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Abstract

A survey was conducted of opinions of 24 psychologists in South Australia about the intrusiveness of 89 interventions including methods that might be used to reduce challenging behaviour. Interventions arose from a variety of sources, including behavioural psychology and medicine. Interventions might infringe on 8 different rights. Respondents rated the degree to which interventions were perceived to intrude on clients' rights, using a 4-point scale: abusive, very intrusive, intrusive, and not intrusive. A reasonable degree of consistency in ratings was found. Respondents did not rate all interventions that infringed on the same right as being equally intrusive. A number of interventions were rated as being intrusive but not abusive. Intrusive methods may be legitimate if properly authorised. The question arises of how decisions should be made to authorise intrusive methods when clients arc unable to make decisions on their own behalf.

Keywords

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Intrusiveness of Interventions: Ratings by Psychologists

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A survey was conducted of opinions of 24 psychologists in South Australia about the intrusiveness of 89 interventions including methods that might be used to reduce challenging behaviour. Interventions arose from a variety of sources, including behavioural psychology and medicine. Interventions might infringe on 8 different rights. Respondents rated the degree to which interventions were perceived to intrude on clients' rights, using a 4-point scale: abusive, very intrusive, intrusive, and not intrusive. A reasonable degree of consistency in ratings was found. Respondents did not rate all interventions that infringed on the same right as being equally intrusive. A number of interventions were rated as being intrusive but not abusive. Intrusive methods may be legitimate if properly authorised. The question arises of how decisions should be made to authorise intrusive methods when clients are unable to make decisions on their own behalf.

The Australian Society for the Study of Intellectual Disability (ASSID) has published a booklet discussing ethical and legal principles that arise when interventions infringe the human rights of clients (Anderson, 1993). An intervention that infringes or restricts rights is said to be intrusive. The use of an intrusive intervention might be justified if it reduces challenging behaviour. However, questions arise both of how to identify intrusive interventions, and how to authorise the use of an intrusive intervention, especially if clients are unable to make decisions on their own behalf. In Australian law, the use of intrusive methods is legitimate only if authorised using a legally recognised decision-making process (Hayes & Hayes, 1982).

Discussion about methods to reduce challenging behaviour has continued since behavioural psychologists first reported effective methods arising from the principles of learning (Foxx, 1982). Subsequent writers have noted that, once the effectiveness of an intervention is established, questions of social acceptability become important (Butterfield, 1990; Gerhardt, Holmes, Alessandri, & Goodman, 1991; Lennox & Miltenberger, 1990).

Special concern has been expressed about aversive interventions (Guess, Helmstetter, Turnbull & Knowlton, 1987). From a social perspective, an intervention is aversive if it produces objective signs of discomfort such as pain reactions, tissue damage, physical illness, severe physical or emotional stress, or conditions that require medical treatment (Association for Persons with Severe Handicaps, 1986). Several writers argue that aversive intervention should not be used with clients who are dependent on carers, are vulnerable to abuse, and are unable to make decisions about interventions (Harris & Handleman, 1990; Horner, 1990; La Vigna & Donnellan, 1986; Repp & Singh, 1990).

In addition to the concern about aversive interventions, Australian lawyers have expressed concern about interventions that infringe any human right of a client (Cootes, Simpson & West, 1988; Hayes & Hayes, 1982; O'Sullivan, 1983; Simpson, 1987). Under Australian law, any person who infringes a

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right of another person without proper consent is liable to legal action.

Cootes et al. (1988), in a book cosponsored by the Law Foundation of NSW, provided a basis for identifying intrusive interventions. They identified 8 rights that might be infringed by carers using programs aimed at reducing challenging behaviour. Proposed rights involved: *Bodily integrity* or the right to be free from unwanted touch and stimulation; being treated with *Respect* by carers; freedom of *Movement*; being free to *Socialise* with peers and friends; having free *Choice* of activities; having free access to personal *Property*; having the *Privacy* of personal information respected; and being free of *Medication* and drugs.

There has been considerable discussion about interventions involving touch. Some lawyers view any unconsenting touch as being assault because it infringes a right to bodily integrity (Cootes et al., 1988; Hayes & Hayes, 1982; Simpson, 1987). On the other hand, psychological research shows that touch plays an important role in nonverbal communication, and has a positive influence in forming interpersonal relations (Thayer, 1988). Touch can communicate messages of support, encouragement, appreciation, affection, caring, and reassurance. Further, therapists from diverse theoretical backgrounds have defined specific types of touch as being therapeutic if used appropriately. Touch has been shown to calm people who are distressed (Triplett & Arneson, 1979), to provide alternative sensory input for people with severe behaviour disturbances (Jones, 1980), to prompt people to use skills (Foxx, 1982), to assist sensory integration (Ayres, 1972), and to replace maladaptive patterns of behaviour with more appropriate behaviour (Doman, 1974).

Concern about intrusive interventions has not been restricted to those interventions arising from the principles of behavioural psychology. Lawyers express concern about intrusive practices arising from any source, including from medical practitioners who recommend drugs, from physical therapists who recommend equipment such as splints and helmets, and from institutional practices. This produces a need to assess the intrusiveness of interventions independently both of the source of the intervention, and of the reason for using the intervention.

In Australian law, use of an intrusive intervention is legitimate only if it has been approved by a person authorised to give legal consent on behalf of the client. This decision maker resolves whether the proposed intervention is justifiable in the circumstances of the case.

Parents may wish only to be informed about decisions involving discipline of their children, rather than be asked to make decisions themselves (Lusthaus, Lusthaus, & Gibbs, 1981). This leaves unresolved the question of who should authorise the use of intrusive interventions so as to safeguard both clients and therapists.

The ASSID document proposes that different decision-making practices be used to authorise behaviour management programs, depending on the intrusiveness of the intervention. It was recommended that all formal behaviour management programs be recommended by qualified professionals. A decision to implement a formal program would be made either by the client, or by the client's parents or advocate, or by a relevant service manager. If a program involves very intrusive methods, then a decision to implement the program might be made by a legal body, such as a guardianship board or a delegated guardian.

Psychologists have previously examined the acceptability of interventions using two approaches, namely ratings of social acceptability (Blampied & Kahan, 1992; Singh, Watson & Winton, 1987), and hierarchies of restrictiveness (Morgan, 1989). However, as neither approach deals directly with the issue of infringement on human rights, neither approach distinguishes intrusive from nonintrusive interventions.

Ratings of the social acceptability of interventions are obtained by asking respondents to rate the acceptability of an intervention for reducing a specific problem behaviour (Kazdin, 1980a). Respondents are asked to balance the intrusiveness of an intervention against the severity of a behaviour, rather than to judge the intrusiveness of the intervention.

Morgan (1989) provided a critical review of hierarchies of restrictiveness of interventions provided by 5 individual experts. Morgan found differences of opinion between the experts, with experts being unable to agree even on the number of categories required to describe levels of restrictiveness. There was criticism of the approach of using individual opinions instead of the collective judgment of members of a professional group.

The intrusiveness of interventions might be assessed using a scale where respondents rate the degree to which an intervention infringes on a human right. No studies using this approach were found.

The present study aimed to identify the opinions of a group of psychologists about the intrusiveness of a wide range of interventions. The opinions of psychologists or clinical psychologists about intrusiveness are relevant as: (a) some interventions were introduced by psychologists, (b) psychologists are asked to recommend methods for managing challenging behaviour, and (c) psychologists are asked to comment on interventions proposed by others.

Interventions were included that were expected to be rated on each point of a continuum from being abusive to being nonintrusive. Some interventions were included as markers because they are widely considered to be abusive and are not part of any therapy.

METHOD

A questionnaire was sent to 32 senior psychologists in South Australia, under the sponsorship of the South Australian branch of the Australian Behaviour Modification Association. Responses were received from 24 respondents, giving a response rate of 75%

Respondents were asked about the clients they worked with, the reasons why clients were referred to them, and how frequently respondents used behavioural interventions.

The percentages of respondents who reported working with each category of clients were:

- 83% worked with adults
- 67% with families
- 63% with high school children
- 42% with primary school children
- 38% with pre-school children

The percentages of reasons why clients were referred to psychologists were:

- 63% for behaviour problems
- 50% for mental health problems
- 42% for skill development
- 33% for problems associated with developmental disability.

The percentages of respondents who reported using behavioural interventions were:

- 45% "frequently or often"
- 42% "sometimes"
- 13% "rarely or never".

A definition of intrusiveness given on the questionnaire emphasised human rights: "An intervention is intrusive if it limits or restricts what is normally considered a right". A statement was made that rights may be restricted only if adequate reasons are provided in a legitimate decision-making process.

Respondents rated the degree of intrusiveness of each intervention using a 4-point scale: not intrusive (1), intrusive (2), very intrusive (3), and abusive (4).

It is assumed that abusive methods are never legitimate. Intrusive methods may be legitimate if they are authorised using proper decision-making procedures. Nonintrusive methods do not require extraordinary decisionmaking procedures.

Respondents were asked to rate the degree of intrusiveness of each of 89 interventions, which were described by labels and definitions. Labels for interventions are given in Table 1. Definitions are available from the authors. Some illustrative definitions follow. *Touch reinforcer* was defined, "A carer briefly and gently touches a client on a public part of the body (e.g., a hand or shoulder) either to show affection or to reinforce behaviour". *Isolation timeout* was defined, "Following a defined misbehaviour, a client is confined alone into a locked room for a brief period of about 15 minutes, and remains until the behaviour has stopped". *Exclusionary timeout* was defined, "Following defined misbehaviour, a client is removed from a reinforcing environment for a specified period of time, but is not placed into a secure area". *Teasing* was defined, "Someone continually says something to a client which has the primary effect of annoying the person, rather than teaching the person to behave more appropriately". *Restricting access to meals* was defined, "A procedure where carers refuse access to meals at usual mealtimes following misbehaviour such as disrupting a dining room or leaving a dining room".

Interventions were grouped in the questionnaire according to the human right involved, using the categories suggested by Cootes et al. (1988). The numbers of interventions associated with each right were: 32 with *Bodily integrity*, 26 with *Respect by carers*, 8 with *Movement*, 7 with *Socialisation*, 6 with *Choice of activity*, 5 with *Property*, 3 with *Privacy of information*, and 2 with *Medication*. The classification of each intervention is shown in Table 1.

RESULTS

Three measures were used to summarise ratings by respondents: (a) modal rating or rating given by most respondents, (b) mean rating, and (c) per cent of respondents who rated an intervention as being contentious (rating between 2 and 4). Table 1 shows these measures for each intervention.

TABLE 1 Interventions Ranked by Modal Rating, with Mean Rating, Per Cent of Respondents who Considered the Method Contentious, and Right Infringed

INTERVENTION	MODE	MEAN	PER CENT CONTENTIOUS	RIGHT
Abusive				
Corporal punishment	4	3.92	100	Bodily integrity
Strike	4	3.75	100	Bodily integrity
Sexual touch	4	3.70	100	Bodily integrity
Ridicule	4	3.57	100	Respect
Painful stimuli	4	3.54	100	Bodily integrity
Tease	4	3.45	100	Respect
Very intrusive				
Intrude on privacy	3	3.39	100	Privacy
Restrict communication	3	3.04	100	Socialise
Restrict family contact	3	3.00	100	Socialise
Prohibit contact	3	2.96	100	Socialise
Sensory irritant	3	2.92	100	Bodily integrity
Restrictive clothing	3	2.87	85	Bodily integrity
Preventive restraint	3	2.86	96	Bodily integrity
Confine	3	2.83	96	Movement
Custodial care	3	2.79	92	Movement
Secure area	3	2.70	100	Movement
Mechanical restraint	3	2.63	92	Bodily integrity
Water mist	3	2.61	91	Bodily integrity
Physical restraint	3	2.58	96	Bodily integrity
Peer retaliation	3	2.56	92	Socialise
Bodily restraint	3	2.54	92	Bodily integrity
Smack	3	2.54	92	Bodily integrity
Flooding	3	2.50	87	Respect
Isolation time out	3	2.48	100	Movement
Detain	3	2.46	96	Movement
Unpleasant stimuli	3	2.43	76	Bodily integrity
Forfeit property	3	2.33	83	Property
Intrusive				
Punish	2	2.41	95	Bodily integrity
Visual screening	2	2.35	91	Bodily integrity
Negative peer pressure	2	2.33	87	Respect
Flannel	2	2.30	87	Bodily integrity
Public reprimand	2	2.30	87	Privacy
Restrict meal access	2	2.29	91	Choice
Medication	2	2.25	88	Medication
Enter personal space	2	2.25	96	Bodily integrity
Push	2	2.21	91	Bodily integrity
Sensory extinction	2	2.13	87	Bodily integrity
Contingent restraint	2	2.09	83	Bodily integrity
Interrupt sleep	2	2.09	83	Choice
Response interruption	2	2.08	83	Bodily integrity
Negative practice	2	2.04	73	Respect
Stigmatising equipment	2	2.00	70	Respect
Group contingency	2	1.96	80	Privacy
Forced exercise	2	1.96	75	Bodily integrity
Token program	2	1.96	75	Property
Peer assertion	2	1.96	70	Respect
Over correction	2	1.92	83	Respect
PRN medication	2	1.92	62	Medication
Restrict peer contact	2	1.91	83	Socialise
Semisecure area	2	1.91	70	Movement
Response cost	2	1.88	75	Property
Restrict movement	2	1.88	70	Movement
Suspension	2	1.88	58	Choice
Emotional reprimand	2	1.86	68	Respect
Manual restraint	2	1.83	75	Bodily integrity
Lift person	2	1.83	65	Bodily integrity
Group program	2	1.79	56	Respect
Structured program	2	1.75	59	Choice
Required relaxation	2	1.71	59	Respect
Physical correction	2	1.71	58	Bodily integrity
Separation	2	1.67	62	Socialise
Exclusionary time-out	2	1.65	57	Movement

TABLE 1 Continued

INTERVENTION	MODE	MEAN	PER CENT CONTENTIOUS	RIGHT
Intrusive cont'd				
Satiation	2	1.57	53	Respect
Massage	2	1.57	52	Bodily integrity
Nonexclusionary time out	2	1.52	52	Respect
Positive practice	2	1.50	50	Respect
Nonintrusive				
Monetary compensation	1	1.52	44	Property
Posture	1	1.50	41	Respect
Covert sensitisation	1	1.48	43	Respect
Physical guidance	1	1.46	46	Bodily integrity
Desensitisation	1	1.46	37	Respect
Reflect feelings	1	1.46	29	Socialise
Structured day	1	1.42	37	Choice
Ignore behaviour	1	1.39	39	Respect
Calming touch	1	1.35	35	Bodily integrity
Physical prompt	1	1.30	30	Bodily integrity
Self defence	1	1.30	29	Bodily integrity
Joke with person	1	1.26	21	Respect
House rules	1	1.25	25	Choice
Restitution	1	1.25	25	Property
Gesture	1	1.25	21	Respect
Tactile stimulation	1	1.23	23	Bodily integrity
Touch reinforcer	1	1.22	23	Bodily integrity
Reprimand	1	1.22	23	Respect
Firm calm reprimand	1	1.22	17	Respect
Authoritative manner	1	1.17	17	Respect
Correction	1	1.08	9	Respect
Divert	1	1.08	9	Respect
Discrimination training	1	1.08	9	Respect

Interventions were classified into 4 categories according to modal ratings. Six interventions were classified as being Abusive, 21 interventions as being Very intrusive, 39 interventions as being Intrusive and 23 interventions as being Nonintrusive. Classifications of interventions are shown in Table 1.

Interventions classified as abusive had mean ratings over 3.40 and were considered contentious by all respondents. Interventions classified as very intrusive had mean ratings between 2.33 and 3.40, and were considered contentious by between 76% and 100% of respondents. Interventions classified as intrusive had mean ratings between 1.50 and 2.45, and were considered contentious by between 50% and 96% of respondents. Interventions classified as nonintrusive had mean ratings between 1.08 and 1.52, and were considered contentious by between 9% and 46% of respondents. By these criteria, interventions are given similar classifications using modal or mean measures.

Relations between rated degree of intrusiveness and right infringed are shown in Table 2. Of the 6 interventions considered abusive, 4 involved bodily integrity and 2 involved respect by carers. Of the 21 interventions considered very intrusive, 9 involved bodily integrity, 5 involved movement, 4 involved socialising, and 1 each involved respect, property, and privacy. Of the 39 intrusive interventions, 13 involved bodily integrity, 11 involved respect from carers, 4 involved choice, 3 involved movement, and 2 each involved socialising, property, privacy, and medication. Of the 23 nonintrusive interventions, 12 involved respect, 6 involved bodily integrity, 2 involved choice and property, and 1 involved socialisation.

Infringements on 3 rights were always considered contentious. These rights involved movement, privacy, and taking medication.

No strong relation was found between specific right infringed and degree of intrusiveness. Of the 32 interventions associated with bodily integrity, 13% were rated as being abusive, 28% as being very intrusive, 40% as being intrusive, and 19% as being nonintrusive. Similarly with interventions associated with the right to be treated with respect by carers; 8% of interventions were rated as being abusive, 42% as being intrusive, and 46% as being nonintrusive. Infringements on these rights were rated across the full range of intrusiveness from being abusive to being nonintrusive.

The study identified 60 interventions as being intrusive but possibly legitimate.

DISCUSSION

Psychologists were asked individually to rate the degree to which 89 interventions infringe on human rights. Interventions were selected to give examples arising from several sources, including behavioural psychology, medicine, and other sources. Interventions were selected that were likely to fall along a continuum from being abusive to being nonintrusive.

Ratings were summarised using 3 measures. Classifications of degrees of intrusiveness of interventions were similar, using the alternative measures.

The study did not find a strong association between degree of intrusiveness and specific rights infringed. Some interventions that infringed all of the 8 rights were considered to be contentious. At the same time, other interventions that infringed the same rights were rated as nonintrusive. Interventions rated as nonintrusive included some infringements on bodily integrity (physical guidance, calming touch), on property (restitution, monetary compensation), on choice (structured day, house rules), and on respect (reprimanding, using an authoritative manner).

Findings can be compared to opinions expressed by legal commentators. Respondents in this study rated some but not all interventions that infringe on bodily integrity as being abusive. Four types of touch were considered abusive. At the same time, some interventions involving touch were rated as being intrusive, but not abusive. As noted above, a number of interventions involving touch were not considered intrusive, including physical guidance, calming touch, and touch reinforcers.

Some legal commentators have described any intervention that restricts freedom of movement as being false imprisonment (Cootes et al., 1988). In the present study, interventions that restrict freedom of movement were rated as being intrusive, but not abusive. Isolation time-out was rated as being very intrusive, while exclusionary time-out was rated as being intrusive.

The results of the survey can also be compared with opinions expressed in the ASSID document. The present study agreed with the ASSID document that certain interventions are unacceptable. Methods classified as unacceptable by ASSID and as abusive in this study are inflicting painful stimuli, corporal punishment, striking a client, and teasing a client.

The ASSID document identified some methods as being unacceptable, while the criteria applied in the present study classified the methods only as being very intrusive. Such methods included isolation time-out, using mechanical restraint, and restricting access to meals.

The results of the present study can also be compared to studies of social acceptability. Isolation time-out was rated as more intrusive than exclusionary time-out, agreeing with Kazdin (1980a). Painful stimulation was rated as more intrusive than medication, which in turn was rated as more intrusive than discrimination training, consistent with the findings of Kazdin (1980b). Time-out and medication were rated as more intrusive than overcorrection and discrimination training, consistent with the findings of Singh et al. (1987). Medication was rated as

TABLE 2 Numbers of Interventions Rated at Each Level of Intrusiveness, Separated by Rights

	RATED DEGREE OF INTRUSIVENESS				
RIGHT	Abusive	Very Intrusive	Intrusive	Not Intrusive	Sum
Bodily integrity	4	9	13	6	32
Respect	2	1	11	12	26
Movement	0	5	3	0	8
Socialise	0	4	2	1	7
Choice	0	0	4	2	6
Property	0	1	2	2	5
Privacy	0	1	2	0	3
Medication	0	0	2	0	2
Totals	6	21	39	23	89

more intrusive than exclusionary time-out, as was found by Kazdin (1984).

The study represents a step towards establishing normative views of psychologists in Australia about the intrusiveness of a range of interventions. As the study involved a comparatively small group, replication studies are important. Surveys of opinions of people from different professional backgrounds will show whether psychologists have similar views to other groups.

The study identified several interventions rated by psychologists as being intrusive but legitimate if properly authorised. Commentators emphasise the need to obtain formal consent before using intrusive interventions. To achieve this, it will be necessary to clarify decision-making procedures that are suitable for authorising the use of intrusive interventions. In time, information will become available about grounds that have been widely accepted as justifying the use of intrusive interventions.

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