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The Therapeutic Value of Using Physical Interventions to Address Violent Behavior in Children

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A quick review of the published information on physical interventions over the last three years would seem to indicate that a fundamental and universal shift has occurred, away from the use of therapeutic restraint, as well as the use of seclusion, to address violent behavior in children. However, this is somewhat deceptive. Treatment environments have been faced with increasingly violent and assaultive children in a continuing trend that was identified a decade ago (Bath, 1992; Crespi, 1990). This challenge must be considered along with the fact that young children most often present violent behavior in treatment settings (Miller, Walker & Friedman, 1989). Unlike the impression given by recent media, the reality is that most treatment centers for young children use physical interventions to address violent behavior in a safe and effective manner. It is true that physical interventions have been the subject of substantial training to insure they are done according to national crisis management guidelines, but it is not true that the mental health community has abandoned physical interventions for violence.

It is important to clarify the interchangeable terms therapeutic holding and physical restraint. This physical intervention is when a trained adult stops a child from hurting self or others by using approved crisis intervention holds to protect the child until the child is no longer a danger. There are a variety of approved holds but all of them restrain the child from being violent and causing damage to self or others. A distinction must be made between the type of holding discussed in this article and "holding therapy," which is a physically intrusive method to produce a crisis in a child and force the child to experience physical or psychological pain. Holding therapy and other similar intrusive techniques are not sanctioned by any legitimate professional organization and in the opinion of the authors are not therapeutic and are not valid psychological treatment.

There is increasing pressure on these programs to become restraint and seclusion free, but is this direction in the best interests of the children? The answer will emerge only after a dialogue of the valid points on both sides of this issue, but to date only one point of view has been advanced. The purpose of this article is to provide another perspective on this issue, one that has not been previously put forward.

A variety of interventions have been used over the years to address violent behavior among children and adolescents (Troutman, Myers, Borchardt, Kowalski & Burbrick, 1998). In settings such as psychiatric hospitals and treatment programs, two of the most frequently used interventions are therapeutic holds (also called therapeutic restraint) and giving the individual a chance to regain self-control in a seclusion or quiet room. Interventions less often used to address violent behavior are mechanical restraints and using medications for chemical restraint (Measham, 1995). Over the last ten years the latter two interventions, mechanical and chemical restraint, have been criticized as excessive and too restrictive. Mechanical and chemical

restraints have declined in some programs and have been eliminated in others, particularly in non-hospital settings.

More recently, in the last three years, restraint and seclusion have been the subject of considerable controversy. A host of arguments have been presented against the use of restraint and seclusion to address violent behavior in children (Wong, 1990). Most notable was an investigative series in a Connecticut newspaper, the Hartford Courant (Altimari, Weiss, Blint, Pointras, & Megan, 1998). This expose of injuries and deaths reportedly caused by the use of restraint and seclusion is often credited with starting the current wave of criticism for the use of restraint and seclusion. This controversy has run the gambit from media coverage to policy change and new federal legislation.

The array of criticism directed at the use of restraint and seclusion has one glaring absence, a review of the therapeutic benefits of physical holds to address violence among children. Although seclusion is often used interchangeably for therapeutic restraint, the two are very different interventions bringing up very different issues. The focus of this article will not be seclusion, but rather a review of the therapeutic components of physical restraint.

Before addressing the potential therapeutic components of physical restraint, it is important to briefly consider the most frequent criticisms of using this intervention. A recent nationally published article is a good example of the criticism being directed at the use of physical restraint (Kirkwood, 2003). The article calls restraint violent, dangerous, and even potentially deadly to children. The point is made that this intervention can actually cause further trauma due to concerns such as counter-aggression by adults and repeating abuse the child has experienced in the past. Restraint is called a violent means to maintain control and “rule over” children. Rather than use physical restraint, the article recommends negotiating with the child, understanding the reasons behind the behavior and giving the child choices. Some critics have gone so far as to say a physical restraint should be avoided at all costs and any use of physical restraint is a treatment failure.

In the face of such harsh criticism, is there any defense for physical interventions such as restraining violent children? The authors believe there is, but the starting point of discussing the therapeutic components of physical restraint must begin with an acknowledgement that even good interventions when done poorly, or at the wrong time, lose some or all of their therapeutic value. Rather than an indictment of all physical interventions, the criticisms outlined in the article mentioned above can serve to improve the quality of physical restraint and, for that matter, all other behavior management.

All behavior management can become ineffective, demeaning and even psychologically damaging if done poorly. It is safe to say that using a violence intervention to “rule over” children is poor behavior management. Like other types of behavior management, if physical restraint is done in a violent and dangerous way, it may be possible to replicate the past abuse of the child, at least in the child’s mind. However, physical restraint is not step one of any intervention with a child. Physical restraint should not be a shortcut to taking the time to understand the child and the reasons behind the child’s behavior. Restraint is also not the opposite end of the continuum from appropriate negotiations and setting out clear and

meaningful choices. Physical restraint is properly used only when the adult is trying to understand the child and other limit setting techniques have failed to safely address the violent behavior of the child. Interventions are also not therapeutic when they are based on a power struggle or when the adult is out of control. Any behavior management approach loses its therapeutic value if used to merely control the child without supporting and understanding the child's thoughts, feelings and goals for the behavior. This is true for all behavior management interventions such as: time outs, logical consequences, giving choices, negotiating as well as physical restraint. It is not necessarily the technique that makes an intervention therapeutic, it is more often the when, how, why and by whom the technique is employed that makes the difference.

If physical restraint is a legitimate part of any behavior management plan, it must have the potential of therapeutic value when used appropriately. Among nationally recognized crisis behavior management systems there are clear guidelines as to the appropriate use of physical restraint. Behavior management systems such as Crisis Prevention Institute (CPI) and Professional Assault Response Training (PART) are two well known examples. Both outline the safe and effective use of physical interventions after crisis de-escalation techniques have been used to address the situation.

National accreditation organizations such as the Council on Accreditation (COA) and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) sanction the appropriate use of physical restraint. If any legitimate organization were to declare physical restraint a "treatment failure," an expression currently being used by opponents of physical interventions (National Technical Assistance Center for Mental Health Planning, 2002), one would expect it to come from entities that hold organizations to the highest standards of the industry, and yet all major national accrediting bodies sanction the use of physical interventions. It is difficult to find any national professional organization, such as the American Academy of Pediatrics, that does not agree with the general statement, "Restraint and seclusion, when used properly, can be life-saving and injury sparing interventions" (American Hospital Association and National Association of Psychiatric Health Systems).

Here are some of the reasons why physical restraint, when done well, can be an important, effective and therapeutic intervention to address the violent behavior of children.

- ♦ Physical touch can be very therapeutic to children, particularly in a crisis. Long before a child learns English, Spanish or Swahili, the first language a child learns is the language of touch. Touch is considered a basic need for all children. When a young child is frightened, the first instinct is to hold on to a trusted adult. Children who demonstrate serious acting out often do not know how to ask for what they need, yet supportive, firm, and safe physical touch can give a child a message of reassurance. If touch is poorly used, such as slapping or striking a child, the message of such a touch can be very frightening. When a young child is in a crisis situation, touch can be one of the most reassuring interventions when the touch lets the child know that the adult will insure the situation will be managed safely for everyone.
- ♦ Emotionally defended children can become psychologically more real and available after an emotional release during a physical restraint. This dynamic is not restricted to children. It is often when our emotions overwhelm us that we open to learning something new that we have

defended ourselves from. There is a parallel in psychotherapy to this dynamic when a client has a difficult but insightful experience that usually includes being catapulted beyond the individual's ability to keep out important information. For some children it is difficult to get to this place without some form of emotional meltdown that often accompanies a physical intervention.

- Children need to know the adult will insure everyone's safety. The adult is responsible to insure the child cannot hurt him or herself or others, if other management methods fail, physical interventions are important. The adult cannot put the responsibility on a child to regain inner control once it has been lost. The amount of time it takes for any crisis situation to be under control, during which time chaos reigns, is the amount of inner fear the child has. Children can regain their footing, but the assistance from a supportive adult can be critical.
- Young children with emotional disturbances need and often seek closeness with adults and violence is less threatening than other forms of intimacy. Behavior cannot always be taken at face value with children who experience violent rages. In fact, these children can often act counter-intuitively. They can push you away when they want closeness, they can strike at you when they are beginning to care about you, and they can act in ways to receive reassuring touch by becoming aggressive and violent to self or others. It is important to understand why a child is acting the way they are. At times, a frightened child seeks and needs the reassurance of physical touch when they can't allow themselves to ask for physical comfort. It is often trusted adults that young children become violent with, because they know they are safe and they will get the reassurance they need. If they do not find the physical reassurance they need and seek, they will often raise the level of acting out until they get it.
- Physical restraint is the surest and most direct way to prevent injury and significant property damage when the child loses control. The above referenced article in Children's Voice (Kirkwood, 2003) begins with a description of a child doing significant damage to a car with a rock. In this example the adults stood by and did not stop the child and the author called this a better, however more costly, intervention. This seems to defy common sense. Would any parent stand by as a child does thousands of dollars in damage to the family car? Recently, a child in our program picked up a rock, ran around a new car and heavily scratched it to the amount of $2,650 damage. Afterward the child felt badly for such out of control behavior and said good kids do not do such bad things. It is important to understand that kids, as well as adults, view themselves in relation to their own behavior. It only makes sense from a practical and therapeutic perspective to stop children from hurting others and doing damage they will use to feel worse about themselves. Physical interventions may be the best way to insure this.
- Traumatized children must learn that emotionally charged situations and all physical touch does not end in being used or abused. The human being has several types of memory, including factual (explicit), subjective (implicit), emotional, experiential and body memories (Ziegler, 2002). Early experiences of touch can establish a lifelong trajectory of meaning attributed to physical touch. It is common that children with emotional disturbances have difficulty with caring touch. Body memories need to be addressed while the child is still young or the child can avoid the very closeness they need. Abused children learn that when someone gets angry someone else gets hurt. Supportive physical restraint retrains the body not to fear touch from others.

- An intervention considered to be good parenting is likely to be good psychological treatment. Psychologists, family therapists and parent trainers would all call stopping a child from running into a busy street good supervision and effective parenting. They would also recommend a parent prevent an older and much larger sibling from physically harming a younger sibling. It is not hard to imagine the same parenting consultants suggesting that when an angry child is heading for the family car with a baseball bat, that the bat be taken away before the damage occurs. If these parenting interventions would be basic common sense to most everyone, why would some call these same interventions unhelpful and non-therapeutic to children with serious anger problems?
- Children with emotional disturbances need the assurance that adults are safely and appropriately in control of the environment. Serious acting out such as violence is often seeking this assurance. Most emotional problems in children have their source in chaotic, abusive and/or neglectful home environments at some point in the child's life. To be in a home where the adults are not in control of themselves or the environment is like going down the road in the back seat of a car with no one driving, it is terrifying to a child who has been there. These children often push a new environment to the point that the child finds if the adults can safely and appropriately manage the challenges. Often when the child has such reassurance and can rely on others for basic needs, he or she can once again get back to the task of being a child.
- Treatment programs are responsible for directly addressing violent behavior and not just skillfully preventing the behavior from presenting itself during treatment only to reappear in the home or community after treatment. The argument that all physical restraints can and should be avoided at all cost may address the principle of prevention, but misses the point of treatment. In the extreme, all physical restraints could be avoided, this simply requires an adult to passively stand by and allow a child in a rage to do whatever he or she wants to do. One may call this "preventing" a restraint, but how did it address the responsibility of a treatment program to treat and extinguish serious violent and antisocial behavior? The role of prevention and treatment are quite different. Not intervening when a therapeutic response is called for is not so much prevention as it is abdicating adult responsibility. If someone needed treatment for a debilitating phobia of spiders, the symptoms could be prevented by having an insect free environment, but this would not be treating the phobia. Programs charged with treating violent behavior cannot simply insure that the symptoms never come up in the treatment environment because they will surely resurface once the child leaves that setting. In psychological terms, treatment often requires steps such as re-exposure to stimuli, cognitive reprocessing, skill development, practice and mastery, none of which have an opportunity to happen if preventing symptoms or preventing a particular intervention at all cost is the goal.

Are therapeutic benefits guaranteed by the appropriate use of physical interventions? No intervention comes with a guarantee. However, as one side of this debate offers sensational media stories and points to abuses of physical interventions (and there have been abuses), there exists research and professional literature that has found therapeutic value in physical restraint when used properly. Restraint has been found to shorten the crisis over other interventions (Miller et al., 1989). Research studies have found physical restraint effective in reducing severely aggressive behavior, self-injurious behavior and self-stimulatory behaviors (Lamberti & Cummings, 1992; Measham, 1995; Miller et al. 1989; Rolider, Williams, Cummings & Van

Houten, 1991). Physical restraint has been found helpful in treating aggression with dissociative children (Lamberti & Cummings, 1992). Physical interventions have also been recognized in the role of re-parenting children who have not been taught limit setting due to absent parenting (Fahlberg, 1991). Physical restraint has been called an effective intervention to protect the child and others from harm and prevent serious destruction of property (Stirling & HcHugh, 1998).

A frequently cited criticism of restraint is that it takes away the ability of the child to learn and internalize self-control. However, research studies have found the opposite. In two studies nearly a decade apart, physical holding produced rapid gain in internal behavioral control (Miller, Walker & Friedman, 1989; Sourander, Aurela & Piha, 1996). Physical restraint has been called ethically sound (Sugar, 1994) and recognized for significant therapeutic benefits (Bath, 1994).

The arguments for and against the use of various interventions such as medications, institutionalization, physically intrusive therapies, seclusion, and physical restraint are important discussions. However, children are not served when only one point of view is expressed. Many interventions, including physical restraint, can have damaging consequences when improperly used, however, at times the consequences of not using serious interventions can be even more damaging to a child. A five-point evaluation of interventions for violent behavior has previously been recommended (Ziegler, 2001), 1. Was safety insured? 2. Was self control internalized? 3. Was the intervention individualized and based on understanding the child? 4. Was the intervention therapeutically driven? and 5. Was the intervention effective in producing the desired result?

If we are to meet the challenge of increasing numbers of violent children in our system of care, we must carefully consider how we can best meet the short and long term needs of these children, while insuring the safety of other children, their parents, and the community at large. A reasoned approach to this question would be careful consideration of all the issues and not a singular movement to reduce or eliminate physical interventions, which have been found to be safe, ethical, effective and therapeutic.

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