited in the form of insults, cursing, and threats of violence. This finding supports Duxbury (2015) who found that displays of aggression and violence reflected a sense of powerlessness and frustration for both the staff and patient. Several participants expressed experiencing emotional distress due to the realization that less restrictive strategies being implemented were ineffective in decreasing verbally aggressive behavior exhibited by a patient. Participants explained that this realization often intensified their experience of nervousness, fear, anger, frustration, stress, and annoyance as a restraint or seclusion would likely need to implemented. This is comparable to findings by Berg et al. (2013), whose interviews with staff identified verbal aggression as a violation of psychological space and cause for emotional distress.

The experience of fear was a reoccurring emotion shared by participants due to the uncertainty of knowing or the inability to predict the trajectory of how a patient may react or behave when in a heightened state of aggression. Some participants described that often it was that experience of fear for the safety of others that reinforced their decision to engage in a physical restraint. This finding supports previous research by Brophy et al. (2016), who found that fear was perceived by staff as a common contributor to the use of a restraint or seclusion. Contradictory to this finding, a few participants expressed that experiencing fear made them reluctant to engage in a physical intervention due to the intensity of the aggression displayed by the patient. This is comparable to findings by Duxbury (2015), who found that due to the powerful nature of anger, treatment providers exposed to any anger may feel fearful or intimidated resulting in the avoidance of interacting with patients. Overall, findings from this study indicate that treatment providers may benefit from training that teaches emotion-focused coping strategies, like stress or anger management skills to implement when addressing challenging behaviors to reduce their levels of emotional arousal throughout the intervention process.

Superordinate Theme 2: Warning Signs and Triggers

I was not surprised by the findings that knowing the patient and understanding their warning signs and triggers helped treatment providers to alleviate challenging situations. Participants expressed that knowing the patient and being familiar with certain antecedents of behavior helped with identifying warning signs and triggers for problematic behaviors. This is comparable to findings by Wilson et al. (2018) who sought

strategies to reduce the use of physical restraint from both staff and patients. During interviews with 13 staff members, the participants stressed the importance of getting to know the patients (Wilson et al., 2018). The staff members shared how their experiences of knowing the patient made it easier to identify their warning signs and triggers and was beneficial in decreasing escalation and reducing the use of physical restraints (Wilson et al., 2018).

All participants shared experiences of how knowing the patients and what may trigger them assisted with strategies on how to prevent or prepare for an intervention. This supports previous research indicating that obtaining a better understanding of the warning signs prior to the display of aggressive behavior exhibited by children/adolescents allows treatment providers to conduct a risk assessment of the patient to ensure the implementation of safe, ethically sound, and more consistent aggression management (Faay et al., 2017). Participants shared that having the knowledge of why the behavior was occurring caused them to interact with the patient differently than if the behavior was unprovoked. This finding reaffirmed that of Berg et al. (2013), that challenging behaviors can often be minimized if the treatment provider develops a better understanding of the antecedents of aggression, likely resulting in the management of aggression implemented by other means aside from restraints and seclusions.

Each participant shared their knowledge of the population they serve, describing that most patients admitted to the facilities are either diagnosed with a mental health disorder or have severe behavioral issues. With this knowledge, participants described

that often there may be no trigger or situation that elicited a negative response; the antecedent to the aggressive behavior could be attributed to the patient's mental health or behavioral problems. This finding is comparable to Berg et al. (2013), who indicated that psychiatric disorders were perceived to be a precursor of aggressive behavior. Staff familiarized themselves with the adolescents' psychiatric diagnosis, making it easier to understand their aggressive reactions and in turn react appropriately (Berg et al., 2013). The participants in this study explained that they do not necessarily receive training to understand the various psychological disorders diagnosed to patients; however, they shared that continuous exposure and experience of working with patients allowed them to familiarize with and identify when certain patients presented with difficulty in communication, understanding, and the use of coping skills, ultimately resulting in aggressive behavior. Participants described that this knowledge simplified their ability to interact and understand patients, resulting in aggressive incidents that did not lead to a restraint or seclusion.

These findings provide additional knowledge regarding staff's perceptions of child/adolescent aggressive behavior in a psychiatric setting. The connection expressed by participants of understanding warning signs and triggers and how this contributes to a reduction in the occurrence of aggression may improve the therapeutic milieu of the unit and strengthen the relationships between staff and patient.

Superordinate Theme 3: Process of Intervention

Understanding the process of intervention from the treatment provider's perspective is an important extension of the literature due to the gap in research regarding

the lived experiences of treatment providers who have engaged in restraints or seclusions with child/adolescent patients. Each participant in this study provided thick descriptions of their experiences during the intervention process, providing insight into their thoughts, perceptions, and overall experience of engaging in crisis intervention. All participants expressed that the standard protocol for their facility is only to engage in a physical intervention as a last resort, when verbal deescalation is ineffective and there is a potential of harm to others or the patient. This finding supports that of Minjarez-Estenson (2016) who stated many facilities make clear that restraints and seclusions are intended only after less restrictive alternatives have been implemented but shown to be ineffective. Participants described the importance of their position to provide security and ensure the safety of themselves and those on the unit, explaining their reasons for intervening as "following protocol and procedure" and it being "the right thing to do for everyone's safety." This is comparable to findings by Caldwell et al. (2014), whose interviews with staff saw the implementation of these procedures to be routine stating the implementation of restraints and seclusions is a "necessary evil" to protect staff and children

Participants shared their experiences of questioning whether they were following protocols and procedures during the intervention process especially during their first encounter with a restraint or seclusion. Many participants expressed that they experienced their first restraint or seclusion within the first few months of being employed. These participants shared that during their first experience with a restraint the incident occurred rapidly, resulting in difficulty with recalling the movements and techniques for following certain procedures received during preemployment training. Due to the difficulty of recall

some participants shared that they acquired minor injuries during their first restraint. This finding supports that of research cited by Duxbury (2015) who discovered that new staff members were more likely to become injured during a restraint than experienced staff members. Van Loan et al. (2015) stated that staff who engage in restraints should be mindful of the impact it may cause on the patient, such as, emotional and physical trauma. Participants in this study mimicked this train of thought during the process of engaging in an intervention as each participant shared that most times during a restraint procedure they sought to ensure that the technique implemented was secure while also being mindful of how the patient was responding. Participants shared that if the patient was expressing extreme discomfort (i.e. inability to breathe, soreness/pain) they would loosen the hold and reposition to try to accommodate the patient while continuing to restrain.

Physiological reactions along with some physical ailments were experiences shared by participants which occurred during each restraint. Rise in adrenaline, muscle tension, fatigue, soreness, and injuries are experiences participants shared that occurred during the restraint process. Participants described that each restraint experience would differ based on the duration of the restraint, technique used, and behavior of the patient. Most participants shared that restraints that lasted longer than ten minutes resulted in muscle tension, soreness, fatigue, and occasional injury due to engaging in a hold for an extended amount of time. Participants expressed that although they have experienced restraints lasting less than 5 minutes in which an injury occurred, most often injury would occur with restraints lasting longer durations. These findings seem to reiterate that of

research cited by Duxbury (2015) who found that the duration of the restraint, impact of the struggle, level of arousal and fatigue, and a number of other cumulative stressors were identified as contributing factors leading to an intervention resulting in injury.

The findings from this study are unique for adding new knowledge to the scarce research in the field of child/adolescent residential treatment and the experience of treatment providers when engaged in methods of physical restraint to address aggressive behavior. It is not difficult to understand how treatment providers and patients can be negatively impacted by the use of physical restraint. The process of engaging in a physical restraint shared by participants in this study, expands on the research regarding restraint use, providing a different perspective and better understanding of the mental and physiological experiences endured by treatment providers.

Superordinate Theme 4: Organizational Culture

Deveau and Leitch (2015) suggested that considerations be given to external factors that include the organizational culture such as staff's ability to tolerate aggressive behavior, staff's beliefs regarding the therapeutic benefits of restraints and seclusions, and whether the treatment facility itself places emphasis on therapeutic outcomes. In support of those suggestions, participants in this study discussed their experience and perceptions of the organizational culture within their respective facilities. Themes that emerged were power and control, communication and relationships, trust and support, and debriefing and processing. Participants shared that oftentimes there would be a disconnect in communication between staff and patient in which they observed their coworkers using aggressive tones to communicate with the child/adolescent patient as a

way of asserting power and authority, most times resulting in an intervention. This finding supports the research by Ling et al., (2015) who found that staff members style of intervention and communication with adolescent patients were perceived as conducive to acts of aggression. Additionally, these researchers found that an authoritarian communication style provoked aggression and resulted in use of more physical techniques to control adolescent patients.

Ensuring unit rules were being followed was expressed by participants as an important factor when it came to treatment and ensuring the safety of patients. Participants described experiences in which patients struggled with following the unit rules and that most patients admitted to the facilities had a history of behavioral issues surrounding non-compliance. Participants expressed that due to this factor there existed a clear power differential between treatment provider and patient. Ling et al. (2015) produced similar findings in their research revealing that patients experienced a loss of autonomy as staff expected patients to abide by unit policies, causing tension to arise when patients would disagree as they sought expectations to maintain their freedom and choice.

Several participants shared observation of their coworkers using the threat of a restraint in an attempt to control a patient's behavior. These participants expressed that although this was not an organizational rule/procedure, this was often perceived as the norm within their organizations as a strategy to deescalate aggressive behavior. Most participants who observed this type of "technique" shared their perception of this strategy to be ineffective as it oftentimes increased the aggression of a patient. Research

conducted by Van Loan et al. (2015) supports this finding as these researchers found that too often child/adolescent treatment programs encourage staff to use restraints or the threat of restraints as a key approach in managing behavior.

Although each participant expressed that their decision to intervene in crisis situations was mostly due to a threat of safety to other patients and the aggressor, some participants shared that "calming the chaos" and "maintaining a calm and therapeutic milieu" were also motivating factors for engaging in an intervention. These participants expressed that some patients would become so aggressive and "out of control" that on occasion this would begin to stir the other patients who would then begin to display agitation. Participants described that in order to "calm things down" the solution would be to seclude or restrain the patient exhibiting aggression. Similar to this finding, research cited by Duxbury (2015) reported that nursing staff view "taking control" as essential regarding their decision to use restraint to suppress aggressive and violent behavior. These nursing staff expressed that restraint use was a way to maintain order and stability within the organizational setting. The nursing participants in this study perceived the use of physical intervention as a "battleground for control" between patients and staff.

The importance of establishing a therapeutic relationship with patients was a repetitive theme stressed by participants who all shared that the building of therapeutic relationships is encouraged by their organizations. Participants shared that by establishing relationships with the patients it was easier for them to redirect them when they became agitated or aggressive. This finding is similar to that of Wilson et al. (2018) who found that the most frequent suggestion made by staff in order to reduce restraint use was to

spend more time with patients in order to build relationships, communicating that they care and are available. The building of trust and ensuring that patients are supported was expressed by participants as an important factor for patients to meet their treatment goals and to minimize the use of interventions. Most participants described their job roles as consisting of running therapeutic groups, which allowed for the opportunity to get to know the patients better and build trust. Many participants shared experiences of incidents when a patient would be engaged in aggressive behavior and they were able to pull the patient to the side and talk one on one due to the positive relationship established between them. These findings echo that of research by Ling et al., (2015), who found that patients exhibit vulnerability and rely on staff for many of their basic needs. These researchers stated that the development of a therapeutic relationship between staff and patient is beneficial toward their treatment progress, and it is not a reasonable expectation of patients to participate in treatment if there is no trust between them and the care provider.

The process of debriefing following the implementation of an intervention may assist a treatment provider in developing an understanding as to why a physical intervention occurred and help the patient to overcome a rise in negative emotions to reduce the chance of further displays of aggression, as noted by Denison (2016). Findings from this study showed that the opportunity for most treatment providers to debrief with the patient does not come immediately due to the need of continued support on the unit floor. Participants in this study expressed that there is a need for debriefing, stressing that reviewing the events that have just occurred during an intervention and evaluating their

decisions and actions taken would assist in determining if anything else could have been done to prevent the use of a physical intervention and allow for their emotions to become regulated. This finding is supported by research from Ling et al. (2015), who stated that debriefing can be viewed as an opportunity for clinicians to develop a better understanding of crisis events to improve patient safety and treatment plans.

Most participants shared that their opportunity to debrief regarding an intervention typically occurs during team meetings or in supervision which was reported to take place either weekly or biweekly. Participants expressed that although they found the review of incidents to be beneficial, it was conveyed through the interviews unanimously, that the preferred time to debrief would be immediately after the incident occurred or at the end of their shift. This finding supports that of research cited by Duxbury (2015), that indicated a collaborative debriefing with staff following a physical restraint is essential for staff growth, along with staff's ability to reflect and review if the restraint was necessary, with hopes to prevent future incidents.

Throughout the United States, time, resources, and space are not sufficiently dispersed throughout all child/adolescent psychiatric facilities to practice client-focused mental health care (Noyola, Sorgi, Alday, & Reidler, 2014). Participants in this study expressed that change in organizational culture is needed so there is less focus on staff to patient ratio and more focus on the self-care of patient and staff to improve therapeutic relationships and reduce the use of restraints and seclusions.

Summary

This study provided findings that confirmed that of previous research of treatment providers' perspectives and lived experiences of engaging in restraints and seclusions with child/adolescent patients. Findings from this study showed that descriptions participants shared regarding the cause of a patient's challenging behavior affected the nature of emotions they experienced; that identifying warning signs and triggers can help treatment providers react appropriately in challenging situations; that an increase in physiological responses to a challenging behavior can hinder focus and recall of proper techniques and procedures; that respectful communication between treatment provider and patient is essential for maintaining a therapeutic environment; and that the process of debriefing for treatment providers after engaging in an intervention is a necessity but often missed due to organizational demands of ensuring coverage.

Participants shared their beliefs that the possibility of restraint reduction could occur with the support of their administration. Participants expressed that the values and initiatives set forth by their organizations are mostly communicated from supervisors to employees. All participants described that they perceive their supervisors to be representative of the organization's administration who set the tone for the culture and milieu of treatment programs. With the assistance of administrators in providing high quality trainers, additional resources from outside agencies, and the encouragement for open communication with staff members, restraint reduction may occur as staff begin to foster high quality relationships with patients.

Theoretical Framework

Fairly consistent with the main theoretical foundation for this study, attribution theory (Heider, 1958), participants described their perceptions and interpretations of why patients displayed certain problematic behaviors and made meaning of these behaviors to assist in decision making regarding suitable behavior interventions. According to Green-Hennessy and Hennessy (2015), treatment providers' attributions regarding the challenging behavior of physical and verbal aggression from a child/adolescent patient shape their response or reaction. Results from this study indicated that knowing the warning signs and triggers of a patient and having established a therapeutic relationship simplified the participant's ability to determine the cause for behaviors and how to react. The main components of attribution theory focus on an individual's interpretation of events and how this relates to his or her thinking and behavior (Heider, 1958). According to Heider (1958), there exist two types of attributions, internal and external. An internal attribution is the assumption that an individual is behaving a certain way due to his or her attitude, character, or personality. An external attribution is an assumption that an individual is behaving a certain way due to situational or environmental factors.

Findings from this study indicated that factors such as a patient returning from an unsuccessful family therapy session, being bullied or teased by other peers, wanting to challenge staff, seeking staff attention and physical contact, being told what to do, receiving negative consequences for certain actions, and behavioral/mental health issues, were all attributions described by participants that were interpreted as causes leading to displays of problematic behaviors. Participants shared experiences of emotional reactions

such as, frustration, annoyance, anxiety, and anger when unable to identify any cause to attribute to the display of a problematic behavior. Participants described how internal attributions associated with verbal or physical aggression with no identified external cause would oftentimes elicit the experience of a negative emotion leading to less patience and understanding when addressing a problematic behavior. Results from this study indicated that the experience of negative emotions would occur typically with new patients whose background was unfamiliar, and with whom a relationship was not yet established, thus limiting the ability to attribute an external cause for behavior. Participants described that external attributions associated with the display of verbal or physical aggression elicited feelings of remorse and were approached with more tolerance and sympathetic reactions.

Although attribution theory can be explained in relation to participants' experiences of emotional reactions, understanding warning signs and triggers, and various aspects of organizational culture such as communication and relationships, support and trust, and power and control, this theory did not account for participants' experiences of physiological reactions and recall of techniques and procedures during the restraint process. Additionally, the attribution theory does not address the findings indicated by participants regarding their experience of debriefing and processing following an intervention. These findings do not appear to be explained well enough, if at all by the current theory. The possibility may exist that a greater development occurs in relation to treatment providers' experiences during and following the intervention process. There exists a need for further and more thorough theoretical investigations to

entirely comprehend these experiences from the perspective of the treatment provider. Future researchers may seek to add to this data to further expand theoretical explanations that center on the aspects involved when treatment providers share experiences of the intervention process and debriefing in child/adolescent treatment facilities.

Limitations of the Study

All participants for this study met the criteria of having experienced implementing restraints or seclusions during crisis situations on at least 3 separate occasions in a selected region in a large Midwestern city. Findings of this study should be interpreted keeping aware of certain limitations. First, this study involved a small sample size due to my use of IPA, in which groups of participants are typically small, thus allowing the researcher to offer an interpretation of the material provided by participants which are grounded in their experiences (Smith et al., 2009). For this purpose, the number of participants selected for this study was limited to eight. Second, the sample included participants from five different locations with each facility having their own set of procedures and protocols. This was reflected in participants' descriptions of experiences prior to, during, and following an intervention. However, participants generally described similar if not identical procedures and protocols enforced by their facilities. Additionally, the sample encompassed participants in various occupational positions who may view problematic behavior and aggression from different perspectives based on how closely they work with the child/adolescent patients, influencing their reaction or response to the behavior. However, all participants were professionals who shared the experience of

facing challenging situations that required the use of a restraint or seclusion to manage problematic behaviors.

My experience of working with children and adolescents in psychiatric treatment facilities was another limitation of this study. I bracketed my prior experiences and biases allowing participants' lived experiences to develop. Additionally, I made the intention of using my knowledge of engaging in interventions and working with this population to inform treatment providers that I understood what they were describing to me from time to time during the interviews. Another limitation was that the location of this study is limited to a selected region in a large Midwestern city. Therefore, this study provided no information about treatment providers who work in child/adolescent psychiatric facilities in other regions. Another study might broaden the location to other regions, which could alter the findings.

A noteworthy limitation to this study involved certain aspects regarding the platforms used to conduct the interviews. As discussed in Chapter 4, four interviews were held face to face, three interviews were held via the Internet using Skype/Zoom, and one interview was held over the phone. In conducting interviews over Skype/Zoom as well as over the phone, difficulty could arise in the ability to build the same rapport with participants as face to face interviews. Given the necessity to obtain rich, in-depth descriptions of participants experiences, establishing rapport and helping the participant feel comfortable with sharing details of their experiences is important. One of the advantages of conducting phone and Skype/Zoom interviews are that these platforms allow participants to be interviewed from their homes or a chosen personal space,

producing the possibility for a comfortable environment easing the opportunity to build rapport. The limitation to this advantage is that as the researcher I lacked control over the participants physical environment, which creates the opportunity for the participant to become distracted. In the context of the detailed information provided within each interview for this study, I found no problem with maintaining attention and building rapport with participants. Should I have had a participant who was more reserved and less responsive this could have created an issue with data collection.

The process of conducting a phone interview limited my ability to notice nonverbal cues such as, facial expressions, body language, and gestures. With in-person and Skype/Zoom interviews I was able to see facial expressions, however during some video calls participants positioned their camera at an angel in which only the head and shoulders were visible. Therefore, I was unable to obtain the full range of posture, gestures, and expressive movements of the body; however, I was able to listen more carefully to the participant's voice, and carefully observe their facial expressions to discern certain emotions and meanings of statements. Another limitation for both phone and Skype/Zoom interviews is the potential for experiencing technical difficulties which may diminish the intimacy and rapport built between researcher and participant. If there is a lost connection, delay in streaming, or loss of power, this can cause a sudden abruptness to an otherwise emotional and intense conversation, causing difficulty with getting back on track. I experienced no difficulty with interruptions during any of the interviews for this study.

Interviewing participants via phone or Skype/Zoom lacks the social contact and energy received when interviewing participants in person, however, the interviews that did not take place in person went on for a longer duration as participants were either in the comfort of their own home or chosen personal space. Further investigation should be done regarding the benefits of using platforms such as Skype and Zoom to conduct research interviews as these online tools may be useful for other studies designed to include of a wider range of treatment providers from facilities in other regions of the country.

Recommendations

Although previous research has addressed treatment providers' attitudes toward the use of restraints and seclusions in child/adolescent treatment facilities, the amount of research focused on treatment providers' perspectives when implementing restraints and seclusions on children/adolescents between the ages of 3-18 has not been closely studied. As specified in the literature review, there exists a gap in peer-reviewed literature exploring the phenomenon of treatment providers' experiences leading up to, during, and following the use of restraints and seclusions on child/adolescent patients. The findings from this study contribute to addressing this gap, providing new knowledge about how treatment providers perceive, interpret, and experience problematic behaviors from child/adolescent patients leading to the implementation of a restraint or seclusion. Additionally, findings from this study have also produced further questions that require exploration regarding potential impacts from the use of a restraint and seclusion on a child/adolescent patient. I have listed key recommendations for the future.

- To extend research efforts to several additional organizations in different cities in other regions of the country that specialize in child/adolescent inpatient mental health treatment, further exploring the concept of treatment providers' perspectives of engaging in interventions with child/adolescent patients. In addition, findings of these studies should be compared, to develop a further understanding of the experience of treatment providers prior to, during, and following the implementation of a restraint or seclusion.
- To specifically study beliefs and interpretations of problematic behaviors made by treatment providers that lead to the use of a physical intervention.
- To further examine physiological and psychological feelings/emotions associated with addressing problematic behaviors, to obtain a better understanding of potential influences for engaging in a restraint or seclusion.
- For professional organizations, offices of states, and federal government to give thought to the input of treatment providers who work in child/adolescent psychiatric treatment facilities, in which their direct involvement and relationships with the patients impact the overall organizational culture.
- To reassess policy and procedures of child/adolescent psychiatric treatment facilities with the consideration of involving treatment providers in the development of restraint and seclusion prevention policies.
- To continue to examine on local levels (in different geographic locations), specifically how engaging in restraints and seclusions impacts organizational

cultures, treatment providers, the need for debriefing, and the concept of building therapeutic relationships to minimize problematic behaviors.

- To develop mental health awareness surrounding the importance of understanding treatment providers experiences when working with child/adolescent patients in psychiatric treatment facilities.
- To further explore how the process of data collection through a single platform (face to face, phone, or video chat) may affect the outcome of shared information.
- To conduct more quantitative research regarding the use of restraints and seclusions from the perspective of the treatment provider. Studies of examining and understanding the factors related to or affecting excessive/reduced use of restraint techniques by treatment providers, discerning how education in trauma-informed care and other trainings on less restrictive procedures impacts how treatment providers approach problematic behaviors, are just some of the quantitative studies that could be conducted to expand the literature on the use of physical interventions.

Implications

The findings from this study were produced from data collected from treatment providers working in child/adolescent psychiatric treatment facilities who have engaged in a restraint or seclusion on at least three separate occasions. This study produced findings that have led to possible impacts for positive social change in many areas. From this study's findings I have learned how organizational policies and procedures impact treatment providers' decisions to engage in an intervention. Significant factors identified

for positive social change are treatment providers concerns regarding the culture of their facilities and the lack of focus on the mental and physical effects of restraints and seclusions on treatment providers, and how this could negatively impact the therapeutic environment. In addition, treatment providers' statements emphasized issues with debriefing and processing that should be considered when determining strategies for decreasing the use of physical interventions. Reassessment of current policies and procedures may be required as treatment providers should have a voice in these facets of decision making to incorporate less restrictive intervention strategies.

Crisis intervention trainings should include exploration of treatment providers attitudes, perspectives, and beliefs regarding interventions as this input may contribute to positive changes in the overall milieu of facilities. Information shared by participants may assist in the development of performance improvement programs addressing restraint/seclusion use, offering alternative methods for treatment providers to decrease the overall use of physical interventions in these psychiatric treatment facilities.

Shifting the focus toward treatment providers and developing an understanding of their perceptions and experiences offers implications for social change as this may encourage them to work more effectively in building therapeutic relationships with child/adolescent patients. If attention were placed more on the input given by treatment providers from their experiences they may be able to obtain more professional and personal support, possibly changing their experience and approach when addressing negative behaviors.

Treatment providers who participated in this study were appreciative for the opportunity to assist in providing a better understanding to the mental health field and other audiences of their experiences prior to, during, and following an intervention. Participant 4, who holds the title of mental health counselor, stated that his motivation for participating in this study was with the hopes that upper-management at the organization where he works will finally consider what he and his coworkers go through on a daily basis. He stated, "I like that you're doing this study because higher ups don't know what goes on the units and it's important that they see through our eyes what we deal with every day." Participant 7, who holds the title of unit supervisor stated,

> I've been working with this population for a long time and I can count on one hand how many times I've been asked about what my experience is like. With you doing this study I don't feel like what I have to say about what I experience when working with these kids is being ignored. Maybe now more people will listen and pay attention because I feel like there need to be some changes.

Similar sentiments were expressed by the other six participants who were interviewed for this study. Participants expressed sincere gratitude for the chance to share their experiences of engaging in restraints and seclusions with child/adolescent patients.

In part, the motivation for conducting this study was to explore the phenomenon of experiencing a restraint or seclusion from the perspective of the treatment provider. I recommend future research surrounding this topic continue to involve input from treatment providers, but also advocates, families, policymakers, and government

agencies, as the field of mental health continues to strive toward incorporating more humane practices in addressing crisis situations to achieve restraint reduction.

Theoretical

As explained earlier in this chapter, further theoretical exploration is required to explain the experiences of treatment providers prior to, during, and following the use of a restraint or seclusion. The attribution theory appears to provide an explanation for certain aspects of a treatment provider's experience when faced with a crisis situation involving a physical intervention. Attribution theory provides explanations for participants' ability to determine the cause for behaviors and how to react by knowing the warning signs and triggers of a patient and having established a therapeutic relationship. Additionally, attribution theory helps explain participants' experiences of emotional reactions when the cause for a problematic behavior is identified or unrecognizable. However, participants' experiences of physiological reactions and recall of techniques and procedures during the restraint process is not fully explained by this theory. In addition, participants' experience of debriefing and processing following an intervention should be taken into consideration. Future research should build upon these findings to improve understanding of potential theoretical explanations connected to this phenomenon.

Conclusion

Interests that guided me to conduct this research involved the unique ideology of examining the concept of the effects of engaging in a restraint or seclusion from the perspective of the treatment provider. There is a current significance and necessity that continues to call for such research. Data from this study offered important insights for

child/adolescent treatment facilities. The findings aid in stressing the need to find the best alternative intervention strategies that decrease the use of restraints and seclusions globally, in psychiatric treatment facilities. Research has indicated that obtaining information from the perspective of the staff can contribute to the development and implementation of best practices in crisis situations (Scott et al., 2014). This study adds to the knowledge that the voices of treatment providers must be heard to help with the development of new less intrusive prevention strategies.

Discovering more about the experience of treatment providers prior to, during and following interventions added supplementary value as findings began to surface from the data, as there is currently a shortage of information on the topic. This study appears to be one of the first to focus on this this topic. This study provides information that may further initiatives aiming to reduce the use of restraints on children/adolescents in psychiatric treatment facilities. I have identified four factors that may relate to the continuation of restraint and seclusion use in psychiatric facilities including: a lack of input by treatment providers regarding facility policies and procedures, resulting in experiencing overwhelming experiences of negative emotions and feeling unheard, that is linked with a negative impact on the building of therapeutic relationships, resulting in issues with communication leading to increased use of interventions. Specifically, the lack of acknowledgement by policymakers, legislators, and offices of state regarding how organizational policies and procedures impact not only the patient but the treatment provider, may lead treatment providers to experience hopelessness and frustration due to their voices being unheard. These findings have yielded further unexplored questions

regarding the experiences and use of restraints and seclusions on child/adolescent, and it is urged that research be continued in this area of study.

Findings also revealed that participants would prefer not to engage in a restraint or seclusion with a child/adolescent patient, thus supporting the findings of Langone et al. (2014) that treatment providers expressed aversion in explaining their experiences of implementing seclusions and restraints on a child/adolescent describing these interventions as dehumanizing. Furthermore, treatment providers perceptions of the value and appeal of restraints and seclusions may differ from the perceptions of organizational leadership. Findings from this study confirm that the lived experiences of treatment providers can make a significant contribution to deepening the understanding of what goes on in child/adolescent facilities and what needs to change and why. An immense amount of credibility exists in the words of those who have experienced restraint and seclusions firsthand. When assessing intervention strategies, the voices of those with such experiences should be considered vital to providing input and recommendations for prevention of restraint and seclusion use, based on the evidence from research, and should be considered a contributory decision-making factor.

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Appendix A: Research Flyer

PARTICIPANTS NEEDED FOR RESEARCH IN QUALITATIVE STUDY

Males and Females Needed

Restraints and Seclusions: How They Affect You

The purpose of this study is to understand how treatment providers process their experiences of using restraints or seclusions on child/adolescent patients.

By participating in this study you can contribute to positive social change as the results of this study may influence child/adolescent facilities with developing the most appropriate intervention for their patients.

Your participation in this study will remain confidential. If you agree to participate in this study you can withdraw at any time. All participation is voluntary and there is no compensation.

Disclaimer: This Research study is not affiliated with any service providers or local government organizations involved with providing services to Children and Adolescents.

Location

- A single interview with me over the phone, skype, or face-to-face at a location of your choice (quiet setting at the library or coffee shop for 1-1 ½ hours of your time). Answer questions regarding your experiences of implementing restraints or seclusions on children/adolescent patients.

Are you eligible?

- Participants must have engaged in at least 3 incidents of restraints or seclusions
- Comfortable using English language to do interview

If you would like to participate in this research study I can be contacted at 785-840-5215, or you can email me at

Email address

Contact Info

Calpurnia Okwuone Phone

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Appendix B: Prescreening Questions

1. Which child/adolescent facility are you currently working for?
2. How did you hear about this study?
3. Have you engaged in a restraint or seclusion with a child/adolescent patient?
4. How many restraints have you experienced?
5. How many seclusions have you experienced?
6. Are you comfortable speaking English to do the interview?
7. Are you comfortable completing the interview in-person?

Appendix C: Interview Protocol

Participant Name: _____

Participant Number: _____

Participant Position: _____

Name of Interviewer: _____

Interview Location: _____

Date: _____

Restraints: _____

Seclusions: _____

Researcher Introduction:
Hello (name of participant). Thank you for agreeing to be a participant in this study. I am Calpurnia Okwuone and I attend Walden University as a doctoral student in the school of psychology. I am the primary researcher for this study. I want to remind you that during our session together I encourage you to ask any and all questions.

Participation in this study includes this interview which is estimated to take no more than one to two hours of your time. During the interview, I may be taking notes and occasionally checking the recorder to ensure that everything you say is captured. Should a follow-up call be required for me to clarify something that you said it will take no more than 20 minutes. Before we begin the interview I want to review the consent form with you.

Interview Questions and Background Data:

1. How are you today?

2. Where are you working now? How long have you been working for (facility name)?

3. Tell me about your work experience in child/adolescent treatment facilities.

   a. What other population have you worked with where you had to use restraints or seclusions?

4. How would you describe the children/adolescents in (facility name)?

5. When you hear the term restraint what does that mean to you?

6. When you hear the term seclusion what does that mean to you?

7. Tell me about one time that you were involved using a restraint.

8. Tell me about one time that you were involved using a seclusion.

9. Please think back to your first experience when you implemented a restraint or seclusion and what was it like for you?
   a. Tell me what it was like for you prior to the use of the intervention.
   b. Tell me what it was like for you during the implementation of the intervention.
   c. What was it like after you used the intervention?

10. Now that you had experience how would you compare that first experience to subsequent experiences using restraints or seclusions?

11. Tell me what influences you to use a restraint on a child (ages 3-12).

12. Tell me what influences you to use a seclusion on an adolescent (ages 13-18).

13. Tell me about the support you get or have gotten when using a restraint or seclusion.

14. What else can you tell me about your experiences that we have not discussed?

Closing Statement

(Participant Name), I would like to close this interview by thanking you again for participating in this study. Please ensure that you keep the paperwork regarding informed consent and my contact information. Feel free to contact me should you have any additional questions.