The widespread use of seclusion and restraint in child psychiatric hospitals to manage aggression and noncompliance is based on the assumption that coercive consequences reduce the frequency of undesirable behaviors exhibited by the patients. We report a study of the use of seclusion and restraint in a public child psychiatric hospital during a 3-year period. Twenty-eight percent of the patients had been secluded or restrained a total of 1670 times. About 25% of these patients had been secluded more than five times during their hospitalization, and 32% had been placed in restraints more than once. Behaviors that typically resulted in repeated seclusion included physical aggression toward staff, verbal aggression toward peers, non-compliant or oppositional behavior, and self-harm. Variables that predicted patients most at risk for repeated seclusion included age, gender, and psychiatric diagnosis. The predictor variables for those most at risk for repeated restraint included age, property destruction, and self-harm. The high rates of use of seclusion and restraint suggest that these methods for controlling the behavior of children and adolescents in this child psychiatric hospital may not have been therapeutic. We suggest that staff in such hospitals engage in a pattern of behavior characterized by an aggression-coercion cycle, in which increasingly aggressive and coercive behaviors are exhibited by both patients and staff.

KEY WORDS: seclusion; restraint; coercion; aggression; child psychiatry.
The widespread use of seclusion and restraint to manage aggression and non-compliance in child psychiatric hospitals (Fassler & Cotton, 1992) is based partly on the long held and largely unchallenged assumption that coercive interventions, which impose control through force or pressure, effectively reduce patients' aggression and lead to more adaptive behavior (Cotton, 1989; Gutheil, 1978). However, counter-aggressive or coercive staff interventions may not necessarily produce the desired effects and, in fact, may paradoxically maintain and exacerbate undesirable behavior in institutionalized or hospitalized patients (Garrison et al., 1990). For example, Natta et al. (1990) showed that punitive staff interventions were reliably associated with an increase in subsequent negative child behaviors. Their findings support Patterson's (1976; 1982) contention that children are trained in coercion via membership in systems in which negative behaviors are mutually reinforced. Patterson (1976) described a family cycle in which the children, when confronted by coercive parents or siblings, either adopt a submissive stance (thereby demonstrating that coercion is a successful strategy), or increase the rate and intensity of their misbehavior and perpetuate an extended interchange of increasingly intensified coercion. Similarly, Patterson and Forgatch (1985) reported that in their study of therapist-client interaction, punitive staff behaviors significantly increased the likelihood of clients' non-compliance, while positive staff behaviors significantly increased the likelihood of compliance.

Wahler and Fox (1981) have suggested that the study of children's socially significant behavior would be enriched by a conceptual and methodological expansion involving investigation of setting events, such as, environmental conditions already in place, or events which may precede or occur at the same time as the behaviors that they affect (Singh & Repp, 1988). This ecobehavioral approach emphasizes the study of individuals within their social and physical contexts and provides a methodology to describe the interactions and interrelationships that occur between individuals, behavior, their physical and social settings, and internal state (Singh & Aman, 1990). Thus, an ecobehavioral approach to the study of setting events related to cycles of aggression-coercion within an inpatient child psychiatric hospital might include consideration of such influences as institutional history, staff ideology, level of family involvement, use of physical space and organizational policy as measures of control, and the rules governing staff-child interactions during episodes of aggression or non-compliance.

While the published literature on aggression management in child psychiatric hospitals is sparse, it does reflect a discernable shift in emphasis from the individual characteristics of aggressive youngsters to an appreciation of the impact of interpersonal and environmental factors on the incidence and