Touch, Physical Restraint and Therapeutic Containment in Residential Child Care

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Abstract

The relationship between touch and physical restraint in residential child care is not well understood. Theories of therapeutic containment offer insight into the practice of physical restraint, the place of touch in residential child care practice and the impact of wider fears about touching between children and adults. Early experiences of containment necessarily involve touch through feeding, holding and other forms of soothing. Yet, for those who have not had ‘good enough’ early experiences of containment, their need for containment (including containing touch) may remain high. Physical restraint, a not uncommon practice in residential child care, simultaneously embodies extremes of both touch and containment. This paper, then, uses theories of therapeutic containment to illuminate the relationship between touch and physical restraint. It offers findings of a large-scale, qualitative study that explored the experiences of physical restraint of children, young people and staff in residential child care in Scotland. It provides evidence that staff experience anxieties related to touching young people, that some young people use physical restraint to meet needs for touch, that touch is used to contain distress and avoid restraint, and that touch-related fears may be limiting its ameliorating use, thus potentially increasing the use of physical restraint.

Keywords: Residential child care, physical restraint, containment, touch, moral panic

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Introduction

In Scotland, approximately 1,500 children and young people who cannot live within their families of origin reside in care establishments (Scottish Government, 2010). Some of these children exhibit potentially (or actually) harmful behaviour, and sometimes staff respond to this behaviour by physically restraining them. There have long been concerns about physical restraint and there are growing concerns, coming from a much wider context than residential care, about touching between adults and children. Physical restraint involves touching, and the relationship between the two is not well understood. The aim of the paper, then, is to illuminate this relationship, and theories of therapeutic containment are used to achieve this end. Therapeutic containment is reviewed first, followed by a review of issues of touch and physical restraint, all in relation to residential child care. Findings of a large-scale, qualitative study of staff and young people’s experiences of physical restraint are then offered. These findings focus on issues of touch and are discussed through the lens of therapeutic containment, providing insights about the relationship between touch and restraint, and highlighting some implications for practice. (Note on language: because a higher proportion of young people in residential child care are male, the male pronoun has been used when referring to them in the third-person singular. Similarly, because a higher proportion of front line staff in residential child care are female, the female pronoun has been used when referring to them in the third-person singular. When referring to quoted study participants, the pronoun reflects the sex of the participant.)

Containment and residential child care

Containment theory was first introduced by Bion (1962) and offers a way of understanding how early experiences of care provide a foundation for the management of emotion. Care giver(s) provide containment through the continual process of hearing and absorbing the infant’s cries of hunger, anger, fear and/or confusion, and responding accordingly—‘giving back’ the emotions in a more manageable form. This process enables the development of thinking in order to make sense of experience and feelings. Bion applied this concept to the relationship between therapist and client, stressing the importance of metaphoric containment as part of the process of healing and recovery. Containment has subsequently been applied to other relationships and settings, including health care (Hinshelwood and Skogstad, 2000), social work (Ruch, 2007), social work education (Ward, 2008) and even business (Kahn, 2001).

While the need for containment occurs throughout the lifespan, it tends to be the greatest during the early years. Yet, for those who have not had
‘good enough’ early experiences of containment, their need for containment (including containing touch) may remain high. This is often the case for children in residential child care.

Most people have experienced anxiety or distress such that they were unable to think clearly or speak about it. This can be a perpetual state of being for some young people in residential care. Nevertheless, they do communicate their feelings in unconscious, sometimes subtle ways that create a similar state of mind in staff. When staff can tune into these projected feelings and identify them as originating from the young person, they are in a better position to understand that young person’s experience and respond to the need rather than simply the behaviour (Kahn, 2005). Staff can also serve to hold or contain the uncontainable feelings for the young person and, through mirroring them back in a more manageable form, help the young person to gradually learn to understand and contain them himself (Ward, 1998). Ward (1995) describes both the literal containment of children in terms of basic care and the setting of boundaries, and metaphoric containment. The latter involves verbal interpretation and the development of an overall atmosphere that absorbs or contains disturbances while simultaneously conveying acceptance, respect and understanding. Therapeutic containment, the combination of literal and metaphoric containment, can be seen as the primary task of residential child care.

Helping young people to make sense of their feelings and learn to talk about them rather than act on them destructively resonates with the way many residential child care practitioners make sense of their work. With the declining influence of psycho-dynamic approaches to social work and the rise of managerialist regimes (Rojek et al., 1988; Sharpe, 2006), however, fewer residential practitioners actually think about their work in explicit terms of therapeutic containment. The term ‘containment’ is more often used pejoratively, indicating simple warehousing of children and young people. Yet, critically, front line practitioners require support for making sense of strong, absorbed emotions and how these emotions may trigger counter-aggressive or counter-transference reactions. The anxiety provoked by the work disrupts their clear seeing and thinking, in obvious and subtle ways. All too often, containing support is absent in residential child care settings despite the central importance of providing containment for those doing therapeutically containing work (Steckley, 2010).

**Touch**

Early experiences of containment necessarily involve touch through feeding, holding and other forms of soothing. Touch is critical to human development across the lifespan, particularly in childhood (Brazelton and Cramer, 1990). It has been linked to physical, emotional and cognitive development.
development, as well as the more specific areas of attachment, self-esteem and the ability to manage stress (Field, 2001).

Touch can be an integral component in providing therapeutic containment for many young people in the day-to-day lifespace of residential care. In addition to its developmental benefits, ameliorating effects of touch have also been documented. Massage has been found to decrease levels of depression, anxiety and stress hormones in children and young people who have experienced abuse and neglect, as well as those diagnosed with bulimia, post-partum depression or post-traumatic stress (Field, 2001).

There is even emerging neurological evidence that supports the sensitive, attuned use of touch when children are in the throes of distress. In a recent study, Coan et al. (2006) found that hand-holding positively benefitted neural responses to threat, especially in areas of affect regulation and bodily arousal. Of particular relevance was their finding related to the quality of relationship between the participants, suggesting that ‘individuals in higher-quality relationships benefit from greater regulatory effects on the neural systems supporting the brain’s stress response’ (Coan et al., 2006, p. 1037). In other words, the higher-quality relationships yielded more ‘containment’ (affect regulation and bodily arousal as reflected in the brain scans and self-reports from participants) for the hand-holders, and even holding the hand of a stranger yielded more containment than no hand-holding at all.

Despite the increasing understanding of the essential role of touch, there is also a divergent development, one that has been referred to as the moral panic of ‘no touch’ (Johnson, 2000). A wider culture of fear has arisen related to touching children, resulting in confusion and inconsistencies in guidance, policy and practice as well as an erosion of trust in adults’ motives and actions in almost all realms in which adults and children interact (Piper et al., 2006). In a recent study examining practices, beliefs and meanings related to touch between adults/professionals and children across a range of educational settings, Piper and Stronach (2008) found precautionary regimes in which the omnipresent potential of a sexual monster (or the false allegation of such) drove increasingly proscriptive policies and guidelines, thus creating a ‘new inhumanity of care and a new insanity for the self’ (Piper and Stronach, 2008, p. 35). A key consequence has been the adoption of practices by professionals that are incongruent with their own knowledge bases and are contrary to the interests of children in their care. In indentifying the detriment caused by the publicity associated with child abuse cases, Scotland’s former Commissioner for Children and Young People has identified children as the ‘new Untouchables’ (Marshall, 2004, p. 8).

Ward (1999) identified touch-related anxieties particular to residential child care and, more than ten years on, they continue to be highly relevant. A significant dimension of this relates to practical, affectionate and controlling aspects of touch. Children, young people and their families can have
anxieties about whether touch might become inappropriate or even abusive, and this can often be related to previous experiences of transgressive touch. All of these complexities are compounded by a wider context of ambivalence and suspicion towards residential child care and, by implication, residential child care workers (Corby et al., 2001; Smith, 2009).

Physical restraint in residential child care

Physical restraint embodies extremes of both touch and containment. In Scotland, young people with some of the most damaging life experiences end up in residential child care; some of these experiences manifest in extremely violent, aggressive and/or self-destructive behaviour, and physical restraint (i.e. the physical containment of behaviour) is sometimes used to restore safety. For the purposes of this paper, physical restraint is defined as ‘an intervention in which staff hold a child to restrict his or her movement and [which] should only be used to prevent harm’ (Davidson et al., 2005, p. viii). Related risks and poor practices have long been a concern, with significant instances of abusive restraints and even restraint-related deaths (Nunno et al., 2006). Contextual complexities compound these serious problems, including: an inadequate evidence base to inform practice; complex relevant legislation; a lack of regulatory frameworks to monitor related training packages and practices; a mismatch between required qualifications and complexity of demands placed on front line residential workers; and a general ambivalence and even suspicion of residential child care that contributes to the aforementioned damaging life events encountered by young people and the poorly qualified workforce attempting to meet their needs (Steckley, 2010).

The study

The aim of the study was to explore the views and experiences of children, young people and staff related to physical restraint in residential child care in Scotland in order to inform policy and practice. It was funded by Save the Children, Scotland, and involved seventy-eight in-depth interviews. Data collection was carried out between February 2004 and May 2005 using vignettes and semi-structured interview schedules. The study adhered to the procedures for ethical approval of the University of Strathclyde.

Using the Scottish Institute of Residential Child Care’s database, all residential child care establishments in Scotland were invited to participate in the study. The sample of participating establishments was comprised of all respondents to an invitational letter and information sheet who then also co-ordinated interview times and collected parental assent for participants under sixteen years of age. Twenty establishments took part in the study;
ten were operated by private or voluntary organisations and ten by local authorities. The establishments included residential schools, secure accommodation services and children’s homes. Two establishments catered to young people with disabilities. This diversity reflects the range of services in the residential child care sector.

Thirty-seven young people and forty-one residential staff members participated in the study. Gate-keepers at each establishment elicited volunteers for interview and the information sheet stressed the voluntary nature of participation. Because of the sensitive nature of the research focus, a key member of staff was identified in advance of each interview should a young person become distressed and require additional support. Confidentiality was explained and the limits of confidentiality were stressed at the outset of each interview. A process of ongoing consent (Flewitt, 2005), particularly with young people but also with staff, was negotiated (for a more detailed discussion of the ethical dimensions of carrying out this study, see Kendrick et al., 2008).

Young people were between the ages of ten and seventeen. Staff had worked in residential child care for between one and twenty-nine years, although the amount of experience was not a major factor in the findings. Twenty-six young people were male and eleven were female; seventeen staff were male and twenty-four were female.

Young people’s interviews lasted an average of thirty minutes and staff interviews around 100 minutes. Interviews were recorded, transcribed verbatim and analysed using qualitative research software. A general or ‘classic’ set of analytic moves, as identified by Miles and Huberman (1994), was followed, including applying codes to each interview transcript; taking note of reflections or insights [memoing]; identifying similar themes, relationships or patterns between interview transcripts; and gradually identifying a smaller body of generalisations that cover the consistencies across transcripts, and confronting those generalisations with formal theories. The use of qualitative software enabled frequent ‘cycling’ between coding, memoing (di Gregoria, 2003) and the use of visual mapping to enable a simultaneous grasp of the finer details and the data as a whole.

While not statistically generalisable, the findings aid understanding in similar cases or situations and contribute to the development of related theory, otherwise known as theoretical generalisation (Robson, 2002).

The semi-structured interviews explored: participants’ views about and experiences of physical restraint generally; a particular incident of restraint in which they were involved; precipitating and subsequent events; incidents of injury; and the impact of relationships on restraint and restraint on relationships. Four vignettes depicted situations in which a young person or young people were exhibiting behaviour that could be perceived as problematic and/or risky, and participants (staff and young people) were invited to comment on what they thought should happen in each situation.
While the focus of interviews and vignettes was not on touch per se, issues related to touch naturally emerged. The purpose of this paper, then, is to explore more deeply the findings related to touch, illuminating its relationship with physical restraint and making links to broader findings, relevant literature, contextual factors and practice implications.

Both staff and young people spoke about touch, but touch-related data from staff interviews were of a greater volume and reflected greater ambivalence and complexity. This likely reflects, amongst other possibilities, developmental differences (in terms of articulateness and reflection) between the two and, as such, accounts for the greater volume of content representing and analysing staff views. Both staff and young people, however, make illuminating and interrelated contributions to understanding the relationship between touch and physical restraint, and so both are addressed in the sections that follow.

All study participants were self-selecting and organised through gatekeepers at each residential establishment. While the actual impact of this cannot be known, those who were more comfortable articulating their thoughts and/or who had a higher degree of trust in the researcher or research process are clearly more likely to be represented in the findings. It is also possible that those with damning things to say might have been excluded by establishments’ gatekeepers, particularly given the sensitive nature of the research subject. Despite this potential, staff and young people did indeed share some very negative views during interviews. For the purposes of confidentiality, pseudonyms have been used throughout.

Findings

Overall, a broad range of views and experiences were represented in the data, revealing greater subtlety and complexity than has been previously reflected in the literature. Clarity as to the necessity of restraint in situations of imminent harm was consistent. Ambiguity as to the actual nature of imminent harm and notions of last resort emerged as interviews unfolded. Staff’s experiences of restraint were described using consistently negative emotions, although some also identified positive dimensions of restraint for the young person. Young people expressed a variety of emotions about restraint, with anger most frequently cited. Some spoke of restraints that were unjustified or too forceful. Conversely, some young people also spoke of positive emotions, including feeling cared for, safe and glad at having their behaviour stopped (for a more in-depth discussion of overall findings, see Steckley and Kendrick, 2008a, 2008b).

It became clear in listening to participants’ responses that it was not simply the event of physical restraint that shaped their experience of it. It was the context within which the restraint occurred that was significant, including preceding and subsequent events as well as the overall quality of
relationships and ethos of the establishment. For those young people who described more positive views about being physically restrained, there was evidence of overall experiences of therapeutic containment in their descriptions. Generally, there was indeed evidence of processes between staff and young people that could be understood as containing, but only at a very basic level. There was almost no evidence of the kind of containment that could enable staff to make sense of their intense emotions or the complex, uncertain or contentious elements of their practice in such a way that reduced the disruptive effects of anxiety (for a more detailed analysis of the findings related to containment, see Steckley, 2010). Issues related to touch emerged as significant, both in terms of the anxiety they provoked and for their potential influence on the overall experience of physical restraint.

Themes specific to touch were identified as: touch as risky for staff; touch as aggression for young people; features of aggressive touch for staff; and physical restraint, touch and catharsis for both young people and staff. They are discussed in turn. (Note on presentation: interviewers’ minimal encouragers (e.g. ‘uh hu’) are offset by forward slashes and in italics. Any other content by the interviewer appears on its own line.)

Touch as risky: staff

Staff spoke of the defusing potential of touch when young people experienced heightened emotions, but, within this, they spoke more often of the potential of touch to escalate those emotions further. In addition to the risk of being counter productive during difficult situations, the touching of young people was described as risky in other ways as well:

Neil (staff): I still think there’s a [place] for hands on in a comforting way as well ….. And I’m comfortable enough with that if I know the young person, although I realise, you know, there’s a lot of issues about and, you know, there’s risk there as well. You don’t do it when you’re on your own and you make sure it’s not square on contact that could be deemed sexual in any sort of way.

In their discussions about responding to heightened emotions, whether or not this response involved touch, most staff spoke of the importance of knowing the young person. In regards to Neil’s quote, one is left wondering who might deem the contact to be ‘sexual in any sort of way’. If the worker knows that young person’s history, current functioning and quality of relationship with herself, then a general sense of whether physical contact will be perceived as sexual is already assessed within knowing the young person. There are parallels here with in Piper and Stronach’s (2008) findings that many professionals ensure that they only touch children in public view, implying a perception of the child or themselves as potentially dangerous. An element of surveillance has become necessary.
No one explicitly expressed an unwillingness to hug, cuddle or offer comforting physical gestures to young people, although some (both male and female participants) referred to women as being more capable of this type of interaction:

Ilene (staff): I think it’s risk assessment, totally risk assessment. I think the same ah, um, like a comfort hold, which I use quite a lot now and that’s more of a… ‘come on,’ you know, kind of a side hug /Right/ side hug, um, appropriate, having people there when you do it, but it can de-escalate a person so quickly because half the time they want to cry and they don’t want to fight… and I think women have a better feel of doing that, to girls and boys, because we’re seen in that role more. Aye, I think if a guy walks over to a guy and goes up to them it would be like [roaring sound].

Ilene, who works in a different establishment from Neil, also refers to the importance of others providing surveillance, in this case for something as risky as a side hug. Interestingly, on the one hand, she is describing an intuitive, practical-moral understanding of touch in enabling young people to bear psychological pain and cry. Yet, she is also, simultaneously, using technical-rational language, likely derived from her establishment’s chosen training method for physical restraint, to refer to the basic human act of hugging (a ‘comfort hold’). The term ‘technical-rational’ is used here to identify an instrumental orientation that emphasises function and technique, as opposed to a ‘practical-moral’ orientation, emphasising ethical service to others (Whan, 1986). Ilene’s language was not unique, as technical references to touching and hugging were made by other staff (from other establishments) as well.

The following excerpt demonstrates the sometimes conflicting demands made by technical-rational and practical-moral approaches to the very complex domain of responding to human pain (and the place of touch within that):

Maureen (staff): Now what is not part of the guidelines is that the boy is still in the physical assist position while we’re going through that process. But sometimes we’ve found that that’s the best time to do it…. He might want to talk and if he wants to talk then we might say, ‘Do you want to get up and we’ll talk’? ‘No, I want to stay here.’ So then we’re going to do it down there. But the guidelines are that the young person should get up on a chair doing it, but we feel, I feel if that’s where he feels comfortable then, if he’s on his stomach, face down then quite often they’ll just put their arms out. We stand at the side, either side, more often than not. Absolutely no body contact, but we’re sat either [side] and we’ll talk.

Indeed, Maureen’s response was conflicted as well. Initially, her response reflects a child-centred orientation in deviating from the guidelines by not requiring the young person to sit up. However, her almost defensive assertion of ‘absolutely no body contact’ while staff stand or sit on either side of the young person jars. Given the significant physical contact that occurs during a physical restraint (which frequently is of a much more aggressive
nature), abstaining from any form of reassuring or comforting touch seems incongruent with a focus on the needs of young people (notwithstanding the importance of knowing and attuning to the particular young person in the particular circumstance).

**Touch as aggression: young people**

The vast majority of young people spoke of touch in a negative way. This finding was likely shaped in part by the focus of the interviews and the fact that no direct questions were asked about other forms of touching. When the word itself (‘touch’) appeared in their language, it was consistently used to indicate aggression or a transgression of rights:

*Davy (young person):* . . . nobody on this earth should be allowed to either, shouldn’t be able to touch us at all.

No young person spoke of experiences of touch helping to diffuse heightened emotion such that they were able to avoid being restrained, and no young person described restraint or touch that felt sexually inappropriate. The vast majority of discussion that included the dimension of touch was in relation to physical pain experienced while being restrained:

*Coleen (young person):* I don’t think they should do it too hard because they don’t know how it feels to be sitting in the middle /ah ha/ getting all the hurt and that . . . Cause once I got restrained and I came out my restraint and my arms were all red.

Over half of the young people interviewed described at least some of their restraints as physically painful, and many raised concerns about restraints that were too rough. Some described injuries, including bruises, carpet burns and a bloodied nose. In almost all cases, young people indicated they did not think the injury was intentionally inflicted but was a by-product of the struggle and violence of the restraint, of which they played a part. In some cases, they expressed this with a tone of bravado. A few indicated that they thought staff were doing the best they could under difficult circumstances and stated that staff hated restraints as much as they did. However, related to roughness in particular, it was significant that some young people, albeit a small minority, felt that staff intentionally inflicted physical pain:

*Interviewer:* Do you think that the staff, you said earlier that the staff are doing the best they can, but they could do better, and during a restraint, do you think the staff are doing the best they can but maybe just get a bit too/

*Ryan (young person):* Frustrated.

*Interviewer:* Yeah, or do you think they are purposely trying to be too hard, too intense during a restraint? Like, I don’t know/
Ryan: Teach them a lesson.
Interviewer: Sorry?
Ryan: Teach them a lesson, so they don’t do it again.
Interviewer: Do you think that they, yeah?
Ryan: I’ve always thought it.

Interestingly, Ryan and most of the others who indicated at least some degree of intentionality surrounding painful restraints identified these as occurring in former placements. These participants spoke more positively, by comparison, of how restraints were carried out in their current residence. Others distinguished between their experiences based on the member of staff within a single establishment:

*Michael (young person):* I’d prefer if it’s a good staff; not a staff that’s going to try and hurt you. Like there’s big George. He used to be a boxer and he’s quite big, but he doesn’t try and hurt you. He’s quite gentle with you; he doesn’t pure jab you and all that and swing you about. But whereas, like big Mike, Mike grabs you and swings you about.

**Aggressive touch and staff**

Staff also spoke of the touching dimension of physical restraint in negative terms, with some describing it as uncomfortable, unnatural and/or physically distressing. In describing their experiences of physically restraining, some spoke of concerning themselves as to whether the hold was being done correctly, whether it was hurting the young person and/or whether there might be the perception of inappropriate sexual touching. Just over half described injuries to young people, most of which were identified as bruises, carpet burns or other abrasions. One participant spoke of a young person’s sternum breaking as a result of the two of them falling to the ground in a lead-up to a restraint. Unsurprisingly, none of these participants identified any of these injuries as deliberate, and many spoke of deep guilt they felt at being unable to successfully keep the young person safe. Some also noted these injuries as more minor than the ones they anticipated the young person receiving if they had not physically intervened.

Over two-thirds of staff told of receiving physical injury in the lead-up to or during a physical restraint. Just under half of the injuries were described in similar terms to those of young people: bruises, carpet burns and other abrasions. Just over half were more serious, including: broken ribs, fingers and noses; damage to backs, knees and teeth; black eyes; and a knife wound to the abdomen. Some of these injuries were described as unintentional on the part of the young person, but others were characterised as the result of deliberate assault (primarily kicks, head-butts and punches). While a small minority of staff recounted difficulty in continuing to work with the young person subsequent to the assault, others conveyed understanding for issues underlying the young person’s behaviour:
Richard (staff): The boy that broke my nose didn’t make me angry…. We had a great relationship before, but it’s better now.

Interviewer: … How did you account for it being better after him breaking your nose?

Richard: Because I think he expected me to, possibly to hit him when he was on the ground…. But I went through it with him and he’s quite protective of me now. It’s quite strange ….

Interviewer: Did he ever apologise to you?

Richard: Very grudgingly. But the main apology was physical. He would come and sit beside and talk to me. He gave me a little key ring, so he did it that way…. I think he thought, ‘Well all males are like that.’…. So he found that they’re not. And that’s maybe why it’s better now. The relationship’s better now. Much, much better.

Rather than anger towards young people, staff expressed anger much more frequently about a perceived lack of management support. They described inadequate acknowledgement of and response to staff injuries, and insufficient staffing levels.

Unsurprisingly, the impact of physical hurt on relationships was overwhelmingly negative. Both staff and young people identified staff not intentionally hurting the young person as a key element in preserving or even building trust, and young people conveyed a distrust of those staff whom they believed were unnecessarily rough. One young person even spoke explicitly of measuring how much he could trust a member of staff by how much force was used while restraining him.

Physical restraint, touch and catharsis

Another, more complex dimension of the physical component of physical restraint also emerged. Almost a third of staff spoke of young people in their care whom they perceived had sought out being restrained in order to meet touch-related needs:

Veronica (staff): … we had a child that [pause] he was seventeen. Tall, tall chap, but really had an IQ and the ability of like an eighteen month, two year old. /Aye/ And he used to do things that he knew would get him supined [held] for the comfort of that. /Aye/ And that was just to get people, because he was seventeen, you know, great big, strapping guy. You couldn’t give him a hug and that was the closest thing he could get to a hug, and the security of ‘there is staff round about.’

Again, a reticence to hug or hold outside of the context of physical restraint is reflected in Veronica’s account. While developmental considerations and the impact of some forms of disability can complicate issues of touch, most of the staff who spoke of a more deliberate use of restraint
on the part of the child were not working in establishments that catered to young people with disabilities.

When staff began to speak about a more ‘deliberate’ use of restraint, they belied a degree of cautiousness. It often appeared that they thought that what they were saying would not be believed or would be considered inappropriate:

Jean (staff): . . . part of it is because particular young people who had at that time, their emotional needs were so great that they almost encouraged restraint so that, I know that doesn’t sound very good, but they did encourage restraint. They pushed things to an extent where we could do nothing else but restrain them . . . . Their emotional needs were not being met by anything else and they needed somebody to hold on to them and say, ‘Tell me what is wrong.’ Now my preference would to be able to go up this person at any point and give them a hug and say, ‘Tell me what’s wrong,’ but I feel with some of the young people, [in] particular they have had, they have been so unused to that kind of pressure of somebody actually saying, ‘Tell me what’s going on.’ They have been abused. They don’t know how to verbalise their feelings without having first being through a physical fight almost.

While not drawing on therapeutic containment explicitly, Jean, like some others, made a link between being held and the development of the ability to verbalise feelings as a way of managing them. She also went on to assert that, over time, many of the young people who fit this description developed trust in staff, learned to speak to them about their feelings and had significantly fewer or no physical restraints.

An element of catharsis can be interpreted in the previous account as well as the one to follow, and this was a common feature of staff’s descriptions of young people being ‘deliberately’ restrained. Additionally, over half of the staff interviewed described working with one or more young people whom they had to repeatedly restrain, and there were frequent connections made between repeated restraints and restraints used for catharsis. They expressed deep concern about these young people, and spoke of the physical and emotional toll it took on themselves and their colleagues:

Emma (staff): One of the ones that I key worked, I mean she admitted, because she kept trying to get restrained and we weren’t. We just kept not, but then she just kept upping, she would do something more violent and more, so you didn’t have any choice than to kind of put a hold on to her. But when we talked about it, she said it was just because it meant, like, somebody was physically holding her and that’s what she really missed. She missed somebody actually, like, physically, physically holding her . . . [it] just seems bizarre because it was horrible to go through to actually get that. And we tried to kind of show her, ‘Well just ask.’ Or we would come up with different ways, ‘If that’s the only reason you’re doing it, then you shouldn’t have to go to that kind of extreme to get a hug or something.’

As the two preceding excerpts reflect, the way staff experienced and talked about the perceived motivations of young people tended to be
gendered; while they acknowledged the presence of uncontrollable feelings for both sexes, there tended to be an emphasis of fighting and/or the venting off of anger with boys and the seeking out of some form of cuddle with girls. Interestingly, the few young people who spoke of a deliberate pursuit of being physically restrained (either related to themselves or their perception of their peers’ behaviour) also tended along similar gendered lines:

Jason (young person): . . . there’s times where you need to be restrained and you feel yourself, there’s some boys in here in the, even, see in [name of establishment] there’s boys that speak to each other and, like, say, ‘Aye, I feel like I like getting restrained to take my anger out away.’

Two other young people spoke candidly of being restrained that reflected a relationship between the need for touch and catharsis:

Sharon (young person): Some kids just need to be held to comfort them.
Interviewer: As a comfort thing?
Sharon: Yeah.
Interviewer: So sometimes do they get held when they haven’t, when they’re not putting anybody at risk, but they just need the comfort of being held? OK.
Sharon: Well they won’t, but like you have to mad before they can do it.
Interviewer: Oh, I see. So maybe a kid really just needs the comfort, but they have to kind of go into that ‘putting at risk’ place to be able to get the hold. Aye? That, what do you think about that?
Sharon: Well I’ve done it a few times.
Interviewer: Yeah? That’s really honest. If there was a way to be able to get that need met without having to go mad, would you have liked to have had a way to do that?
Sharon: Hmm [affirmative].
Interviewer: Yeah?
Sharon: I don’t know how to for, [pause] you don’t, you need to get all your anger out and then you just go mad and then you need to be held.

Helen (young person): I think I just needed a cuddle . . . . That’s just my way of dealing with anger . . . . most of my restraints have been my fault, and it’s through drinking . . . .
Interviewer: You said early on in the interview that you felt like you got restrained, sometimes, to be able to cry.
Helen: Aye.
Interviewer: Do you think sometimes you get restrained to let your anger out?
Helen: Aye, that’s what gets me angry, and I cry . . . . When I’m restrained still, I try and fidget about . . . . the staff will sit there as long as until I calm down . . . . I’m that much angry with all these people around me and I can’t
get any control, and then I start getting angry and then, my eyes all fill up
and then I cry, and once I’ve cried, then I’m alright again . . .

Discussion

Physical touch and holding are central to early experiences of containment. While consistent, intense holding tends to recede as children develop, the need to be held, for many, never completely dissipates. In the private sphere of home life, the way touch-related needs are negotiated rarely falls under scrutiny. Yet, due, in part, to residential child care’s location in the complex and contentious borderland between public and private, touch between staff and children is increasingly perceived as risky.

Staff anxieties about the risks of physical restraint were clearly expressed in interviews. When they spoke of touching young people in nurturing or affectionate ways, their anxieties were conveyed more subtly, percolating through their discussions via the technical-rational language of risk, precaution, surveillance and techniques. Reflections of the wider contexts of moral panic, gendered notions of care and suspicion towards residential child care can be seen in their accounts. These anxieties did not appear to be addressed or managed in ways that could be deemed containing, and this has clear implications for their ability to reflect on and think clearly about their practice.

A potential, unwitting by-product of recent trends towards rules, regulations and procedures may be the legitimisation of physical restraint over other forms of physically touching young people. The feeling of clarity afforded by prescribed techniques and procedures may become unconsciously preferable to the murky, un-prescribed territory of, for example, embracing a young person who simply wants to be held. Twenty-five years on and Whan’s (1986) argument—that rather than serving the practical-moral endeavour, a reliance on the technical-rational is obfuscating it—resonates strongly.

Piper and Smith (2003, p. 883) suggest that child care workers develop ‘distorted cognitive schemas’ as a result of constant fears of accusation. In such defensive climates, ‘affectionate or supportive touch becomes interpreted as extraordinary and abusive, whereas aggressive touch is regarded as the ordinary’ (Piper and Smith, 2003, p. 883). While the dominance of connections between touch and aggression in the young people’s interviews likely reflects a number of factors (e.g. their histories, the focus of the interviews), it nonetheless cannot be ignored as a potential indicator of normalisation of aggressive touch.

The prevalence of pain in participants’ accounts also warrants deeper consideration. Young people’s experience of physical pain, particularly when it is perceived as intentionally inflicted, significantly decreases the
likelihood that physical restraint will be experienced as part of an overall, therapeutically containing process. Moreover, physical pain and occurrence of injury can eclipse underlying emotional pain, shifting focus away from deeper healing work. Anglin (2002) identifies the primary challenge of residential practice as responding to the psycho-emotional pain and pain-based behaviour of young people—pain that is often glossed over in practice and in the literature.

Yet, the divide between physical and emotional pain can be unclear and, for some young people, there is evidence that verbal and symbolic processes may be insufficient to contain their pain and confusion at points of extreme distress. At the same time, the insufficiency of non-physical, non-coercive interventions may reflect a lack of robust therapeutic containment more generally. Herein lies the fundamental question: can a sufficiently therapeutically containing environment render the use of physical restraint unnecessary? While there are reasons to consider this possible (Stevens, 2010), findings from this research also suggests a potential, misguided, opposite answer. It is possible or even likely, given the impact anxiety has on clear thinking, that, in some cases, physical restraint may be misused in order to bring about catharsis. Many of the staff who identified young people as using restraint for purposes of catharsis also described their efforts to avoid the use of restraint. However, in the lead-up to a physical restraint, the complex interplay of emotion, motivation and perception is anything but straightforward and the line between purpose (i.e. prevention of harm) and potential outcome (i.e. catharsis) can become easily blurred. In addition, the anxieties discussed above may inhibit defusing, ameliorating uses of touch and very likely prevent non-coercive holding.

Conversely, there are exceptions. One establishment that participated in the study has an explicit policy that proscribes the use of physical restraint. They do, however, provide massage for young people and staff. In another establishment, a member of staff spoke of non-coercively sitting with her arm around a young person for a prolonged period of time and how this event appeared to stop a pattern of the young person deliberately eliciting physical restraint.

There are no easy formulas for reducing physical restraint; there is also evidence of unreflective, damaging practices resulting from attempts to avoid restraint (Steckley, 2009). As previously stated, for staff to provide therapeutic containment to the young people in their care, they require containing support for the emotional and complex nature of the work. Touch, both its general use in practice and its intensity during physical restraint, is a particularly complex and emotional dimension of the work. Staff’s personal histories and the establishment’s culture both impact on how these complexities are understood and, within the wider contexts of moral panic and suspicion towards residential child care clarity and child-centeredness are extremely difficult to achieve. On the one hand, it can be seen as positive that no staff stated they felt fearful or unwilling to touch young people
in supportive ways. On the other, the apparent lack of reflection on the way touch is constructed and the implications related to the use of physical restraint offer further evidence of the compelling need for more robust containment for staff.

Providing therapeutic containment requires levels of investment: staff must be supported to manage the difficult emotions triggered by the work, they must have clarity of purpose, policy and procedure, and they must have forums for making sense of the uncertain, contentious and complex features of their practice (Ruch, 2007). They, in turn, will be more enabled to absorb the unbearable pain and confusion young people bring to their placements, responding in ways that promote development and healing. This cannot be achieved by an overreliance on technical-rational approaches to understanding and managing practice.

This paper has attempted to establish the relationship between touch, physical restraint and therapeutic containment—a relationship that is not well researched or understood. The wider preoccupation with touch as risky has significant implications for efforts to minimise physical restraint, provide therapeutic containment and increase the likelihood that, when restraints do occur, they are congruent with (rather than damaging to) processes of therapeutic containment.

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References


