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Body Presence of Public Safety Officers in the Emergency Room and Effect on Pediatric
Psychiatric Patients' Behavior

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Abstract

This paper addresses how the body presence of public safety officers in hospitals affect pediatric psychiatric patients' behavior while in the emergency department of a community hospital.

When speaking of pediatric psychiatric patients, the age range is 4 through 21 years of age. This paper used research on self-regulation, body stance and presence, nonverbal communication and how it played a role into the experience of the pediatric psychiatric patients' behavior. Theories such as Kestenberg Movement Profile and the Laban Movement Analysis are included as well.

Keywords: public safety officers, emergency department, child life specialists, emotional regulation, escalation, body presence

I acknowledge my race and experiences. I am a cis-gender, middle-class, White woman from New England. I live in Massachusetts and had few interactions with non-White peers until attending high school, undergraduate college and post-graduate college. In writing and researching this paper, I consciously sought out work created by Black writers, researchers, and artists to anchor this thesis in the lived experiences of Black individuals and communities.

Introduction

Public safety officers body presence affects pediatric psychiatric patient behavior. A negative or positive stance can shift how patients feel in the moment and may impact their sense of safety. Body language constitutes much of our nonverbal communication as individuals. Approximately sixty five percent of the social meanings of the messages are exchanged with others non-verbally. Human emotions can effectively be transformed through nonverbal communication and are likely to influence others' perceptions. (Subramani, 2010)

Though public safety officers have a different role than traditional police officers, their shared goal is to maintain safety within the hospital including staff, patients, and visitors. It is imperative that public safety officers acknowledge their own body language and non-verbal cues to better serve the pediatric psychiatric population in the ER. From my clinical observation, public safety officers' body language in the emergency department affects pediatric psychiatric patients' behavior and can either be positive, negative, or neutral. Nonverbal communication is the foundation of a successful relationship or encounter between criminal justice personnel and suspects or criminals, as well as being a powerful method that cannot be feigned (Otu, 2015).

Public safety officers' training consists of verbal de-escalation/crisis intervention, HIPAA and privacy laws, security equipment training, active shooter response, use of force and restraints, incident reports, CPR/first aid, infant and child abduction response, firearms training and drug diversion training (Staff, 2019). While integral topics are addressed in the training of public safety officers, there is a lack of body attunement and awareness being taught in the training. Interestingly enough, additional insights from this site include that just under a third of hospital respondents (31 percent) said they are somewhat to very unsatisfied with the amount of

training their officers receive (Staff, 2019). Speculation for the unsatisfied training could be around the missing piece of the body.

American Dance Therapy Association (ADTA, 2022) defines training for therapists as focused on movement behavior as it emerges in the therapeutic relationship. Expressive, communicative, and adaptive behaviors are all considered for group and individual treatment. Body movement, as the core component of dance, simultaneously provides the means of assessment and the mode of intervention for dance/movement therapy.

From the definition of training criteria above, there are similarities in the training that officers and dance movement therapists have such as focusing on relationships whether it be through de-escalation or attunement, however the crucial element missing is the movement behavior and how it affects the relationship between public safety officers and pediatric psychiatric patients.

Emotional regulation is a topic that is brought up when working with children. Emotion regulation consists of the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features, to accomplish goals (Thompson, 1994). Emotion regulation is connected to attentional and stress response systems (Gross, 2007; Shields & Cicchetti, 1998) and the maturation of brain systems involved in emotion regulation is facilitated by the early affective communications of the attachment relationship (Schore, 2000). Overtime, the interactive, dyadic process of emotion regulation becomes increasingly internalized and autonomous (Calkins et al., 1998). This progression illuminates why children raised by caregivers who are unable to soothe their distress, who may be a source of terror, or who are unable to read and respond to their cues have difficulty restoring inner emotional equilibrium (Devereaux, 2008). In the hospital, many of the

children that are in the emergency department as pediatric psychiatric patients have difficulty with self-regulation.

Self-soothing is a skill that takes scaffolding and resilient early childhood providers to teach:

When parents are unable to provide soothing and responsive care-taking, children struggle to learn how to modulate their emotions. Maltreatment exists on a continuum and is addressed in this section from mild to more severe forms. Negative and controlling maternal behavior has been related to poor physiological regulation, less adaptive emotion regulation, and noncompliant behavior in 2-year-old children (Calkins et al., 1998). Another study revealed that children whose parents responded to their negative emotions with harsh coping responses and high levels of personal distress showed fewer negative emotions with peers overall, but occasionally exhibited intense and dysregulated displays. (Fabes, Leonard, Kubanoff, & Martin, 2001)

This was presumably due to having stored and suppressed much of their emotional experiences.

Several other studies have examined the behavioral indices of emotion regulation skills in severely maltreated children. Institutionalized children who spent their first two to four years of life in a residential nursery, where personal relationships between staff and children were discouraged and staff changes were frequent, have presented with atypical emotional developments and attachment difficulties, even after adoption or restoration to biological parents (Tizard & Rees, 1975). Their most common challenges included poor peer relationships, temper tantrums, clinging, and poor concentration. Four- to six-year-old children exposed to early abuse and/or neglect have been shown to exhibit more dysregulated emotion patterns in response to witnessing inter-adult anger

than non-maltreated children (Maughan & Cicchetti, 2002). In six- to twelve-year-old children living in impoverished inner-city neighborhoods, a history of abuse has been shown to predict emotion dysregulation, affective lability/negativity, and socially inappropriate emotion expressions (Shields & Cicchetti, 1998). In another study of maltreated children ages six to twelve years, the children expected less maternal support in response to emotion displays, reported being less likely to display emotions to their mothers, and generated fewer effective coping strategies for anger than a group of non-maltreated children. These studies reveal the profound impact of early maltreatment on childrens' emotional development. (Betty, 2013)

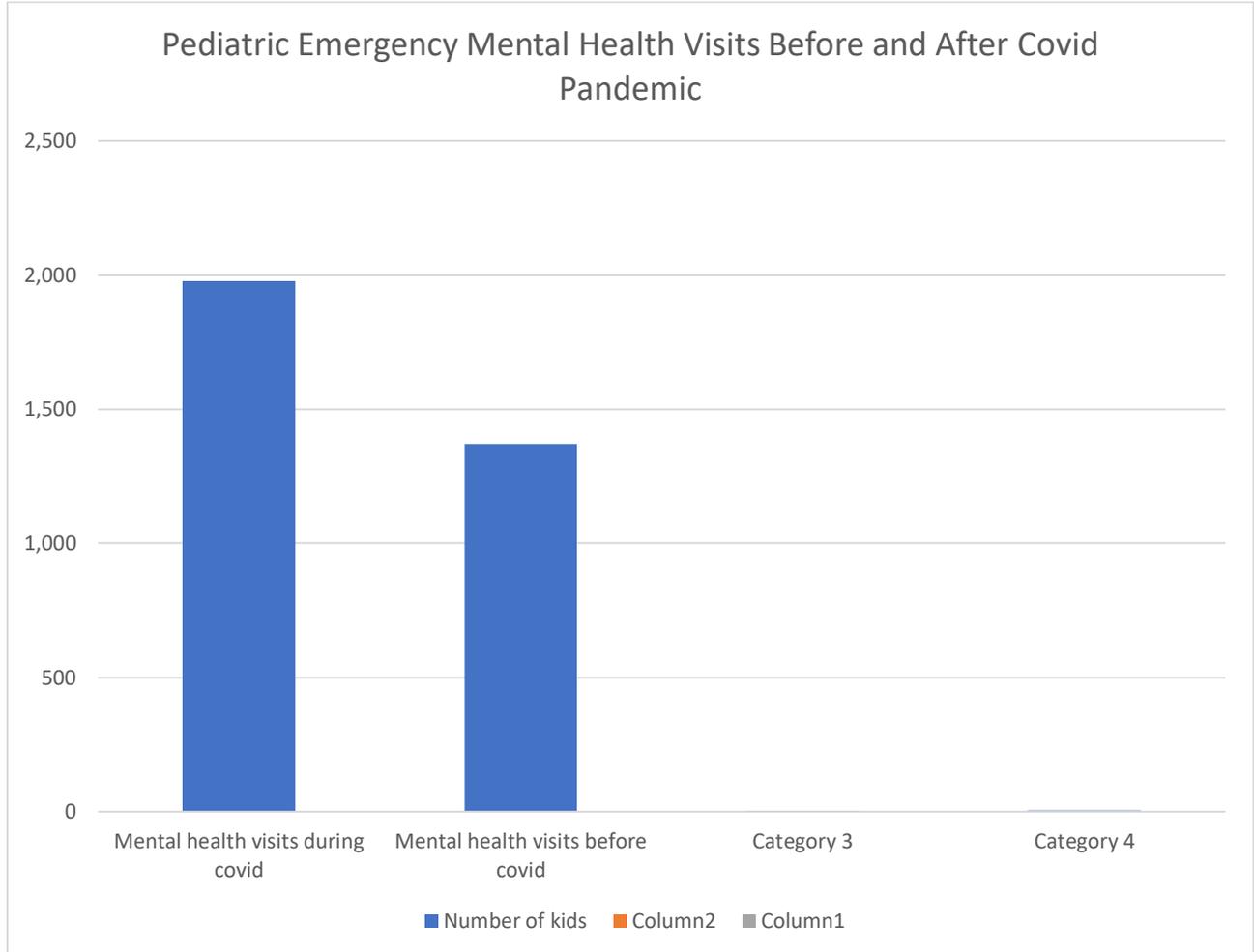
This could relate to hospitalized children as there are many factors that bring them into the emergency department such as abuse, malnourishment, behavioral outbursts, and difficulty self-soothing. Public safety officers can sometimes act on as a parental figure in the hospital while no other parent is present. They enforce rules and structure, scaffold with activities of daily living, and are an overall consistent presence throughout the department for the children.

Wright (2010) stated how law enforcement can use gaze aversion and body language as a tool for deception in cases. The study involved 50 police officers with a mix of men and women who watched videos of tapes of people testifying and had to decide if they felt the person was lying or not. The top categories they found for deception in the results section was eye contact, body language and vocal characteristics.

Overall, the findings from the Wright (2010) study suggested that police officers' beliefs about cues to deception may not be inaccurate stereotypes. The high mean accuracy of the officers in classifying pleaders as truthful or deceptive and the high use of cues known to discriminate between truthful and deceptive pleaders in the stimulus materials suggest that

officers use some reliable cues to make veracity decisions. In line with previous research, the most often used self-report cue was eye contact. This finding is usually reported as demonstrating inaccuracy of beliefs about cues to deception, but as previously argued, findings from mostly low stakes research may not necessarily be applicable in some high stakes contexts; indeed, in the stimulus materials used in the present study, gaze aversion was related to deception (Wright, 2017).

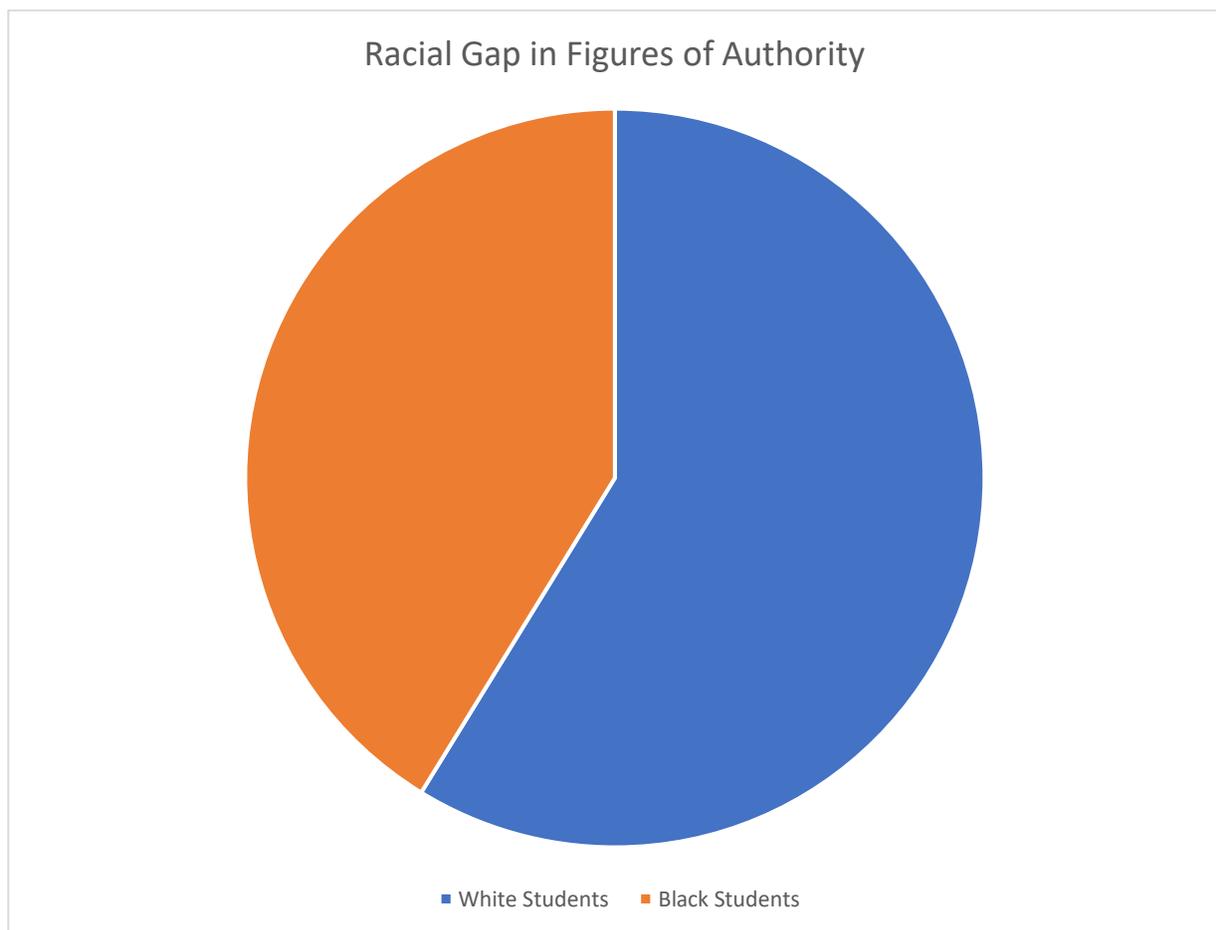
With this being said, pediatric patients in emergency rooms have been facing an epidemic of not enough psychiatric hospitals for them to get treatment, especially in the midst of the COVID pandemic. While the rate of pediatric emergency medical visits decreased during covid, the rate of mental health-related visits increased by 44.2% (1,977 visits) in comparison to the average rate from 2017 to 2019 (1,371 visits in average) (Fernandez & Gindt, 2021). In response to this upsurge, the children often wait in the ER for an extended period of time, sometimes up to multiple weeks for a pediatric psychiatric bed to become available. Throughout their stay in the ER, they meet with nurses, doctors, mental health counselors, social workers, public safety officers, and child life specialists daily to co-create treatment plans for them. Professionals in all fields should be mindful of their body language and how their appearances send a message to communicate effectively, especially medical professionals. (Ravi & Vethabothagam, 2021).

Figure 1

Non-verbal communication plays a vital role throughout the medical interview. The public safety officers' jobs are to make sure the children are acting safe in the hospital and are often present during the medical interview with the doctors, nurses, social workers, and child life specialists. Professionals in all fields should be mindful of their body language and how their appearances send a message to communicate effectively, especially medical professionals. Non-verbal communication plays a vital role throughout the medical interview (Ravi & Vethabothagam, 2021).

Due to this, public safety officers stand outside the children's rooms, oftentimes with their arms "crossed" or hands behind their back, which could be perceived as somewhat threatening based on children's experiences with public safety officers or police presence in their lives. There is a large racial gap in children's experiences with figures of authority such as security guards and police. In a New Orleans school study, about 77% of white students reported feeling safer when guards were present, but only about 54% of black students reported the same. (Bryan, 2020).

Figure 2



What initially peaked this literature interest for me was through my experience and initial observation while working at emergency departments in an urban northeastern town in the United States. Through my observation and interoceptive experience as a certified child life specialist, I noticed when working with pediatric patients experiencing psychiatric crises that public safety officers play an integral role in the treatment team in the de-escalation process of the child and how greatly their body presence can affect that. When a child becomes agitated, I have observed when officers utilize a more “neutral” non-verbal stance such as relaxed shoulders, hands by their side, and a relaxed gaze that children are more receptive to verbal de-escalation. When an officer answers a call or interacts with others, they must project a sense of authority and confidence without making citizens feel uncomfortable or intimidated. By focusing on making adjustments to personal body language based on the situation, an officer could improve their ability to address concerns or handle challenges within the community he or she serves. (March 6, 2019. (n.d.).

Literature Review

The body holds trauma. Unconsciously, trauma or body language experience stays with the body even after consciously forgotten. The body remembers everything what has happened—emotions felt, sensations experienced, whether butterflies in the stomach or a jolt of shock in the chest. (Wu, 2019) This concept is integral when thinking about pediatric psychiatric patients in the emergency department and where they may hold trauma in the body. When patients enter an emergency department, which is already a stressful and potentially traumatic situation, and they may experience harsh or negative body language and that experience remains in their body throughout their entire stay at the hospital. This effect can remain prevalent long after the

negative body language has been directed towards them because bodies unconsciously remember negative experiences. Therefore, the negative body language patients experience when entering the emergency department will stay in them with their body's subconscious memory after the negative feelings of the body language were felt.

Throughout the pandemic, pediatric psychiatric cases rose substantially. The increased caseload causes increase stress on both medical staff and public safety officers. Increased stress and more workload During March through October 2020, among all emergency department (ED) visits, the proportion of mental health-related visits increased by 24% among U.S. children aged 5–11 years and 31% among adolescents aged 12–17 years, compared with 2019 (CDC, 2022).

Mehrabian (1971) published a book that assessed how much nonverbal communication is accounted for in conversation. From his research, he concluded that 55% of communication is dependent on the speaker's body language, 38% to the tone of their voice, and only 7% to the credibility of the actual words. In a recent study, Sarla (2021) explained that body language and non-verbal communication are unconscious acts that could be more telling than our verbal language. Non-verbal communication is comprised of the "physical attitude of our body, facial expressions, gazes, and body gestures all [conveying] our intentions and purpose while we communicate" (p. 1). Based on Mehrabian (1971) and Sarla's (2021) studies, it can be suggested that the relationship between public safety officers and pediatric psychiatric patients is highly influenced by body language and behavior.

When talking about body language, there are two different types: open and closed body language. Body language dates back to ancestors who utilized their body as communication when written language was not identified. By opening the hands, unfolding the arms and bodies

people still show that they mean the other person no harm. When people have closed body language, they appear to be physically showing that we are hiding something from the other person and this can be threatening to them. These messages are often received subconsciously by the other person who starts to distrust words and what is meant by them. (Patel, 2014)

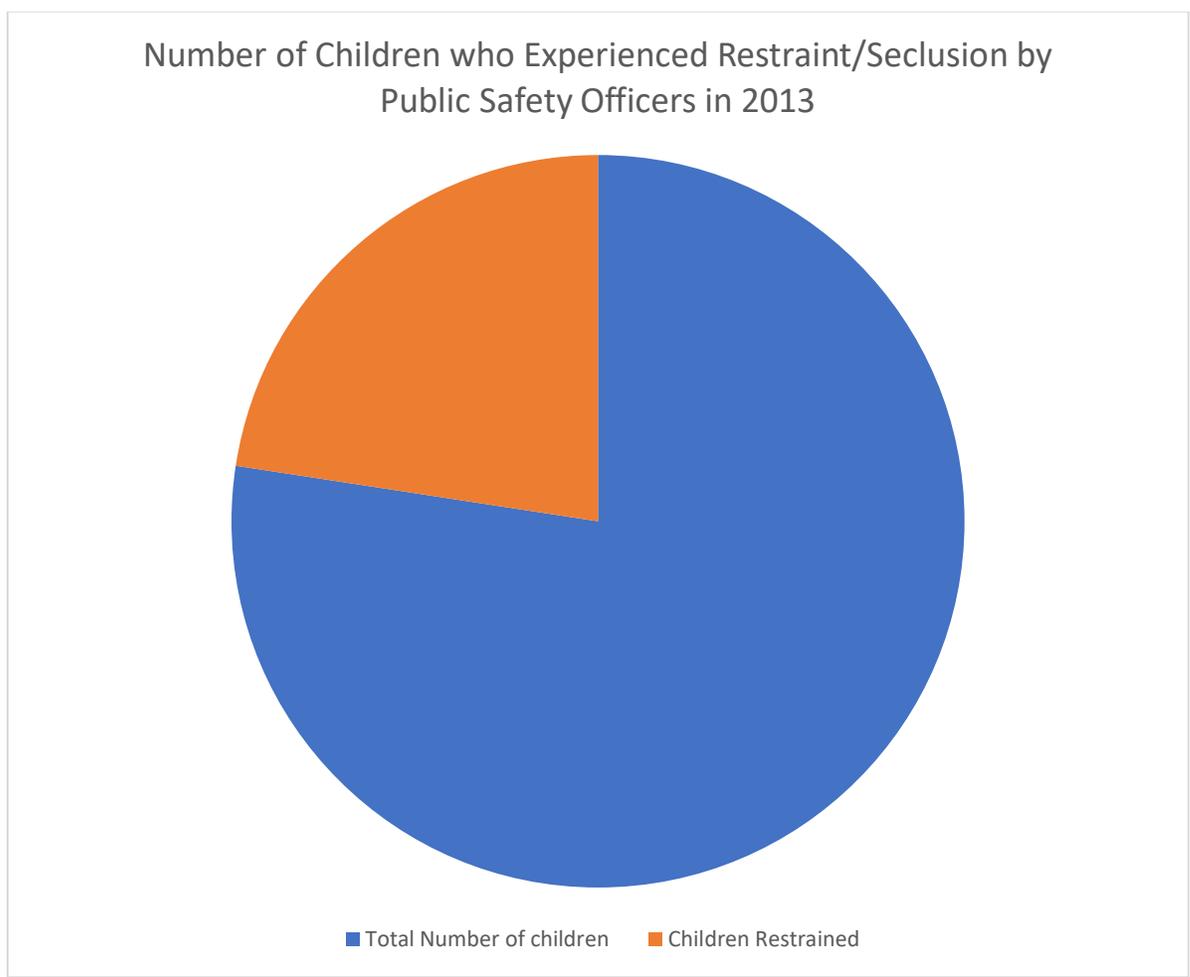
This theory is applicable to public safety officers because their stance and body positioning is an aspect that pediatric patients witness for 24 hours a day, often for multiple days and even weeks at a time. Having an open body language is essential to building positive rapport and minimizing escalations within pediatric patients whereas a closed body language could trigger a patient to act out.

Kinesthetic empathy is a term used in the dance movement therapy field. This term describes the ability to connect with someone through movement. This can be experienced from watching someone move, and by moving with another person. Ressler and Kleinman's (YEAR) study states the final concept discussed is that of kinesthetic empathy, which is "the ability, on a body level, to understand and sometimes experience what others are feeling" (p. 355). This is integral for a positive relationship with patients and public safety officers. When officers and children have shared kinesthetic empathy, their relationship is based on understanding the other person's perspective, therefore increasing the rapport between them. This is important because as the officers "watch" the patients all day, the children are more apt to remain calm while in the emergency room therefore increasing their chances of getting placement at a psychiatric hospital. An example of this is if a child is getting agitated and throwing their hands in the air, the officer could empathetically connect with the child from matching some of their movements, not in a way that is mocking. The officer could lean their arm on the wall while attempting to deescalate so their arms are in the same "space" as the child's.

Laban Movement Analysis is adept at describing what moves, where it moves, how it moves, and the ‘why’ of movement, in the relationship of the mover to self, others and the environment (Davis, 1970). The smallest (irreducible) movement units described by LMA are components of four main movement categories: Body, Space, Shape, and Effort (Davis, 1970; Bartenieff and Lewis, 1980). The Body category describes “what is moving,” e.g., which body parts are moving, and the coordination of these parts as well as basic actions such as walking or jumping. The Space category describes “where the body moves,” such as the direction of a movement (up/down, forward/backward, sideways open or across), planes the movement occurs in (vertical, sagittal, and horizontal), as well as use of the Kinesphere (e.g., far-reach space, peripheral movement), and more. The Shape category can describe changes in the shape of the body itself, moving in relation to one’s surroundings, to others and to one’s own needs, often reflecting the “why” of movement. We observe Shape when we note such things as whether a body encloses or spreads, rises or sinks. The last movement category is Effort, describing “how the body moves”: the qualitative aspects of movement such as lightly, suddenly, freely, etc. Effort reflects the mover’s inner attitude toward the movement as manifested in four different Factors: Weight, Space, Time, and Flow, each spanning two opposite polarities. Weight-Effort spans between the poles of *Strong* and *Light* and refers to the amount of force invested in the movement. Space-Effort ranges between *Direct* and *Indirect* and refers to the attitude toward the movement’s direction or focus. Time-Effort spans from *Sudden* to *Sustained*, reflecting the acceleration and deceleration of movement. Flow-Effort expresses the mover’s attitude toward controlling the progression of movement, from a higher control–*Binding* to little control or moving with abandon–*Freeing* (Studd and Cox, 2013).

This is important because public safety officers must be mindful of their own space, weight, and time positions when working with the kids. A misalignment in their own self-awareness of body language could lead to the child having an outburst and even needing to be restrained. In a study completed in an in-patient hospital, out of 2,411 child and adolescent in-patients admitted during the period under review, 703 (29%) experienced restraint or seclusion (Pogge, 2013)

Figure 3



When thinking about kinesthetic empathy and incorporating space, weight, and time, a training piece could be integrated into public safety officers for shared space as a recommendation based on the literature and my own as a child life specialist working with this population. The pediatric patients could utilize an intervention where they have to guess what the public safety officers' body language and posture is showing through mirroring. This shared empathy could gently inform the officers what their posture is saying to the children who are observing. It would also be empowering for the children to "try on" movement from the officer, who is in a position of authority.

Body alignment is a large factor that contributes to public safety officers and pediatric psychiatric patients interactions with one another. In dance movement therapy, we often talk about body "planes" and the three usually mentioned are horizontal, vertical, and sagittal. When humans and animals function out of the horizontal plane, movement begins with the head with the weight of the body sitting back into the heels. Individuals tend to lean when talking or resting to one side. It is truly the position of listening, open communication, and exploring. The body makes the classic S-shaped curve when the plane is underdeveloped. These sagittal plane adjustments are due to an inability to achieve verticality due to being clinically fixated or stuck in the earlier developmental horizontal plane. This posture gives the impression that individuals "can't" do what needs to be done in order to be proactive and move forward in life. (Amighi, et.al., 2019 p. 311) Developmentally speaking, we begin in the horizontal position by lying down and learning gross motor milestones. If someone spends much of their body space in the horizontal plane, it may be suggested that the individual has unresolved issues from the first year of life.

The vertical plane is known as the up and down plane. Individuals taking up space in this plane tend to sit upright and self-supported, exhibiting a bipolar shape to the body, even when standing. This plane is projected as power, presentation, asserting, and control. The pelvis is usually tilted forward and legs are wide as in second position in ballet. This posture gives the impression that the individual “won’t” much like toddlerhood stage in children. This posture can be typically seen in the classic state troopers stance or salesmen presenting persistently without communicating (Amighi, et.al., 2019 p. 312) Individuals who take up space in this plane may appear with over developed calf muscles, hamstrings, and quadriceps.

The sagittal plane is the forward and backward plane. Individuals who spend time in this plane tend to sit forward or go backwards. They typically narrow bipolarly so that the body has an arrow-like penetrating appearance. If forward in the sagittal, they often have to keep busy “doing” to avoid feeling deeply. They may appear officious, impatient, and work-addicted. They may also demonstrate a held upper torso shift forward or backward. (Amighi, et.al., 2019 p. 312). Sometimes people in this plane can be described as having a histrionic personality and a history of sexual trauma.

This knowledge of planes is integral for public safety officers as they need to be mindful of their body positioning, especially when thinking in the vertical plane. As stated above, this is the plane typically seen in the classic state trooper’s stance. Children, due to their size and their developmental level often take up space in the vertical plane as well. A way to modify this for officers to meet children where they are at, and to minimize their assertive presence, is to shrink down to the child’s level in the vertical plane. This can create the kinesthetic empathy and rapport building through a body spatial lens just by a small modification. (Amighi, et.al, 2019)

A Kestenbergl Movement Profile (KMP) concept is matching and clashing. Matching, sometimes referred to as affinity, demonstrates support, sympathy, and systemic agreement when movement elements are horizontally affined. (Amighi, et.al., 2019 p. 336) Matching could be useful with officers when a child is dancing around the room, or engaging in visual art making and the officer inquires about the art making to the child. This instills confidence and “matching” within the officer and patient relationship. The officer and child are in harmony. There are times when the officer may actually not want to match with the child. This next concept is called clashing. Clashing demonstrates conflict and can occur vertically within a system. When corresponding movement elements exhibit horizontal clashing, it is called mismatching. (Amighi, et.al., 2019 p. 336)

Clashing could be useful for officers when a child is acting out in a way that is truly unsafe towards the officer such as spitting, kicking, or biting. The officer may clash by changing their tone of voice to sterner to set a boundary, or by standing up over the child to assert a more vertical plane. Clashing may also be used and noticed when there has been a breach of a boundary such as a child asking about an officers’ personal life.

In a study (Biondo, 2017), a training program, Nonviolent Crisis Intervention (NCI) was facilitated through Drexel University involving the use of DMT theories and de-escalation. Findings suggest an increase in observational skills, empathy levels, and self-efficacy, and positive views regarding the overall training program as reported by participants. Results from this program evaluation suggest that de-escalation with DMT could be useful in increasing skills that would support safe and effective de-escalations. The study shares two definitions of restraint and seclusion which are used in this specific hospital for de-escalation practices. Generally,

seclusion can be defined as a period of time controlled by staff that a patient spends alone in a locked room. Restraint is the use of mechanical or physical holding in order to immobilize a patient. (Biondo, 2017) Typically, seclusion is used as a measure before restraining as it is least restrictive for the patient.

A description of the NCI training is below:

The NCI training model aims to decrease physical and emotional risks for both staff and patients. The program “combines innovative concepts regarding violent behavior into an educational system that gives staff at all knowledge and experience levels easy-to-understand models to use when confronted with anxious, hostile, or violent behaviors.” The NCI model emphasizes early verbal and non-verbal interventions aimed at identification and prevention of potentially dangerous situations prior to the point of escalation. In addition to training in such preventative work, NCI also trains participants in physical interventions, which are practiced through role-playing and experiential learning activities. (Biondo, 2017)

With this implemented training, significant decrease in restraints was noted in the psychiatric department. Though the study did not formally mention public safety officers, it could be implied that the term “staff” encompassed this role into the study.

Observational skills were another dynamic noted throughout the literature:

Prior to the point of escalation, movement observation skills can be useful in the detection of indicators that may lead to escalation. There was noted different degrees of aggression ranging from low levels to higher levels regarding the assessment and management of

violent patients. Early recognition of the degree of aggression present can allow for staff members to respond accordingly. Dulicai (1973) recorded movement observations she made of patients in a psychiatric setting over a 14-month period in order to track behavior patterns of these patients (N = 42). In this preliminary study, an emphasis was placed on movement observation and how observed movement related to a patient's behavior. DMT concepts of body attitude, Laban Movement Analysis Effort elements, use of space, and posture/gesture combination were utilized in the study. Dulicai (1973) was able to categorize her patients into three groups according to movement Effort preferences. She noted that patients who were referred to the ward for aggressive tendencies had minimal changes in flow, with a preference for bound flow, and also a preference for increasing pressure. She concluded that using observation skills could support the anticipation of violence or escalation. DMT sessions led by Dulicai (1973) for the staff members included working on heightening observation skills in order to track the behavior changes in patients. This structure can be recreated and taught to staff members at psychiatric hospitals to help them decipher precursors to aggression in order to support de-escalation of patients.

Though this study was conducted in a psychiatric ward, similar principles could be relayed to the emergency department. Simply through teaching observational DMT skills to public safety officers could change the relationship and behaviors of pediatric psychiatric patients behavior in the emergency department.

Discussion

Recommendations developed from the literature were that public safety officers' body language has an effect on pediatric psychiatric patients' behavior in the emergency department

using specifically research from Biondo (2017) and Wright & Wheatcroft (2017). By bringing awareness to open and closed non-verbal stances, vertical planes, matching and clashing, it could be concluded that building a stronger rapport with officers and patients begins with the body. Shared kinesthetic empathy is an important factor that I believe could be more widespread knowledge when working with this population. Recommendations for further research would be to include statistics of restraints and hospitalized pediatric patients from outside of the United States as well as restraint practices in other countries. Another recommendation could be if gender plays a role in how a child attunes to a public safety officer as well as past experience with law enforcement in a child's life and the Adverse Childhood Experience (ACE's) score could affect this outcome. A further recommendation would be a four-hour training for public safety led by a dually certified child life specialist and dance movement therapist on how body presence impacts pediatric psychiatric patients' behavior in the emergency department as stated in Biondo (2017).

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