

THE IMPACT OF RESTRAINT ON SEXUALLY ABUSED CHILDREN AND YOUTH

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Abstract

Two outcomes of child sexual abuse have been well researched and documented. For many children, the experience is a traumatic one and results in clear symptoms of post-traumatic stress disorder. Many other children, and sometimes the same children, evidence what is referred to as “abuse-reactive disorders”, including learned helplessness and compensatory reactions. Both of these outcomes and symptom patterns are exacerbated by either being restrained and witnessing the restraint of others. In this article we examine some specific features of post-trauma responses and how restraint affects such children/youth. With increased sensitivity to these issues, it is hoped that youth and child care workers will become more reluctant to restrain and seek more creative options for intervening with violent behavior.

The entire “helping” profession is experiencing a dramatic challenge with regard to the practice of client restraint, due to the effects of physical restraint on clients of all ages and disabilities. Dramatic meetings on the national level, significant policy changes within many agencies and organizations, and the “smell of change” in the wind is causing many who work with abused, troubled, disadvantaged, and mentally ill people of all ages and in many kinds of settings to face serious challenges to business as usual with regard to using manual and mechanical restraints to interfere with client attempts to harm themselves or others. The shameful number of client deaths, injuries to both staff and clients, costs of workman’s compensation claims, and risks of legal actions following harmful restraints, are causing both internal and external “powers that be” to seriously consider limiting the ability of professionals and para-professionals to lay hands on clients to force them to stop intended activities. Much is being written and discussed these days, approaching the issue from a variety of angles and viewpoints.

I would like to suggest that one way to reduce the amount of physical restraint in a treatment program is to encourage staff to view restraints from the clients point of view. It is customary for practioners to view restraint as a “necessary” intervention to prevent harm. As long as workers with the troubled and troubling populations view restraint as necessary, the practice is likely to continue despite efforts to reduce or eliminate it as commonplace. Perhaps learning to see how being restrained, regardless of the justification, impacts those who have already been controlled in hurtful ways can give those tempted to intervene in such a controlling way enough pause to allow consideration of other, equally safe and helpful, and definitely more “therapeutic” interventions. It has been proven that in organizations that either prohibit restraints, or that consistently view restraint as a “treatment failure”, staff who have the restraint “hammer” removed as an option find other ways to pound the nail! That is, creativity of staff is seriously limited by giving them restraint as an option, causing them to view it as an unavoidable intervention. When that option is removed, either by policy or by staff commitment to intervene

in other, more therapeutic ways, we find that safer methods are invariably found to keep children and staff safe. Many treatment facilities and mental health hospitals have been able to document dramatic reductions in client restraint after program re-design and intensive staff training.

In those circumstances where restraint cannot be avoided because the risk of restraining is outweighed by the risk of not restraining, an understanding of the impact of either being restrained, or watching another child/youth being restrained, can assist staff in understanding and intervening with those children/youth in more therapeutic – i.e. healing – ways after such an incident. Thus, careful contemplation of restraint from a child/youth's point of view can help both to avoid unnecessary restraints, and to facilitate helpful interventions after restraints.

For purposes of our consideration here, we will focus specifically on the impact of being physically held and restrained on children who have been sexually abused. We can note that the impact is similar for adults with histories of sexual abuse.

In any treatment facility - residential programs, day treatment programs, special education schools, youth correctional facilities - there are two groups of children/youth who have been sexually abused. One group are those who have been identified either by referral material, or by self-disclosure. There is always a second group, some may even wonder if it's the larger group, of children/youth who have in the past experienced sexual violation and for all the reasons we now understand have not yet disclosed such abuse. Both of these groups of children/youth will have very particular responses to either being restrained or watching restraints that can be understood using two frameworks. The first is to view youth responses through the Post-Traumatic Stress Disorder symptom model, the other through the Abuse-Reactive framework.

Children/Youth who have experienced “traumatic” sexual violation

Many of the “traumatic” components of sexual abuse are stirred up during restraint episodes. While all of the components play out in treatment settings, and will need to be addressed in various formats, we will note here just those aspects of sexual abuse that cause internal distress for youngsters during restraints. One of the most important aspects of sexual abuse for children is a fact that is too frequently obscured by the language of denial and minimization often used even by those of us trying to help these children recover from the trauma of their experiences. I'm not sure who or when someone decided to use the term “molest” to describe sexual abuse, but it has been a great disservice to those children who have been sexually violated. According to the dictionary, to molest means “to bother”. Calling someone who forces children to have sex a child “molester” implies only that s/he “bothered” a child. If we stay distanced from the actual experience of sexual victimization, we risk either not noticing, or not understanding, the symptoms of such victimization that indicate how deeply a child/youth has been wounded. On the other hand, if we read the DSMIV definition of a “trauma” we see that all, or almost all of the components apply. The DSMIV says that a “trauma” involves four responses: intense fear; helplessness; horror; and mental disorganization/agitation. Thinking of children who have been sexually abused, often from a very young age, we see that all of these responses are typical, rather than unusual. Because both the sexual experience and the context in which it occurs is more often traumatic than not, sexual and other symptoms begin to display themselves in one or all of the three categories of symptomatology outlined. Sexually abused children frequently

display symptoms in the categories of re-experiencing, avoidance, and arousal. Each of these symptom categories is more likely than not to be stimulated during a restraint episode, whether the child/youth is being restrained, or watching another child being restrained.

Before we move into specific considerations of each category, let's take a minute to review some other pertinent aspects of trauma which impact children's experience. First, the criteria for labeling an experience traumatic involves the four features outlined and one of four experiences: 1.) Actual or threatened death or serious injury; 2.) threat to one's physical integrity; 3.) witnessing an event that involves death, injury or a threat to the physical integrity of another person; 4.) learning about unexpected or violent death, serious harm or threat of death or injury experienced by a family member or other close associate. Using these objective criteria, we can easily see that a good number of child clients being treated in child serving facilities have had experiences in one, two, three, or all four of these definitions!

We know from hearing from women who have been raped that often such a sexual encounter is experienced more as "murder" than sex! Most women who are raped believe that they are also being killed. With children, the fact that they often bleed during sexual rape often causes them to fear death as well. Further, similar to adults who are raped, a vast majority of sexual abuse victims are threatened with death – to themselves, family members, or pets – or other physical or emotional injuries as a way to keep them quiet after the assault(s). This terror, of course, not only serves to keep the secret safe for months or even years, but serves to fulfill the criteria for "trauma". That is, not only is the sex often traumatic, so is the secret and the conditions under which it is kept! Such violation of one's body also fits the second criteria of damaging one's physical integrity. Some of our children have also witnessed violence against others in their homes – the abuse of siblings, or in cases of domestic violence, the abuse of their mothers. All of these experiences apply to the possibility of having a traumatic response to restraint in a facility where either the child him/ her self may be subject to restraint, or may witness a restraint, or learn about the restraint of another peer.

The literature also reminds us that there are different trauma "types": A "type 1" trauma is exposure to such an experience as outlined above one time; a "type 2" trauma is repeated exposure to such experiences. We know that while women who are raped are usually raped only once, children who are sexually violated are most often exposed to such an experience many times. This renders our children more like soldiers than like car accident, earthquake, or rape victims. This helps to explain why their symptoms are so often quite blatant and difficult to extinguish. All of this must be kept in mind when trying to understand the reaction of sexually abused children to situations where restraint occurs.

Re-experiencing responses

Reviewing the five possibilities for this category of post-trauma responses, we see that quite a few might be operating during restraint episodes. First, recurrent and intrusive recollections of the traumatic event tend to cause inadvertent stimuli to produce a sexual image. For example, a child/youth sees a banana and "plays" at masturbating it; a hot dog is taken from the bun and the child begins to felate it; discussions about almost anything wind up taking on sexual connotations regardless of how removed from sex the subject might be. Workers in treatment

facilities have often experienced such symptoms (much to their chagrin). It is therefore important to keep in mind that if a child/youth has displayed such inability to screen out sexual imagery on other occasions, it is very likely that this same mental distortion will occur when s/he witnesses or feels adults straddling, laying on top of, next to, against him/her self or another child. We see restraint; the child/youth sees sexual violations. This is not something that is done on purpose, to challenge and annoy us, but to let us know that the child is suffering and has not recovered from an experience. It is also true that “flashbacks” often occur during experiences that are close to the earlier victimization, causing dissociative states, illusions, and hallucinations. The DSM tells us that “in young children, trauma specific reenactment may occur”, which may explain why children in restraints often accuse staff of rubbing against them, or worse, or may even begin to initiate sexual conversation during a restraint. We also know that “intense psychological distress and reactivity at exposure to **internal or external** (italics mine) cues that symbolize or resemble an aspect of the traumatic event” are a classic PTSD response. The learning point here, of course, is that what staff think is happening is not what the child/youth thinks is happening. The young person will react not to the reality of the situation, but to **their** internal reality. Thus, while staff are speaking soothing words about keeping the child safe, the child may not even be able to hear what is being said but is instead “re-living” his/her earlier traumatic experience of being sexually violated by adults. This is but reason that some Crisis Intervention programs strongly advocate against one-person restraints, since these cannot be done without holding the child close against one’s body, increasing the chance that the child/youth will have a re-experiencing event. This particular symptom also explains what are sometimes referred to as “false accusations” against staff where a child says that they did something sexual during the restraint. This is also hard to “disprove” when one was alone.

Avoidance responses

The second category of symptoms has to do with “persistent avoidance of stimuli associated with the trauma, and the numbing of general responsiveness”. In this case, the child either mentally or literally attempts to avoid the situation which would cause emotional distress. The young person may deny what is happening, or if it is happening to another child may either go into a dissociative state where s/he will be unaware of what is happening, may run and hide somewhere in the facility, or may run away from the facility. Thus, during a de-briefing with those clients who were not directly involved in the restraint, a particular child/youth may state that they did not see such a restraint, even though they have been in the immediate area. Such a denial should prompt staff to understand that the distress caused by the restraint event was too much for the child/youth to tolerate so they “left” the situation mentally. The “numbing” aspect of the symptom may cause additional concern since the child/youth may be unaware of physical injury being sustained during the restraint, and may report that they are okay when in fact they are being harmed. Psychic numbing is a defense mechanism that is sometimes used by victims of sexual abuse in an effort to avoid the feelings of guilt and shame being produced by the sexual encounter. When a client has been subjected to repeated sexual abuses this may become a patterned response to either being touched or to sexual-like situations (sometimes producing “frigidity” in adult survivors). A milder form of this symptom may be noticed when a child refuses to engage in any kind of post-restraint debriefing and discussion. It may also serve to “fool” some naïve staff who may think that because the child/youth does not report or evidence any deep distress that they are not experiencing any. This will cause the child/youth to not

receive the interventions they need to work through the exposure to yet another traumatic experience. The adults may be experiencing no distress at all and see the restraint as business as usual, and miss the child/youth who is experiencing significant symptoms of avoidance.

Arousal responses

The third PTSD symptom category is that of persistent symptoms of arousal, evidenced frequently by levels of hyperactivity that mimic ADHD, difficulty with falling or staying asleep, irritability and outbursts of anger, difficulty concentrating, hypervigilance, and an exaggerated startle response. We are told that “intense psychological distress or physiological reactivity often occurs when the person is exposed to triggering events that resemble or symbolize **an aspect** (*italics mine*) of the traumatic event. Thus, the close physical contact either felt or witnessed can cause the child to react as if s/he was being sexually victimized all over again.

We can see how these categories may not occur in an isolated fashion, but may feed into each other, causing a child/youth to experience a number of simultaneous symptoms during a restraint event. The hypervigilance makes the child particularly sensitive to people touching him/her, and this may then stimulate a re-experiencing event. Afterwards, the tendency to mentally avoid the event will be attempted, but may manifest in serious ways, such as thinking about suicide as a way to avoid such experiences from happening again.

Abuse-reactive responses

Consideration of the presenting problems of children/youth needing therapeutic services reveal that even those abused clients who do not evidence overt symptoms of post-traumatic stress disorder often display symptoms related to significant “power and control” issues. For these youth, past experiences of being controlled in harmful and frightening ways, and being on the wrong end of the mis-use of power, causes them to have very severe reactions to situations in which others try to control them. These reactions can be unhealthy in one of two extreme ways, neither better than the other. A significant amount of research has been done in the area of “learned helplessness”, documenting the dysfunctional response to prolonged situations of abuse in which a child/youth becomes so accustomed to being controlled that they only feel comfortable in situations where they are being subjected to hurtful control. These are the compliant girls or boys, doing very well on the level system, doing what is expected by staff, while at the same time attracting and attaching themselves to abusive girl or boyfriends. Research indicates that this pattern foretells a likelihood of becoming tomorrow's battered woman or mistreated man (but that was another article). These children/youth are unfortunately quite docile about being restrained, and may even solicit such an intervention since it fits into their “scheme” of how life works, i.e. other people control you and there's nothing you can do about it. The opposite extreme reaction, stemming from the same source of distress, is that of refusing to comply with even simply requests to avoid feelings of being controlled, or becoming involved in relationships with “helpless” others to feed one's feelings of power. Staff can sometimes become unwitting partners in this destructive dyad. In this situation, staff may define violent behavior as “out of control” behavior, when in fact the child/youth is engaging in quite deliberate “in control” acts of violence in an attempt to get others to respond. When a restraint is initiated in response to such behavior, while the adults may feel and believe that they are controlling the

child/youth, the young person feels that they, in fact, are controlling the adults by forcing them to “stop them”. This dynamic runs completely counter to the goals of empowerment which is, after all, the ultimate goal of any good treatment program. When we “force” compliance with restraint, we ultimately re-enforce the unfortunate view that one gets what one wants by using control, intimidation, and physical strength – exactly the lesson the child/youth learned while being sexually abused. Then, rather than providing an alternative model of healthy negotiation, therapeutic assistance, and “self-control”, we demonstrate the identical characteristics of the child abuser, forcing compliance with intimidation and dominating strength.

Both the Native Americans and the psychologist Carl Rogers have counseled about the enormous benefit of “walking a mile in another person’s moccasins”, or extending “empathy” to one who is hurting. Hopefully, our willingness to look at restraint of previously abused children and youth from their point of view, putting ourselves in their shoes, as it were, will be helpful in reducing and possibly even eliminating the practice of forcible physical restraint to change potentially violent behavior.

Transforming our thinking and expectations

When I talk to parent groups about the practice of hitting (“spanking”) children and outline the many ways in which such behavior is harmful to children, it is common to hear phrases such as “that’s the only thing she understands” and “it’s the only way he’ll stop”. In other words, people who hit their children are often completely convinced that it is a “necessary” intervention. Of course we know that parents who have decided not to hit their children are not raising out-of-control brat children who are completely unruly. What happens, instead, is that parents committed to non-violent child rearing find other methods of helping children choose acceptable behavior. It is my conviction that the same is true of those of us engaged with more challenging children/youth. Once we commit ourselves to non-violent, non-physical means of helping children/youth to choose safe behaviors, we will discover that we can do what sometimes seems impossible. Both we adults and the children/youth we serve discover creative reserves that can be tapped to provide safety to everyone while maintaining an orderly, structured, therapeutic environment in which hurt and hurting children can heal and learn new ways to view themselves, life, and to make choices that serve them better.

I am not so naïve that I believe there are no circumstances in which a specific child/youth may need to be restrained to keep them safe, or even alive. It is not “therapeutic” to allow a child/youth to harm themselves or anyone else. For those rare situations when there truly is no other way to protect those we care for, other than to restrain them, we will serve them most lovingly when we remember the kinds of experiences that bring them to us. Keeping these thoughts in mind as we attempt to protect, and to heal will undoubtedly allow us to create alternative interventions which honor their history and respect their dignity. Thoughtfulness, after all, is a way of loving.

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