

Cheryl A. Alexander
Understanding Experiences:
Exploring the Effects of
Physical Restraints on
Previously Traumatized
Adolescents

ABSTRACT

This study was undertaken to explore the effects of physical restraints on previously traumatized, adolescent patients, and to examine the relationships that exist between psychological trauma and physical restraints.

Seven adult individuals who identified as having had trauma histories prior to experiences with physical restraint during their adolescence participated in this study. Demographic and qualitative data were collected. Demographic questions pertained to the age, gender, racial/ethnic identity, family income, and education level of each participant. The qualitative questions were open-ended, semi-structured, and retrospective and included inquiry into participants' thoughts about what their treaters had understood about their prior histories.

All participants reported to have developed traumatic symptoms in response to experiences with restraints, most notably feelings of anger, powerlessness, confusion, loss of control, an inability to trust, and nightmares about specific incidences of restraint.

A major conclusion of this study was that restraint procedures did not appear to incorporate the therapeutic concept of empowerment espoused by trauma theory.

UNDERSTANDING EXPERIENCES:
EXPLORING THE EFFECTS OF PHYSICAL RESTRAINTS ON
PREVIOUSLY TRAUMATIZED ADOLESCENTS

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Therapy should empower us.

An authentic healing presence does not replicate the patriarchal, patronizing, power-over god who knows what's best for us. The healer does not attempt to maintain power-over the patient, to control or infantilize the patient.

A problem with the parent-child analogy of the therapist-patient relationship is that it tends to hold in place a power-over model of healing...it sets itself up as a special case to justify the therapist's maintenance of power-over the patient, even after this has long since become inappropriate to the relational process between them. This "father (mother) knows best" image serves to hold in place a model of relational control that, because it is unchanging, is intrinsically abusive.

An alternative model is for therapist and client to work at sharing power, to come to therapy as a spiritual space into which each person goes neither to give up power nor to gain it over the other, but to learn to share it-to be empowered and to empower. Into this space we go to claim our voice, touch our strength, and experience ourselves authentically, whether we are doctors or patients.

- Carter Heyward

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CHAPTER I
INTRODUCTION

The use of physical restraints in psychiatric institutions continues to be one of the most controversial, yet nebulous issues in the arena of mental health. For many concerned advocates of the mentally ill, physical restraints are associated with institutional abuse (Steel, 1999). However, physical restraints currently exist as acceptable methods for the management of psychiatric patients in this country (Cohen-Cole, 1996).

Prior to my first year internship at an adolescent behavioral inpatient unit, I had no knowledge of restraints or the rationale(s) behind their utilization at psychiatric settings. Consequently, upon bearing witness to the employment of multiple restraints on a daily basis, I had a great many questions to ask the various mental health professionals with whom I came into contact. I soon perceived that there was no *consensus* as to the rationale behind the use of restraints on psychiatric patients. Some of the individuals with whom I had conversations were of the opinion that restraints were to be used as sparingly as possible, and constituted *emergency measures* only. Others declared that restraints had *therapeutic* benefits, and were in fact, reassuring for the patients upon whom they were being used. Significantly fewer of these individuals were comfortable considering that the use of restraints could be perceived as inducing, increasing, or

re-introducing *traumatic* symptoms in these psychiatric patients.

Although thousands of psychiatric studies have been done to test various drugs, compare various strategies and to correlate diagnostic categories, very few studies have been conducted on the *impact of restraints*, despite the fact that they are currently practiced on large numbers of patients in psychiatric hospitals on a daily basis (Cohen-Cole, 1996).

*This is a study that explores the effects of physical restraints on previously traumatized, adolescent psychiatric patients, and examines the relationships that exist between psychological trauma and physical restraints; an investigation into whether the utilization of physical restraints on consumers in an inpatient setting constitutes therapeutic treatment, iatrogenic trauma, and/or something else. The effects of physical restraints will be examined from the *consumers'* perspective. Data collection for this qualitative study will be based on the narratives of 7 adult individuals who have experienced restraint by mental health professionals in an inpatient setting.

I interviewed the research participants using a semi-structured, open-ended interview guide. Questions for this interview guide drew upon both trauma (Herman, 1993) and empowerment theory (Gutierrez 1999). I also reviewed additional professional literature pertaining to restraints, adolescent development, and iatrogenic trauma, in order to ascertain what is already known about my subject that may have further relevance to the study and design. This is a qualitative study that employed

fixed methods, and is *relational* in design.

The findings of this study will be relevant and important to the field of clinical social work. Empowerment-based social work seeks to foster client self-empowerment by taking individual clients and client groups seriously as experts on their own lives, and as citizens and claimants both within the particular dominions of social and human services, but also, within the larger polity (Simon, 1994). For social work professionals who are committed to empowerment techniques, to meeting the client where he or she is at, and to using a person-in-environment perspective, this study will be especially useful as it is designed to give these clients a voice.

This study is designed to give clinical social workers a more authentic appreciation and understanding of the experiences of individuals who have been physically restrained; indeed, many clinical social workers, at some stage of their career, will enter into a therapeutic relationship with an individual who has experienced physical restraints. In short, this study was designed to enable clinical social workers to hear directly from the most genuine experts on the subject of restraints and their effects - the clients/consumers. It is my hope that the findings of this study may contribute to already existing, but rather scant literature on the subject.

* It is my hope that no one reading the following document will be offended or hurt as a result of any of the terminology and/or concepts utilized in its construction. Within this research paper I have tried to allow my own, and others' experience-based ideas and concerns to be given expression, while simultaneously staying within the confines of certain rules pertaining to "unbiased" empirical research; this was, at times, a formidable task.

CHAPTER II
LITERATURE REVIEW

The purpose of this research study is to gain a better understanding of the experiences of adolescents with trauma histories, who subsequently received physical restraints in an inpatient treatment setting; to examine the relationships that exist between psychological trauma and physical restraints. This is a qualitative study that will employ fixed methods, and is *relational* in design.

Although there is a fair amount of literature available pertaining to certain theories behind restraints and their use, there is comparatively little to be found on the subsequent *effects* of restraints. The sections of this literature review fall into five main areas of inquiry. These areas are: (a) A description and investigation of restraints and various rationales behind their utilization. (b) The historical significance behind this qualitative study's aims to investigate the effects of physical restraints on previously traumatized, adolescent psychiatric patients. (c) An overview of the developmental phase of adolescence, and other factors pertinent to this stage. (d) A description and investigation of trauma; its causes and manifestations. (e) A description and investigation of iatrogenic trauma.

Definition of Terms

Peterson (2000) describes *physical restraint* quite succinctly, as a procedure by which a person uses his or her body to effectively control or immobilize another. Steel (1999) noted that many more detailed definitions of differing lengths and content exist, and asks whether phenomenon of many and varied definitions could possibly be related to the fact that many states do not have any clear definitions of the term 'restraint'.

Reber (1985) defines *adolescence* as a developmental phase that is marked at the beginning by the onset of puberty and at the end by the attainment of physiological or psychological maturity, underscoring that the term "adolescence" is much less precise than it sometimes appears since both the onset of puberty and the attainment of maturity are impossible to define or specify.

Matsakis (1996) states that on a physical level, *trauma* has two meanings. The first meaning is that some part, or specific organ of the body has been damaged suddenly by a force so tremendous that the natural protections of the body were unable to prevent subsequent injury. The second meaning refers to injuries in which the 'natural' healing abilities are not sufficiently able to repair the wound without assistance of a medical nature. However, just as a body can be traumatized, so can the *psyche* (Matsakis, 1996). On the mental and psychological levels, then, trauma refers to the *wounding* of one's emotions (Matsakis, 1996) spirit, beliefs, dignity, and sense of security.

The term *iatrogenic* can technically be understood as something that is induced inadvertently by a surgeon or physician, or by medical treatment or diagnostic procedures (Webster, 1994). Reber (1985) describes an iatrogenic disorder to be an 'abnormal' condition, physical or mental, that is produced by a physician, and *caused* by the *effects* of such treatment. The connotation was that such problems could have been avoided (although Reber states that such a connotation is not always fair).

The preceding section underscores and defines the theoretical concepts of physical restraint, adolescence, trauma, and iatrogenic trauma in order to provide readers with a basic understanding of the major, significant issues pertaining to this research project.

Restraints: An Overview

Peterson (2000) states that the words "physical restraint" are sometimes used to address *three* different kinds of restraint. The first type refers to the use of devices or objects that are *mechanical* in nature, and that serve to restrict a person's movement (mechanical restraints). The second type is chemical restraint which makes use of *medication* in order to control behavior. The third type typically involves one or more people holding or physically manipulating another individual in order to restrain that person's movement. Peterson (2000) asserts that physical restraint is almost *universally* viewed as an emergency

procedure to protect people and property, should only be used as a last resort, and should not be regarded as a primary management or intervention technique.

Peterson also wrote that physical restraints are viewed as a physical safety mechanism that can enable other therapeutic interventions to be continued once the restraint is over. His assertions catalyzed my consideration of literature that would provide additional information on the "universal understanding" of physical restraints. The position taken by The National Alliance for the Mentally ill (NAMI 1998) supports Peterson's (2000) assertions. NAMI states that physical restraints can only be justified as emergency measures, and only so long as the individual is unable to commit to the safety of themselves or others.

Steel (1999) notes that the utilization of physical restraints in psychiatric settings is one of the most controversial issues that exists in mental health treatment today. She asserts that clinicians have so far been unable to reach a consensus, differing strongly about whether such practices should ever be used as therapeutic interventions, or whether they should be utilized as last resorts in order to secure the safety of patients and staff. Some concerned advocates regard the use of physical restraints to be a form of institutional abuse (Steel, 1999) while others view such procedures to be necessary, and moreover, to sometimes be a therapeutic technique for managing many individuals in psychiatric settings.

The Alzheimer Society (2003) believes that physical restraints when used appropriately can have *therapeutic* effects for the alzheimer patient. The use of a "lap belt", for example, can enable elderly individuals to sit up and participate in a group activity. In addition, the short term use of medications can decrease wandering and hallucinations.

Fisher's (1994) review of literature supplemented with statements made by certain psychiatric survivors partially supported the concept of *therapeutic restraints*; restraints were believed at times to be safe, effective, useful for preventing injury, and helpful in the building of therapeutic relationships (Fisher, 1994).

Cohen-Cole(1996) noted that the views of certain professional individuals pertaining to the *effects* of restraints have a tendency to shift in a defensive manner according to the type of criticism that is being leveled towards the restrainer(s). If opponents of restraint declare that physical restraints are harmful, the response of the particular individual(s) under "attack" might be to assert that such restraints are instituted out of a genuine concern for the patients safety. However, if the criticism is moral in nature, the response might *shift* to suggest that physical restraints actually have therapeutic effects. Hence, the mental health field employing restraints under the guise of humanitarianism, or "in the best interest of the patient".

In an attempt to address the safety and care of children and

adolescents in the mental health system, the Child Welfare League of America (2002) put together an annotated bibliography that concerned itself with the examination of empirical studies on the use of physical restraints and seclusion practices. The following section relays five of these empirical studies with much the same detail as was provided in the original sources:

(a). In a study entitled *Rapid assessment of the effects of restraint on self-injury and adaptive behavior* Wallace, Iwata, Zhou and Goff (as cited by the Child Welfare League of America, 2002) sought to determine what they referred to as the *optimal levels of restraint* by measuring occurrences of self-injurious behavior and adaptive behavior under varying levels of response.

The subjects were two people with mental retardation, both living in a state residential facility. They had both been referred for assessment, and for treatment of self-injurious behavior. Self injurious behavior (head-banging and mouthing) and adaptive behavior (drinking) were defined for each subject. Arm restraints with 5, 10, 15, 20, or 25, removable, thin metal stays were utilized. The subjects were observed for self-injurious, and adaptive behavior during three to nine daily sessions. A second observer recorded data independently during 41.9% of sessions. The mean agreement was 98.9% for self-injurious behavior, and 97% for adaptive (drinking) behavior.

The empirical examination of adaptive, and self-injurious behaviors enabled the researchers to identify the level of

restraint (number of stays) that allowed for maximal adaptive behavior while minimizing the self injurious behaviors. For one subject, arm restraints with no stays were most effective in reducing self-injurious behavior while maintaining adaptive behavior, while in the other subject, 20 thin stays completely eliminated self-injurious behaviors, and had little to no effect on (adaptive behavior) drinking.

One of the recommendations emerging from this study was that other tasks such as self-care, and vocational tasks should be included in analysis in order to better determine the extent to which restraint level(s) interfere with adaptive behavior.

(b). In a study entitled *A restraint on restraints: The need to reconsider the use of restrictive interventions* Mohr, Mahon and Noone (as cited by the Child Welfare League of America, 2002) sought to investigate whether certain treatment milieus catalyzed processes that "are not in the best interests of the child" . Qualitative methods were used. The study reported findings from a multiple case study design that utilized archival data and in-depth interviews. Archival material consisted of 550 medical records, patient questionnaires, and interrogatories which were reviewed over a 4 month period, in order to provide a context for in-depth investigation. Exactly 4,321 entries, and individual treatment plans and updates were reviewed, including 102 assessments, and consultations recorded in charts. The interview material constituted case studies of 19 individuals who

were hospitalized during 1985–1991. Face to face interviews were conducted with these 19 subjects, with interviews ranging between 3.5 to 6 hours. Questions pertained to asking subjects what the best, and worst experiences from the hospital were. The cases were coded, and the frequencies were determined. Cases were then analyzed for processes and variables via cross case analysis.

Three patterns of response pertaining to experiences with staff members, and seclusion and restraint emerged from the data. These were vicarious trauma, staff alienation, and direct trauma (as cited by the Child Welfare League of America, 2002). The study's findings highlighted that institutionalization can be a traumatic event that may involve an intrusion into the normal course of development, and the majority of interactions between staff and patients occurs with direct care staff, who are generally the least educated members of the patient's treatment team. The study recommended that researchers need to establish what the knowledge of direct care staff is, as it pertains to behavior management, and that deficits in this knowledge need to be addressed. Also, it was recommended that future research should concern itself with intervention studies designed to determine the efficacy of restraint and seclusion practices.

(c). In a study entitled *Patient perspectives on restraint and seclusion experiences: A survey of former patients of New York State psychiatric facilities* Ray, Myers and Rappaport (as cited by the Child Welfare League of America, 2002) sought to

explore patient perspectives on experiences with restraint and seclusion. Out of 3000 surveys that were mailed statewide to individuals affiliated with various mental health treatment facilities 1,040 were responded to. The survey comprised 36 true/false items related to the participant's assessment of their stay in an inpatient setting; 21 true/false items related to utilization of restraint and seclusion, and 7 yes/no questions related to the types of inpatient and outpatient mental health care facilities utilized by participants. In addition, respondents were encouraged to make narrative comments.

All of the 1,040 respondents to the survey had been treated in an inpatient setting in the past, 41% had received inpatient treatment in the last two years, over 80% were currently accessing outpatient treatment facilities, and 54% (560 respondents) had been restrained or secluded during their inpatient stay. Out of these 560, 94% had one complaint or more about how restraint and seclusion had been applied in the facility, and 73% believed that they had not been a danger to themselves or to others at the time that the procedures had been implemented. In addition, many of the respondents reported staff violations of the New York state mental health law and regulations, 62% reported that they were not protected from harm during the interventions. Three major findings emerged from the study:

(a) The majority of individuals who had been restrained or secluded reported negative memories of the occasions on which the interventions were applied.

(b) Restraint and seclusion appeared to influence the overall treatment experience of the individual in a negative way.

(c) Respondents believed that staff had failed to try less restrictive interventions prior to application of restraint and seclusion.

(d). In a study entitled *The social validation of three physical restraint procedures: A comparison of young people and professional groups* McDonnell and Sturmey (as cited by The Child Welfare League of America, 2002) sought to examine the acceptability of three different restraint procedures. Three groups of raters were asked to evaluate methods of physical restraint. The first group comprised of special education teachers, and paraprofessionals who worked with children and adolescents with severe to moderate developmental disabilities. There were 41 subjects whose mean age was 35. The second group were residential staff in community and hospital settings who worked with people who had developmental disabilities. There were 47 subjects whose mean age was 30. The third group were high school students who did not have experience in the field. There were 74 subjects whose mean age was 17.

Actors developed video clips which demonstrated a male "aggressor" and two staff (one male, one female). In each of the clips, the aggressor rushed toward the staff member attempting to pull her hair. The staff people called for assistance and a particular restraint procedure was implemented.

(a) This was a floor restraint; face down, arms behind back.

(b) This was a floor restraint with two staff astride the subject, holding the arms.

(c) This was a restraint that took place in a chair with arms. The subject's arms were held on the chair by the staff.

The abovementioned video clips were shown in randomized order. The participants of the study were asked to watch the video clips, and to subsequently complete a validated measure of treatment acceptability (Kazdin Treatment Evaluation Inventory). Data were analyzed for unequal n's using a two-way ANOVA (3 groups x 3 restraint methods). Each of the three groups found the chair restraint to be most acceptable.

It was recommended that the study be repeated, evaluating more than three forms of restraint, and that data be analyzed for gender differences among the raters.

(e). In a study entitled *Staff opinions about seclusion and restraint at a state forensic hospital* Klinge (as cited by the Child Welfare League of America, 2002) sought to investigate staff opinions on seclusion and restraint practices. A questionnaire comprised of 22 forced-choice items about attitudes and opinions on restraint and seclusion practices, and an additional 8 open-ended items to examine reasons behind certain responses was distributed to 129 staff members of a forensic hospital utilizing seclusion and restraint. Staff were also asked eight demographic questions. Data was analyzed using descriptive statistics,

intercorrelations, and 2x2 analyses of variance.

Out of the 129 distributed surveys 109 were returned. Out of these 109, 52 of the respondents were male, and 57 were female. The median age was 42 years. The mean level of education was 15.5 years; median was 15.5 years (approximately three years of college). Average number of years spent working at the hospital was seven. Of the respondents, 5 were psychiatrists, 12 psychologists, 10 social workers, 4 unit supervisors, 23 nurses, 9 rehabilitation therapists, and 46 level-of-care staff. Approximately 63% of the respondents preferred medications, 29% preferred restraint or seclusion to medication, and 8% were not sure. Approximately 44% believed that seclusion was more effective at calming than restraint, and 56% thought that restraint was more effective than seclusion. Approximately 86% of staff thought that patients received more attention in restraint than in seclusion. Approximately 63% of staff believed that such attention made patients feel better, 29% believed that it made patients feel worse, and 7% were unsure.

Female staff thought that the quality of attention patients received while in restraints was positive, while male staff believed it was negative. More educated staff believed that physicians should not be the only ones given authority to write restraint and seclusion orders, while staff with less education thought that only physicians should have the authority to issue restraint and seclusion orders. More educated staff thought that seclusion, and restraints were overused, as opposed to less

educated staff members. One conclusion that came out of this study was that the differences in the way that male and female staff perceive the reinforcement efficacy of retrain and seclusion has important implications for the training of staff.

Unfortunately the preceding five studies lacked some of the information that was necessary for their critique, such as more specifics of the samples used, more details about the researcher(s) who conducted the studies and a more thorough description of the ways in which data was collected and analyzed, thus making it difficult to comment on issues of reliability, validity, representativeness and recall and philosophical bias. The Child Welfare League of America (2002) assert that according to their abovementioned review of the selected empirical studies, there appear to be very few *definitive* findings regarding the utilization of restraint; this is especially true when the patients are children or adolescents. They go on to say that much more research needs to be conducted in order to fill in the gaps that exist in knowledge pertaining to this area. They recommend that such research be concerned with:

(a) The combinations of patient characteristics most likely to result in restraint and seclusion use.

(b) The safest and most effective types of seclusion and restraint methods.

(c) The most effective alternative behavior management methods.

(d) The type of training most effective in reducing restraint and seclusion use.

(e) The psychological effects of restraint and seclusion.

The preceding literary section indicates a discernible lack of consensus, and a certain amount of confusion on the part of mental health practitioners with regards to the rationale behind physical restraints and their utilization with clients. Such literary "evidence" can be partially interpreted as providing a certain amount of validation for the significance of a research project that investigates the clinical efficacy of the practice of physical restraints with mental health consumers.

Historical Context

The following section will explore the historical significance behind this qualitative study's aims to investigate the effects of physical restraints on previously traumatized, adolescent psychiatric patients, paying particular attention to the concept of child and adolescent mental health/illnesses, the state of psychiatric institutions, and the evolution of attitudes toward physical restraints.

Awareness of Child and Adolescent Mental Health/Illness

According to the National Institute of Mental Health (2001) the first book on pediatrics "The Boke of Chyldren" was written by Thomas Phairst and published in 1544. This book was significant as it marked one of the first occasions that the concept of childhood

development was distinguished as its own phase, separate from adulthood. In his book, Phaire listed various diseases including "apostume of the brayne" (this may be interpreted today as meningitis) colic, and bad dreams.

Childhood *mental* illnesses, however, did not emerge as a concept until the end of the 19th century, and it was not until the early part of the 20th century that they began to be conceptualized as being distinguishable from adult manifestations of mental illness. In 1909 William Healy set up the first child guidance clinic in the United States. In both treatment and research Healy tended to advocate use of the "team approach" and the "child's own story" (National Institute of Mental Health, 2002). In 1935 the first English-language text on child psychiatry was published, and by the 1940's Autism and ADHD (known then as hyperkinesis) were understood and recognized as childhood disorders. The concept of childhood depression did not arise until the 1950's.

The coding scheme for clinical syndromes in child psychiatry was first suggested in the 1970's during a WHO seminar on the classification of mental disorders for the International Classification of Diseases (ICD), and the first multiaxial scheme for children was subsequently developed and evaluated in 1975, forming the basis for later refinement in the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association. Although the DSM is generally considered to be an authoritative compilation of diagnostic categories for

mental illness it was not until its third edition that child and adolescent mental disorders were designated their own distinct section within the DSM classification system (National Institute of Mental Illness, 2001).

The preceding information indicates that the acknowledgment, and recognition of mental disorders among children and adolescents is a relatively new phenomenon; the development of appropriate and effective treatments for these mental illnesses are understood to be even more recent. The past two decades, however, has been a period of time during which the knowledge base on treatments, services, and prevention programs has expanded significantly. This has been partly due to swift advances in psychopharmacology, adaptations of adult psychosocial treatments for use with children, and the advent of community based rather than institutionally based care (National Institute of Mental Illness, 2001).

Mental Illness and Treatment in Psychiatric Institutions

According to the National Mental Health Association (2003) during the 17th and 18th centuries, mentally ill individuals endured great suffering at the hands of American society. Generally characterized as senseless animals they were treated in "deplorable" ways, often receiving physical and mental abuse. The use of physical restraints - straight jackets and heavy arm and leg chains - was widespread, and served to deprive patients of their dignity and freedom.

In a historical review (commencing at the late 19th century) of the treatment of mental illness in the United States Ann Palmer (n.d.) asserts that mental illness was once considered to be a disease of personal failing, or a spiritual disease in which the afflicted patient was understood to be possessed by evil spirits, under the spell of witchcraft, or influenced by the moon. Palmer (n.d.) goes on to say that the "insane" were viewed as being incurable "subhuman creatures" and were subsequently doomed to a life in shackles and chains at an almshouse (poorhouse) or in jail cells for the mad.

Ultimately *asylums* were created; the idea being that such "lunatics" needed to be removed from the community in order that they might be restored to health in a "therapeutic environment" (Ann Palmer, n.d.). The ostensible long term goal behind the creation of asylums was the establishment of a place in which to promote recovery in order that the mentally ill individuals would eventually be able to return to their particular communities. Physicians who worked in the asylums utilized bromides and other drugs to induce calmer states in their more "agitated" patients, as well as ankle and wrist restraints, and straitjackets. In the cases that were deemed to be more severe and/or incurable, sterilization of patients was employed as an intervention. The initial therapeutic goals of the asylums were soon exhausted. One of the reasons for this pertained to custodial concerns; a significant problem was the lack of beds for the patients. One of the ways in which conditions in the asylums were brought to light

was when certain individuals were confined in error.

The State Care Act was established in 1890 (Palmer, n.d.) leading to state responsibility for mentally ill individuals; at the time it had been hoped that this state of affairs would ensure accountability and higher standards of care for the mentally ill. One of the consequences of the act was that the almshouse's function of caring for the mentally ill was adopted by mental hospitals, which also took on the role of old age homes by looking after the elderly population; most often individuals who were suffering from Alzheimer's disease or dementia. In addition to this, people who were plagued by insanity resulting from venereal diseases were cared for. It was at this time that doctors discovered that the progression of the paralysis caused by certain venereal diseases could be stopped by injecting the afflicted patient with malaria. The patient was subsequently given quinine to alleviate the malaria. It was the preceding treatment in particular that introduced the concept that *biology* might be effective in treating people who suffered from severe mental illness. With the rise of scientific medicine, then, there was a distinct shift from custodial care to an in depth exploration of the etiology of mental illnesses from a biological perspective (Ann Palmer, n.d.).

In 1900, a young businessman and Yale graduate named Clifford Beers suffered an acute breakdown that was triggered by the illness and subsequent death of his brother (National Mental Health Association, 2003). Beers was hospitalized (shortly after

a suicide attempt) in a private mental institution in Connecticut, where he was later forced to endure a number of difficult experiences including degrading treatment in the form of mental and physical abuse. Beers spent the next few years in various other institutions where he continued to be treated poorly by his "attendants". When news of the deplorable treatment Beers had received in these institutions was brought to light, reform care for mentally ill individuals was brought to the forefront of American society.

In 1908 Beers published *A Mind that Found Itself*. The book, an autobiography illustrating Beers' mental health challenges, and the brutal treatment he had received in the institutions in which he had spent time altered mental health care in the United States permanently (National Mental Health Association, 2003). The impact of this book was immediate; Beers' vision of a monumental mental health reform movement was communicated in the United States and abroad. That same year (1908) Beers founded the Connecticut Society for Mental Hygiene, which evolved the following year, into the National Committee for Mental Hygiene. The society established the following goals:

- (a) to improve attitudes toward mental disabilities and mentally ill individuals;
- (b) to work to improve services for the mentally ill;
- (c) to identify and practice preventative interventions and to promote good mental health.

The 1930 International Congress for Mental Health Hygiene was viewed to be the pinnacle of Beers' career, and by the time of his death in 1943 the Mental Health Movement was well established.

After 1945 significant efforts were made to shift the treatment of mentally ill populations from asylums to communities (Palmer, n.d.). An organization entitled "The Group for the Advancement of Psychiatry" sought to develop mental health policies, establish political agendas, and shed light on the severe problems that still existed in mental hospitals in the United States. By 1946 the Mental Health Act had awarded grants in order to set up mental health clinics and outpatient treatment centers, the results of which was the creation of an organized health lobby which was to lead to better policy making (Palmer, n.d.).

In 1952, Henri Laborit discovered chlorpromazine (Thorazine) a drug considered to be wondrous at the time because it ostensibly alleviated symptoms of hallucination, delusions, and other states of agitation. Although one major side effect of the drug was later discovered, *tardive dyskinesia* - when the patient exhibits involuntary, embarrassing, and uncontrollable body movements - the introduction of Thorazine was to initiate the age of psychopharmacology, which in turn, began the era of deinstitutionalization (Palmer, n.d.).

In 1953, the National Mental Health Association, whose goals were to eliminate the deplorable treatment of mentally ill individuals made efforts to create a symbol of both hope and

freedom, by casting a bell that was made from hundreds of metal restraints that had formerly been used in mental hospitals across the United States. Inscribed on the bell is the following: "Cast from the shackles which bound them, this bell shall ring out hope for the mentally ill and victory over mental illness."

By the late 1950's the Joint Commission on Mental Illness and Health (JCMIH) submitted a report called *Action for Mental Health*, in which the need for increased research, increased funding, more appropriately trained staff, new services for the mentally ill, and more effective ways of increasing public awareness about mental illness was underscored (Palmer, n.d.). After the release of this report there appeared to be more awareness regarding the unsatisfactory state of institutions for mentally ill populations.

In 1960, R.D. Laing introduced the concept that mentally ill people might actually be displaying a sane response to an insane society, while a sociological theory known as "labeling theory" purported that the field of psychiatry encouraged self-fulfilling prophecies by virtue of the fact that individuals who were diagnosed with mental illnesses were consequently subject to stigmatization and subsequently produced the behavior that the field of psychiatry labeled "disturbing". By the 1960s and 1970s the field of psychiatry had come under attack and scrutiny (Palmer, n.d.). Supporters of the antipsychiatry movement asserted that mental illness was not a medical condition, but was a phenomenon that had its roots in social, political, and legal areas. Another thing that happened in the 1970's was that a large

number of mentally ill people were discharged from mental hospitals, yet the Commission on Mental Health discovered that many individuals who had been released from these hospitals were at high risk of rehospitalization due to inadequate resources such as food, clothing, housing and community supports.

The Mental Health Systems Act was signed into law in 1980, outlining the basics of a national system for mental health community care and treatment. Unfortunately, the newly appointed President Ronald Reagan was to initiate an immediate end to the policy, demanding that federal funds be cut. The United States failed to create the outpatient services that had been intended to replace the state hospitals. This state of affairs was to continue over the next two decades until measures were taken in an attempt to alleviate the problem (Parker, n.d.).

Evolution of Attitudes Towards Physical Restraints

According to Steel (1999) there are significant disparities *between nations* with regards to the utilization of physical restraints on mentally ill populations; in many Western European countries, the use of restraint as an intervention is unacceptable, whereas *some* degree of use is deemed to be almost inevitable in the United States. Consequently, physical restraint continues to be an issue in this country, while in many parts of Europe they are no longer widely debated because they are so rarely employed. Here follows a brief illustration of the

evolution of different perspectives on physical restraint.

Phillipe Pinel removed the "shackles" from the mentally ill individuals he was treating at Bicetre Hospital in Paris, in 1793. This was considered to be a dramatic move that brought light to the necessity of humane, rather than inhumane treatment for people with mental illnesses (Steel, 1999). It is important to state that Pinel did not think that restraints should be totally abolished, but believed that safety should be balanced with the rights of the patient.

Not long after, members of the Society of Friends began to espouse "moral treatment" as a concept, indeed, minister and preacher Samuel Tuke published an account of this particular perspective with regard to the way in which it was being put into practice at the Quaker Retreat at York, England. Consequently, at the York retreat and the Philadelphia Friends' Asylum in the 1820's the use of restraints began to be employed in a very sparing manner. Similar to Pinel, these early proponents of "moral treatment" did not *totally* reject the idea of utilizing restraints (Steel, 1999). Later on, however, some British physicians at the Lincoln and Hanwell asylums began to conceptualize restraints as "neglectful" treatment, asserting that their use in *any* circumstances was merely an unsatisfactory substitute for the much needed attention that the patients needed, yet were not receiving.

In 1833, a total of 12,003 hours and 1,109 instances of physical restraint for 44 out of 87 patients in the Lincoln Asylum had been recorded (Belkin, 2002). In 1838 (a mere 5 years later)

despite an expanded census of 148, no more instances of restraint were documented for the whole year. In 1838 Robert Gardiner Hill, a British physician who worked at the Lincoln Asylum delivered a triumphant speech in Lincoln, England, during which he asserted: " In a properly constructed building, with a sufficient number of suitable attendants, restraint is never necessary, never justifiable, and always injurious, in all cases of lunacy whatever" (Belkin, 2002).

By the mid 1840's then, the utilization of restraints in many Western European psychiatric institutions had been reduced to a bare minimum. This was especially true in public hospitals because there was no concern about liability suits if patients were to harm themselves, or others. In short, a "culture of non-restraint" had emerged that continues to this day (Steel,1999).

The United States moved in a different direction than Western Europe in the 1840's and later years. It seemed that although the concept of "moral treatment" resonated with American physicians on some level, they also maintained the belief that physical restraint had value as a *therapeutic* intervention (Steel, 1999). In addition, concerns pertaining to liability and public relations led to a high value being placed on safety, a value that evidently trumped that of freedom. In order to defend their utilization of restraints American psychiatrists began to espouse the idea that American patients were in fact, more "aggressive" and "less responsive" to authority than their British counterparts (Steel,

1999).

According to Steel (1999) American psychiatry continues to argue in defense of the "judicious" use of restraints. Among certain professionals within this country, however, there is a discernible lack of consensus regarding their employment. Proponents of restraint purport such interventions to be ways in which caring can be demonstrated, and maladaptive behaviors can be eliminated. Current proponents have also described restraints as "safe", "effective", "useful for preventing injury" and "building therapeutic relationships" (Steel, 1999) while *opponents* of the practice of restraint have described restraints using adjectives such as "unnecessary", "punitive" and "degrading", pointing out that restraints are often *counterproductive* in that they have the potential to be experienced as "reinforcers" by restrained individuals.

The preceding section pertaining to the historical significance behind this study sought to provide readers with some basic insight into the state of psychiatric institutions in the United States and the treatment of the individuals within them, the emergence and recognition of child and adolescent disorders as being distinguishable from adult disorders, and the evolution of attitudes towards physical restraints within and between nations. The literature illustrates that society's conceptualizations about the causes of mental illnesses, and the ways in which to treat them have evolved on scientific and political levels, that the acknowledgment and recognition of

mental disorders among children and adolescents is a relatively new phenomenon, and that the issue of restraints and their utilization has been widely debated since the 19th century. In addition, the sources indicate that although a distinct consensus regarding the unsuitability of employing physical restraint was achieved in Western Europe well over a century ago, this matter was never resolved in the United States.

Adolescence: An Overview.

Before embarking upon an exploration into how the practice of physical restraints may have impacted the physical, emotional, social, and psychological experiences of previously *traumatized* adolescents, it can be considered necessary to acquire a basic understanding of the adolescent stage of development; of how adolescence, *in and of itself*, is theorized to impact/contribute to the experience of the adolescent individual in *general*, to gain insight into some of the major social and mental health problems encountered by adolescents, and to review some related demographics. Hence, the following section will highlight various theoretical concepts of adolescence, explore some of the social factors that effect individuals during adolescence, discuss some of the major mental health problems currently affecting adolescents in this country, and provide demographic and statistical information pertaining to adolescents in psychiatric settings.

Theoretical Considerations

Numerous authors have speculated and theorized about the phenomenon of adolescence. Berzoff, Flanagan, & Hertz (1996) state that the stage of adolescence is understood, almost universally, to be one that is fraught with difficulties, during which individuals between the ages of 11-18 face rapid hormonal changes, shift their reference group from parents to peers, become deeply preoccupied with themselves, and become engaged in painful conflicts pertaining to self-acceptance, and acceptance from others.

Morrison and Anders (1999) describe the onset of adolescence as being so variable that it is impossible to herald an exact age, and assert that while early adolescence is marked by *puberty*, - which can, in some girls, be as young as 10 - mid-adolescence typically refers to a period that begins 2-3 years later, with late adolescence commencing another few years after that. Another marker of adolescence is the beginning of the shift from same sex to opposite sex preoccupations and activities (Morrison and Anders, 1999). Sibling rivalry often becomes quite intense, and outside the family, competition in a variety of areas such as athletics, attractiveness, and academic pursuits, can also become greatly intensified. Early adolescents experience a growth spurt (Morrison and Anders, 1999) that begins in boys around the age of 12, and begins about a year earlier in girls. Studies indicate that boys who mature early tend to be better adjusted than their

less mature counterparts, due to more favorable interactions with both their peers and adults, whereas the teasing and self-consciousness that has been associated with early maturation in girls can produce psychosocial trauma (Morrison and Anders,1999).

Miller, Rathus, Linehan, Wetzler, and Leigh (1997) contend that unique psychological problems are associated with the developmental period that marks *adolescence*. On a biological level, hormonal changes contribute to lowered moods and increased affective dysregulation, with the onset of puberty marking a time of parent-adolescent conflicts and emotional distance, drug and alcohol use, sexual experimentation, and various accidents involving firearms, motor vehicles, and athletic endeavors. On a cognitive level, adolescents enter Piaget's developmental stage of formal operations and develop abstract thinking, which has the effect of contributing towards an increase in argumentativeness, questioning of social conventions, and egocentrism (Miller et al. 1997). Very often impulsive behavior that is manifested during the adolescent stage of development arises out of becoming somewhat "paralyzed" by an array of new capacities; it simply becomes too difficult for the adolescent to consider all the information that has suddenly become available (Miller et al. 1997).

From a social and emotional standpoint, the main psychological task of adolescence is identity formation (Miller et al. 1997). Although many individuals actually experience an increase in self-esteem during this stage of development, those

with the poorest outcomes of self esteem and self identity are faced with an increased amount of vulnerability to mental challenges such as depression, suicidality, and delinquency, and it is during this second separation-individuation phase (Miller et al. 1997) that adolescents will demand more freedom, experience an increase of conflict with their parents, and devote an increased amount of time to their peers, which frequently results in them becoming more susceptible to various types of peer pressure. In summary, Miller et. al. (1997) assert that the combination of the aforementioned biological, cognitive, social, and emotional changes that inevitably occur during adolescence often result in problems that plague even "normal" individuals, hence, one can expect adolescents with particular vulnerabilities based on environmental and/or constitutional factors to be faced with elevated levels of risk.

According to Wolman (1998) the transition from childhood to adulthood is an uneven, often disharmonious process of biological maturation, often greatly complicated by sociocultural factors. There are significant developmental differences between children, adults and adolescents. While childhood is a period of dependence, when children's needs for food, shelter, and love are (hopefully) met by their parents, and adulthood is a period of interdependence where self-supporting activities necessitate interaction with other adults, *adolescence* represents a transition from childhood to adulthood, with a great many inevitable problems. Hence, adolescents appear to be stuck somewhere in

between; although they have outgrown the need for continuous parental care, they are not yet ready for sharing adult responsibilities. Adolescents don't want to be dependent on their parents, yet they are simultaneously unable to take part in the interdependent system of adulthood (Wolman,1998).

According to Elson (1986) self psychologist Heinz Kohut theorized that throughout the stages of adolescence and young adulthood, *self objects* play a particularly significant role in the strengthening of self esteem, and ideals, and can be broken down into three different subtypes:

(a) Mirroring self object: individuals who confirm and respond to a child's innate sense of greatness.

(b) Idealized parent imago: those with whom the child can merge as an image of calmness.

(c) Alter-ego/twinship self object: those with whom the child is able to feel an essential likeness.

The adolescents' capacity to seek out and enjoy self objects that either perform confirming roles, and/or permit idealization was interpreted by Heinz Kohut to be evidence of good psychological health (Elson, 1986). Kohut also theorized that the struggle to achieve mature empathy was most graphically engaged during *adolescence* when exploitation of self objects, and generosity to self objects (of an exceptional nature) attest to the process by which empathy ultimately becomes transmuted as a reliable function of the cohesive self.

Erik Erikson was significant as an ego psychologist who

theorized that the ego evolved not only as a result of biological and psychological forces, but also by *social* ones (Berzoff, Flanagan, & Hertz, 1996). According to Erik Erikson's subsequent psychosocial theory which explores the ways in which social relationships and institutions can foster or hinder ego development throughout the life span, the main psychosocial "task" of adolescence is to achieve a sense of self (identity) that is stable, and that fits in with the image that the individual has of his/her past, present, future and larger possibilities (Erikson, 1968). It is important to mention that Erikson did not establish a set standard for the development of a healthy identity. Rather, Erikson was adamant that in order for one to develop an understanding of the behavior, and experiences of an adolescent, it is imperative that the sociocultural and historical contexts in which that adolescent developed are taken into serious consideration (Erikson, 1968).

Continuing alongside the theme of *identity*, psychologist Beverley Tatum (1997) states that creation of the self (a process she describes in part, as simultaneous reflection and observation) is most commonly experienced during adolescence in the United States and other Western societies, and is triggered by biological changes associated with puberty, the maturation of cognitive abilities, and changing societal expectations. According to Tatum (1997) the search for personal identity is greatly intensified during the adolescent phase, and often involves several dimensions of the adolescent's life such as: vocational plans, religious

beliefs, values and preferences, political affiliations and beliefs, gender roles, and ethnic identities. In an expansion of Erikson's psychosocial stage of identity versus identity diffusion, the process of identity exploration has been theorized by James Marcia (1966) to vary across the preceding identity domains. Marcia describes four different identity "statuses" to characterize such variation in the identity search process. The specific identity statuses are as follows:

(a) *Diffuse*, a state in which there has been scant exploration or consideration of any particular domain and no commitments have been made.

(b) *Foreclosed*, a state in which a commitment has been made to particular roles and/or belief systems in the absence of alternative considerations.

(c) *Moratorium*, a state of active exploration of roles and beliefs without any commitment.

(d) *Achieved*, a state of strong personal commitment to a particular dimension of identity following a stage of high exploration.

Due to the fact that most individuals are unlikely to explore all of the aforementioned identity domains simultaneously, adolescents frequently explore one particular dimension while others remain unexamined (Marcia, 1966).

Phinney and Kohatsu (1997) assert that ego identity research has, for the most part, focused on the various ways in which adolescents deal with specific challenges presented by the need to

make certain choices pertaining to occupation, ideology and lifestyle, and also, on historical and sociocultural factors in development. Phinney and Kohatsu (1997) contend that as far as research interests are concerned, far less attention has been given to the role of the *context* in identity formation. This is concerning when we consider that the significance of the context in identity formation is exacerbated for adolescents from the specific ethnocultural groups: African American, Latino, Native American, and Asian/Pacific Islander. Phinney and Kohatsu (1997) underscore the fact that adolescents of color are distinct from European American adolescents in many ways. One significant way in which adolescents of color differ from their white counterparts pertains to the fact that in order to successfully transition to healthy functioning in adulthood, a secure sense of their particular ethnic/racial identity must be achieved; a considerable task given cultural differences and subsequent conflicts, restricted opportunities, and pervasive stereotypical images of specific ethnocultural groups. In short, Phinney and Kohatsu (1997) contend that individuals of color face significantly more pressures that are related to mental health (particularly psychological adjustment) during their adolescent years than do white adolescents.

According to Blos (1967) the biological processes of growth and differentiation that occur during puberty bring about changes in the structure, and in the functioning of the individual which occur in a typical and sequential order, that can be referred to

as "maturation". The same, it is thought, can apply to the *psychological* changes that occur during adolescence (Blos, 1967). These changes also follow a developmental pattern, but are different in order due to the fact that they draw content, aim, stimulation, and direction from an extremely complex interplay of both internal *and* external impingements, ultimately giving way to new stabilizing processes and alterations of psychic structures; both of which can be regarded as the result of adolescent accommodations. Blos (1967) conceptualized the points at which both pubertal maturation, and the adolescent accommodations intersect in order to become integrated as "adolescent phases"; milestones of progressive development, each of which are marked by a phase specific conflict, a maturational task, and a resolution that is preconditional to advance to higher levels of differentiation.

Blos (1967) identified *character formation* to be one of the most significant phases of adolescence, believing it to be the outcome of "psychic restructuring" and/or the manifest sign of a completed (though not necessarily complete) journey through adolescence, and as such advocated that theorists and clinical practitioners concentrate on this phase in particular, in order to develop an increased insight into the formative processes of character during adolescence, and into the concept of character in general. Blos (1967) selected four adolescent developmental challenges/preconditions which he identified as being closely related to character formation. The first of these so called

challenges/preconditions was conceptualized by Blos as the *second individuation process* (Blos, 1967), a process that is characterized by the adolescent's emotional and physical withdrawal from childhood dependencies towards passionate, often transient, peer relationships. During this particular challenge shifting identifications are often manifested through differences in posture, attire, speech, value systems, and opinions.

Blos conceptualized the second of these challenges as *residual trauma*; a precondition that requires us to consider the effect of trauma on adolescent character formation (Blos, 1967). Blos contends that trauma is a universal human condition occurring during infancy and early childhood that inevitably leaves a permanent "residue", even under the most favorable of conditions. Such residues can be recognized by an individual's sensitivities to certain stimuli, internal and external, as well as in affinities to, or avoidances of certain experiences (Blos, 1967). Blos theorized that such residues are factors to be reckoned with, and need containment - especially where the maintenance of psychic equilibrium is concerned - and furthermore, contends that the automatization of the containment process is virtually identical to the function of character. Adolescents who avert the process of transformation of residual trauma into character formation are theorized to project the danger situation into the outside world, thus avoiding any internal conflicts that accompany it.

The third precondition for character resolution can be conceptualized as *ego continuity* (Blos, 1967). According to Blos

(1967) adolescent development can only be carried forward if the adolescent ego achieves the establishment of a historical continuity within its realm; a tendency toward internalization or disengagement from the adult caretaking environment (the immature ego of the child) can be observed, during which ego maturation gives rise to the adolescent's own subjective sense of wholeness during this developmental period. During adolescence, ego continuity has an integrative and growth stimulating effect. Should ego continuity be prevented, however, the psychic restructuring of adolescence will remain incomplete, hence, adolescent development will be partially foreclosed.

Finally, the fourth precondition of adolescent character formation can be understood to be that of *sexual identity* (Blos, 1967). In order for character formation to ensue, it is theorized that sexual identity formation evolves along a path leading to either masculinity or femininity, and that any remnants of bisexual orientation are excluded from expression and absorbed into character formation. When there is an ambivalence of sexual identification, however, the ego is affected by the ambiguity of the drives, maturational processes are defeated, and an identity crisis, or identity diffusion is experienced (Blos, 1967).

Social and Demographical Factors

The question of the role of social stressors upon children and adolescents continues to be unclear (Canino and Spurlock,

2000). Some social scientists claim that multiple life stressors can increase the likelihood of illness and/or influence the timing of the onset of particular diseases/disorders. Others studies suggest that experiencing *certain* stressors may actually increase the competence of the immune system, while other stressors may have the reverse effect. The frequency and timing of certain stressors are other variables that should be considered (Canino and Spurlock, 2000). Data has suggested that health - related difficulties may arise when coping abilities are taxed. This has been found to be particularly true when many stressful events are experienced within a brief period of time. The relationship between cumulative family stressors and the later manifestation of internal and external behavioral problems in children/adolescents was recently confirmed by a recent study (Canino and Spurlock, 2000).

According to Canino and Spurlock (2000) ethnic development interacts with class, religion, migration status, area of residence, and especially with experiences of prejudice and discrimination. Canino and Spurlock (2000) assert that as most culturally diverse children and adolescents move into the broader society, the potential to experience the social stressors of prejudice and discrimination increases. Racial/ethnic prejudice is continuously reinforced by labels that are originally unrelated to race. Such labels evolve into epithets that can provoke psychological pain for the young individuals who are on the receiving end. Canino and Spurlock (2000) recommend that

clinicians working with children and adolescents frequently assess the impact of prejudice and discrimination practices on the self-image, self-esteem, and self identity of the child/adolescent of a different racial or cultural group while simultaneously increasing an awareness of their own particular prejudices, in order to avoid serious interference with evaluative and therapeutic interchanges.

Many culturally diverse children and adolescents are recent or past immigrants. Data on population change, family environment, and immigration of children under 18 years old for 1990 indicate that 69.1% White-non-Hispanic, 14.7% Black-non-Hispanic, 12.1% Hispanic of any race, 3.1% Asian and Pacific Islander, and 1.0% Native American and Other were classified as immigrant children (Canino and Spurlock, 2000). Reasons and circumstances for individual migrations can vary greatly, and it is important that these variations are learned about, and *understood* by the mental health professionals who are working with such children and adolescents (Canino and Spurlock, 2000). For those families that came to America for better educational and job opportunities, and/or who were fortunate enough to arrive in a host community that was receptive to them, the immigration process may have been voluntary, and positive. For other families who may have been seeking refuge from war torn countries, and/or were faced by host communities that were hostile, and exposed them to further violence and discrimination, immigration may have been a significantly different process. The children of the less fortunate families may be required to undergo a process of

understanding, accepting, and adapting to a society, that does not support the traditions of their countries of origin, which in turn, has the potential to affect these children's sense of identity (Canino and Spurlock, 2000).

According to Canino and Spurlock (2000) many immigrant children experience *acculturation* to be an extremely stressful process. This seems to be the case most often when children do not feel securely rooted in either culture. It should be stated that differences in acculturation stress can occur for native-born and American-born children with parents of the same ethnic background. Further studies assessing acculturation stress found such differences between Cuban and Nicaraguan adolescents, and also, between native-born and American-born Latino adolescents (Canino and Spurlock, 2000). These differences appeared to be strongly associated with acculturation conflicts with parents, derogation by teachers (as perceived by the adolescents), family cohesion, and self-esteem.

Finally, it is asserted by Canino and Spurlock (2000) that additional stressors faced by immigrant children and adolescents emerge from difficulties in adapting to migration within the particular host country, and also, from the pressures of attempting to function in a dominant society that routinely discriminates against them.

A growing problem for adolescents in the United States is *poverty*; a phenomenon occurring in both rural and urban areas, and increasing in marginalized ethnic and racial groups (National

Association of Social Workers, 2003). A 1998 report indicated that more than 14 million children in the United States lived below the poverty line (Canino and Spurlock, 2000). The National Association of Social Workers (2003) report that adolescents who live in poverty suffer from recurrent untreated health problems, and more acute illnesses than those from wealthier families. Although new programs have been established to supplement Medicaid and to assist low-income adolescents, studies continue to indicate that there are some adolescents who do not receive health insurance. For example, in 2002, there were nine million children under age 19 who had no health insurance, and who could not qualify for Medicaid and SCHIP (National Association of Social Workers, 2003).

According to the National Association of Social Workers (2003) adolescents without health insurance do not receive preventive treatment, and emergency rooms appear to have become their primary source of care. Furthermore, these low-income youth tend to experience longer, unnecessary periods of time in hospital settings. The National Association of Social Workers (2003) contend that low income minority adolescents - especially those who are African American and Hispanic - are most at risk for being uninsured, stating that a 1998 survey conducted in New York indicated that more than *half* of minority populations had no health insurance. Due to the fact that economically disadvantaged culturally diverse families tend to access health care only during emergencies, or long after a disease has progressed, the evolution

and prognosis of their illnesses are often negatively affected (Canino and Spurlock, 2000).

A factor that influences adolescent pathology rates is area of residence (Canino and Spurlock, 2000): Rates tend to be higher in the inner city, and lower in rural areas. Canino and Spurlock (2000) contend that inner city living has the potential to expose children to a lack of social cohesion and integration, to buildings that are overcrowded and unsafe, and to multiple environmental changes that often require quick adaptation. According to Canino and Spurlock (2000) there are few studies that explore the effects of a child's immediate environment on his/her psychological health, however, they do allude to a 1989 study conducted by Homel and Burns, during which the home, street, and neighborhood were focused upon, in order to determine the effect of each, while controlling for other sociodemographic factors such as parents' occupations and ethnocultural backgrounds. The results of this study concluded that children who lived in inner city areas were significantly different from other children as far as feelings of loneliness, dislike of other children, feelings of rejection, worry, fear, anger, unhappiness, and a general dissatisfaction with life, and their families were concerned.

Many adolescents have *no* residence and live on the streets (Canino and Spurlock, 2000). The youth who find themselves in this unfortunate position have left their homes for various reasons, and hail from diverse socioeconomic backgrounds. A large proportion of them come from heavily challenged families, and have

been exposed to physical and psychological abuse within these families. Some of the youth are forced out of their homes by their parents, often as a result of behaviors deemed unacceptable, such as drug taking and truancy, while others are rejected from the family unit as a result of declaring a homosexual identification. Canino and Spurlock (2000) contend that a large proportion of adolescent runaways find themselves using drugs as a way of "self-medicating" for clinical depression, and, moreover, those who have been rejected and/or sexually and physically abused by their families can be provoked into attempted suicide(s). Some theorists note that the most frequent symptomatology manifested in runaway adolescents is a "stress response" to abusive environments, both in the home, and on the streets, while others have focused on the behavioral and academic difficulties that runaway youth experience throughout their student life (Canino and Spurlock, 2000).

The educational environment can be added to the above mentioned potential stressors faced by adolescents. Inadequate school supplies and equipment, and structurally unsound buildings are some of the hazards faced by adolescents hailing from low socioeconomic communities. Many schools, overcrowded with poor student-teacher ratios and insufficient control in the classroom, are unable to address the preceding problems, hence, the existence of an educational atmosphere that is not conducive to learning or teaching. Schools such as these place children at greater risk, as opposed to providing an environment in which they can be

protected (Canino and Spurlock, 2000).

Specific groups of children: learning disabled, emotionally and behaviorally challenged, and language deficient are often at higher risk for low *self-esteem* as a result of their experiences in school settings (Canino and Spurlock, 2000). It is necessary that the various mental health professionals involved with children within the said groups explore their individual school experiences. Children in special education classes, for example, may have particularly significant responses to, and feelings about, their specific special education program. Often a downward cycle of low self-esteem, unruly behavior, and/or feelings of alienation may occur. In addition, such children may be targeted as objects of ridicule. In short, it has been posited that the long term effects of special education placements on students' social, psychological, academic, and vocational future, warrant a more thorough, and critical examination of the effectiveness of referral, assessment, and placement procedures (Canino and Spurlock, 2000).

The National Association of Social Workers (2002) published an article highlighting their concern about the impact that negative *stereotypes* pertaining to adolescents are believed to have on adolescent health and well-being. In the article it is contended that widely held views and pervasive ideas about adolescents are particularly unfavorable, and a 1999 survey is referenced, in which adults, when asked to describe the youth of today, used descriptive words that were extremely pejorative, such

as "irresponsible" "lazy" and "disrespectful". Less than half of the adults in the study conveyed a belief that the next generation of young people would contribute to the country in any meaningful way. The National Association of Social Workers (2002) state that the preceding contemporary views of adolescents are shaped by dynamics of theory and culture, and go on to say that traditional conceptual frameworks about adolescent development are constructed, in part, through the utilization of certain concepts, and specific terminology that serves to mold a professional orientation toward "pathology" in understanding adolescent development.

According to the National Association of Social Workers (2002) although stereotypes are based on generalizations, and often contradict information that is based on fact, they tend to have a powerful effect on the development of ideas and concepts about specific societal groups. Stereotypes pertaining to adolescents facilitate and perpetuate views about the characteristics and behaviors of youths that are extremely limited in nature, thus offering an analysis of the effect of the social context that is *incomplete*. Compounding issues can be added to the negative labels that are attached to adolescents overall. These include: racial and ethnic stereotyping, gender stereotyping, sexual orientation stereotyping, religious orientation bias, and generalizations formed on the basis of socioeconomic status and area of residence. The above mentioned biases/stereotypes have the potential to evolve into consequences

that are harmful to adolescents in many ways:

Images that distort reality can instigate fears and/or misperceptions related to the actual cause(s) of specific adolescent challenges, and also, can contribute to the implementation of inappropriate strategies for resolving problems.

The effect of *labeling* is another negative consequence of stereotyping. Labels that pathologize youths can facilitate adolescents' internalization of negative messages, affecting self-image and self-esteem, and potentially alienating them from certain organizations that could provide them with much needed services. In addition, unfavorable images and concepts about adolescents can contribute to the development of a communication breakdown between youths and the various (social) systems providers with whom they interact.

The direction of adolescent programs and policies can be indirectly, and unconsciously influenced by biases and stereotypes, leading to the development of programming and policy decisions that may not *truly* be in the best interests of youths. For example, various types of funding for certain programs may be influenced by erroneous perceptions about who and what represent problems, and who is most suited to specific types of services. Biased and stereotypic concepts may affect the nature of policies; whether policy initiatives are established in order to promote positive youth development, or whether they are set up to be especially punitive. This can be evidenced in certain mental health, and juvenile justice related practices and policies;

youths of color continue to be disproportionately referred to, and represented within the juvenile justice system, as opposed to the outpatient mental health system (National Association of Social Workers, 2002).

The National Association of Social Workers (2002) caution social workers, and other service providers who work with adolescents about the way in which erroneous beliefs can evolve into clinician bias when it comes to the identification of the presentation and prevalence of "problem behaviors"; many providers continue to misdiagnose certain problems, and/or make recommendations for treatment that are inappropriate due to misconceptions that are based on stereotypes. Moreover, such skewed provider perspectives can actually serve to impede the accurate detection of problems/disorders if they dictate the unlikelihood, or inevitability of certain societal groups to be faced with specific emotional, psychological, physiological and/or environmental challenges.

Adolescent Mental Health Disorders and Demographics

The "normal" development and functioning of children and adolescents can be affected by mental health problems. According to the National Institute of Mental Health (2002) a 1999 study indicated that approximately 21% of children and adolescents between the ages of 9 and 17 had a diagnosable mental or addictive disorder. This estimate dropped to 11% when the diagnostic

criteria were limited to disorders that caused *significant* functional impairment. The study also indicated that in any given year, less than one in five of these youth receives the treatment required for recovery. The National Institute of Mental Health (2002) refer to recent studies performed by the World Health Organization, which indicate that by the year 2020, there will be a 50% rise in childhood neuropsychiatric disorders on an international level, thus making neuropsychiatric disorders one of the five most common causes of morbidity, disability, and death among children and adolescents.

One group of mental health disorders affecting children and adolescents are categorized as *depressive*, and include major depressive disorder, dysthymic disorder, and bipolar disorder. These disorders can affect mood, energy, interest, sleep patterns, and overall functioning. It is important that symptoms of depressive disorders are not confused with the "normal" emotional experiences of sadness, loss, and/or transient mood states; the symptoms of depressive disorders are *extreme*, in that they are persistent, and pervasive enough to significantly disrupt the adolescent's ability to function in many important areas, such as school, home, and with peers. Studies indicate that the occurrence of any of the above mentioned forms of depression among children and adolescents in the United States is higher than 6% in a six-month period, with almost 5% being diagnosed with major depressive disorder. The Treatment for Adolescents with Depression Study (TADS) is an ongoing study founded by the

National Institute of Mental Health that is currently working to compare the effectiveness of an SSRI medication, Cognitive Behavioral Therapy, and a combination of the two, in an attempt to determine the best approach for treating major depression in adolescents, while other studies continue to evaluate the efficacy of various psychotherapies for treating depressive disorders in adolescents (National Institute of Mental Health, 2002).

Anxiety disorders are currently the most prevalent group of mental illness to occur in children and adolescents. Studies indicate that the frequency of any anxiety disorder existing among children and adolescents is 13% in a six-month period (National Institute of Mental Health, 2002). There are numerous different types of anxiety disorder. These include but are not limited to:

Generalized anxiety disorder - when the individual is plagued by persistent worries pertaining to daily events.

Obsessive-Compulsive Disorder (OCD) - when the individual is plagued by intrusive, repetitive thoughts, feelings, and behaviors.

Panic Disorder - when the individual experiences extreme feelings of fear and dread, that may occur unexpectedly and repeatedly without apparent cause. The feelings are often accompanied by physical symptoms, such as chest pain, and shortness of breath.

Post-Traumatic Stress Disorder (PTSD) - occurring after exposure to a terrifying event(s) and/or experience(s), characterized by repeated experience of the event(s) through

intrusive memories, nightmares and/or flashbacks. PTSD can have the effect of deadening the emotions, and causing extreme hypervigilance.

Phobias - when the individual maintains exaggerated fears of a particular object(s) or situation(s).

The above-mentioned anxiety disorders are currently treated by various forms of psychotherapy, including cognitive behavioral therapy and family therapy, and various selective serotonin reuptake inhibitors (SSRIs), while research on the efficacy and safety of these interventions continues (National Institute of Mental Health, 2002).

Approximately 4% of children and adolescents in the United States are currently affected by attention deficit hyperactivity disorder (ADHD) in a six-month period (National Institute of Mental Health, 2002). Some of the main symptoms of this disorder include difficulty concentrating, extreme distractibility, and marked impulsivity. Children and adolescents who are challenged by ADHD tend to have impaired functioning within multiple settings, including home and school, and also experience difficulties conducting relationships with their peers. When undiagnosed and untreated, ADHD can have long-term effects on academic performance, vocational achievements, and social-emotional development. Some of the most widely researched, and frequently utilized treatments for ADHD are psychostimulant medications, such as methylphenidate (Ritalin) and amphetamine (Dexedrine and Adderall). The National Institute of Mental Health

(2002) assert that numerous short-term studies have established the safety and efficacy of the above-mentioned medications, and psychosocial treatments for ADHD.

Serious disturbances in eating behavior, such as drastic reductions in the intake of food, and/or negative feelings and thoughts about one's body shape and weight are referred to as *eating disorders*, and appear to be most common amongst adolescent girls, and young adult women. Such disorders tend to co-occur with others, such as depression, substance abuse, and various anxiety disorders. Eating disorders can also seriously affect the physical health of adolescents, leading to serious conditions of the heart and kidneys. The etiology of eating disorders are complex, and are often highly specific to the particular individual. Studies that look into the causes of eating disorders, and the effectiveness of specific treatments continue to be performed (National Institute of Mental Health, 2002).

Pervasive developmental disorders (PDDs) are disorders of the brain that occur in approximately 2 to 6 per 1000 children and adolescents in the United States (National Institute of Mental Health, 2002). These disorders include Autism, Asperger's, Rett's, Childhood Disintegrative, and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS). The ability to communicate, establish relationships, and generally respond appropriately to the outside world are some of the key areas which are affected by these disorders. Although the signs of PDDs usually become evident by 3 years of age, the symptoms and

deficits that are associated with each PDD tend to vary among children and adolescents; while some individuals are able to function at relatively high levels, others are developmentally delayed, have serious language difficulties and/or may not speak. Research has made it possible to initiate early intervention by identifying children who are showing signs of developing a PDD at earlier ages (National Institute of Mental Health, 2002). In addition, research has demonstrated that although a range of medications that were originally developed to treat other disorders with similar symptoms have shown themselves to be effective in treating PDDs, the use of behavioral and/or educational support is sufficient for many individuals. Furthermore, research indicates that it is important that the decision to use medication is based on the symptoms causing the most distress and functional impairment, and also on the possible risks and advantages of using or not using medication.

Approximately 1% of the U.S. population are affected by *Schizophrenia*, a disorder characterized by symptoms such as hallucinations, false beliefs, cognitive distortions, and social withdrawal, with a tendency to emerge in late adolescence or early adulthood (National Institute of Mental Health, 2002). Although schizophrenia is extremely rare in children, current research studies are indicating that various cognitive and social impairments may be able to be identified early in children who go on to develop schizophrenia, thus leading to the development of preventive interventions for children. Researchers are beginning

to make significant headway into understanding the etiology of schizophrenia; it is now thought that genetic factors combine with other factors early in life to interfere with "normal" brain development. Eventually these developmental disturbances may appear many years later - typically during late adolescence or early adulthood - as symptoms of schizophrenia. Apparently, treatment for schizophrenia has improved enormously; antipsychotic medications have become more readily available, and are showing themselves to be somewhat helpful in the reduction of hallucinations and delusions in children and adolescents.

Children and adolescents with schizophrenia can also benefit from supportive counseling, psychotherapy and social skills training designed to assist them in identifying effective ways of coping with the illness (National Institute of Mental Health, 2002).

According to the National Institute of Mental Health (2002) three national surveys conducted between 1996 and 1998 indicated that approximately 5-7% of children used any mental health services in a year. Although this average rate is similar to the rate in adults, it masks the major differences that exist across age groups; 1-2% of preschoolers, 6-8% of children between the ages of 6-11, and 8-9% of *adolescents* between the ages 12-17 utilized such services.

There is some variation in the utilization of mental health services across racial/ethnic groups. Among European American, African American, Hispanic, and "other" adolescents, Hispanics are

the *least* likely of all of the groups to access specialty care (5%) even though they and African Americans have the highest rates of need (10.5%). According to National Health Interview Survey (NHIS) measures, approximately 7% of the families with a child in need of such services describe financial obstacles to be the reason that they are unable to gain access to mental health care. More than half of all outpatient specialty mental health services for children who have private insurance are provided out-of-plan; a significant amount of these services are believed to be provided by the education sector. Approximately 0.2% - 0.3% of children between the ages of 1 and 17 receive *inpatient* mental health services in community hospitals. This rate is lower than the rate for adults (0.6%). Adults and adolescents have more inpatient days per 1000 population than young children do, and this is the case across all insurance types, however, adolescents' use of inpatient services are higher than that of adults, and this trend exists among the privately insured and the uninsured. Among the publicly insured, inpatient days per 1000 population are greater for adults than they are for adolescents (National Institute of Mental Health, 2002).

The preceding section on *adolescence* has reviewed various theoretical perspectives on adolescence as a stage of development, discussed some of the major social factors pertaining to adolescents, and their potential impact, highlighted some of the most prevalent mental health disorders affecting adolescents today, and provided demographic and statistical data regarding

adolescents and their utilization of mental health services.

The literature suggests that most of the authors who have speculated and theorized about the adolescent stage of development agree overall that it is a challenging period. Some theorists infer that the main problems associated with adolescence are psychological, others purport social challenges to be at least as significant as psychological ones, some highlight biological considerations, while most appear to allude to their utilization of a biopsychosocial lens in their attempt to best convey, and understand this convoluted developmental phase.

The question of the role of social factors upon adolescents is evidenced to be unclear. One of the reasons for this may pertain to the fact that relatively few studies explore the effects of the individual's environment on his/her psychological health. However, the literature indicates that some studies linking poverty, racism and discrimination, negative educational environments, area of residence, and pervasive stereotyping with adolescent pathology have indeed been completed.

As far as mental health disorders among adolescents are concerned, the literature indicated that 21% of children between the ages of 9-17 had a diagnosable mental or addictive disorder while only 1 in 5 received the treatment required for recovery. Anxiety disorders appeared to be the most common, while schizophrenia was evidenced to be least likely to occur.

Finally, the statistical and demographic information on the utilization of mental health services by adolescents reveals

notable disparities between adolescents from marginalized cultural backgrounds and the "majority" population as far as access to mental health care is concerned. Such differences may be open to interpretation.

Trauma: An Overview

In order to embark upon a study that is designed to investigate the potentially traumatic effects of physical restraints it is important to review literature that specifically addresses the phenomenon of trauma; what it constitutes, how it is manifested, what triggers it, and theories as to how it can best be treated. Numerous authors have written on the subject of trauma, including Van der Kolk, Herman, Chu, Charcot, and Freud. In a journal article that explores the psychobiology of posttraumatic stress, Van der Kolk (1994) states that trauma was rediscovered as an etiological factor in psychological disorders approximately 20 years ago, and that during these past 20 years there has been an explosion of knowledge pertaining to the ways in which people's life experiences can impact the central nervous system, and also the formulation of the self. This author also asserts that in most clinical settings, treatment seeking individuals have likely been exposed to a wide range of traumatic events over their lifespan.

In another journal article Chu (1992) provides information on the various ways in which mental health practitioners can be

advised to treat, and work with patients who have had various traumatic experiences, strongly underscoring some of the potential pitfalls that can occur if one is to embark upon a treatment intervention with a trauma survivor without a full appreciation of the ways in which the trauma has impacted the individual on interpersonal, affective, and behavioral levels. The information in this article sheds some light onto how mental health practitioners may be advised to structure treatment interventions around certain, almost inevitable factors, such as the "resistances" (1992) that are commonly displayed by trauma survivors: a certain amount of reluctance to deal with prior abusive experiences, an inability to adequately trust the therapist who is working with them, and a sensitivity to power imbalances in relationships, and coercive treatment techniques.

In her book *Trauma and recovery* Herman (1992) initially provides readers with a brief history of *hysteria* and references Charcot and Freud. Herman then describes some of the *effects* that trauma has on its victims including hyperarousal, a feeling that someone has been intruded upon, surrender and constriction and the feeling of disconnection. In addition, the psychological symptoms of being held captive for both a short term and a long term are examined. Herman's writing on trauma is particularly pertinent to my sample who have experienced an imprisonment of sorts, by virtue of having existed in a locked ward in a psychiatric hospital. Herman (1992) added that traumatic reactions occur when action is of no avail, and when resistance and escape are impossible. As a

result, the normal human system of defense has a tendency to become confused and overwhelmed.

Herman (1992) also discusses the *re-victimization* of individuals by their caregivers. Certain dangers are apt to arise if a therapist engages in destructive interactions in which the *medical or mental health system replicates the behavior* of the abusive family. Herman (1992) wrote that the first principle of recovery is the *empowerment* of survivors. It is the survivor who must be the author and arbiter of her/his own recovery. I found this assertion to be consistent with a significant portion of the ideas behind my study.

Saakvitne, Gamble, Pearlman, and Lev (1999) argue that the most respectful, effective, and empowering clinical model for helping individuals who have been traumatized is a *trauma* model.

Such a model understands that the mental health professional may have useful information to impart, but is by no means an "expert" or an "authority" on every matter that concerns their consumers.

The trauma model conceptualizes the client as being an important member of her/his treatment team, and that each member of the team needs to work collaboratively in order to assist the client to move forward (Saakvitne et al., 1999).

Like Herman (1992) Saakvitne et al. (1999) regard empowerment to be a significant concept where trauma is concerned. They stress that survivors of trauma need to feel safe, and that in order to feel safe they need to feel empowered. Such empowerment is best facilitated by clients being encouraged to participate

actively and collaboratively in their treatment, and to have control over the decisions they are affected by. Saakvitne et al. (1999) suggest that many mental health professionals feel pressured to demonstrate effectiveness and efficiency when it comes to treating their clients, and that these pressures can contribute to their insistence on their clients' "obedience", causing them to feel anger and frustration when the clients do not conform to their instructions. Saakvitne et al. (1999) stress that it is at times like these that mental health professionals need to remember that clinically effective assistance for their clients can only be achieved when the traumatic context of the clients symptoms is consistently kept in mind; such a context explains why cooperation and compliance with authorities can feel like being controlled and abused. In short, an understanding of trauma enables all that are involved to bring more enlightened perspectives to the assumptions and practices of many mental health professionals.

The preceding section on trauma suggests that the majority of individuals receiving care on inpatient units have likely been exposed to significant trauma(s), which is important to consider when regarding the proposed sample of this study, and the question that is being asked pertaining to the suitability of the utilization of physical restraints on such individuals. This section also highlights the significance of mental health practitioners gaining and maintaining an understanding of the effects of trauma on their clients, and of what they can be

prepared to encounter within the therapeutic relationship. Finally, this section underscores that it is imperative that survivors of trauma are worked with in a way that is *empowering*. Such a concept pertains to the issue of the clinical efficacy of the utilization of physical restraints on trauma survivors; do physical restraints, in philosophy or practice incorporate the particular therapeutic concept of *empowerment* that trauma theory espouses?

Psychiatrically Induced Trauma

In order to acquire a greater understanding of the concept of *iatrogenic trauma*, it was important to explore literature pertaining to the inadvertent consequences of certain procedures - namely physical restraints-implemented by authorities who maintain the belief that such practices are in the best interest of the patients. A body of research currently exists pertaining to the effect of traumatic events on victims (Briere & Runtz, 1990; Brock & Perry, 1995). However, significantly less attention has been directed towards the effects of *iatrogenic* trauma on individuals in psychiatric settings (Mohr, 2003). The chary empirical literature related to the psychological and cognitive effects of physical restraint indicates that "restrainees" may experience it to be "punitive" and "aversive", with the potential for traumatic after effects. In one study women with histories of childhood sexual abuse recalled the experience of being physically restrained as "representing a reenactment of their original

trauma" (Mohr, 2003, p.5). The restraint experienced years later was associated with traumatic emotional reactions, such as fear, rage, and anxiety. Similar to the preceding group, children and adolescents who had experienced restraint during time spent in psychiatric hospitals recalled experiencing nightmares, intrusive thoughts, and avoidance responses which they believed resulted from their experiences with restraints. They also spoke about painful memories and fearfulness upon seeing or hearing other children undergoing restraint procedures, and reported a general distrust of mental health professionals. The children and adolescents in this study reported that they continued to experience the symptoms of intrusive thoughts, recurrent nightmares, avoidance behaviors, startle responses, and mistrust up to five years after their hospitalization (Mohr, 2003).

According to Bloom (1997), the field of psychiatry has a history that is rife with examples of professionals' unwillingness to acknowledge that certain practices directed at patients in the name of *treatment* have caused the patients extensive damage. Bloom (1997) writes that mental health professionals' growing understanding about the complex biopsychosocial impact of overwhelming experiences should be able to provide them with a lens through which to re-evaluate practices such as physical restraints that is significantly more *accurate* than previous perspectives. This lens also speaks to the importance of establishing environments that genuinely support psychiatric patients' recovery processes. Bloom (1997) noted that

psychiatry's formal recognition of the impact of traumatic experiences on mental health did not occur until 1980 after which the diagnosis of PTSD was established. Unfortunately, it has taken another two decades for psychiatrists to comprehend the implications of PTSD for the inpatient treatment of the mentally ill. Despite the fact that decade old studies show that a high proportion of psychiatric patients who are hospitalized are actually trauma survivors, the impact of such trauma is really only just beginning to play a role in the treatment plans and formulations of patients (Bloom,1997).

Saakvitne et al. (1999) assert that mental health interventions that do not offer a trauma framework have the effect of teaching mental health practitioners to categorize their clients according to their symptomatic behavior instead of paying attention to the varied and complex meanings, causes, and functions that actually lie behind the manifested behavior. Saakvitne et al. (1999) reveal that many consumers who are trauma survivors attest to experiencing "harm" as a *result* of treatment applications that are symptom-focused, solution oriented, diagnosis based, and treater-as-authority based. They suggest that the power structure of the medical model within which most mental health practitioners practice in inpatient settings recreates a situation of "dependence", which consumers often associate with danger, pain, and betrayal.

Steel (1999) asserts that histories of physical and sexual abuse are extremely prevalent amongst women, children, and many

men who are treated in mental health settings, and informs that in 1996 a Massachusetts Department of Mental Health Task Force on the Restraint and Seclusion of Persons who have been Physically or Sexually Abused addressed this concern, subsequently noting that there was growing evidence that in most mental health settings, individuals who have been victimized in the aforementioned ways are likely to be retraumatized (particularly by the utilization of seclusion and restraint) as a *consequence* of inadequate assessment and inappropriate treatment, leaving such individuals in a continuing cycle of trauma and response. Moreover, such consumers have reported that physical restraint often bears a marked similarity to their prior traumatic experiences, thus, having the opposite effect from the ostensible intent behind the intervention (Steel, 1999).

In a report on the connection between diagnoses of mental illness and trauma and abuse histories, Auslander, Bustin-Baker, Cousins, Hilton and Penney (1998) state that many mental health consumers spend years in the psychiatric system without ever being asked about their trauma histories, or other aspects of their personal stories; their behavior, rather than their life experiences are what their treatment is focused on. As a result of this disregard for the prior trauma experiences of consumers, many of them are being retraumatized in psychiatric settings (Auslander et al., 1998). Although traumatic experiences are not always interpersonal, one of the key feelings that victims identify is helplessness, after losing control as a result of an

overpowering event or condition. Auslander et al. (1998) state that the risk for any individual entering the mental health system is a fundamental loss of power. In this sense, one can appreciate that the process of entering into, and existing in an inpatient setting *in and of itself* may be experienced as traumatizing. Auslander et al. (1998) suggest that mental health professionals would do well to assume that the whole process of encountering the mental health system is potentially traumatizing or at the very least, a potential trigger of prior experiences, concluding that anyone entering the mental health system under a presumption of trauma would inevitably be treated in a way that was more "humane" and efficacious, automatically eliminating the utilization of physical restraints.

In *Double Bind* (1996) Cohen-Cole asserts that physical restraints meet the DSM IV definition of human-induced traumatic stressors, constitute psychiatric abuse, and have negative effects that can be referred to as *iatrogenic trauma*. She also suggests that if the DSM IV's definitions of traumatic stressors were being applied *consistently*, physical restraints would be included on the diagnostic criteria.

The preceding, final section of this literature review suggests that the field of psychiatry is historically significant as one in which professionals appear to have been reluctant to consider and acknowledge that damage may have been caused to some consumers as a result of certain treatment interventions. It also highlights that trauma as a phenomenon is a relatively recent

concept in the area of mental health, one that is only just beginning to be taken into consideration while formulating treatment plans and interventions for consumers. This last point is extremely pertinent when investigating the clinical efficacy of physical restraints on individuals who are likely to have experienced trauma; in order to ensure that treaters are doing the best that they can for the consumers with whom they are working it appears to be *imperative* that they are knowledgeable about the effects of trauma, and the potential for iatrogenic trauma, so that they can avoid causing further psychological harm to consumers through ineffective and inappropriate treatment interventions.

In order to cover the significant areas of a research project which explores the effects of physical restraints on previously traumatized adolescent psychiatric patients, I considered it necessary to highlight literature that addressed the key concepts of my study: physical restraints, the historical significance behind the study's aims, adolescence, trauma, and iatrogenic trauma.

The preceding concepts will be examined within this study; the methodology, inclusive of the interview instrument, will incorporate the significance of this content.

CHAPTER III
PROBLEM FORMULATION

Research Design

The purpose of this research study was to gain a better understanding of the experiences of adolescents with trauma histories, who subsequently received physical restraints in an inpatient treatment setting; to examine the relationships that exist between psychological trauma and physical restraints. This was a qualitative study that employed fixed methods, and was *relational* in design . Qualitative methods are used to capture the phenomena of interest in the words or actions of the individuals who have experienced them (Anastas, 1999). Such a purpose is directly related to the *empowerment* perspective, a framework upon which this study was based. Due to the fact that empowerment theory and practice have roots in community organization methods, adult education techniques, feminist theory, political psychology, and social work, the use of the term "empowerment" is often vague, and can mean different things:

According to Gutierrez (1999) "empowerment" can be described as a process of increasing personal, interpersonal, or political power, in order that people become able to take action to improve their life situations. While authors on the macro level tend to define empowerment literally, often depicting it as the process of

increasing collective political power, authors on the micro level have been known to describe empowerment as the development of a personal feeling of increased power and control without a necessary change in any structural arrangements. A third group of authors have begun to explore what can be described as an interface of the preceding two approaches; how individual empowerment can contribute to group empowerment, and how the increase in a group's power can actually enhance the functioning of the individual members of that group (Gutierrez, 1999). Saakvitne, Gamble, Pearlman, and Lev (2000) equate the *trauma* model with an empowerment model, explaining that although a "helper" may have useful information to impart, such a model does not consider he or she to be "the expert" or "the authority" on all matters concerning a trauma survivor. Rather, the client/consumer is regarded, *and* treated as an important member of his or her own treatment team, and every single person on the team is expected to collaborate in order to assist the client to move forward. For purposes of this particular research study that sought to gain a better understanding of the experiences of adolescents with trauma histories, who subsequently received physical restraints in an inpatient treatment setting, the concept of the empowerment perspective can be considered to refer to all of the above mentioned definitions.

Previous research has been scant with regards to the *effects* of physical restraints on consumers, tending to focus more on various rationales behind different techniques and frequencies of

use, usually from the perspective of mental health professionals; the literature I have reviewed thus far illustrates a discernible lack of consensus, and even confusion amongst various professionals regarding the issue of physical restraints and trauma.

This qualitative study was designed to elicit narratives from adult individuals who self identified as having experienced trauma(s) prior to receiving physical restraints in an inpatient treatment setting at some time during their adolescent years. Participants were asked to describe their experiences in the inpatient treatment setting, paying particular attention to the kind of restraints they experienced, what was involved on one or more occasions in which they were restrained, what they thought, and how they felt about the experience(s) at the time that they occurred, and how they understood those experiences now.

Primary engagement was facilitated through my attendance at Freedom Center, and Lighthouse meetings, during which the nature and purpose of the study was fully explained. I also learned about two other places, the Starlight Center, and Green River House; both organizations established to support and empower individuals with mental health challenges, and was subsequently invited to attend meetings there. In addition to contacting the aforementioned organizations and attending support group meetings, the snowball method was utilized; potential participants were identified by friends and acquaintances who were affiliated with the study.

This study utilized fixed method qualitative research in the form of semi-structured interviews. Interviews were originally intended to take place in the participant's home, or other sites such as an office at the Freedom Center, or Lighthouse, however, I found myself having to be much more flexible with regards to each of the participants' individual feelings, and requests about where we were to meet. For example, one participant stated that she would feel most comfortable meeting in her favorite coffee house, so I accommodated her request and we met at her favorite coffee house, early in the morning when no one but ourselves, and the staff were there. Two other interviewees requested that we meet in the library, as they intuited that the peace and quiet of such an environment would be calming, and another individual requested that we meet in the cafeteria of a college in Springfield as it was a place with which she felt comfortably familiar. An additional three of the participants did not feel comfortable meeting in *person*, and requested that we do telephone interviews. After consulting the Human Subjects Committee regarding this request, I was able to accommodate their wishes. Thus, as it turned out, neither the Freedom Center nor the Lighthouse were utilized for any interviews.

Participants were asked to complete a demographic information form prior to the onset of the interview which took approximately 10 minutes of their time. The interviews lasted for approximately 1 hour. Although I had originally intended to audiotape interviews and code each tape with a number, it became necessary

to alter these prior plans according to the particular wishes and fears that were expressed by individual participants. (More is explained about this alteration in the *data collection methods* section).

Sample

The sample used for this study was non-probability and purposive, due to the fact that I deliberately sought out individuals who met the requirements for this study. The participants for this study were adult individuals who identified as having had trauma histories prior to experiences with physical restraint at some point during their adolescence. A specific trauma background was not required. In an attempt to allow for the processing, evaluation, and possible re-evaluation of their experiences, it was required that a *minimum* of five years between the last episode with physical restraints as an inpatient, and the time of participation in this study had lapsed. This study did not discriminate against gender, age, or ethnicity. However, due to my own limitations it was required that all participants be English speaking. Participants were primarily generated through support/activism meetings provided by the Freedom Center, a human rights group run by, and for people labeled with mental illness, support meetings provided by the Lighthouse, an organization that provides rehabilitation services to adults with mental health challenges, and other community support groups. Additional participants were generated through the use of flyers, which were

posted in mental health agencies, religious institutions, and college campuses. Each of the aforementioned organizations were utilized as modes of communicating information about the study subsequent to receiving permission from the appropriate parties. The idea behind this strategy was that I may be provided with a relatively diverse sample that would ultimately illustrate the ways in which racial, age, and gender differences may impact the topic being explored, and in addition, allow for possible divergent data.

The snowball method was utilized, as participants were encouraged to inform friends who fit the criteria for the study. Since the participants were generated primarily from Freedom Center and Lighthouse meetings, indicating a self-identified interest in addressing the subject of this study I had not expected the level of vulnerability of participants to be significantly high. It did appear, however, that any such vulnerability appeared to vary according to the length of time that had lapsed between the last time the participants had experienced physical restraint in an inpatient setting, and the time of this study, and also, according to the length of time spent in the institution(s). A list of references was made available to each participant in the event that follow-up resources were needed.

Efforts to achieve diversity in the sample were made by attending support groups that were both urban and suburban based. As I had anticipated, the ages of the participants varied

significantly due to the fact that individuals aged 18 years and older were sought for participation. However, the gender, and "race" of the participants did not vary at all; every interviewee was female, and identified as white. Although a sample size of 15 was aimed for, it turned out, that despite what I considered to be a major effort to find people willing to participate, the most I was able to interview for this study was 7.

The issue of confidentiality was verbally discussed with the participants of the study, and was also presented in the informed consent form.

I submitted materials to The Human Subjects Review Committee in October, 2003. Early in December I received a letter confirming their final approval.

Types of Data

Two types of data were collected; demographic data, and qualitative data. The demographic questions I asked pertained to the age, gender, racial/ethnic identity, family income level and education level of each participant. I also asked questions about the type of physical restraints that were experienced, the type of hospital setting that participants had received treatment in, the number of hospitalizations experienced, the age at which hospitalization had first occurred, the length of time spent at the inpatient setting, the diagnosis that participants had been given at the time, and any special limitations, such as learning,

physical, and/or speech and language, that the participants may have.

The qualitative questions I asked were open-ended, semi-structured and retrospective, and included inquiry into the participants' understanding about why they had been hospitalized, the physical restraints that they had experienced, relationships with people who had restrained them, the constancy of the restrainers, and the participants' thoughts about what the mental health professionals who treated them understood about their backgrounds. I also asked questions that were particularly concerned with participants' understanding about how they felt about their experiences at the time that they occurred, and how they felt about them today.

Data Collection Methods

The main method of data collection I used was interviewing. Although I had originally intended to record the material by means of a tape recorder, I soon discovered that my research participants were not comfortable with this. In fact, a number of people who had initially agreed to participate in the study pulled out, apparently after making the connection that I was actually going to be recording their voices during the interview. It was only after I had attempted to explore the reasons behind their sudden withdrawals that I learned that they had their origins in fear, and mistrust. According to Herman (1992) one of the major

effects of trauma is difficulty trusting, based on experiences of terror, and disempowerment, thus making assurances of safety and protection hugely important. Despite both written, and verbal assurances that no names would be attached to recordings of interviews, some participants expressed concern about the possibility of being identified by certain individuals who may be angered by what they chose to reveal. In order to respect, accommodate, and, attempt to understand their individual needs, I asked the participants individually what method they would feel comfortable about allowing me to utilize as a data gathering tool. Each participant asserted that they would feel significantly more comfortable if I took field notes, than if I were to record the interviews, hence, after communicating these changes to the Human Subjects Review Committee, that is what I did.

The interviews were semi-structured, with open - ended questions. In the interview, the researcher and informant meet in person, or interact over the telephone, in a way that purposefully generates data that is useful for research (Anastas,1999). Because my study focused, in part, on mental health practitioners' acknowledgment (or lack thereof) of mutual reciprocity in therapeutic relationships, with regard to both the failures and successes of treatment interventions, the technique of interviewing seemed to be particularly fitting; the interview is an interaction that is shaped by the interviewer and the research participant (Anastas, 1999). Another advantage of interviewing

was that I was able to clarify certain answers that were given by the interviewees, thus reducing any ambiguity that might have existed. In addition, I believe that my chosen method of interviewing had the capacity to generate material that was particularly rich and meaningful to my research question. Having said this, I became aware of some of the disadvantages connected to the interviewing process such as the lack of anonymity, and a certain amount of intrusiveness; two factors that were articulated to be mildly distressing for some of the individuals in my chosen sample. In an attempt to temper some of the effects of such distress, as I indicated earlier, I was fully prepared to make arrangements for my interviews in ways that were mindful of the potential effects of such factors on a population that may be particularly vulnerable. Another disadvantage of which I became aware was the issue of recall bias, an important bias to consider due to the fact that I was collecting data from individuals directly, as opposed to obtaining this data from past records; some of the participants in this study appeared to find it challenging to respond to some of the retrospective questions concerning cognitive and affective states, and changes in these states.

Data Analysis

According to Anastas (1999) the nature of a qualitative analysis emanates from the material at hand, and there are no

specific rules or procedures upon which one is required to depend. Nevertheless, it was first necessary for me to employ a stance of self awareness and skepticism during the analysis of my qualitative data, in order to establish ways in which to keep personal biases and reactions - that might interrupt the knowledge building process - at bay. I was prepared for the transcription of the data to be a somewhat tricky, and time consuming process, even though I ended up taking notes, as opposed to using a tape recorder.

My analysis of the data took place by means of coding. I aimed to ensure that my coding categories were neither too broad or too narrow, yet were able to capture the major ideas and meanings - such as types of physical restraints, traumatic effects of treatment, therapeutic effects of treatment, and nature of relationships between patient and practitioner - in the data. I coded the narrative data by recording on the interview notes pencil marks to indicate the codes that apply to each part, and then assembling copies of all the data in one given code category altogether (Anastas, 1999).

During data preparation and/or analysis one factor that must be taken into consideration is *reliability* (Anastas, 1999). I was aware of the importance of making sure that I attend to the written notes that I had taken, almost immediately after completion of each interview, in order to ensure that what I had written was legible, and intelligible, so that accurate, final notes were made possible.

CHAPTER IV

FINDINGS

This research study was conducted with intent to gain a better understanding of the experiences of adolescents with trauma histories, who subsequently received physical restraints in an inpatient treatment setting; to examine the relationships that exist between psychological trauma and physical restraints.

Summary of Demographics

Seven people participated in this study. Four out of the seven were 30 years or under, one out of the seven fell into the 31-40 age bracket, and two of the seven reported to be between the ages of 41-50. All participants were female, and all participants identified as white.

Three participants reported becoming hospitalized for the first time, at age 12. One person reported first hospitalization to have occurred at age 14. One person reported first hospitalization to have occurred at age 15. Two participants were hospitalized for the first time at age 18.

Two people reported their family to have had a low-socioeconomic status at the time of hospitalization. Two people reported their family to fall within "middle income" range, at the time of hospitalization. Three of the participants declined to

report an answer to this question.

Out of the seven participants, one had been hospitalized once, one twice, one 4 times, one 5 times, one 11 times, one 15 times, and one 50 times.

Three people reported PTSD to be their primary diagnosis, two reported a diagnosis of bipolar disorder, one reported being hospitalized due to "drug induced schizophrenia", and one declined to answer.

Three people were hospitalized at state mental institutions, four people were hospitalized in adolescent, inpatient treatment settings. Length of stay for each of the 7 participants was reported as follows: 2 weeks, 30 days, 3 1/2 months, 9 months, 2 years, 3 years, and, "a long time".

Each of the 7 participants reported to have been restrained by physical, mechanical, and chemical means.

Four people did not report to have any special limitations. One person had a "cognitive" disability. One person had "ADD", one person reported to have "learning hyperlexia", and "speech and language difficulties associated with autism".

Each of the 7 participants reported to have some college credits. Out of the 7, 3 reported that they were currently enrolled in Bachelor degree programs.

Summary of Responses

When asked about their understanding of the reasons why they

were hospitalized, 6 out of the 7 participants reported difficulties in the home, related to conflict with family/parents to be a contributory factor. Three out of the 7 participants reported to believe that self-injurious/suicidal behaviors resulting from depression and/or trauma constituted reasons for hospitalization. Two out of the 7 participants reported drug abuse to be a reason, and, 1 out of the 7 believed that her hospitalization was primarily due to her experiences as an individual with Bipolar Disorder.

"I was having blackouts...I would wake up with cuts. Self mutilation. People were worried I would harm others. Prior trauma. Wanted to get away from home. Commitment was always voluntary. I wanted to get help. My home life was dismal."

"There was depression...I was depressed, and there were family complications. I was cutting. The whole time was very confusing; I was confused about why I had to stay there so long. I had no choice."

"There was a jail problem. The whole thing all happened very quickly...it was very abrupt. I remember that I had been smoking weed and drinking beer, and that my parents thought I was too defiant...but their expectations were too high...they wanted me to be perfect...it was impossible."

In response to the question pertaining to the type of restraints experienced in particular inpatient settings, all 7 of the participants remembered that they had experienced restraint physically, mechanically, and chemically. In addition, 2 out of the 7 identified *seclusion* as a form of restraint. 1 out of the 7 described the experience of being on a locked inpatient unit to be akin to a form of restraint.

"Twice were mechanical. The rest of the restraints were physical (people). Sometimes I was given inappropriate meds...Paxil. Tegretol."

"They would usually begin by physically restraining you...you know, people holding you down...but then they would often escalate into mechanical ones...like a safety coat type of thing...we had a nickname for it...we used to call it the burrito...those would often become chemical."

"Just being on a locked unit was like being restrained. I remember they gave me some really intense drugs. Lithium...this was the early 1970's...and I have a vague memory of being tied down...chased...held down to receive more medication...and then waking up...after I was restrained...in a locked room."

In response to being asked to describe one of the times in which they had experienced restraint, 3 out of the 7 participants reported to have been restrained as a result of conflict between themselves, and the staff member(s). Each of these respondents reported to believe that inflexibility, lack of negotiation skills, and an inability or unwillingness to attempt to understand them, on the part of the staff members involved, had contributed to their eventually being restrained. 2 out of the 7 participants reported that feeling unsafe in the hospital and attempting to leave because of these feelings had resulted in restraint. 2 out of the 7 reported that they had been beaten up during their particular experience of restraint; 1 by staff members, and the other by a patient. General feelings of humiliation, confusion, frustration, helplessness, and fear were reported by study participants to have been experienced in response to being restrained.

"I was 15 years old at the time. There was no privacy. I wanted to close the door to my room..they wouldn't allow me to...I threw something at the wall. I just wanted to be allowed to close my door. They were so inflexible...wouldn't bend the rules...they wanted to control me. A lot of the staff caused trouble...they started the trouble. This particular restraint lasted 8 hours. There were 2 women and 1 man. It was surreal. I felt humiliated..embarrassed."

"Really hard to remember...I can remember small pieces of different experiences...fragments...I remember being really frustrated, punching a wall and hitting the floor, really hard. They trip you up, they use their feet to get you to the floor. I fell sideways. One large guy used his weight to pin me down...I was totally helpless..."

"I told them I didn't want to take the Prolixin. I told them I didn't want it. They said I had to come with them...and that I was being dramatic...they told me it was stupid to struggle when I couldn't get away...they said I was ungrateful, and overdramatic. I was really having trouble breathing. They said they thought I was faking it...after then I was very weak and compliant. After that I would say anything they wanted me to say."

"I didn't feel safe in the hospital so I decided to leave. I remember a woman chasing me. I asked her not to touch me. 9 men and 1 woman dragged me into the "hole"-that was what it was called. They made me take off all my clothing. They ripped off my clothing. They took pictures. They busted my mouth, they bruised me up. They beat me up. I remember them taking pictures. I was in there for 2 weeks. They were mad at me. There wasn't much care. It was cold. I remember feeling humiliated because I was naked. I was scared."

In response to being asked about their relationships with staff members who had restrained them, 1 out of the 7 participants described such relationships to be "close", 1 reported that relationships were "variable", and 5 out of the 7 reported not to have had positive communicative relationships with staff members.

"At that time I had a pretty primitive conception of relationships...but I do remember that it was impossible to communicate with them."

"I don't really feel like I had any kind of relationship with any of them. They were my authority. I guess they were authoritative relationships."

"There was no relationship. The staff members were your means of eating and getting to go outside. They were in it for the job and the thrill of it."

"Close relationship. The two women I liked. You were typically restrained by someone you knew. Antagonistic with male. I thought that particular man was afraid of me...of what I might say to him..it was like he couldn't see beyond the label they had given me."

In response to the question pertaining to constancy among restrainers, 1 out of the 7 participants reported that the people who had restrained her had been constant. Six out of the 7 reported a lack of constancy among restrainers, and attributed this to the type of restraints that were being utilized at the time, and the fact that different staff members tended to work different shifts.

"It really depended on whoever was working."

"It really depended on the shift. Different staff worked different shifts."

"Yes and no...it was whoever was there on staff...whoever was on duty at the time...usually the males."

When asked to describe how they understood their experiences with restraint at the time that they had occurred, participants recalled having had feelings of anger, embarrassment, confusion, powerlessness, physical pain, and loss of control in response to being restrained. Participants also reported having believed at the time that the restraints had been "unnecessary", and

"nonsensical".

"At the time I thought it was really unnecessary. I was really angry. I wanted to fight. I was embarrassed. I had to make a choice to let people do that to me. I struggled. You had to go limp in order to be left alone. It was confusing."

"I thought it was uncalled for. I remember thinking that they were trying to be too consistent. They were not protocol...not emergency situations. There was no flexibility with people."

"I didn't understand why, if I went in there because I had been abusing drugs...why they were giving me more drugs, forcibly. I was confused. I felt powerless."

When asked to discuss their *current* understanding of previous experiences with restraint, 2 out of the 7 respondents reported to have a better understanding of some of the reasons why they had been restrained. Two out of the 7 believed that "ignorance" on the part of staff had played a part in the utilization of restraints. One out of the 7 believed that a lot of the restraints could have been avoided if patients had been listened to. One out of the 7 stated that her understanding of her experiences with restraint was no clearer today than it had been at the time that restraints had been experienced. General sentiments expressed by respondents were anger at having been made to feel "helpless", and anxiety and concern around the fact that restraint is currently utilized in inpatient treatment settings.

"Restraints were part of adolescent institutional culture. Today I have a better understanding of situations in high stress environments; they tend to trigger restraints. It's retriggering not to be allowed to have privacy, or to have physical contact from anyone."

"I don't understand it. It makes me really angry...physical restraints are not as bad as chemical. Chemical restraints controlled your mind. That's what makes me the most angry. The mind control...complete helplessness."

"Well...today I can understand why that was done to me. It was done because I was totally delusional. It was the only way they could find to control me. It does seem extreme...but at that point in time, other interventions weren't in place. I see that. They were partially ignorant. Restraint was the only means at that time in the field."

In response to being asked to discuss their thoughts pertaining to what the mental health workers who had worked with them directly had understood about their history prior to hospitalization, 7 out of the 7 participants reported to have experienced a fundamental lack of understanding amongst mental health workers with this regard.

"In some places they understood more than in others. Some of the places they treated you like you were just obstinate or bad. They didn't get the trauma. Behavior was looked at differently from black kids than white kids...sexual orientation was a problem - seen through the lens of whatever prejudices the staff had. People's language needs were not always met. Girls were labeled promiscuous. Prior abuse was incidental..they just weren't interested."

"Most of them didn't get it...they filled in the gaps wrong. I was often told, if I said what I was thinking, that I was being dramatic. I was rarely listened to, or taken seriously. There was very little understanding amongst the professionals."

"Well...I think they understood very little...they didn't have any idea. I don't think they even knew my diagnosis at the time...I was just...like another number."

When asked to describe how traumatic experiences had affected subsequent experiences with restraint, 2 out of the 7 participants responded by saying that most of their trauma had been experienced

in psychiatric inpatient treatment settings. Three out of the 7 respondents believed that the symptomatic effects of prior trauma had been exacerbated by their experiences with restraint, and 1 out of the 7 likened her experiences with restraint to abuse she had suffered prior to hospitalization. 7 out of the 7 respondents believed that they later developed trauma symptoms as a result of having been restrained. These symptoms included nightmares of being restrained, anxiety about others being restrained, flashbacks of restraint episodes, an inability to trust mental health professionals, confusion, and fear of losing control in day to day situations.

"It was a disaster...people's abuse history was pretty recent. PTSD was made worse by restraints. I still have dreams where I wake up and can feel my wrists hurting...the memory of restraints...restraints as another trauma...the two things are inextricably linked. The context of the restraints permeated the experience of the adolescents. I can't get over it physically. I have problems with my back, my knees. Bruising. My pubic bone is bruised...painful. I have back and knee problems. Flashbacks. Trauma stuff going on. Anxiety-panicking-not in reality... sometimes I go back to where I was at that time. Restraints made earlier trauma feel much worse...really sucks."

"Most of the trauma I experienced was at the hospital. The whole process of hospitalization was traumatic. It's like the system holds you...it doesn't help you. I had problems adjusting to high school...if I hear certain noises, like a jingle, or whatever, I remember being in restraints."

"Being restrained made a traumatic time in my life more traumatizing...it took it to a higher degree...it made things more confusing, more frightening. It left an emotional scar. It affected me in ways that took years to understand. It's like, today, I always need to have a way out, some kind of escape route. I have this fear of losing control."

"Having someone pull my pants down was terrifying...being held down gave me flashbacks of earlier abuse...it caused

more trauma. Flashbacks piled themselves up on top of each other. At the time, I didn't even know what a flashback was...so I had no idea what was happening. I remember the guilt. I was told that everything that happened was my fault. The previous abuse was nothing in comparison to the stuff I experienced in psych. wards."

The preceding summary of participant responses to the listed questions illustrates the findings that emerged as a result of conducting this study. The key findings, and major themes of the study will be presented in the following chapter; key findings will be connected to the literature reviewed earlier, alongside a discussion of the strengths, and limitations of the study, and, an exploration of the implications of the study, as far as social work practice and policy are concerned.

CHAPTER V

DISCUSSION

The purpose of this research study was to gain a better understanding of the experiences of adolescents with trauma histories, who subsequently received physical restraints in an in-patient treatment setting. Specifically, the research focused on the impact of physical restraints as experienced by previously traumatized adolescents.

Key Findings

The majority of participants reported conflict with family/parents to have contributed to their hospitalization. The majority of the participants remembered that they had experienced restraint physically, mechanically and chemically; *seclusion* was also identified as a form of restraint. The majority of the respondents reported to believe that inflexibility, lack of negotiation skills, and an inability or unwillingness to attempt to understand them, on the part of the staff members involved, had contributed to their eventually being restrained. General feelings of humiliation, confusion, frustration, helplessness, and fear were reported by study participants to have been experienced in response to being restrained. The majority of participants

reported not to have had positive communicative relationships with staff members. The majority of the participants reported that there had been a lack of constancy among restrainers, and attributed this to the type of restraints that were being utilized at the time, and the fact that different staff members tended to work different shifts. The majority of participants recalled having had feelings of anger, embarrassment, confusion, powerlessness, physical pain, and loss of control in response to being restrained. Participants also reported having believed at the time that the restraints had been "unnecessary", and "nonsensical". General sentiments expressed by respondents were anger at having been made to feel "helpless", and anxiety and concern around the fact that restraint is currently utilized in inpatient treatment settings. The majority of participants reported to have experienced a fundamental lack of understanding amongst mental health workers with this regard. The majority of respondents believed that they later developed trauma symptoms as a result of having been restrained. These symptoms included nightmares of being restrained, anxiety about others being restrained, flashbacks of restraint episodes, an inability to trust mental health professionals, confusion, and fear of losing control in day to day situations.

The preceding few pages document the key findings of this study, and can be evidenced to correspond to much of the literature reviewed earlier. Consistent with Miller, Rathus, Linehan, Wetzler, and Leigh's (1997) assertions about the unique,

and inevitable psychological problems of parent-adolescent conflicts, drug and alcohol use and hormonal changes contributing to lowered moods, affective dysregulation and suicidality that are associated with the *normative* developmental period of adolescence, the majority of participants reported to believe that the reasons for their hospitalization were primarily due to family/parent conflict, drug and alcohol abuse, and self-injurious/suicidal behaviors resulting from depression/trauma.

Peterson (2002) and NAMI (1998) stated that restraints should only be used in *emergency* situations. However, consistent with Saakvitne, Gamble, Pearlman, and Lev's (1999) suggestions that many mental health professionals feel pressured to demonstrate effectiveness and efficiency when it comes to treating their clients, leading to an insistence on their clients obedience, and ultimately causing them to feel anger and frustration when their clients do not conform to their instructions, study participants reported that restraint tended to occur as a result of conflict and power struggles; inflexibility, lack of negotiation skills, and an inability or unwillingness to attempt to understand them, on the part of the staff members involved, and did *not* occur as a result of emergency situations. Participants also reported believing that restraints were unnecessary, nonsensical, and could have been avoided if people had been listened to.

Fisher's (1994) review of literature supplemented with statements made by some psychiatric survivors partially supported

the concept of restraints as *therapeutic*, in that they were believed at times, to be effective in preventing injury, and helpful in the building of therapeutic relationships. Restraints were also reported by the Alzheimer Society (2003) to have therapeutic value, due to their ability, when used appropriately, to enable elderly individuals to participate in activities that they may ordinarily have been unable to do. It should be said, however, that the concept of therapeutic restraints did not correspond with the beliefs of the sample used for this particular study.

In accordance with Auslander, Bustin-Baker, Cousins, Hilton and Penney (1998) and Steel (1999) who discussed the importance of taking patients prior (trauma) histories into consideration when formulating, and implementing treatment techniques, and the perceived general absence of this sort of acknowledgment, and/or understanding among mental health professionals in inpatient treatment settings, all of the study participants described any such consideration or understanding on the part of the mental health professionals treating them to be essentially absent; some respondents described staff as being "ignorant".

Consistent with Auslander et al. (1998) who talk about the key feelings of traumatic experiences most typically being *helplessness*, after losing control as a result of an overpowering event or condition, and a fundamental loss of *power*, participants identified similar feelings that they experienced in response to being restrained. One participant also stated that the experience

of being on a locked inpatient unit was akin to a form of restraint, which corresponds with Auslander et al.'s (1998) suggestion that the process of encountering the mental health system is potentially traumatizing, or at the least, a potential retrigger of traumatic experiences.

Although Herman (1992) wrote that the first principle of recovery among trauma survivors is empowerment, and Saakvitne et al. (1999) stated that survivors of trauma need to feel safe, and that in order to feel safe they need to feel empowered, the trauma survivors (participants) in this study described feeling unsafe, humiliated, confused, helpless, and terrified during much of the time they spent in the hospitals in which they were treated, attributing many of these feelings as direct responses to experiences with restraint.

Consistent with Mohr's (2003) Bloom's (1997) Saakvitne et al.'s (1999) and Cohen-Cole's (1996) discussions and reports on the experiences of consumers in relation to iatrogenic trauma, 7 out of the 7 participants in this study believed that they developed trauma symptoms as a result of being restrained. These symptoms included nightmares of being restrained, anxiety about others being restrained, flashbacks of restraint episodes, an inability to trust mental health professionals, confusion, and fear of losing control in day to day situations. One respondent reported that she was additionally *physically* unable to get over her experiences with restraint due to recurrent problems with her back and knees.

The key findings of this empirical study, in conjunction with some of the major aspects of the literature reviewed appear to illustrate some interesting phenomena:

(a) The majority of patients treated in hospital settings are likely to be trauma survivors.

(b) Some normative aspects of adolescence may be regarded as being potentially traumatic, in and of themselves.

(c) The process of encountering the mental health system may be traumatic for some individuals.

(d) A lack of understanding/knowledge of adolescent developmental phases exists among many mental health workers in inpatient settings.

(e) A lack of understanding/acknowledgment of the manifestations and effects of trauma exists among many mental health professionals who work in inpatient treatment settings, thus leading to the inadequate, and inaccurate assessment of consumers.

(f) Empowerment is key when it comes to helping trauma survivors.

(g) The most empowering way to treat people who have been traumatized is by applying interventions that offer a trauma framework.

(h) The medical model applied in most inpatient settings is treater-as authority based, and is often associated with pain.

(i) Iatrogenic trauma in individuals who have been

treated in psychiatric hospital settings appears to be a real, yet underreported, and underinvestigated occurrence.

(j) Restraint procedures do not appear either practically, or philosophically to incorporate the particular therapeutic concept of empowerment that trauma theory espouses, nor does it seem as though they are intended to.

(k) There appear to be distinct parallels between the particular sensitivities of adolescents, and those of trauma survivors, including a heightened awareness of power imbalances, a fear of loss/lack of control, problems with identity confusion, a reluctance and/or fear of complying with authorities, and a certain amount of affective dysregulation, and cognitive difficulties. These parallels can be considered to be especially significant when the characteristics of the participants of this study are taken into consideration, and highlight the fact that hospitalized adolescents are an especially vulnerable population.

Strengths and Limitations of this Study

Relational research has several advantages (Anastas, 1999).

Firstly, from a theoretical point of view, relationships among various phenomena is core to theory development, and secondly, relational research denotes a form of research that is frequently used in the helping professions and social sciences (Anastas, 1999). Thus, the relational nature of this study may be regarded as one of its strengths.

I was extremely aware that I was entering into the process of conducting this research project with a certain amount of philosophical bias, and that it was important in the interest of knowledge, to do my utmost to operate in an unbiased fashion. I believe that my awareness of the potential for this sort of bias, constitutes a strength of this study; at the same time I believe that my ability to listen, understand, and interpret what was reported by respondents may have been somewhat enhanced by my own philosophical leanings regarding clinically efficacious treatment of traumatized adolescents.

Prior to preparing the data of this study for analysis I considered the issue of *reliability*, subsequently making sure to attend to the written notes that I had taken almost immediately after completion of each interview, in order to ensure that what I had written was legible, and intelligible. I believe that my early consideration of the issue of reliability contributed to the production of final notes that were highly accurate. It should be said, however, that interobserver reliability was impossible due to the fact that the documentation process was single. My strict adherence to using language that had been supplied by the research participants themselves sufficiently addressed issues of validity.

The main method of data collection used in this study was interviewing. One advantage of interviewing was that I was able to clarify certain answers that were given by the interviewees, thus reducing any ambiguity that might otherwise have existed. In addition, I believe that my chosen method of interviewing had the

capacity to generate material that was particularly rich and meaningful to my research question. Having said this, I became aware of some of the disadvantages connected to the interviewing process, such as the lack of anonymity, and a certain amount of intrusiveness; two factors that were articulated to be mildly distressing for some of the individuals in my chosen sample, and may have affected their responses. Another disadvantage of which I became aware was the issue of recall bias, an important bias to consider due to the fact that I was collecting data from individuals directly, as opposed to obtaining this data from past records; some of the participants in this study appeared to find it challenging to respond to some of the retrospective questions concerning cognitive and affective states, and changes in these states.

One issue related to selectivity in sampling is representativeness (Anastas, 1999). Unfortunately my sample were not as diverse, or as numerous as I might have hoped. Although there was some diversity with regards to age, the gender, and "race" of research participants did not vary at all; all interviewees were female and all identified as white. Thus, I consider inadequate representativeness to be a limitation of this study; results cannot be generalized from a research study using a sample of 7 white females to all people.

The generality of any study's conclusions, known as its external validity, is most convincingly enhanced by repeated

demonstrations (Anastas, 1999). Thus, one of my recommendations is that this study be conducted again; I suggest that a *replication* study on a larger and more varied sample be done at a later stage.

Implications of this Study for Practice and Policy

The implications of this study, as far as social work practice is concerned, pertain to the importance of professionals and paraprofessionals who work with adolescent trauma survivors in inpatient settings being encouraged, supported, and assisted to develop an *authentic* understanding of the life experiences of their young clients, hopefully becoming able to recognize the undeniable parallels that exist between certain challenges faced during the adolescent phase of development and various symptomatic responses to traumatic experiences, subsequently utilizing treatment modalities (trauma and empowerment oriented theories) accordingly, and eschewing those that are inconsistent with clinically efficacious treatment of trauma.

As far as social work policy is concerned, one may infer from this study that clinical social workers have, by virtue of our code of ethics and our clinical knowledge about traumatized individuals, a responsibility to speak up when we witness vulnerable consumers being subjected to treatment practices that may be outdated, inefficacious, disempowering and re-traumatizing; this study signifies the importance of social workers becoming

inspired to work collectively to effect policy changes that eradicate treatment practices that have been evidenced to induce more harm than help. In addition, this study reflects a *national* trend now embraced by the federal government to reduce, and ultimately end restraints; The Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the U.S. Department of Health and Human Services (HHS), was established by an act of Congress in 1992 under Public Law 102-321 (Substance Abuse and Mental Health Services Administration, 2003) and has launched a vision to eliminate the use of seclusion and restraint practices in institutional and community-based behavioral health care settings. SAMHSA recognizes that an effective national action plan to reduce and ultimately eliminate seclusion and restraint will take the combined efforts of a range of public and private stakeholders (Substance Abuse and Mental Health Services, 2003).

To conclude, current literature, and empirical studies pertaining to the utilization, and psychological effects of restraining traumatized children do not represent a basis upon which mental health professionals can continue to utilize them on this population uncritically. Although pieces of the literature reviewed point to restraint practices as having therapeutic value, and being helpful in preventing injury when exercised appropriately, significantly more of the literature points to the potential for restraint to be experienced by individuals as retraumatizing, and/or as an introduction of new trauma. It is my

hope that during the process of undertaking this research process I was able to underscore the importance of those of us working in the area of mental health striving to genuinely listen to the so frequently ingnored perspectives of mental health consumers, and attempting to learn, and make changes *according to what they have to say about what they need from us*. In addition, it is my hope that I may have succeeded in assisting some previously disempowered individuals to speak on their own behalf about this controversial issue, and that having this experience may somehow facilitate more opportunities for these individuals, and others, to speak further about their experiences.

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Appendix A

Human Subject Review

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Project Title: Understanding experiences: Exploring the effects of physical restraints on previously traumatized adolescents.

Project Purpose/Design:

The purpose of this research study is to gain a better understanding of the experiences of adolescents with trauma histories, who subsequently received physical restraints in an inpatient treatment setting. Specifically, the research will focus on the impact of physical restraints as experienced by previously traumatized adolescents. Previous research has been scant with regards to the *effects* of physical restraints on consumers, tending to focus more on various rationales behind different techniques and frequencies of use, usually from the perspective of mental health professionals. This qualitative study is designed to elicit narratives from adult individuals who self identify as having experienced trauma(s) prior to receiving physical restraints in an inpatient treatment setting at some time during their adolescent years. Participants will be asked to

describe their experiences in the inpatient treatment setting, paying particular attention to the kind of restraints they experienced, what was involved on one or more occasions in which they were restrained, what they thought, and how they felt about the experience(s) at the time that they occurred, and how they understand those experiences now.

Participant Characteristics:

The participants for this study will be adult individuals who identify as having had trauma histories prior to experiences with physical restraint at some point during their adolescence. A specific trauma background is not required. In an attempt to allow for the processing, evaluation, and possible re-evaluation of their experiences, it is required that a *minimum* of five years between the last episode with physical restraints as an inpatient, and the time of participation in this study be lapsed. This study will not discriminate against gender, age, or ethnicity. However, due to limitations of the researcher all participants must be English speaking. Participants will primarily be engaged through support/activism meetings provided by The Freedom Center, a human rights group by and for people labeled with mental illness, support meetings provided by the Lighthouse, an organization that provides rehabilitation services to adults with mental health challenges, and other community support groups, such as alcoholic anonymous and narcotics anonymous. Additional participants will be generated through the

use of flyers, which will be posted in mental health agencies, religious institutions, and college campuses. The snowball method will also be utilized, as participants will be encouraged to inform friends who fit the criteria for the study. The vulnerability of participants is expected to vary according to the length of time that has lapsed between the last time they experienced physical restraint in an inpatient setting and the time of this study. Since the participants will primarily be generated from Freedom Center and Lighthouse meetings, indicating a self-identified interest in addressing the subject of this study, participants' level of vulnerability is expected to be relatively low. It is anticipated that the ages of participants may vary significantly due to the fact that individuals 18 years and older will be sought for participation. Efforts to achieve diversity in the sample will be made by attending support groups that are both urban and suburban based. A sample size of 15 is aimed for.

Nature of Participation in Research:

Primary engagement will be facilitated through the investigator's attendance at Freedom Center, and Lighthouse meetings, during which the nature and purpose of the study will be fully explained. In addition to contacting The Freedom Center, and The Lighthouse, and attending support group meetings, the snowball method will be utilized; potential participants will be identified by friends and acquaintances who are affiliated with the study. This study will

utilize flexible method qualitative research in the form of semi-structured interviews. Interviews will take place in the participant's home, or should the participant prefer, another site such as an office at the Freedom Center, or Lighthouse may be used. Participants will be asked to complete a demographic information form prior to the onset of the interview which will take approximately 10 minutes of their time. Duration of the interviews will be approximately 1 hour. The interviews will be audiotaped, and each tape will be coded with a number. The tapes will be transcribed in full, with all identifying information removed to protect the participants' privacy. (See attached).

Potential Risks:

It is expected that the interviews might elicit strong feelings in some participants as the relaying of their story may cause them to relive various painful aspects of their experiences in an inpatient setting. A list of referral resources will be provided to each potential participant with the informed consent form. (See attached).

Potential Benefits:

The benefit of participation in this study is to provide previously disempowered individuals with an opportunity to create narratives about their experiences with physical restraint in psychiatric settings during adolescence. In addition, it is hoped that this study will provide mental health practitioners with some insight into how the practice of physical restraint is experienced

by previously traumatized, adolescent clients.

Informed Consent Procedures:

Participants will be required to sign a consent form agreeing to participation in the research interview. The form identifies the rights of the participant, including the right to refuse to answer questions and the right to withdraw from the study at any time prior to April 23, 2004. The participant and the researcher will each keep a signed copy of the consent form. The signed consent forms will be kept in a secured cabinet for three years after the conclusion of the study.

Precautions to Safeguard Identifiable Information:

In order to protect the privacy of participants, audiotapes used to record interviews will be labeled with a number and a date. No names will be attached to the interviews. During the transcription process all names and other types of identifying information will be removed. The tapes will be kept in a secured environment in a locked cabinet, separate from the consent forms, for three years following the completion of the research. After this time all data including tapes and transcripts will be kept locked and secure or destroyed.

Investigator's Signature: _____ **Date:** _____

Advisor's Signature: _____ **Date:** _____

Appendix B

Demographic Information

Please provide the following information as part of your participation in the study.

Current Age:

Under 30 _____ 31-40 _____

41-50 _____ 51-60 _____

Over 60 _____

Gender : _____

Racial/ethnic identity: _____

Age at time of hospitalization: _____

Family's income level at the time of hospitalization: _____

Number of hospitalizations: _____

Reasons(s) for hospitalization/ Diagnosis: _____

Type of setting: _____

Length of stay: _____

Type of physical restraint(s) experienced _____

Special limitations:

Learning _____ Speech and language _____

Physical _____ Other _____

Education level:

Some high school _____ Associate's degree _____

High school degree _____ Batchelor's degree _____

Some college _____ Graduate degree _____

Appendix C

Interview Questions

I am interested in hearing about your experiences as an adolescent in a psychiatric setting, pertaining especially to your understanding of how any physical restraints you received may have impacted you. When I use the term "physical restraints" I am referring to any one of the following three types:

Mechanical restraints in which devices or objects were used to restrict your movement, chemical restraints which involved the use of medication(s), and/or restraints that were conducted by means of one or more people holding or physically manipulating you in order to restrain your movement.

Tell me about your experiences in the hospital/psychiatric setting in general.

What do you understand about the reasons you were there?

What kind of physical restraints did you experience in this setting?

Tell me about one of the times you were restrained. How many people were involved during this particular restraint? What happened after the restraint was over?

Tell me about the relationship you had with the person/people who restrained you.

Were your restrainers constant, or were there many different people who restrained you?

How did you understand the experience at the time?

How do you understand the experience now?

What do you think the mental health professionals who treated you understood about your background/prior experiences?

You have indicated that prior to your hospitalization you experienced trauma. How do you think your experiences of trauma affected your experience of being restrained, if at all?

Appendix D

Informed Consent

November 22, 2003

Dear Potential Research Participant:

My name is Cheryl Alexander, and I am a graduate student at Smith College School for Social Work. I am conducting a study that explores the effects of physical restraints on previously traumatized, adolescent psychiatric patients. Your perspective is important and valuable to further the development of research on the experiences of previously traumatized adolescents who have been physically restrained in an inpatient treatment setting. This study is being conducted in partial fulfillment of the Master's of Social Work degree at Smith College School for Social Work, and for the possible future presentation and publication of this topic.

You are being asked to participate as an adult individual who has experienced physical restraint during adolescence in an inpatient setting subsequent to earlier trauma. A specific trauma background is not required. In an attempt to allow for the processing, evaluation, and possible re-evaluation of your experiences, it is preferred that a *minimum* of five years between the last episode with physical restraints as an inpatient, and the time of participation in this study be lapsed. This study will not discriminate against gender, age, or ethnicity. However, due to my own limitations it is required that all participants be English speaking. If you choose to participate, I will ask you to sit in an interview with me which will take approximately 1 hour of your time. This interview will include questions about your experiences of physical restraint in an inpatient setting, and your understanding of these experiences. I will also ask you about demographic information in survey format which will take approximately 10 minutes to complete.

I will take notes during the interview, and ensure your privacy by assigning numeric codes to each subsequent transcript, removing names and locations from the transcript. I will keep the information in a locked drawer for three years, consistent with federal regulations, after which the material will be kept secured or destroyed.

There will be no financial benefit for this study, however, I hope it will allow you to share your experience of how the practice of physical restraint impacted you as an adolescent with a prior

trauma history. In addition, it is my hope that this study will provide mental health practitioners with some insight into how physical restraints are experienced by their adolescent clients, and into the efficacy of using physical restraint with adolescents who are traumatized.

There are some potential risks of participating in this study. The interviews may bring up painful feelings related to your experiences. If at any time during the interview you do not want to answer a question, you have the right to refuse to do so without repercussions of any kind. A list of referral sources are included should you wish to utilize them.

You have the right to withdraw from this study at any time: before, during or after the interview, until April 23, 2004. Once again, you may choose not to answer any questions during the interview without repercussions of any kind. Thank you!

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

Signature of Participant

Date

Signature of Researcher

Date

IF YOU HAVE ANY QUESTIONS OR WISH TO WITHDRAW YOUR CONSENT PLEASE CONTACT:

Cheryl Alexander
Valley Psychiatric Service. Inc.
511 East Columbus Avenue.
Springfield, MA 01105

413.827.8959 X 380
calexand@email.smith.edu

Please keep a copy of this form for your records.

Community Referrals

Lighthouse
1401 State Street, Springfield
413.736.8974

Crisis Telephone Numbers:
Springfield: 413.733.6661
Holyoke: 413.536. 5473
Westfield: 413.568.6386

Freedom Center
413.582.9948
www.freedom-center.org

Helpline
184 Mill Street, Springfield
413.737.2712

National Alliance for the Mentally Ill (NAMI)
(Special Support Center)
703.524.7600
www.nami.org

National Empowerment Center (Massachusetts)
599 Canal Street, 5 East, Lawrence
1.800.power2u
1.800 TTY-POWER (TTY)
www.nec.org

First Call for Help
Amherst - 413.256.0121
Greenfield - 413.774.2318 X108
Worcester - 508.755.1233

Social Work Therapy Referral Service (Massachusetts)
1.800.242.9794
www.therapymatcher.org

Men's Resource Center of Western Massachusetts
236 N. Pleasant Street, Amherst
413.253.9887

School Street Counseling
33 School Street, Springfield
413.846.4300

Community Care Mental Health Center
273 State Street, Springfield
413.736-3668

Pioneer Valley Mental Health Clinic
110 Maple Street, Springfield
413.734.3151

River Valley Counseling Center
303 Beech Street, Holyoke
413.534.6836

Appendix E

Human Subject Review Approval Letter

