

2018

The Psychological Effects of Restraints on Mental Health Workers

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Running head: Psychological Effects of Restraints

The Psychological Effects of Restraints on Mental Health Workers

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DISSERTATION

Submitted in partial fulfillment for the degree of
Doctor of Psychology in the Department of Clinical Psychology
at Antioch University New England, 2018

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**THE PSYCHOLOGICAL EFFECTS OF RESTRAINTS
ON MENTAL HEALTH WORKERS**

presented on August 23, 2018

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Abstract

This dissertation describes an empirical study of the psychological effects of restraints on mental health workers that perform this duty. To date, there is little research on the long-term, detrimental, and potentially traumatizing effects of restraints on an individual's personal and professional life. Five self-report measures assessed the frequency that participants performed restraints, use of support after a restraint incident provided by their employer, perceived social support within their work environment, intention to leave their job, absenteeism, levels of job burnout, and post-traumatic stress symptoms. The study investigated the relationship between exposure to restraints and adverse stress effects and the extent to which social support changes this relationship. A hierarchical regression revealed no statistically significant relationships between exposure to restraints, use of support by an organization, and any adverse stress effects. However, the frequency of restraints modified the relationship between perceived social support and acute stress responses. For a participant with a lower restraint frequency, their expected acute stress response decreased as their perceived social support decreased. In contrast, participants with higher restraint frequency experienced increased acute stress response as their perceived social support decreased. Additionally, staff perception of social support at work was a predictor of levels of burnout, turnover intention, and acute stress responses. With these findings in mind, recommendations were included for ways in which institutions can create a culture and milieu of support for their employees.

Keywords: restraints, mental health workers, psychiatric staff, post-traumatic stress disorder, burnout, social support, work stress

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The Psychological Effects of Restraints on Mental Health Workers

Problem Identification

Restraint procedures are used in a multitude of treatment settings when responding to acute safety concerns by patients who exhibit severe psychopathology, symptomatology, and/or emotional and behavioral dysregulation (Fisher, 1994). These practices are most frequently used in settings that provide higher levels of care to patients (e.g., locked facilities, inpatient units, and residential programs). Physical intervention is reserved for situations when there is immediate danger to the patient and/or others in the vicinity. However, despite varying guidelines available for when and how to initiate this intervention, there are no standardized use procedures across treatment settings; their implementation is frequently dependent on the subjective opinion of the workers involved in the situation (Huckshorn, LeBel, & Jacobs, 2014). Some programs that utilize this kind of intervention deem physical and medication restraints necessary interventions designed to create a safe milieu for patients and staff by regulating emotional crises displayed by patients in their care (Fisher, 1994). However, recent research has challenged these assumptions, demonstrating that physical interventions, such as restraint and seclusion, can actually diminish the safety of patients and staff and increase the risk of injury. Additionally, there is some controversy over the function of restraints and the need for them in treatment settings. In a study by Bigwood and Crowe (2008), nurses admitted their aversion to and discomfort with utilizing restraint to control a client's behavior but recognized this intervention as a vital part of the milieu's safety and their role as psychiatric nurses. There also appears to be a dearth of scientific evidence supporting their use, as a safety measure of last resort (Huckshorn et al., 2014). Despite the controversy over effectiveness and necessity, the interventions are still used.

Use of physical and medication restraint interventions are associated with a range of

negative psychological effects. Fisher (1994) notes that the use of restraint can have “substantial deleterious physical and (more often) psychological effects on both patients and staff” (p. 1590). Previous research on staff experiences of restraint has shown its effects from a short term perspective. Three studies (Bigwood & Crowe, 2008; Bonner, Lowe, Rawcliffe, & Wellman, 2002; Sequeira & Halstead, 2004) have clearly revealed that staff have strong reactions to restraining patients during and immediately after restraint, including anger, frustration, anxiety, fear, distress, and feeling conflicted. The longitudinal effects of these emotional and psychological reactions have yet to be examined. Although the mental health field has responsibly responded to the needs of patients, organizations, and their employees by putting forth effort to reduce restraints, and rework procedures and policies to ensure everyone’s safety, overall there has been less focus on research to better understand and explore staff experiences. Research has not been conducted on the potential long-term effects of performing restraints that may alter an individual’s functioning and/or lead them to develop mental health problems. Past research has approached the topic from a trauma framework exploring staff’s posttraumatic stress responses to the use of restraints. Most of the research conducted in this specific area has been qualitative in nature, with several themes arising from participants’ responses in interviews. Themes include: (a) traumatization, (b) feelings of anger, (c) distress, (d) frustration, (e) anxiety, (f) automatic responding without feeling, and (g) fear (Bigwood & Crowe, 2008; Bonner et al., 2002; Fisher, 1994; Sequeira & Halstead, 2004). It is significant, however, that no quantitative measures have captured this phenomenon.

Treatment center staff can be affected to varying degrees by having to use restraints on patients. Knowledge and better understanding this phenomenon and the specific ways staff are affected could positively impact staff, patients, and organizations as a whole. Research has

examined how the dangerous aspects of other professions, particularly first responders, military personnel, and police officers, impact mental health functioning and job performance (Asmundson & Stapleton, 2008; Berger et al., 2012; Brown, Fielding, & Grover, 1999; Carlier, Lamberts, & Gersons, 2000; Weiss et al., 2010). As a result, significant support interventions have been developed and implemented across these professions. Similar studies of mental health work might result in similar interventions that counteract detrimental effects and maintain organizational quality of care while adding value to the changes and interventions already taking place.

Restraint reduction. Over the past two decades, research has consistently demonstrated the negative effects of restraints on patients, employers/organizations, and the workforce. Studies have shown that restraints contribute to increased work-force related costs and reduced quality and effectiveness of care to patients (Chan, LeBel, & Webber, 2012). Additionally, it exacts an unquantifiable personal cost on all individuals involved. In response to the financial, physical, and psychological cost, mental health/psychiatric organizations have applied strategies for tracking the number of restraints implemented and identifying clinical and non-clinical factors that contribute to restraint—all with the goal of reducing restraint use rates (Colton, 2007). With psychology, psychiatry, and other mental health professionals at the helm, an evidence-based approach to reducing restraints and seclusions was developed in the United States after scathing national media reports and congressional investigations that documented restraint and seclusion deaths and abuses (LeBel et al., 2014). This resulted in national scrutiny over restraint and seclusion practices, and sparked a movement to mitigate the problem.

In 2002, the National Association of State Mental Health Program Directors' (NASMHPD) received funding from the Substance Abuse Mental Health Services

Administration (SAMHSA) to develop curricula to address this problem (LeBel et al., 2014).

The organization created The Six Core Strategies model; this is a model of care “articulated and embedded in a prevention-oriented, trauma-informed care framework that approached the problem of restrictive procedure use from a quality improvement perspective” (Lebel et al., 2014, p.24). The specific core strategies are (a) active leadership toward organizational change, (b) using data to inform practice, (c) developing the workforce, (d) using restraint/seclusion prevention tools, (e) actively including consumers and advocates in the care setting, and (f) rigorously debriefing restraint/seclusion events after they occur (NASMHPD, 2014).

After the initial development of the curriculum, SAMHSA gave eight U.S. states grant money to implement the model and study the effect of the approach on restraint and seclusion use in the participating state facilities (Lebel et al., 2014). This research demonstrated significant positive results with facilities that fully implemented the strategies. Overall, there was more than a 50% reduction in hours of restraint use and percentage of patients who experienced restraint in care (NASMHPD, 2014). These positive results revealed the effectiveness of the Six Core Strategies in reducing restraints in inpatient settings.

While efforts are being made to reduce and eliminate restraints, they are and will continue to be used for the foreseeable future. The national movement has shown promise, especially if facilities utilize the evidence-based approach of the Six Core Strategies. The significant restraint reduction observed in many inpatient settings has benefited staff and clients. However, reduction is not elimination. Even if at a lesser frequency, staff still utilize this intervention in many treatment settings and are still at risk for experiencing harmful psychological effects. The present study adds to the existing research by more specifically understanding the psychological costs of restraints on staff to identify points of intervention;

together, this data has the potential to improve the psychological well-being of staff and subsequently their role in milieu culture, which includes promoting restraint reduction.

The impact of restraints at an organizational level. This research intended to reveal that harmful psychological effects of restraints can impact an entire organization; for example, job turnover, retention rates, staff burnout, work-related stress, and job satisfaction are all impacted by staff's stressful work duties. Although not much is known about the emotional consequences of restraints on staff, there is a growing body of evidence on the negative effects of working with patients who exhibit challenging behavior (which often leads to restraints). It reveals that the more individuals are exposed to such behaviors, the more they are at risk of stress and mental health difficulties (Cottle, Kuipers, Murphy, & Oakes, 1995; Freeman, 1994; Jenkins, Rose, & Lovell, 1997).

Robertson et al. (2005) collected descriptive information through questionnaires and interviews that assessed levels of staff stress, strain, emotional distress, job satisfaction, and intended job turnover in community-based residential services for people with intellectual disabilities and challenging behavior. Results revealed that staff who dealt more frequently with challenging behavior thought about leaving their job significantly more often than the staff who dealt with challenging behavior less frequently. Furthermore, over a quarter of staff who dealt with frequent challenging behavior reported significant emotional distress (Robertson et al., 2005). Hastings (2002) reviewed the literature to determine if there is empirical evidence that challenging behavior affects staff psychological well-being. He found that there was a general consensus in the research that staff experience negative emotional reactions such as fear, anxiety, depression, and anger. These reactions were found to be positively correlated with emotional distress, emotional exhaustion, and depersonalization (Hastings, 2002). Jenkins et al. (1997)

explored the psychological well-being of staff working with individuals who have challenging behaviors. They provided a between-subjects survey to staff working with residents who display challenging behavior and compared it to staff who do not. Results indicated that staff who work with challenging behaviors are more anxious and depressed than those who work with patients presenting with less severe behaviors (Jenkins et al., 1997).

In general, health professionals who experience poor well-being, including high levels of burnout and work stress or low levels of job satisfaction, are more likely to leave their positions (Hayes et al., 2006; Scanlan & Still, 2013). Alexander, Lichtenstein, Oh, and Ullman (1998) explored the relationship between job dissatisfaction and physical management of patients. Results from their study revealed that staff were more likely to resign from their position prematurely if they feared being exposed to physical hazards within the realm of their routine duties.

Taken together, these studies suggest that staff who deal with clients who exhibit challenging behaviors likely experience job dissatisfaction, work-related stress, and a desire to seek other employment. Although not specifically researched, it is reasonable to hypothesize that since challenging behavior often leads to restraint, staff who regularly restrain their patients would likely experience similar reactions. If this is the case, it would be in the organizations' best interest to invest in better understanding how restraint affects these outcomes and what they can do to mitigate some of the contributing factors.

At this time, little is understood about the psychological and emotional sequelae that staff experience as a result of frequent restraint use. This lack of understanding is exacerbated by limited research on the subject, cultures that discourage the discussion of these problems while encouraging the inhibition of staff emotions, and limited resources and support available to staff.

As a result, this becomes an advocacy problem. Hopefully raising awareness of the knowledge gap in the literature and its implications will promote actions to address and correct these issues.

As previously mentioned, the research in this area is limited in breadth and depth. Only a small number of researchers have investigated the subjective experience of staff who participate in restraint (Bigwood & Crowe, 2008; Bonner et al., 2002; Sequeira & Halstead, 2004). This research, however, focuses on initial reactions to restraint and short-term experiences. To date, there are no studies that investigate more long-standing psychological effects. This presents a serious problem for these individuals. Staff are expected as a part of their job responsibilities to participate in this potentially violent practice that is commonplace and standard across many mental health treatment facilities. Yet, the field is not attending to the deleterious effects that this intervention can have on the staff implementing these strategies. A lot of research has been conducted on the effects of restraint, with a focus on trauma and retraumatization, from the client's perspective. Because they are receiving treatment, it seems that their welfare has been the priority and topic of research thus far.

Restraint culture. The culture around restraints and staff's psychological well-being within mental health organizations has not received the attention it deserves. Although not forbidden, organizations implicitly discourage the discussion of the problems and negative effects that staff experience because of restraints. A culture is thus created that inhibits emotional expression, particularly at the time of and after a restraint takes place (Bethel & Beail, 2013). Staff may feel that they cannot safely discuss their responses and reactions out of fear they will lose power in front of the clients, look weak to their peers, and/or be viewed as incompetent (Sequeira & Halstead, 2004). Many of these factors may be partially self-imposed; however they perpetuate when the organization does not take action to foster discussion and a supportive

environment.

Linked with the organizational culture is the lack of support and resources provided to staff. One way that organizations can support staff is by providing debriefing after a restraint takes place. Some sites utilize the Critical Incident Stress Debriefing (CISD) protocol (Antai Otong, 2001; Jacobowitz, 2013) while others utilize a less formal approach which involves a form of discussion (Bonner et al., 2002). CISD or psychological debriefing was originally developed for use with emergency personnel coping in the aftermath of trauma. It is an intervention aimed at helping individuals contextualize their experience of trauma at an early stage with the hope of preventing the development of posttraumatic stress disorder (Irving & Long, 2001). It is a single intervention that is a part of a larger critical incident stress management model (CISM); CISM is an integrated and comprehensive multi-component program that includes crisis intervention procedures to address the spectrum of psychological trauma and post-traumatic stress disorder (Antai-Otong, 2001).

Results are mixed with respect to the long-term effectiveness of critical incident debriefing for both police officers and psychiatric staff. Several studies, including ones that intervened with psychiatric workers and police officers after a traumatic event at work revealed positive effects. It seems that debriefing may be effective for managing short-term emotions and preventing a stress-related response (Jacobowitz, 2013). Also, the tool has been reported to be subjectively effective and helpful by the staff who participate in the process (Bonner et al., 2002). Irving and Long (2001) report that the positive findings from these studies are in line with the outcomes identified in an extensive literature review conducted by Robinson and Mitchell (1993) and a comprehensive review carried out by Everly, Flannery, and Mitchell (2000). However, critics of CISD point to a lack of randomized control studies and other flaws with

methodology as reasons to be skeptical (Bisson & Deahl, 1994; Irving & Long, 2001). Of even greater concern are the studies that have shown no effect of treatment or negative outcomes resulting from debriefing (Arendt & Elklit, 2001). To summarize, the literature is inconclusive; some studies revealed positive outcomes while others indicate negative outcomes (Irving & Long, 2001). It seems that debriefing procedures, whether specifically CISD or other forms of psychological debriefing, are still used in a variety of settings despite the lack of solid evidence to support its use.

Besides debriefing, there are other ways of helping staff process in the aftermath of restraint events in an effort to prevent the development of PTSD and other symptomatology. The processing of traumatic events should be safely and strategically facilitated by a trained professional. The National Child Traumatic Stress Network and the National Center for Posttraumatic Stress created Psychological First Aid (PFA) and made the accompanying Field Operations Guide available to the public (Brymer, National Center for Post-Traumatic Stress Disorder [U.S.] & National Child Traumatic Stress Network, 2006). PFA is an evidence-based approach to help children, adolescents, adults, and families in the immediate aftermath of disaster and terrorism. It can also be provided to first responders and other disaster relief workers. PFA is designed to reduce the initial distress caused by traumatic events and to foster short and long-term adaptive functioning and coping. This approach to intervening does not assume that everyone who experiences a traumatic event will develop severe mental health problems. Instead, it is based on an understanding that disaster survivors and others impacted by such events might experience a broad range of early reactions. Some of these reactions can cause enough distress to interfere with adaptive coping; if this happens, support from a compassionate responder may help their recovery (Brymer et al., 2006).

Unfortunately, it seems that debriefing or processing a restraint incident is either not happening, happening inconsistently, or happening in a manner that is not empirically supported. When debriefing takes place, it is tailored toward the client and their experience or it is aimed at understanding the event to prevent future incidents. I reviewed the research with the goal of learning different organizational responses to staff's involvement in restraint, including what supports and services are available for staff. My search revealed limited results. Even though there are research-based interventions, like PFA, available to this population for utilization on a regular basis, these interventions are not consistently utilized. Organizations are either not providing the support and resources to their employees or research is not being conducted to evaluate effectiveness.

Restraints effect care to clients. Another area of clinical practice and care that is compromised by restraints is the therapeutic relationship between client and staff. The literature suggests that staff's psychological responses to certain interventions, specifically those that require restraint, may impact their ability to offer support and helpful treatment to patients (Sequeira & Halstead, 2004). The therapeutic alliance is a vital contributor to psychological success; the stronger the relationship the better the treatment prognosis (Kottler, 1991; Outlaw & Lowery, 1994). The alliance between staff and patient may change once restraint is used as an emergency intervention. It has been argued that this relationship cannot be therapeutic if staff are prevented from dealing with intense feelings, in particular those which may result from restraint (Steele, 1993). Also, the high level of strain placed on the relationship by virtue of being involved in an intensely personal restraint situation can have adverse effects on the staff, client, and their relationship if not managed appropriately (Fleming & Stenfert-Kroese, 1990; Freeman, 1994; Whittington & Whykes, 1990). Although this topic has not been explored, I hypothesized

that restraining patients would impact the way in which staff engage with clients.

When under stress, staff interact differently with their clients, whether it be because of dealing with challenging behaviors, restraints, and/or daily stressors of the job (Hastings, 2002). When examining reports from staff who work in high-stress group homes, Rose, Jones, and Fletcher (1998) found them less likely to interact with clients or engage with clients in a manner that was positive or helping/supportive. Staff also undertook fewer personal care tasks for the clients. Moreover, Lawson and O'Brien (1994) measured staff reports of burnout and observed their behavior in a correlational approach. They discovered that staff who reported higher levels of emotional exhaustion and burnout were less likely to be observed engaging in positive interactions with clients. It is quite clear that stressful work duties that are inherent in the job of psychiatric staff can have a profound impact on the relationship between staff and client and the care provided to the client.

Mental health professionals are engaging in repeated physical restraint interactions with clients as a part of their job duties. Consequently, they are experiencing negative psychological effects, the scope and depth of which are not well understood at this time. The lack of knowledge and research impacts all parties involved, including staff, clients and the organization as a whole. The objective of this study was to better understand staff's experience of restraints from a trauma framework to assist in learning more about the presence of traumatic stress responses and symptoms. Consequently, the study aimed to strengthen the existing body of research, provide a foundation for a deeper understanding of the issues at hand, and contribute to the development of appropriate support interventions.

A Trauma Framework

In an effort to conceptualize the psychological effects of restraints on staff, I utilized a

trauma framework. First, I describe how restraints rise to the level indicative of a clinically significant traumatic event. Next, I discuss trauma theory and how it can make sense of staff's experiences. Subsequently, by providing evidence that PTSD is present in similar professions, I argue that the staff in question are experiencing traumatic stress reactions.

Restraints are typically implemented when there is imminent risk of serious harm to self or others (Bromley & Emerson, 1995; Fish & Culshaw, 2005; Ryan & Poster, 1989). Examples of such behaviors are assaults (to peer or staff), self-injurious behavior, and attempted suicides. When staff need to implement a restraint they are often met with resistance and violence. According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), a traumatic event is classified as exposure to actual or threatened death, serious injury, or sexual violence (American Psychiatric Association, 2013). Per this criteria, physically restraining a person has the potential to be classified as a traumatic event.

Exposure to a traumatic event has the potential to alter a person's biological, psychological and social stability (van der Kolk, 1996). Most people who are exposed to harmful and threatening experiences do not develop persistent symptoms or psychiatric disorders. Risk factors associated with predicting the development of PTSD are type-severity of traumatic events, socio-demographics, cumulative prior traumatic event exposure and timing of traumatic event exposure, prior mental disorders, acute emotional and biological responses, and proximal social factors occurring in the days and weeks after the traumatic event exposure (Perkonig, Kessler, Storz, & Wittchen, 2000). In addition to these risk factors, an individual's subjective experience of the event is an important element that determines whether or not an individual develops symptoms. After exposure to trauma, almost all people suffer from intrusive thoughts and memories that replay in their mind. The goal of this behavior is to help modify emotions and

allow the individual to tolerate what happened to them. However, some people are not able to do so and struggle to integrate the traumatic experience into their schemata. When this happens, individuals can develop different symptoms specific to posttraumatic stress disorder, including re-experiencing symptoms, avoidance, hypervigilance/hyperarousal, and disassociation. Ultimately, as time passes, the ways in which the brain processes the traumatic event is modified; as van der Kolk (1996) states, “either it is integrated in memory and stored as an unfortunate event belonging to the past, or the sensations and emotions belonging to the event start leading a life of their own” (p. 8). Therefore, exposure to the traumatic event does not necessarily guarantee an individual will have trauma-related symptoms or disorders. Rather, the persistence of intrusive and distressing memories drives the biological and psychological facets of posttraumatic stress disorders (van der Kolk, 1996).

More specifically, there are two models that explain how individuals can develop PTSD; there is a fear-based conceptualization and a shame-based conceptualization (Lee, Scragg, & Turner, 2001). The fear-based hypothesis posits that an individual’s perception of safety and threat during the event will determine the development of symptoms. The shame-based hypothesis posits that an individual’s experience of shame and perception of blame after the event will determine the development of symptoms.

Lee et al. (2001) wrote about the role of shame and guilt in traumatic events and proposed a clinical model of shame-based and guilt-based PTSD. They noted that other affects, including anger, shame, and guilt are frequently associated with traumatic events in addition to fear in the formation and maintenance of PTSD. As individuals think about the event, attempt to process and make sense of it, and replay it in their minds, they may feel ashamed of their behaviors and reactions during the incident. Shame and guilt can be disabling for an individual;

these emotions can affect the experience of self and social behavior, contribute to later psychopathology, effect help-seeking behavior, and impede emotional processing of the event (Lee et al., 2001). When thinking about how this model applies to mental health workers and restraints, staff may experience feelings of shame and guilt over having to use physical interventions and/or failing to prevent the situation from escalating in the first place. Guilt can be experienced if the client restrained was physically or emotionally injured in any way as a result of the incident.

Applying this framework to staff's psychological experience of restraint is straightforward. Staff who participate in physical restraints are often repeatedly exposed to traumatic events. The way in which they interpret these events and their associated emotions highly influences their prospective symptoms. From what we know, they experience a range of emotions during and after a restraint, including but not limited to anxiety, depression, shame, guilt, and confusion (Bigwood & Crowe, 2008; Bonner et al., 2002; Sequeira & Halstead, 2004). If staff are not appropriately dealing with these emotions and developing the ability to tolerate their experience and any accompanying memories, then these short term feelings can turn into more pervasive symptomatology that affects their functioning. I hypothesized that this is more likely to happen when support is not provided and the traumatic event continues to take place.

A trauma framework has been used to make sense of other professionals' reactions to job duties. For example, there has been a significant amount of research investigating the presence of PTSD in police officers, rescue workers, and first responders (Asmundson & Stapleton, 2008; Berger et al., 2012; Brown et al., 1999; Carlier et al., 2000; Weiss et al., 2010). The dangerous aspects of these occupations put them at higher risk for developing trauma-related symptoms (Weiss et al., 2010).

Weiss et al. (2010) indexed the exposure of police to a variety of critical incidents. There were many similarities between these examples and the incidents that psychiatric staff are exposed to during restraints. These similarities include being seriously beaten, making a mistake that injures a colleague, being threatened with knife/weapon, witnessing a patient's mutilated body (from patient self-harm; Weiss et al., 2010). Although the seriousness, frequency, and level of dangerousness may be different in regard to these shared critical incidents, it is possible that the psychological outcomes can still be the same.

Previous Research

Bonner et al. (2002) conducted a pilot study about the subjective experience of physical restraint for inpatients and staff. Their qualitative approach utilized semi-structured interviews with both clients and staff after an incident occurred. Staff reported feelings of anger, distress, and frustration after a restraint. Also, both clients and staff reported re-traumatization whereby the incident brought up memories and feelings associated with previous violent incidents (Bonner et al., 2002).

Sequiera and Halstead (2004) also conducted a qualitative study that sought to explore the psychological response of nursing staff members to restraint. The authors utilized semi structured interviews with staff. Analyses revealed multiple emotional states during and immediately after a restraint, including anxiety, anger, distress and crying, inhibition of emotional distress, and automatic response without feeling (Sequiera & Halstead, 2004).

Bigwood and Crowe's (2008) study aimed to investigate how mental health nurses perceive the experience of physical restraint of patients. Themes that arose in the interviews with the nurses included feeling conflicted, anxious, and scared (Bigwood & Crowe, 2008).

Present Study

This study assessed the psychological impact of performing restraints on staff members.

The quantitative research questions are outlined below in order of importance:

1. Does exposure to restraints lead to adverse effects, or stress? Two levels of severity were examined. Level one entails job-specific adverse effects and level two entails deeper and more pervasive psychological adverse effects.

Level one: Does exposure to restraints lead to work or stress-related issues, specifically burnout, turnover intention, and absenteeism) in mental health staff?

Level two: Is exposure to restraints related to post-traumatic stress symptomatology in mental health staff, specifically acute and chronic reactions?

2. Does formal training in restraint procedures, perceived social support within the job setting, and support provided by an employer post restraint exposure moderate the relationship between exposure to restraints and the experience of level one and two adverse stress. More specifically, is there an interaction effect between support/training and exposure to restraints that moderates the relationship between exposure and adverse effects/stress?

In accordance with these research questions, the following hypotheses are offered:

1. Exposure to restraints is associated with adverse effects:

Level one: Exposure to restraints is associated with work or stress-related issues; as exposure increases, burnout increases, turnover intention increases, and absenteeism increases.

Level two: Exposure to restraints is associated with acute stress reactions and chronic PTSD symptoms; as exposure increases, so too does symptomatology.

2. Training and support received by staff, as evidenced by processing or debriefing after a restraint incident and/or a general feeling of support from an individual's organization, may mitigate the presence of PTSD and work or stress-related issues. A lack of support may increase the risk or presence of PTSD symptomatology and/or work related stress.

Method

Quantitative Design

The quantitative design was correlational and explored the relationship between exposure to restraints and clinically significant traumatic stress symptoms. The predictor variable was exposure to restraints, and the criterion variable was stress. The stress variable was defined on a continuum of severity and two levels were evaluated. The first level was work stress-related issues, including burnout, turnover intention, and absenteeism. The second level was PTSD symptoms. The moderator was level of training and support. Support was comprised of two distinct variables: (a) use of support offered by an organization/employer, and (b) perceived social support at work.

Participants. Seventy participants were included in the study which was the anticipated target sample size. A total of 102 individuals opened the survey link and began participation, but 32 were disqualified for specific reasons (see procedure section for details). There were 56 female participants and 14 male participants. The mean age of participants was $M = 26-30$ years old with a range of 20-50 and older. Eighty-five percent of participants identified as White/Caucasian, 4.3% as Black/African, 4.3% as Hispanic/Latino, 2.9% as Asian/Pacific Islander, and 2% as other. Fifty-four percent of participants indicated that their job title was mental health workers/direct care staff. The remaining participants identified as follows: (a) Clinician/Therapist (17.1%), (b) Nurse (14.3%), (c) DCF Worker/Service Worker (4.3%),

(d) Education/School Employee (5.7%), and (e) Manager/Supervisor (4.3%).

All participants were employed in mental health treatment settings that utilize restraint procedures at the time of their participation. There were multiple criteria for participation. First, to participate in the study, individuals had to be certified and trained in their organization's restraint protocol. Second, there had to be the potential to be involved in a restraint during their daily duties. Third, participants had to have at least six months of experience working in their current position or in a similar setting. Recruitment took place by contacting program directors and unit psychologists at psychiatric hospitals requesting they share information about the study with staff members. Additionally, I posted the recruitment letter and link to the survey on Facebook and requested dissemination of survey information on relevant psychology e-mail listservs.

Measures. The following measures were used to collect data. I received copyright permissions for all measures that required permissions to be used in this study.

Questionnaire. Participants were given a questionnaire (see Appendix C) that requested information about their demographics, exposure to restraints, restraint training, employer support measures, and turnover intention. Demographic information included age, sex, race, current position, frequency of work, length of time in current position, and number of years involved in restraints. Participants were also asked to provide the number of sick days they used in the past year, and how often they are absent from work for other reasons. Detailed information about their exposure to restraints was gathered through questions such as "How often are you involved in restraints?" and "What is your role when you are involved in restraints?" They were asked to rate the severity of restraints for either single or repeated incidents that stood out the most. A Likert scale ranging from "0 = all in a day's work" to "5 = worst possible thing ever" was

provided to rate severity. This method was developed in accordance with the measures used when assessing police officer's rating of critical incident severity. A standardized measure was not typically used and previous researchers chose to imbed the question within another measure that assessed exposure.

Participants answered questions regarding the type and frequency of restraint training they receive by their employer. Three questions related to the type of support provided by their employer and co-workers after a restraint were asked. Lastly, three questions that related to job turnover intention used by Scanlan and Still (2013) were included. Each participant received one score that is an average of the three responses. A higher score indicated a higher level of turnover intention.

PTSD Checklist for DSM-5 (PCL-5). The PCL-5 (see Appendix D) is a 20 item Self-report measure that assesses the 20 DSM-5 symptoms of PTSD (Weathers et al., 2013). It serves a variety of purposes, including monitoring symptom change, screening individuals for PTSD, and making a provisional PTSD diagnosis. This study utilized the brief Criterion A assessment that allows the assessment to be tailored to a specific or continuously occurring index event; for this study, it was either one specific restraint or repeated exposure to restraints. A total symptom severity score (range 0-80) was obtained by summing the scores for each of the 20 items. Criteria for a provisional PTSD diagnosis includes: (a) participant endorsing at least 1 item from questions 1-5, (b) at least 1 item from questions 6-7, (c) at least 2 items from questions 8-14, and (d) at least 2 items from questions 15-20. Additionally, each item rated as 2 (moderately) or higher corresponds to the participant experiencing that symptom (Weathers et al., 2013).

The Impact of Event Scale – Revised (IES-R). The IES-R (see Appendix E) is a 22-item

self-report measure that assesses current subjective distress for any specific life event (Weiss, 2004; Weiss & Marmar 1997). The IES-R has high internal consistency among three subscales: (a) alphas for the “intrusion” subscale between .87 and .92, (b) alphas for the “avoidance” subscales between .84 and .86, and (c) alphas for the “hyperarousal” subscales between .79 and .90. Also, the IES-R has high construct and content validity; the hyperarousal subscale has good predictive validity with regard to trauma (Weiss, 2004; Weiss & Marmar 1997). The total score indicates the participant’s perception of the restraint incidents as stressful and/or traumatic; a higher score indicates perception of the event as more stressful. Each participant received a total score calculated by the mean of all items, with scores ranging from 0-4.

The Oldenburg Burnout Inventory (OLBI). The OLBI (see Appendix F) is a 16-item self-report measure of burnout that was used to assess other work stress related issues. This measure has several advantages over the commonly used Maslach Burnout Inventory. For example, the OLBI has both positively and negatively worded items, focuses on the two most important elements of burnout (disengagement and exhaustion), and is appropriate for human service industries (Demerouti, Bakker, Vardakou, & Kantas, 2003). The OLBI has demonstrated strong psychometric properties, including concurrent validity measured against the Maslach Burnout Inventory and internal consistency for both subscales. The “disengagement” subscale has a Cronbach’s α of 0.76 to 0.83 and the “exhaustion” subscale has a Cronbach’s α of 0.73 to 0.87. Respondents rated their level of agreement on a 4-point Likert scale. Higher scores indicated a higher level of disengagement and exhaustion. In accordance with the normed scoring, for the purpose of this study, each participant received a total score for the disengagement subscale and a total score for the exhaustion subscale and the two subscales were not combined.

The Staff Support Questionnaire (SSQ). In addition to the questionnaire which assesses for use of social support received by an organization/employer, perceived social support was also assessed with the SSQ (see Appendix G). Harris and Thomson (1993) developed the 24-item self-report measure of social support specifically for staff dealing with challenging behavior as a part of their job. The SSQ is organized into four main sections: (a) role ambiguity, (b) personal support, (c) risky situations, and (d) job satisfaction. Twenty of the questions are closed questions and four are open. Eight of the questions are rated on a five-point scale, four on a three point scale, and eight are Yes/No answers. A total score was given to each participant, with the lower score indicating more social support. Evidence suggests that it is a reliable and valid measure (Harris & Thomson, 1993). Concurrent validity was examined by correlating scores on the SSQ with scores from the General Health Questionnaire (GHQ). The results revealed a highly significant correlation between the total SSQ score and the GHQ score. Test-retest reliability found that the percentage agreement for each question on the SSQ was a mean of 87.4%.

Procedure

Participants were recruited through several internet-based venues. I directly contacted program directors and unit psychologists at three psychiatric hospitals using the recruitment letter and requested they disseminate information about the survey with a copy of the online link to colleagues and employees. Additionally, I reached out to various psychology e-mail listservs, but did not get a response back. Finally, the recruitment letter was uploaded to Facebook and shared by others interested in disseminating information about the study. A copy of the informed consent and the recruitment letter can be found in Appendix A and Appendix B, respectively.

All surveys were uploaded to the anonymous, electronic survey distribution website,

SurveyMonkey.com. Participants provide informed consent on the first page of the site. If agreed upon, they were then directed to the first survey and began participation; if participants did not acquiesce, they were directed away from the survey and could not continue. This ensured that only individuals who consented were able to access the surveys and participate.

As subjects in this research study, participants' privacy, rights, and confidentiality continue to be protected. Their participation in and/or withdrawal from the study for any reason was not disclosed to their employer. Prior to signing the consent form, all participants were informed of the sensitive nature of the topic. In accordance with the AUNE IRB guidelines, the potential for minimal psychological harm existed because the study asked participants to remember restraints and answer questions about the incidents; this had the potential for causing varying levels of distress for some participants. Participants were instructed to terminate their participation during any portion of the study if they were uncomfortable or in distress during the process. Participants were encouraged to seek support from local mental health agencies if their distress was too high or grew unmanageable.

Data collection took place over the course of seven months. A total of 102 individuals opened the link to the survey and provided consent. However, as previously stated, the total sample size for the study was 70. Several participants were disqualified from the study for the following reasons: (a) consenting but not completing any other portions of the survey, (b) indicating a restraint frequency of zero on the questionnaire (meaning they do not participate in restraints as a part of their job which was a criteria for participating in the study), and (c) not completing all five surveys in their entirety. Therefore, only individuals who answered all questions and finished all surveys were considered participants in this research study and their data useable.

Variable Definitions

The predictor variable, exposure to restraints, was defined as the frequency that participants took part in restraints as part of their job duties. It was assessed according to their response to this specific question on the questionnaire. Level one criterion variable *burnout* was defined as two separate scores that reflected their total scores on the Disengagement and Exhaustion subscales of the OLBI. Level one criterion variable *absenteeism* was defined as participants' total sick and other non-vacation days used at work within the past year. Level one criterion variable *turnover intention* was defined as the average of participants' responses to three specific questions on the questionnaire. Level two criterion variable *acute stress response* was defined as participants' total score on the IES-R. Lastly, level two criterion variable *chronic PTSD symptoms* was defined as participants' total score on the PCL-5. The moderating variable *support* was defined as two separate domains, use of support that is offered by employer/organization as defined by ranking on the questionnaire to this specific question and perception of overall social support as defined as total score on the SSQ. The moderating variable *training* was defined as participants' response to a question on their level of training by employers/organization. However, all participants indicated that they received sufficient and similar *training and retraining*. Therefore, this variable was not included in analysis given there was no variance in participants' exposure to training.

Results

Quantitative Design

Descriptive statistics. Descriptive statistics were used to analyze the data collected from the questionnaires and measures. To complement the demographic information outlined in the

methods section, the following section details participants' exposure to restraints, hours worked, and the frequency they are forced to stay at work later than their scheduled shift. The mean hours worked by participants was $M = 32-40$ per week, with a range of 1-2 shifts per month to 40+ hours per week. The mean length of time at their current job was 1-3 years, with a range from 0 to 6 months to 8+ years. The present study found that more than half of the participants (58.6%) reported they were not often mandated/forced to stay at work past their scheduled shift while 18.6% stated they did once per month, 8.6% stayed 2-3 times per month, 7.1% stayed once per week and 7.1% stayed more than once per week.

Regarding length of time performing restraints, 37.1% indicated that they have been doing restraints for 1-3 years, 25.7% for 4-7 years, 22.9% for 8+ years, 7.1% for 0-6 months and 5.7% for 7-12 months. Regarding the frequency at which participants engaged in restraints, 35.7% identified 1-2 times per month, 31.4% identified not often, 24.3% identified 1-2 times per week, 5.7% identified once per day, 1.4% identified several times per day, and 1.4% almost never. Regarding participants' most recent restraint at the time of completing the surveys, 28.6% identified as 1-3 months ago, 25.7% last week, 18.6% 2-4 weeks ago, 15.7% 4-6 month ago, and 10% yesterday. As for participants' role in restraints, 67.1% identified as being an active participant, involved in both initiation and duration of the restraint, 15.7% as being an observer, 8.6% as joining in after the initiation of the restraint, and 7.1% as initiating a restraint and then being relieved by someone else.

The mean and standard deviation were calculated for all measures that participants completed. The average score of participants' level of exposure, as defined by frequency of restraint exposure on a scale that ranged from 0 (never) to 5 (several times per day), was $M = 2.06$ with a standard deviation of $SD = .991$. The average score of participants' turnover intention

on a scale that ranged from 0 (no intention) to 2 (intending) was $M = 0.75$ with a standard deviation of $SD = 0.7$. The average score on the Disengagement Subscale of the OLBI was $M = 2.6$ with a standard deviation of $SD = 0.47$. The average score on the Exhaustion Subscale of the OLBI was $M = 2.74$ with a standard deviation of $SD = 0.41$. The average score on the IES-R was $M = .5$ with a standard deviation $SD = .54$. The average score on the PCL-5 was $M = 13.5$ with a standard deviation of $SD = 12.04$. On a scale that ranged from 0 (never) to 4 (always, it's required), participants' average use of support was $M = 1.4$ with a standard deviation of, $SD = 1.16$. The average score on the SSQ was $M = 37.17$ with a standard deviation of $SD = 8.51$.

Hierarchical regression. I conducted a hierarchical regression to determine the main effects and interaction effects of the predictor and moderator variables with the criterion variables. Use of support from employer (use of support) and perceived social support (SSQ total) were viewed as two separate moderating variables and as such analyses were done separately. Additionally, separate analyses were conducted for each of the six criterion variables: (a) acute stress response (IES-R), (b) PTSD symptoms (PCL-5), (c) burnout/exhaustion, (d) burnout/disengagement, (e) turnover intention, and (f) absenteeism. For each criterion variable there are two models within the regression. The first model represents the relationship between the predictor variables (restraint exposure and support) and the criterion variable. The second model represents the interaction effect between the predictor and moderator variables (restraint X support) on the criterion variable. This process was repeated for each criterion variable and for each moderating variable.

There were no statistically significant relationships observed when exposure to restraints and use of support were used as predictor variables (Refer to Table 1 for a complete depiction of results). Neither model (each variable individually and the interaction effect of the two variables)

statistically predicted scores on any of the criterion variables. Therefore, only a small amount of the variance in both level one and level two stress variable scores was accounted for by participants' frequency of exposure to restraints and their use of support by employers.

Regarding the criterion variable IES-R analysis revealed a statistically significant effect between the predictor and criterion variables. Both model 1 (restraint frequency and SSQ scores) and model 2 (restraint frequency and SSQ scores plus the interaction effect between the two scores) predicted scores on the IES-R to a statistically significant degree, $F = 4.807, p = .011$ and $F = 5.009, p = .03$, respectively. The r^2 change from model 1 to model 2 when the interaction was added reached statistical significance, $r^2 \text{ change} = .060, p = .03$. As such, the frequency of restraints modifies the relationship between SSQ total score and IES-R total score.

Furthermore, there was a relationship between SSQ total and several of the criterion variables, specifically burnout/exhaustion, burnout/disengagement, and turnover intention (Refer to Table 2 for complete depiction of results). However, it was SSQ alone, and not exposure to restraints or the interaction effect of exposure to restraints and SSQ, that was predictive of burnout and turnover intention. The individual contribution that an individual's SSQ score had to the prediction of burnout/exhaustion was statistically significant, $b = .023, t = 4.484, p < .001$. The individual contribution that an individual's SSQ score had to the prediction of burnout/disengagement was statistically significant, $b = .031, t = 5.644, p < .001$. The individual contribution that an individual's SSQ score had to the prediction of turnover intention was statistically significant, $b = .038, t = 4.282, p < .001$. Although it did not reach the level of statistical significance, the individual contribution that an individual's SSQ score had to the prediction of PCL-5 scores was close, $b = .314, t = 1.872, p = .066$.

Additional analysis. Additional exploratory analyses were conducted. Given that exposure to restraints defined by restraint frequency did not predict scores on any of the criterion variables, I chose to repeat the analyses with exposure to restraints instead defined as perceived restraint severity. However, no relationships reached statistical significance either. A Pearson correlation was computed to assess the relationship between use of support by an organization (use of support total) and perceived social support (SSQ total). There was a very weak negative correlation between the two variables, $r = -.361$, $p = .002$. A Pearson correlation was computed to assess the relationship between participants' frequency of exposure to restraints and perceived severity of restraints. There was no relationship between the two variables, $r = -.143$, $p = .238$.

Discussion

Personal Bias

Before discussing the results, I will outline personal biases that may have influenced my analysis and interpretation of the results. For several years, including at the beginning of this study, I worked as a Mental Health Counselor on an adolescent inpatient unit at a psychiatric hospital. Participating in restraints was integral to my job, and I have been involved in a number of restraint incidents. Personally, I have seen and experienced the detrimental effects that restraining patients can have on staff members. However, I am aware that my experience is subjective, and potentially different from my co-workers and other individuals in the field. That is what originally sparked my interest in learning more about this topic, and having this experience does provide me with a certain intimate knowledge on the subject.

Interpretation of Results

The primary research question investigated the relationship between restraint exposure and adverse effects, or stress. This question was broken down into two levels: (a) did exposure to

restraints lead to work or stress-related issues, specifically burnout, turnover intention, and absenteeism in mental health staff (level one), and (b) did exposure to restraints lead to posttraumatic stress symptomatology in mental health staff, specifically acute and chronic reactions (level two)? I hypothesized that there is a relationship—as exposure increases so too does burnout, turnover intention, and absenteeism, as well as acute and chronic traumatic stress symptomatology. The findings obtained in this study did not support the primary research question and hypotheses. Results suggested that there was no significant relationship between exposure to restraints and burnout, absenteeism, turnover intention, acute stress response, and PTSD symptoms. Therefore, the frequency that mental health workers are exposed to restraints as a part of their job responsibilities does not predict adverse stress effects, as measured by this study.

The second research question investigated the modifying relationship that formal training in restraint procedures, perceived social support within the job setting, and support provided by an employer post restraint exposure had on exposure to restraints and the experience of level one and two adverse stress. More specifically, does the interaction effect between support/training and exposure to restraints impact the relationship between exposure and adverse effects/stress? I hypothesized that training and support received by staff, as evidenced by processing or debriefing after a restraint incident and/or a general feeling of support from an individual's organization, may mitigate the presence of PTSD and work or stress-related issues. In addition, I hypothesized that a lack of support may increase the risk or presence of PTSD symptomatology and/or work related stress. The findings obtained in this study did not support the second research question and hypotheses. Results suggested that there was no significant correlation between the moderating variable use of support and all of the criterion variables. Therefore,

using the support that is available to mental health workers by their employer after a restraint incident was not related in any way to participants' work related stress (burnout, turnover intention, and absenteeism) or PTSD symptomatology.

The IES-R, a measure that assessed participants' perception of a recent (within the past week) restraint as stressful and/or traumatic, was the only variable that was found to be impacted by the interaction effect of exposure to restraints and perceived social support. This finding was in support of the second research question and one of the hypotheses. Thus, an individual's exposure to restraints and the extent to which they feel a general sense of support at work together predicted how they responded to a restraint. Specifically, for participants with a lower frequency of exposure, the expected IES-R score decreases as there is an increase in SSQ score (a higher SSQ score indicates less support). For participants with a higher restraint frequency score, the expected IES-R score increased as there is an increase in SSQ score. The expected IES-R score increased by 0.05 points for each unit increase in SSQ score; given that the range of possible scores on the IES-R is 0-4, a 0.05 increase is considered decent enough to draw clinical inferences. As participants' exposure to restraints increased, and their perceived social support within their work environment decreased, it was predictive of higher scores of acute stress response. Thus, social support had the mitigating impact that was expected. The less that mental health workers feel supported as they are exposed to restraints the greater the impact this will have on their immediate stress responses to restraints.

There was a significant correlation between perceived social support and several criterion variables. On its own, participants' perception of social support at work predicted their level of burnout (both disengagement and exhaustion), their intention to leave their job, and the acute impact a recent restraint had on them. As participants felt more supported at work, they indicated

less burnout, less intention to quit, and less likely to perceive a recent restraint incident as traumatic/stressful. Although I had not stated any specific hypotheses related to this finding, in a general sense it is similar to the hypotheses associated with the second research question, which argued that social support would be related to an individual's work-related stress symptoms.

Clinical Implications

These results have important clinical implications for treatment centers, employers, and interventions for mental health workers. Given the relationship between exposure to restraints, perceived social support, and acute stress responses, it is important for organizations to create a milieu that promotes support, safety, and security between all employees. Doing so can have an effect on mitigating the potential deleterious effects that restraining patients can have on some staff in the short term. Within the immediate (within one week) time from exposure to a restraint, social support has a positive impact; I am curious if this also serves as a form of prevention of the development of long-term PTSD symptoms. Also, with results revealing the importance of perceived social support on its own to predicting lower levels of burnout and turnover intention, efforts should be made on an organizational level to regularly check-in with staff and assess the work environment. Interventions aimed at increasing staff's perception of social support should be included in standardized restraint reduction procedures and debriefing protocols. In a later section, I expand upon this topic further and explicitly outline steps that organizations can take to increase a general sense of support among their staff rather than solely focusing on restraint specific support.

Ultimately, this finding reveals that participants' general perception of social support at work accounted for more of the predictive variance in the criterion variables than use of formal support after a restraint incident. Therefore, debriefing and other organizational responses in the

immediate aftermath of a restraint was not as helpful in reducing burnout, intention to quit, and perception of a restraint event as stressful; however, overall social support within the work environment was associated with reduced negative effects. This finding is consistent with the literature that has called into question the validity and benefits of some forms of debriefing after a traumatic incident (Bisson & Deahl, 1994; Irving & Long, 2001; Te Pou o Te Whakaaro Nui, 2014). For the participants in this study, it may have been the way in which debriefing and immediate support was offered to them at their organizations that was not helpful, rather than the process in general not being helpful. Based on participants' reports, this type of support is not typically offered to them or is offered inconsistently. These findings provide basis for the argument that organizations need to re-evaluate the debriefing, post-restraint incident support that is offered to their employees, including when it is conducted, by whom, and the training and qualifications necessary to implement it.

A potential alternative evidence-based organizational response that may be more appropriate to staff members' needs post-restraint is the Assaulted Staff Action Program (ASAP). The ASAP is a system-wide crisis intervention for staff that is both voluntary and peer supported designed to address the psychological sequelae in mental health workers who are the victims of patient assaults (Flannery, 2016). According to Flannery et al. (1998), ASAP is based on the dynamics of victimology, especially disruptions in the victim's mastery, attachments, and meanings. The model includes an immediate response after an assault by a ASAP staff member to provide crisis counseling or defusing to the employee who was assaulted, monitoring of symptoms associated with psychological trauma over the next 10 days, trained debriefing for unit staff, a staff victims' support group, family counseling for staff victims, and referrals for professional help when indicated (Flannery, 2016; Flannery et al., 1998). Although restraints

frequently involve assaults to staff, it is not always the case. Therefore, the ASAP model may need to be adjusted to account for the specific psychological sequelae and needs of staff after a restraint incident. There has been no evidence thus far that has evaluated the effectiveness of this program when implemented with restraints only.

On its own, exposure to restraints did not relate to adverse psychological effects in mental health workers. This data does not align with previous research that established negative and deleterious effects of restraint on staff (Bigwood & Crowe, 2008; Bonner et al., 2002; Fisher, 1994; Sequiera & Halstead, 2004). Given this discrepancy, the lack of findings may be reflective of how variables were measured and the assessment instruments used rather than a non-existent relationship. Also, there may be a relationship between the duration of restraints with subsequent adverse stress reactions that was not discovered in this study due to the majority of participants' length of time doing restraints, as well as the length of time at their current job being relatively short (i.e., 1-3 years). Although post-hoc exploratory analyses did not reveal a relationship between these variables, it is possible that this was a result of a poorly represented senior and experienced pool of mental health workers.

More likely, I would speculate as to the validity of participant responding on several of the measures and whether their responses accurately reflect their true experiences. I do not mean to imply that staff were intentionally misrepresenting their experiences. However, many of the questions asked of them across surveys were obvious as to what they were assessing for. Given that many mental health workers feel that assaults and restraints are a part of their job and that they should be able to handle work-related stress and assaults (Te Pou o Te Whakaaro Nui, 2014), it would be a natural reaction for them to ignore any adverse effects they experience or to not feel comfortable sharing it with others. Participants may have either consciously or

unconsciously experienced some degree of fear related to others “finding out” that they were struggling, especially their managers, despite promised anonymity for participation. As organizations implicitly discourage the discussion of staff’s negative reactions to restraints and unit cultures exist that inhibit staff emotional expression, it would become instinctual for staff to suppress, invalidate, and ignore their own feelings (Bethel & Beail, 2013; Sequeira & Halstead, 2004). Furthermore, staff members would have been more likely to minimize the impact of a specific restraint incident if it also involved them being assaulted by a patient; two situations that frequently coincide together with one often triggering the other. Flannery (2016) understands this phenomenon as a result of institutional minimization that is set within a larger, more global minimization and denial of violence in all kinds of victims within the American culture.

However, if the lack of findings do in fact reflect a true non-existent relationship, clinically this may be good news for those working in the mental health field. Certain personality traits, characteristics, psychosocial factors, or other work-specific dynamics particular to this population may serve as protective factors against the development of adverse psychological effect. This hypotheses makes sense given what is known about the factors that contribute to and prevent the development of PTSD after exposure to a traumatic event. Also, given my own personal experience working on a psychiatric unit, I would hypothesize that many mental health workers become somewhat aloof, distanced, and detached within their jobs in general, but also as a way of coping with difficult interactions with clients and restraints. Both novel and experienced staff working in the mental health field utilize various techniques to combat burnout and compassion fatigue when working with difficult clients, including detached concern, intellectualization, withdrawal from clients, and a distinct separation of work from home life (Pines & Maslach, 1978). As the job becomes more emotionally and physically demanding and

challenging for staff, a natural way of managing any stress or adverse psychological effects would be to compartmentalize and distance oneself. Therefore, this prevents staff from either actually taking in the events when they happen and/or numbing their emotional reactions to it. This may be why the current study did not find a relationship between restraint exposure and adverse psychological effects.

Creating an Organization of Support and Safety

Given the study's results highlighting the clinical importance of support within organizations that utilize restraint, I have developed guidelines and recommendations to assist institutions in creating safety and support within their culture and milieu. For a long time, organizations and the mental health field have sought to understand how they can provide support to their employees in an effort to reduce burnout, increase job satisfaction, and improve the overall quality of employee's work and care provided to patients. However, many organizations struggle with knowing the best way to accomplish this. Previous research has focused on understanding what has been beneficial and what has not been effective in developing a general sense of social support between colleagues and within organizations. Additionally, efforts have focused on support specific to restraints via processes such as debriefing (Te Pou o Te Whakaaro Nui, 2014). Despite this, the evidence about how mental health staff might be supported in their work and protected from its potential adverse effects remains limited (Reid et al., 1999; Te Pou o Te Whakaaro Nui, 2014).

Pines and Maslach (1978) found that in psychiatric institutions, taking part in many formal staff meetings was positively correlated with burnout. Based on interviews with direct care workers, they believed this was due to the content and focus of such meetings; many meetings focused on case presentations and discussing clients rather than on staff needs and

experiences on the units. The authors suggested that having mandatory and regular staff meetings that give staff true opportunities to express themselves, to receive emotional and social support from peers and supervisors, to discuss countertransference toward patients, and that focus on developing a greater sense of involvement and commitment to the institution would be experienced as more supportive for mental health workers. In addition to mandatory staff meetings, organizations should attempt to improve the social milieu through bettering relations among staff members, providing additional avenues for staff to express their feelings openly and receive feedback and consultation, peer counseling, team-building activities and organization sponsored social activities (Pines & Maslach, 1978).

Reid et al., (1999) interviewed psychiatric ward staff to better understand their opinions about the support that was available to them within their organization and how this might be improved from staff members' perspectives. The authors found that staff highly valued and felt supported by regular clinical supervision that involved one-to-one meetings with a more senior member of staff and/or their supervisors. However, regular clinical supervision is not a status quo within all work environments. Furthermore, similar to the recommendations previously mentioned, Reid et al. found that staff would benefit from support groups, team building days, and "away days" where staff spend time with one another and participate in a variety of structured activities outside of the institution. Team meals and other social events may also be helpful ways of increasing the availability and frequency of highly valued informal support from peers and colleagues (Reid et al., 1999).

In the current study, when participants were asked directly what support they were looking for in regard to coping with restraints mostly all individuals reported they wanted several options available to them including debriefing, regular supervision and consultation with fellow

staff and management, counseling services provided by an external party, and peer supervision/processing groups. Few participants wrote in their own additional ideas including: (a) “it would be nice to be allowed to step off the unit for 15 minutes after a restraint”, (b) “more time to debrief”, (c) “free gym membership of your choice”, and (d) “staff need more supervision”. This shows that mental health workers are looking for more than they are receiving from their employers. Organizations may want to ask staff directly what they think might be helpful and how they would prefer to be supported. This communicates to staff that their opinion is important and it will be a joint effort to create a supportive and safe work environment.

Limitations

Several limitations to the present study exist. A sample size of 70 provides sufficient power to detect a large moderator effect. Therefore, an effect may be present but was too small to observe. Certain limitations were imposed on this study because it was a doctoral dissertation that interfered with recruitment of participants and ability to obtain a larger sample size, including limited resources for advertisement and dissemination of the survey, and a restricted timeframe for data collection.

The sample size was somewhat homogeneous. The majority of the participants identified as female and Caucasian; it is unclear if this accurately reflects the general mental health worker population or if this study only reached a small subset of this population. If the latter scenario is accurate then these results may not be generalized to the population as a whole.

Two variables were excluded from analysis. The dichotomous way in which this study defined participants’ training in restraints revealed that all participants had received training. The lack of variance between subjects prevented this important aspect from being analyzed. Furthermore, I was originally interested investigating the relationship between restraint exposure

and job satisfaction. However, the measure used to assess job satisfaction was taken from the job satisfaction section of the SSQ; because of this overlap it could not be included in the final analysis.

Future Research

The goal of this study was to contribute to and expand upon the current literature on mental health worker's experience of restraints by more specifically identifying and understanding the emotional and psychological sequelae of restraints. Future research should continue to persist in filling this knowledge gap. Utilizing different measures to assess the same adverse stress effects may produce different results and more accurately capture staff's experience. Additionally, future research should focus on a larger, more diverse sample size that appropriately reflects the current makeup of the mental health work force.

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Appendix A: Informed Consent

Consent to Participate in Research

How Do Restraints Effect Mental Health Workers?

I volunteer to participate in a research project by Jessica Baroni, B.A. supervised by Dr. Theodore Ellenhorn from Antioch University New England. I understand that the project will look into how doing restraints effect the mental health workers doing them. I will be one of about 70 people in this study.

1. I am freely participating in this study. I will not be paid and I can stop at any time without anything bad happening. If I choose to stop, no one at my work will know about it.
2. I will take 5 surveys that the researcher will give to me. It will take about 20 minutes to take all of the surveys.
3. I will be asked to remember, think about, and share my experiences of restraints at my job. This information is sensitive and might be hard to think about. I may get overwhelmed or stressed out when filling out the surveys. If I feel uncomfortable at any time, I can stop. Also, if I feel that I cannot deal with my distress on my own, I can reach out to a mental health professional or health services agency.
4. I understand that the researcher will not identify me by name, now or at any time in the future, and my privacy is safe.
5. No one from my job will know that I am participating in this research study. No one from my job will have access to my information. This will stop any negative consequences from happening.
6. I understand that this research has been reviewed and approved by the Institutional Review Board (IRB) at Antioch University New England.
7. I have read this form and understand what the researcher has told me. I have had all my questions answered and I willingly agree to participate in this study.
8. I have been given a copy of this consent form.

Signature: _____ **Date:** _____
(My signature)

Signature: _____ **Date:** _____
(Researcher's signature)

If you have any questions about the study, contact:

Jessica Baroni

If you have any questions about your rights as a research participant, contact:

Kevin Lyness, Chair of the Antioch University New England IRB

Telephone: 603-283-2149

E-mail: klyness@antioch.edu

Melinda Treadwell, Vice President for Academic Affairs

Telephone: 603-283-2444

E-mail: mtreadwell@antioch.edu.

Appendix B: Sample of Recruitment Letter

Sent to program directors/coordinators:

Hello,

My name is Jessica Baroni and I am a doctoral student at Antioch University New England's Clinical Psychology program. I am working on my dissertation supervised by Dr. Theodore Ellenhorn. I am doing a study that looks at **the psychological effects of restraints on mental health workers**.

I think your employees would be ideal participants for this study. I would appreciate you sending along this information to them. They can contact me directly if they are interested in participating or if they would like to know more information about the study.

Participation is simple. You will fill out 5 surveys that take about 15-20 minutes.

In order to participate, you must:

- Be employed as a mental health worker. This includes direct care workers, nurses, milieu staff, etc.
- Be currently employed in a mental health setting that uses restraints.
- Be certified and trained in your job's restraint protocol.
- Have the potential to be involved in a restraint during your daily job duties.
- Have at least 6 months of experience working in your current or similar job setting.

Please feel free to pass this information along to anyone who meets the criteria.

Thank you!

Jessica

Jessica Baroni, M.S.
Doctoral Student, Department of Clinical Psychology
Antioch University New England

Appendix C: Questionnaire

Demographics

Please circle one.

Age: 20-25 26-30 31-35 35-40 41-45 46-50

Gender: Female Male Other _____

Race: White/Caucasian Black/African origin Hispanic/Latino Asian origin/Pacific Islander
American Indian Other _____

What is your current job? _____

How often do you work? Please mark below.

____ Fulltime

____ Part time: Indicate how many hours per week _____

____ Per Diem (as needed): Indicate how many times per month _____

How long have you been at your current job? _____

How long have you been doing restraints at your job? _____

How many times have you been sick and had to call in sick in the past 6 months? _____

How many times have you been absent from work for any other reason than being sick in the past 6 months? _____

Exposure to Restraints

How often are you involved in restraining a client? Please mark below.

____ Several times per day

____ 1 time per day

____ 1-2 times per week

____ 1-2 times per month

____ Not often: I am usually not one of the people to be involved

____ Never: I have never been involved in a restraint

What do you do when you are involved in restraints? _____

How long ago was the last restraint you were involved in? _____

Overall, how severe is doing restraints for you? Please use scale below to rate.

1 | | | | 7
 All in a day's work Worst possible thing ever

Has there been one restraint in the past that sticks out in your mind? If yes, how would you rate the severity of that one incident? Please use scale below to rate.

1 | | | | 7
 All in a day's work Worst possible thing ever

Level of Training

Did you have training in how to do restraints from your job? _____

If yes, why type of training?

- ___ \geq 1 day in-service with specialized trainers, including hands on practice
- ___ 1 day in-service with specialized trainers
- ___ Training through a computer
- ___ Other:

How often are you re-trained or re-certified in restraint procedures?

- ___ Twice per year
- ___ Once per year
- ___ Every few years
- ___ Never

Support

What type of support is offered for you and other employees after a restraint takes place?

- ___ Debriefing about the incident with both staff and client who were involved, led by management
- ___ Debriefing about the incident with staff only, led by management
- ___ Regular supervision and consultation with fellow staff and management
- ___ Counseling services provided by an external party
- ___ Peer supervision/processing group
- ___ Other:

Do you use whatever support is offered to you?

- ___ Always
- ___ Most of the time

- Sometimes, but not frequently
- No, never

What support do you think should be offered that is not?

- Debriefing about the incident with both staff and client who were involved, led by management
- Debriefing about the incident with staff only, led by management
- Regular supervision and consultation with fellow staff and management
- Counseling services provided by an external party
- Peer supervision/processing group
- Other:

Please circle the response that accurately describes you.

I am actively looking for another job.	No	Unsure	Yes
As soon as I find another job, I will quit.	No	Unsure	Yes
I often think about quitting my job.	No	Unsure	Yes

Appendix D: PTSD Checklist for DSM-5 (PCL-5)

PCL-5

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving *actual or threatened death, serious injury, or sexual violence*. **For the purpose of this questionnaire, please identify a specific restraint or repeated exposure to restraints as the stressful experience.**

First, please answer a few questions about your *worst event*, which for this questionnaire means the event that currently bothers you the most. It could be a single event (one specific restraint) or multiple similar events (for example, repeated restraints).

Briefly identify the worst event (if you feel comfortable doing so): _____

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

- Yes
 No

How did you experience it?

- It happened to me directly
 I witnessed it
 I learned about it happening to a close family member or close friend
 I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
 Other, please describe _____

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

- Accident or violence
 Natural causes
 Not applicable (the event did not involve the death of a close family member or close friend)

Second, keeping this worst event in mind read each of the problems on the next page and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

<i>In the past month, how much were you bothered by:</i>	<i>Not at all</i>	<i>A little bit</i>	<i>Moderately</i>	<i>Quite a bit</i>	<i>Extremely</i>
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (<i>as if you were actually back there reliving it</i>)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4

5. Having strong physical reactions when something reminded you of the stressful experience (<i>for example, heart pounding, trouble breathing, sweating</i>)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (<i>for example, people, places, conversations, activities, objects, or situations</i>)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4
9. Having strong negative beliefs about yourself, other people, or the world (<i>for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous</i>)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (<i>for example, being unable to feel happiness or have loving feelings for people close to you</i>)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "superalert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Appendix E: The Impact of Event Scale – Revised (IES-R)

Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you **DURING THE PAST SEVEN DAYS** with respect to a recent restraint or repeated exposure to restraints, how much were you distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
Any reminder brought back feelings about it	0	1	2	3	4
I had trouble staying asleep	0	1	2	3	4
Other things kept making me think about it	0	1	2	3	4
I felt irritable and angry	0	1	2	3	4
I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
I thought about it when I didn't mean to	0	1	2	3	4
I felt as if it hadn't happened or wasn't real	0	1	2	3	4
I stayed away from reminders about it	0	1	2	3	4
Pictures about it popped into my mind	0	1	2	3	4
I was jumpy and easily startled	0	1	2	3	4
I tried not to think about it	0	1	2	3	4
I was aware that I still had a lot of feelings about it, but I didn't deal with them	0	1	2	3	4
My feelings about it were kind of numb	0	1	2	3	4
I found myself acting or feeling as though I was back at that time	0	1	2	3	4
I had trouble falling asleep	0	1	2	3	4
I had waves of strong feelings about it	0	1	2	3	4
I tried to remove it from my memory	0	1	2	3	4
I had trouble concentrating	0	1	2	3	4

Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart	0	1	2	3	4
I had dreams about it	0	1	2	3	4
I felt watchful or on-guard	0	1	2	3	4
I tried not to talk about it	0	1	2	3	4

Weiss, D.S. & Marmar, C.R. (1997). The Impact of Event Scale-Revised. In J.P. Wilson, & T. M. Keane (Eds.), *Assessing Psychological Trauma and PTSD: A Practitioner's Handbook*. (pp. 399-411). New York: Guilford.

Weiss, D. S. (2004). The Impact of Event Scale-Revised. In J. P. Wilson, & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD: A practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

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Appendix F: The Oldenburg Burnout Inventory (OLBI)**Oldenburg Burnout Inventory**

Instruction: Below you find a series of statements with which you may agree or disagree. Using the scale, please indicate the degree of your agreement by selecting the number that corresponds with each statement.

Strongly Agree	Agree	Disagree	Strongly Disagree
1	2	3	4

1. I always find new and interesting aspects in my work.

1 2 3 4

2. There are days when I feel tired before I arrive at work.

1 2 3 4

3. It happens more and more often that I talk about my work in a negative way.

1 2 3 4

4. After work, I tend to need more time than in the past in order to relax and feel better.

1 2 3 4

5. I can tolerate the pressure of my work very well.

1 2 3 4

6. Lately, I tend to think less at work and do my job almost mechanically.

1 2 3 4

7. I find my work to be a positive challenge.

1 2 3 4

8. During my work, I often feel emotionally drained.

1 2 3 4

9. Over time, one can become disconnected from this type of work.

1 2 3 4

10. After working, I have enough energy for my leisure activities.

1 2 3 4

11. Sometimes I feel sickened by my work tasks.

1 2 3 4

12. After my work, I usually feel worn out and weary.

1 2 3 4

13. This is the only type of work that I can imagine myself doing.

1 2 3 4

14. Usually, I can manage the amount of my work well.

1 2 3 4

15. I feel more and more engaged in my work.

1 2 3 4

16. When I work, I usually feel energized.

1 2 3 4

Demerouti, E., Bakker, A. B., Vardakou, I., & Kantas, A. (2003). The convergent validity of two burnout instruments: A multitrait-multimethod analysis. *European Journal of Psychological Assessment, 19*, 12–23.

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Appendix G: The Staff Support Questionnaire (SSQ)

STAFF SUPPORT QUESTIONNAIRE

All workers need support whatever their work situation. The purpose of this questionnaire is to find out what support you receive, how satisfied you are with this and what support you would like to receive in the future. Please read these instructions carefully before completing.

Please describe in detail the present sources of staff support at your place of work.

How satisfied are you with this? (Circle the appropriate number)

- | | |
|-------------------|---|
| Very satisfied | 1 |
| Satisfied | 2 |
| Undecided | 3 |
| Dissatisfied | 4 |
| Very dissatisfied | 5 |
-

Role Ambiguity

The following questions are about how you see your job.

1. How clear are you about the main objectives you should be working towards in your job?

- | | |
|--------------|---|
| Very clear | 1 |
| Clear | 2 |
| Undecided | 3 |
| Unclear | 4 |
| Very unclear | 5 |

2. How clear are you about what your superior expects from you?

- | | |
|--------------|---|
| Very clear | 1 |
| Clear | 2 |
| Undecided | 3 |
| Unclear | 4 |
| Very unclear | 5 |

3. How clear are you about the limits of your authority and responsibility in your present position?

- | | |
|--------------|---|
| Very clear | 1 |
| Clear | 2 |
| Undecided | 3 |
| Unclear | 4 |
| Very unclear | 5 |

4. How clear are you about how satisfied your superior is with what you do?

- | | |
|--------------|---|
| Very clear | 1 |
| Clear | 2 |
| Undecided | 3 |
| Unclear | 4 |
| Very unclear | 5 |
-

Personal Support

1. Is there somebody you can talk to at work if you are experiencing difficulty in your job?

- | | | | |
|-----|---|----|---|
| Yes | 1 | No | 2 |
|-----|---|----|---|

2. How satisfied are you with this?

- | | |
|-------------------|---|
| Very satisfied | 1 |
| Satisfied | 2 |
| Undecided | 3 |
| Dissatisfied | 4 |
| Very dissatisfied | 5 |

3. If you were unable to cope with a situation at work is there anybody you can call on for practical help?

- | | | | |
|-----|---|----|---|
| Yes | 1 | No | 2 |
|-----|---|----|---|

4. Is there always somebody available?

- | | | | |
|-----|---|----|---|
| Yes | 1 | No | 2 |
|-----|---|----|---|

5. How long does it usually take for help to arrive (in minutes)? _____

6. How satisfied are you with this?

- | | |
|-------------------|---|
| Very satisfied | 1 |
| Satisfied | 2 |
| Undecided | 3 |
| Dissatisfied | 4 |
| Very dissatisfied | 5 |

7. Do you receive regular supervision sessions or performance reviews as part of a structured program of staff development?

- | | | | |
|-----|---|----|---|
| Yes | 1 | No | 2 |
|-----|---|----|---|

8. How satisfied are you with this?

- | | |
|-------------------|---|
| Very satisfied | 1 |
| Satisfied | 2 |
| Undecided | 3 |
| Dissatisfied | 4 |
| Very dissatisfied | 5 |

Risk-taking

1. Have risk situations been clearly identified at your place of work?

Yes 1 No 2 Don't Know 3

2. If yes, were you involved in identifying the risks?

Yes 1 No 2

3. Have clear guide-lines been established about what to do if something goes wrong?

Yes 1 No 2 Don't Know 3

4. If yes, do you agree with the guide-lines?

Yes 1 No 2

Job Satisfaction

Please indicate how much you agree or disagree with the following statements by circling the appropriate number.

1. I am satisfied with my present situation at work.

Agree 1 Disagree 2 Undecided 3

2. I am satisfied with my present level of involvement in decision making at work.

Agree 1 Disagree 2 Undecided 3

3. I am satisfied with the degree of support I receive in my job.

Agree 1 Disagree 2 Undecided 3

4. I often think about finding another job.

Agree 1 Disagree 2 Undecided 3

Harris, P., & Thomson, G. (1993). The Staff Support Questionnaire: a means of measuring support among staff working with people with challenging behaviour. *Journal of the British Institute of Mental Handicap (APEX)*, 21(4), 122-127.

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Appendix H: Permissions

From: **Demerouti, E.**

Date: Mon, Apr 18, 2016 at 8:04 AM

Subject: RE: Inquiring about copyright permission to use the OLBI in a dissertation study

To: Jessica Baroni

Dear Jessica,

Thank you for your interest in our burnout instrument. The OLBI is free of charge for academic purposes.

In the attachment, you can find the OLBI in German and the unstandardized translation in English (checked by an American native speaker). As you will see in the mean time we tried to improve the scale in order to have equal number of positive and negative items.

If you decide to apply it eventually, please let me know whether the instrument has the same structure in your sample as in the German and the Dutch ones.

I have also attached two relevant publications as pdf files. I am looking forward to hearing your results.

Good luck with your study!

Best regards,
Evangelia

Evangelia Demerouti, PhD

Eindhoven University of Technology

Dept. Industrial Engineering & Innovation Sciences Human Performance Management Group

From: Jessica Baroni

Sent: Wednesday, April 13, 2016 12:55 AM

To: Demerouti, E.

Subject: Inquiring about copyright permission to use the OLBI in a dissertation study

Dear Dr. Demerouti,

My name is Jessica Baroni and I am currently a third year doctoral student at Antioch University New England. I am in the process of working on my dissertation; I am conducting a study that investigates the psychological effects of performing restraints on mental health workers. I would love to use the Oldenburg Burnout Inventory (OLBI) as a measure in my study.

I am attempting to determine whether or not this measure requires copyright permission to use in my study, and if so I would like to obtain permission. From reading your articles, I gather that you are the creator, or one of the creators, of this measure. I am hoping to learn who holds the copyright for the OLBI.

Any information would be greatly appreciated! Thank you!

Best,
Jessica

From: Weiss, Daniel
Date: Wed, Mar 30, 2016 at 7:13 PM
Subject: RE: Requesting permission to use the IES-R for research
To: Jessica Baroni

Please see the attached files.

Daniel S. Weiss, Ph.D.
Editor in Chief, *Journal of Traumatic Stress*
Professor of Medical Psychology
Department of Psychiatry
University of California San Francisco

From: Jessica Baroni
Sent: Wednesday, March 30, 2016 09:33
To: Weiss, Daniel
Cc: Sosa, Hugo
Subject: Requesting permission to use the IES-R for research

Dear Dr. Weiss,

My name is Jessica Baroni and I am currently a third year doctoral student at Antioch University New England. I am in the process of working on my dissertation; I am conducting a study that investigates the psychological effects of performing restraints on mental health workers. I would love to use the Impact of Events Scale-Revised as a measure in my study. I found information about this scale on the National Center for PTSD's website and I wanted to inquire about permission to use the scale. I am not sure if it is available to the public or is copyrighted and needs permission from the author to use it. Any information would be greatly appreciated! Thank you!

Best,
Jessica

From: **Wiley Global Permissions**
Date: Tue, Apr 19, 2016 at 9:27 AM
Subject: RE: Inquiring about permissions to use a measure
To: Jessica Baroni

Dear Jessica,

Thank you for your email.

Permission is granted for you to use the material requested for your thesis/dissertation subject to the usual acknowledgements (author, title of material, title of book/journal, ourselves as publisher) and on the understanding that you will reapply for permission if you wish to distribute or publish your thesis/dissertation commercially. You must also duplicate the copyright notice that appears in the Wiley publication in your use of the Material; this can be found on the copyright page if the material is a book or within the article if it is a journal.

Permission is granted solely for use in conjunction with the thesis, and the material may not be posted online separately.

Any third party material is expressly excluded from this permission. If any of the material you wish to use appears within our work with credit to another source, authorisation from that source must be obtained.

Kind regards

Aimee Masheter
Permissions Assistant
John Wiley & Sons Ltd

From: Jessica Baroni
Sent: Thursday, April 14, 2016 4:46 PM
To: Wiley Global Permissions
Subject: Inquiring about permissions to use a measure

Hello,

My name is Jessica Baroni and I am currently a third year doctoral student at Antioch University New England. I am in the process of working on my dissertation; I am conducting a study that investigates the psychological effects of performing restraints on mental health workers. I would love to use the Staff Support Questionnaire as a measure in my study.

Wiley holds the copyright for the article; it can be found here: <http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.1993.tb00712.x/references> . I do not need the entire article, only permission to administer the measure in my dissertation. I attempted to request permission via the instructions on the website but I was denied and it did not explain why.

Any assistance or guidance you can provide to helping me obtain this permission would be greatly appreciated! Thank you! Best, Jessica

Table 1

Results of a Hierarchical Regression Including Main Effects of Restraint Exposure and Level 1 & 2 Criterion Variables (Model 1) and Moderating Effect of Use of Support (Model 2).

<u>Outcome</u>	<u>Model</u>	<u>r²</u>	<u>r² change</u>	<u>p</u>
Level 1				
Burnout/Exhaustion	Exposure + Use of Support	.030		.360
	Exposure + Use of Support + Exposure * Use of Support	.031	.001	.803
Burnout/Disengagement	Exposure + Use of Support	.045		.216
	Exposure + Use of Support + Exposure * Use of Support	.045	.001	.822
Turnover Intention	Exposure + Use of Support	.003		.904
	Exposure + Use of Support + Exposure * Use of Support	.011	.008	.477
Absenteeism	Exposure + Use of Support	.024		.442
	Exposure + Use of Support + Exposure * Use of Support	.031	.006	.510
Level 2				
Acute Stress Response	Exposure + Use of Support	.028		.388
	Exposure + Use of Support + Exposure * Use of Support	.029	.001	.791
PTSD Symptoms	Exposure + Use of Support	.030	.030	.357
	Exposure + Use of Support + Exposure * Use of Support	.033	.003	.664

Note. p value represents Significant F Change test.

* $p < .05$

Table 2

Results of a Hierarchical Regression Including Main Effects of Restraint Exposure and Level 1 & 2 Criterion Variables (Model 1) and Moderating Effect of Perceived Social Support (Model 2).

<u>Outcome</u>	<u>Model</u>	<u>r²</u>	<u>r² change</u>	<u>p</u>
Level 1				
Burnout/Exhaustion	Exposure + SSQ	.251		<.001*
	Exposure + SSQ + Exposure * SSQ	.252	.001	.802
Burnout/Disengagement	Exposure + SSQ	.328		<.001*
	Exposure + SSQ + Exposure * SSQ	.329	.002	.677
Turnover Intention	Exposure + SSQ	.215		<.001*
	Exposure + SSQ + Exposure * SSQ	.225	.010	.358
Absenteeism	Exposure + SSQ	.048		.190
	Exposure + SSQ + Exposure * SSQ	.050	.001	.757
Level 2				
Acute Stress Response	Exposure + SSQ	.125		.011*
	Exposure + SSQ + Exposure * SSQ	.185	.060	.031*
PTSD Symptoms	Exposure + SSQ	.061		.121
	Exposure + SSQ + Exposure * SSQ	.069	.008	.446

Note. p value represents Significant F Change test.

* $p < .05$