University Of Strathclyde
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# Understanding Physical Restraint in Residential Child Care: Juxtaposing Frames of Containment and an Ethic of Care

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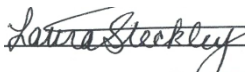
**Declaration of Authenticity and Author's Rights**

This thesis is the result of the author's original research. The critical appraisal and five of the publications have been composed solely by the author; six of the publications have been composed by joint authors (of which the author is one). Details of the author's contributions to the jointly authored publications are provided in Appendix A. This thesis has not been previously submitted for examination which has led to the award of a degree.



Signed:  Date: 8/11/13

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*Due to issues of copyright, the publications are not included in the digital version of this thesis.*

**Abstract**

This PhD is based on 12 pieces of work: 11 published pieces, all of which relate to one large-scale, qualitative study carried out by the applicant and supervised by Professor Andy Kendrick. The study's aim was to explore, in depth, the views and experiences of children, young people, and staff related to physical restraint in residential child care in order to inform policy and practice. The twelfth piece, the critical appraisal, establishes the coherence of the publications, and contextualises and analyses them.

The selected publications reflect a trajectory of development that establishes increasingly complex relationships between features of the social ecology of physical restraint, and theoretical analyses that offer a way of understanding this complexity. Several key themes run through all of the publications, including complexity, ambiguity, relationship, meaning making and therapeutic containment. The last theme, therapeutic containment, is the most theoretically developed and offers an encompassing frame within which to make sense of the others.

The critical appraisal examines the publications from a macro perspective. It introduces Goffman's Frame analysis and explores several frames for understanding the practice of physically restraining children and young people in residential child care. Two new frames are then explored and combined with therapeutic containment, resulting in a three-part combined frame which is offered to better understand and to inform related policy and practice; they are Bion's micro-level containment, Goffman's macro-level containment, and Tronto's political-philosophical ethic of care. The publications are re-viewed through this frame assembly, and the ensuing discussion is organised around three key themes: order versus havoc, anxiety and fear, and policy and practice. It is argued that the use (and misuse) of physical restraint, an extreme form of containment, is predicated on inadequate processes of care and containment at micro and macro-levels.

**Critical Appraisal**

**Chapter 1**

**Introduction**

This PhD by publication is based on 12 pieces of work: five articles from peer reviewed, academic journals; two chapters from edited books; three pieces from online and paper based journals aimed at practitioners and managers; one guidance document commissioned by the then Scottish Executive; and this critical appraisal, the purpose and structure of which will be explained further in this introduction. All of the publications relate (directly or indirectly) to one large-scale, qualitative study[1].

This introductory chapter offers a brief context for the body of work, including a short discussion of the study and its methodology; it also briefly fills in some gaps left by the portfolio of publications. An account of the interrelationship of the publications follows; it explains the choice of articles and establishes their coherence. Finally, the focus and content of this critical appraisal is introduced.

**Context**

The context of physical restraint in residential child care is concerning and complex; it has been addressed directly and indirectly in all of the portfolio publications and will be explored further in this critical appraisal. The history of restraint, however, has not been addressed and it is also a contextual feature. Historically, more appears to be known about the restraint of people with mental illnesses. As far back as Ancient Greece, references have been made to the use of chains and fetters to prevent those deemed mentally ill from causing harm to themselves or others (Vaughan, cited in Garland, 2008). Appeals for proper criteria and humane use of shackles appear as far back as the second century, A.D., though records of more vociferous and coordinated

[1] Kendrick, A. (P.I.) & Steckely, L. (2003-2006). *Children, young people's and staff's views and experiences of physical restraint in residential child care.* Save the Children, Scotland. £25,000.

efforts to address the use of chains and other forms of mechanical restraint started to emerge in the 18th Century (Yorston & Haw, 2009). Gardiner Hill and Charlesworth are generally regarded as the pioneers of the non-restraint movement in the UK, with mechanical restraints being gradually replaced by physical holding in the 19th Century (ibid). 19th Century America, however, had a much more positive view of mechanical restraints, seeing their use as integral to the therapeutic process (Masters, 2008). Innovations in medicine contributed to the use of psychotropic drugs and even surgical procedures (i.e. frontal lobotomy) to restraint patients in the 20th Century, and while physical holding currently tends to be the preferred form of restraint, Yorston and Haw note a "comeback" in the use of mechanical restraining belts in British Hospitals (2008, p.14).

Little has been written about the history of restraint of children and young people, with concerns about physical restraint emerging in the latter half of the 20th Century due to reports of abuse, injuries, restraint-related deaths and the development of the UNCRC (and a related children's rights discourse) – all of which are discussed in publication 3. The clear constant across the history of restraint was and continues to be the struggle to restore or maintain safety in the face of imminently or actually harmful behaviour without causing further damage to those involved.

The study at the centre of the portfolio has been discussed in most of the publications, as has its methodology and methods (in publications 3,4,5,6,8 & 11). Its aim was to explore, in depth, the views and experiences of children, young people, and staff related to physical restraint in residential child care in order to inform policy and practice. 37 young people and 41 residential staff members from 20 residential child care establishments participated in the study via in-depth interviews that used vignettes and semi-structured interview schedules. A methodological dimension heretofore unaddressed is my relationship to this study. Under the supervision of Professor Andrew Kendrick, I designed the vignettes and the semi-structured interview schedules. I also carried out all but two of the interviews and coded all of the interview transcripts. Throughout the process of analysis I also wrote frequent

'memos' (di Gregoria, 2003) – accounts of thoughts, insights and hunches related to individual interviews, patterns across interviews, evolution of codes and links between codes. I did not choose the subject of physical restraint for my first large-scale study; it had been decided upon prior to my arrival in 2003 as a part time lecturer, part time research assistant. It was, however, a subject I had deeply reflected upon due to my own related experiences in practice. I have physically restrained young people, I have trained others in methods of de-escalation and restraint, and I have worked to reduce the use of restraint in my places of work.

Whatever one's history, reflexivity is necessary to manage bias and promote transparency. Etherington (2007) identifies reflexivity as a skill developed in therapeutic settings to enable self-awareness in informing practice. She then transfers this same skill to research, referring to it as a tool that includes the self, "making transparent the values and beliefs we hold that almost certainly influence the research process and its outcomes" (p. 601). My background in residential child care practice (in both the United States and the United Kingdom) was a double-edged sword in carrying out and writing up the research. I suspect that some interview participants may have felt less defensive and therefore spoke in more depth about their views and experiences of restraint than they might have had they thought I had no understanding of the context. At the same time, I had to be ever watchful so that my own views did not direct their responses or obscure my findings. So while I endeavoured to create data collection instruments that were balanced, interview environments that elicited a full range of views (even those that were uncomfortable to hear), and processes of analysis that were consistently self-challenging, I could not (and, in the final analysis, did not want to) erase myself completely from the research context (Darlington & Scott, 2002).

A deeper and more comprehensive discussion of reflexivity in relation to the study is beyond the scope of this critical appraisal[2]. A brief account of my own related values and beliefs, however, is warranted so that readers can

[2] A forthcoming, related article is in progress.

draw their own conclusions about my conclusions. I approached the study with the belief, based on direct experience, that physical restraint was sometimes misused to exact compliance (or worse), and that it was also sometimes necessary to restore safety. I understood this to be a complex and challenging area of practice. I was never satisfied with our efforts, in any of the places I worked, to ensure that restraint was only done to prevent imminent harm and when other, less intrusive responses were not possible. I was also particularly interested in exploring the views and experiences of young people, with a view towards robust inclusion of their voices in subsequent dissemination. Some other values and beliefs are directly relevant and are extracted from a reflexive passage in my Master's dissertation:

> While I believe specialist services or a counselling approach are sometimes necessary to assist young people in recovering from trauma, I believe that relationships between young people and care staff are the most powerful and important aspect of good practice in residential child care. I also believe that an understanding of the potential and complexities of the lifespace, alongside better knowledge and application of developmental theory and models of practice, are necessary for frontline practitioners to utilise this lifespace and relationships for the therapeutic benefit of young people; for this to come about, a significant proportion of research and theory must emanate directly from residential child care (Steckley, 2007, pp. 6-7).

Many of the arguments emanating from this portfolio stem from my belief in and commitment to the ameliorative potential of residential child care to provide therapeutic containment to children, young people and, where possible, their families. As mentioned in publication 8, the need for therapeutic approaches has been highlighted in inquiry recommendations but remains inconsistent in Scotland. Therapeutic communities for children and young people clearly foreground this need for containment (see, for example, Ward, Kasinski, Pooley & Worthington, 2003). Principles of the therapeutic community model of practice include the value of groupwork, community

meetings, individual relationships and everyday interactions as integrated media for the promotion of therapeutic processes (Ward, 2003). What distinguishes therapeutic communities from other models of residential child care is the understanding of the community itself as the source of the therapeutic endeavour rather than simply a place where adults or experts provide therapy (or simply care) to children and young people (ibid). Therapeutic communities are rare in Scotland, and are declining across the U.K. (Hinshelwood, 2012; Pearce & Haigh, 2008; Yates, 2003) While I have worked in residential establishments which had an explicit remit of providing therapeutic services, none have been aligned with enough with the basic principles of the therapeutic communities model to be identified as such. This has been particularly the case in relation to even basic psychodynamic thinking, with an almost complete absence of an active appreciation of and support for the unconscious dimension of practice; this also appears to be the case in all of the workplaces for which I have provided consultancy or from which students have attended my classes. Sharpe (2006) addresses a growing resistance in the residential child care sector towards psychodynamic approaches and argues for renewed investment in their contribution to the work. It is perhaps because of my own experiences of deficiently informed practice in this regard that motivates, at least in part, the completion of this portfolio.

During the course of the study, my related beliefs have become even more complex and nuanced, and this can be seen in the portfolio publications. For example, in publications 7 and 9, I begin to explore whether the belief that physical restraint is sometimes necessary contributes to making it necessary. In publication 11, the impact of our collective (and changing) beliefs about touch between adults and children on physical restraint is explored. And finally, my initial belief in the importance of 'giving voice' has been challenged and deepened, both through the complex practice of endeavouring to do so with integrity to respondents' own meanings, and with the support of related literature (see, for example, Alcoff, 1991; Fielding, 2004; Tangen, 2008)[3].

[3] Another forthcoming, related article is also in progress.

## Interrelationship of the Publications

The selected publications reflect a trajectory of development that establishes increasingly complex relationships between contextual factors that affect physical restraint. They also reflect a development of theoretical analyses which offer conceptual frames for understanding this contextual complexity in a way that can inform policy and practice. For easier observation of these trajectories, they are presented in ascending order of publication date (with the exception of the first publication, and this will be explained below).

The selection comprises more publications than the minimum required; the inclusion of articles addressed to both academic audiences (i.e. peer reviewed) and to practitioner audiences is deliberate (though the two are not mutually exclusive). In practice-based disciplines, quality of research and publication is not simply about measures of academic impact, but also about improving practice for the benefit of service users (Orme & Powell, 2007). The process of professionalizing the residential child care work force has only recently begun, with current practitioners requiring a more accessible pitch and voice in order to engage meaningfully with research literature. This poses different (but nonetheless important) requirements for impact and rigour. Practitioner journals also afford a different kind of space for explanation and exploration, and each publication contains content that makes a unique contribution to this portfolio (A brief summary of each publication can be found in Appendix A).

Five key themes can be identified threading through all of the publications. They are briefly discussed here to establish the coherence of the publications before identifying, in the next section of this chapter, what will be the key themes of the remainder of this critical appraisal – slightly different but strongly related. The first and most dominant is the theme of complexity and ambiguity, with each publication engaging in the complexities of relationship, tensions of care and control, and the ambiguous nature of self, other and child-centredness in highly charged situations. The work of residential child care has tended to be simplified, with an emphasis on providing ordinary,

normalising experiences for children and young people (Ward, 2006). Yet abuse, neglect and other forms of trauma feature in the histories of most children and young people in residential child care, and a greater understanding of the complex, extraordinarily demanding nature of meeting their needs is necessary (Anglin, 2002; Garfat, 1998; Mann, 2003; Ward, 2006). Situations leading up to and involving the practice of physical restraint is one of the strongest illustrations of this demanding complexity, and this is illuminated by the findings of this study.

Advanced notions of relationships as central to practice (Garfat, 2008; Ruch, Turney, & Ward, 2010; Trevithick, 2003) provide the grounding for a second dominant theme across the selected publications: that restraint must be understood within the context of the relationships of those people involved. These relationships necessarily tread an ambiguous 'intermediate zone' (Barter, Renold, Berridge, & Cawson, 2004) where the public world of work and the private world of care-giving and care-receiving overlap – and sometimes collide. Within these relationships, meaning making (Bruner, 1990; Garfat, 2004) can be identified as a third, key theme. Garfat explains the relevance of this concept by highlighting the unique way in which each individual experiences a process or event, and therefore constructs different related meaning about that event or process. By attending to meaning-making throughout the process of intervention, the practitioner can enter an "expanded world of therapeutic opportunity" (Polster, cited in Garfat, 1998, p. 97) and be of assistance in helping the young person to find ways to makes sense of things differently. Attending to the processes through which staff and young people make meaning about restraint generally, and about actual incidents of restraint specifically, would enhance the effectiveness of residential establishments' attempts to address most, if not all, of the themes highlighted by Colton (2004) and the Child Welfare League of America (Bullard *et al.* 2003) for reducing the use of physical restraint.

Beyond a micro level orientation, the complexities related to physical restraint exceed a traditional perspective of the problem residing in either the behaviour of the child or the deficits in the staffs' response (Leadbetter &

Paterson, 2004). They are multi-layered and exist at the interpersonal, organisational and societal levels. A fourth key theme uniting all of the selected publications focuses on the complex interplay of these layers and their impacts on residential child care practice generally, and physical restraint specifically.

Therapeutic containment (Bion, 1962), the fifth identified theme connecting the publications, offers an organising frame for making sense of addressing the above stated complexities in order to reduce or eliminate physical restraint while still meeting the needs of children and young people in residential child care. As a result and for the purposes of this critical appraisal, it is the most important. While the basic principles of containment theory have intuitive appeal, the term carries troublesome (Meyer & Land, 2006) associations which interfere with understanding. This will be discussed further in Chapter 2. It is for this reason that the first publication presented in this portfolio is out of sequence from the aforementioned ascending order, as it offers a clear, illustrative account of containment theory for those unfamiliar with the theory and provides a foundation for understanding containment at the macro-level. The importance of this is explained in the next section.

The central argument emanating from these publications is that for physical restraint in residential child care to be reduced (and where possible, eliminated), the creation of robustly containing environments for children, young people and the residential practitioners who care for them is necessary. Such environments are also necessary so that when restraints do occur, they are more likely to be experienced as part of an overall process of therapeutic containment.

## Critical Appraisal: Focus and Content

The purpose of the critical appraisal, as defined by the University of Strathclyde (HASS Graduate School, 2010), is to establish the coherence of the publications and to contextualise and analyse them. Because most of the publications derive from the study mentioned previously, and because all of them relate to the focus of the study, the work of establishing their coherence to one another can be done briefly (as above). While the complex, multi-layered nature of physical restraint was discussed in many of this portfolio's publications, their focus is primarily at a micro-level. This critical commentary, then, steps back in Chapter 2 to examine the publications from a macro perspective. It starts by focusing on Goffman's Frame Analysis (1974) to argue the importance of considering current and possible frames for understanding and changing the practice of physically restraining children and young people in residential child care. Two new frames are then explored and combined with therapeutic containment, resulting in a three-part combined frame which is offered to better understand and inform related policy and practice. This three-part frame is comprised of: Bion's micro-level containment, Goffman's macro-level containment (1969), and Tronto's political-philosophical ethic of care (1994). The publications are then re-viewed through this frame assembly in Chapter 3, and the ensuing discussion is organised around three key themes: *order versus havoc, anxiety and fear, and policy and practice*. It is argued that the use (and misuse) of physical restraint, an extreme form of containment, is predicated on inadequate processes of containment at micro and macro-levels – both of which are reflected in the three aforementioned themes.

**Critical Appraisal**

**Chapter 2**

**Frames**

This chapter introduces the concept of frames[4] for understanding social phenomenon generally, and establishes their relevance to the phenomenon of physical restraint in residential child care through the application of established frames. Three key frames, based on the work of Bion (1962), Goffman (1969) and Tronto (1994), are then discussed in more depth as they will then comprise a combined frame (or 'frame assembly' (Schieff, 2006)) in the next chapter for use in exploring the portfolio publications.

## Frame Analysis

Frame Analysis refers to the examination of the way in which social situations are defined in accordance with principles of organisation which govern social events (Goffman, 1974). It is a type of discourse analysis (Paterson, 2008). Frames, then, are organised rules, principles and meanings that are applied to social situations; they are often unstated but usually tacitly shared by social actors. According to Goffman, a frame enables "its user to locate, perceive, identify, and label a seemingly infinite number of concrete occurrences defined in its terms" (p. 21). In other words, it makes the world intelligible. Generally, individuals are not aware of the frames through which they make sense of the world, and Goffman's frame analysis is an exercise in making visible this organisation and shaping of meaning.

Jameson (1976), in his lengthy review of *Frame Analysis*, highlights its shift in emphasis from the content of social phenomenon to the form and nature of

[4] The use of the term 'frame' within this critical appraisal is congruent with Goffman's definition as described in the *Frame Analysis* section of this chapter, though it takes an expanded approach. For purposes of clarity, 'frames' and 'framing' refer to collective ways of understanding. These include the general framing of social phenomenon as well as psychological, sociological, and political-philosophical theory as frames.

social meaning more generally. This emphasis on form and nature of social meaning is part of a wider argument that “meanings, in everyday life, are the projection of the structure or form of the experiences in which they are embodied” (ibid, p. 119). This structure has only been touched on in the publications that constitute this portfolio. By focusing on the frames through which residential child care generally and physical restraint specifically are understood, the influence of social structures can be made visible and their influence can be explored.

In a youth-led study of care leavers’ experiences of care, Snow (2008, p. 1290) contends that by “understanding the meaning and structures of a community, we understand more fully the lived experience of a community that is not our own.” The meaning ascribed to individual occurrences of physical restraint and to the practice of physical restraint more generally have been highlighted in several of my publications (3,5,7,8,9 & 11). Also, most of the publications touch on the context within which residential child care struggles to meet the needs of children and young people in its care, and how elements of this context add further layers of complexity to this already complex area of practice. Goffman’s frame analysis is valuable in organising some of that context and adding to it in a way that further illuminates the meanings ascribed to physical restraint. In so doing, those meanings can be challenged and reconstructed in a way that better serves children and young people.

In any moment, several frames may apply, may be applied, and may even come into contradiction with each other in the process of in how individuals make sense of an event. “[A] multitude of frameworks may be involved or none at all” (Goffman, 1974, p. 26). So while the meanings ascribed to an event or phenomenon may indeed reflect wider social structures, individuals exercise some degree of agency over which frames are applied.

By illuminating, challenging and modifying our frames, a greater degree of agency can be exercised related to understanding and addressing the practice of physical restraint.

*Frames of physical restraint*

When primary frameworks are taken together, they constitute a central element of the culture of a given social group and Goffman (1974, p. 27) urges us to "try to form an image of a group's framework or frameworks – its belief system, its 'cosmology'." Much of the work of this critical appraisal is to offer a plausible set of frames for understanding physical restraint in residential child care, and through these frames, explore central relevant tensions; these will be discussed in the *Order and Havoc*, *Fear and Anxiety*, and *Policy and Practice* sections of the next chapter.

Paterson, Leadbetter, Miller and Bowie (2010) identify and apply frames to the cognate area of violence in mental health settings, and physical restraint is discussed in the process. In their analysis, they highlight the confirmation of framing theory in psychological studies and offer Snow, Rochford, Worden and Benford's (1986) two levels of frames: *master frames* which organise meaning more broadly, and *domain-specific interpretive frames* which, as suggested by their title, are specific to a particular domain . The significance of this distinction is twofold: domain specific frames are organised by master frames, and the interaction of master frames within a specific domain, whether aligning or competing, casts an added significance to the shape taken by domain-specific frames.

Paterson et al. (2010) identify three master frames which organise understanding and responses to violence in mental health settings. The first is a classic *discourse of deviancy* in which social control and punishment are necessary to protect society from deviants. The reasons for deviant behaviour is located within the individual deemed deviant, and control and punishment serve the normative function of maintaining moral boundaries between the 'good' and the 'bad'. The second identified frame is that of *mental illness*. In contrast to the deviancy frame, the culpability of the offender is called into question rather than assumed and control continues to

be justified, but *in extremis* in order to preserve safety. It is also significant that, historically, systematic punishment of the mentally ill was considered a form of treatment to induce compliance (Foucault, 1977; Goffman, 1961). The residue of these ways of thinking continues to exert influence in residential child care in subtle ways, particularly in the enduring tendency towards punishment[5], cloaked in the language of 'consequences' or 'point and level systems', as necessary to keep young people under control (Garfat, 2003; Mohr, Martin, Olson, Pumariegia, & Branca, 2009; VanderVen, 1995). The third frame is identified as emerging from current preoccupations with risk and is labelled an *individualising frame (Paterson et al., 2010)*. Risks are attributed to individuals and their behaviour, excluding the consideration of other factors relevant to the situation or the wider context. This individualising frame is reflected in zero tolerance policies, which "fail to acknowledge the need for services to reflect upon what may be the root causes of violence in order to inform preventative strategies" (Paterson et al.2010, p. 312).

*Frames of Restraint in Residential Child Care*

Paterson, Leadbetter, Miller and Crichton (2008, p. 127) identify the same individualising frame as dominating "explanations of aggression and violence in residential services for children." This can be seen as a master frame, affecting the domain-specific frames for restraint across and within the sector. Within many of the publications in this portfolio (2,3,5,6,7,8,10 & 11), I consistently argue that physical restraint must be understood within its wider context, and this argument is necessary because of the individualised way in which restraint is currently viewed – either as a result of the pathology of the child or the inadequacy of the adults who respond to that child (Leadbetter, 1996; Ross, 1994). Residential child care in the United Kingdom has struggled with conflicting tensions of pathologising children, on the one hand, and failing to meet their severe and complex needs in an effort to avoid

[5] It can also be argued that tendencies towards punishment are primarily derived from experiences of upbringing and particularly from the (mis)application of behavioural theory, though there is likely a relationship between the latter and both the discourses of deviancy and the mental illness frame.

stigma (Ward, 2006), on the other. Regardless of efforts to normalise and provide 'normal' experiences and environments, consistent with the Paterson et al.'s (2010) *mental illness* frame, physical restraint in residential child care has consistently been justified in order to preserve or restore safety (publications 2,3,4,5,6,7,8,9,10,11).

While restraint may be seen as justified, it is negatively framed on a consistent basis. Colton (2008) describes this justification or acceptance as existing along a continuum: at one end, it is viewed as a form of control which has little or no clinical empirical support, provides no therapeutic benefits and may lead to further harm. He contrasts this with a view of restraint as a 'necessary evil' when other interventions have failed, but nonetheless seen as one of many available therapeutic interventions. Some sources go so far as to label physical restraint as indicative of treatment failure (LaFond, 2009; The Mental Health Commission, 2012). Restraints as therapeutic in themselves have almost completely disappeared from the literature, and the argument that they may have therapeutic value in their own right is strongly refuted by key authors in the field (Day, 2000; Mohr, Petti, & Mohr, 2003). In this portfolio, similar frames are touched on: publication 7 highlights a view of restraint as always experienced as forceful or coercive, and publication 9 can be seen as a struggle between the two authors to clarify and defend two very different ways of framing restraint. The first author's frame is also one of restraint as (always) violent and damaging, though still justified in order to preserve safety (reflecting the above-mentioned mental illness frame). The way of understanding I am suggesting is more nuanced and reflects frames of containment, care and co-creation (all of which will be discussed further in this critical appraisal).

While other sectors also struggle to address concerns about physical restraint, particularly where injury or death occurs (e.g. mental health settings, law enforcement – see publication 3), that the subjects of physical restraint in this context are children considerably distinguishes the way it is framed. A focus on the multiple ways in which children and childhood is understood has paradigmatically transformed the sub-discipline of childhood history (Morrison,

2012) and current policy and practice; it comprises a broad and deep literature (see, for example, Aries, 1962; James, Jenks, & Prout, 1998; Mayall, 2002; Prout, 2005; Prout & James, 1997). This shift marked a trend towards understanding childhood not simply from adult perspectives, institutions and theorising, but from children's own words (Clark & Statham, 2005; Greene & Hogan, 2005; Hallett & Prout, 2003). Clearly, my study was influenced by this shift (i.e. in the decision include in-depth interviews with young people). While the frames through which we understand children and childhood clearly are master frames that influence the domain-specific frames of residential child care, due to the scope and primary focus of this critical appraisal, they will only be touched upon briefly here.

Publication 4 highlights dominant discourses of children as victims or villains, with an emphasis on the former that frames children as weak, poor, needy, vulnerable and incompetent (p. 80 citing Moss & Petrie, 2002). Related to child welfare, Abrams (1998) highlights a rescue agenda driving the boarding out and provision of institutional care for children from the nineteenth century onwards. The frame of children as victims can be seen in the way they are deemed innocent of the actions of their 'worthless, indigent parents' (p. 27). By rescuing them from the appalling conditions of poverty and from the 'moral decay' (ibid) of their environment, their potential to become useful citizens was supposed to be fostered. At the same time, up to the last few decades, children's homes have been characterised by pervasive regimentation and discipline, keeping children under control and out of mischief (ibid) so that they do not become villainous. The residue of the rescue impulse can still be seen in residential care today, with disproportionately little and/or negative focus on the family (Pilkington, 2010). There is a dearth of research and evidence-based literature on family work in the sector, and in my own experience of practice, teaching and consultancy, working with families rates a low priority with few or no dedicated resources. At the same time, children in residential child care also continue to be associated with villainy – so much so that a government supported anti-stigma campaign ('Give me a Chance') was started in 2008.

Other master frames also organise the domain-specific way physical restraint is framed in residential child care. The remainder of this chapter is dedicated to two: frames of containment and frames of care. Each is discussed in turn.

*Containment*

In charting the trajectory of the publications that constitute this PhD, therapeutic containment evolves into the most dominant and developed theoretical thread, or domain-specific frame, for understanding physical restraint in residential child care. Several publications explain and apply Bion's theory of containment (1962) in some depth (1,3,5,6,7,8,10 & 11), with publication 1 placed at the beginning to provide a basic, straight forward introduction for those unfamiliar with the theory. The explanation and application of his theory will not be reproduced here, but several key elements that make it particularly useful for understanding physical restraint in residential child care are noted: its focus on the development of thinking to manage experience and emotion; its applicability not only to young people in crisis, but to staff and organisational needs as well (linking macro-elements to the micro-level); its illumination of the disruptive impact of anxiety on clear thinking; and its congruence with caring processes – the relevance of which should become clearer later in this chapter. Bion's (2003) thinking also addresses containment at organisational levels, with Menzies (1960, laterally known as Menzies Lyth) building on that thinking to offer an empirically informed theory of social defences that continues to illuminate the "interplay between organisational processes and anxiety across a range of contexts" (Lees, Meyer, & Rafferty, 2011, p.5). These social systems, which function to protect workers from anxieties triggered by the work, are likely to be rigid, uncomfortable and difficult to change as long as they remain unconscious processes (Pearce & Haigh, 2008). Insight into these processes can serve to bridge our understanding of micro and macro-level phenomena, though given the scope of this critical appraisal, a more in-depth exploration and analysis from a (psychodynamic) social systems perspective will not be included.

From a macro point of view, one that examines processes and structures at societal levels, containment tends to be seen in a negative light. The word 'containment' is almost always used in the process of describing the constraining, oppressive, marginalising and silencing effect of social structures. For example, Tronto (1994), who is discussed in greater depth further in this chapter, describes how the work of care is 'contained' in ways that marginalise those who directly give care, keeping it in the province of the least powerful in society. Even Goffman, in *Frame Analysis* (1974), uses the term 'contained' to refer to individuals who are intentionally deceived into false understandings. That containment is used so disparagingly in the residential child care sector is addressed in publications 1, 7, 8 and 11, and this negative macro view is a likely contributor.

Despite Goffman's use of the term (as described above) in *Frame Analysis* (1974), he is one of the few macro theorists who takes a more complex and nuanced view of macro-level containment[6]. It is a theme running through many of his books (*Asylums, Stigma, Frame Analysis)*, but is most clearly articulated in a short (relative to Goffman) essay called *The Insanity of Place* (1969). In it, Goffman identifies the significant limitations of the medical model for understanding mental illness and related 'mental symptoms'. He made this argument at a time when psychiatric institutionalisation was losing hold as the default response to people with significant symptoms of mental illness. *Insanity of Place* argues for a precursor to what, today, would be labelled 'community care', and in the process, highlights the social impact of 'mental symptoms'. It is within this argument that his philosophy of containment is articulated.

Generally speaking, Goffman's containment refers to the constant effort to maintain social order. Its opposite, havoc, is the disruption of social order. "It is this havoc that the philosophy of containment must deal with," Goffman proclaims (p. 369) and its meaning a way in to understanding "what

[6] Walter Reckless is probably the most notable containment theorist, but because his focus is on deviance and his context is criminology, Goffman's containment, while less well known, is more relevant for the purposes of this critical appraisal. The relevance is demonstrated in this section.

containment implies" (p. 358). We come to understand containment by looking at its opposite. The social disruption caused by a person in a manic or actively paranoid state are, for Goffman, particularly revealing in the resultant havoc that is produced, telling us about the processes of social control that are necessary for containment.

Conceptualisations of residential child care tend to shy away from language that explicitly focuses on control. Yet the processes of unravelling that lead to a young person being removed from his or her family of origin, and the chaos that can often thrum below the surface in a residential establishment – sometimes breaking through in ways frightening to young people and staff alike – keep the issue of control always close at hand. It is within this tension that the thinking about and practice of physical restraint can become unclear and damaging, and this will be explored in more depth in the next chapter.

Similarly, tensions related to reticence about and misuse of power can undermine efforts to reduce restraint. Power can be defined as "being able to make or to receive any change, or to resist it" (Lukes, 2005, p. 69) and this definition was chosen because it incorporates more than just observable events or outcomes to include capacities of individual agents, the relevance of their contexts, and the structures within which they operate. While Goffman has been criticised for neglecting the importance of power (Gouldner, cited in Jenkins, 2008), Jenkins argues that close reading of his work yields significant insight into the essence and workings of power such that "we ought to think of Goffman as a significant theorist of power" (Jenkins, 2008, p. 157). The previous discussion on frames can indeed be seen as an exploration of one aspect of power in simultaneously facilitating and constraining interpretation and meaning.

Increasingly, links between Goffman and Foucault, arguably the most significant theorist of power of the late 20th Century (Gaventa, 2003; Jenkins, 2008; Lukes, 2005), are being made (Burns, 1992; Hancock & Garner, 2011; Jenkins, 2008). Both Foucault and Goffman reveal the 'micro-physics of power' as well as "processes of ideological control" – referred to as 'bio-

power' and 'discourse' by Foucault, and as 'frames' and 'normative order' by Goffman (Hancock & Garner, 2011, p. 334). Both also share similar conceptual ground in their treatment of power as ubiquitous and mundanely invisible (Burns, 1992), and both view power as both repressive and productive (Hancock & Garner, 2011).

Also of relevance to this discussion is Foucault's assertion about the inextricable, even symbiotic connection between knowledge and power:

> We should admit rather that power produces knowledge…that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (Foucault, 1977, p.27).

So while my own efforts to illuminate the practice of physical restraint by combining the views of those who are simultaneously most affected and least powerful with an analysis of the often invisible contextual factors that powerfully affect this practice, I am also bound up in a "socially constructed (and implicitly disempowering) system of knowing things" (Schwan & Shapiro, 2011, p. 47). Thus, my attempts to reveal and reframe are limited by the ways in which my own position of relative power and related dominant frames constrain my ability to see, think, write or practice. For example, seeing the interview as a "blunt instrument" (McLeod, 2007, p. 281) or the ubiquity of power issues within every aspect of research relationships (Etherington, 2007, p. 614) did not occur to me at the time of data collection, but only subsequently as part of my exposure to frames of research reflexivity.

Goffman's theory of containment offers insights about power; it can illuminate the macro dimension of physical restraint in residential child care and help us to think more clearly about the relevance of power and control. This will be explored in more depth the *Order versus Havoc* section in the next chapter.

Goffman's philosophy of containment, then, is a frame for understanding social regulation and social control and he offers a detailed account of how it works. It is enacted by individuals exercising *personal control* over their own conduct, offering subtle warnings or disapproval to fellows through *informal social control,* and exercising societally sanctioned controls through *formal social control.* The three are interrelated and each affects the other; this takes on a particular relevance when considering the havoc wrought by the symptoms of an individual with mental ill health, as Goffman points out:

> …the efficacy of informal and formal social control depends to a degree on personal control, for control that is initiated outside the offender will not be very effective unless it can in some degree awaken corrective action from within (364).

Like people in a manic or actively paranoid state, young people who have experienced significant disruption to their development (especially their development of self-regulation and/or empathy) may not have the capacity to take corrective action themselves. Indeed the processes of regulation that take place in the family are part of the development of self-regulation for all children. Also, many young people who find themselves in residential child care have significant, justified rage (Barton, Gonzalez, & Tomlinson, 2012; Daniel, Wassel, & Gilligan, 2011). A lack of motivation for self-correcting action, when everything round about feels (and often is) wrong, can be seen as a sign of health rather than deviance.

Additionally, Goffman is arguing that social control is far less mechanistic than that which might be rendered by this model (thus far). Disruptions, transgressions and deviations can be contained not only by corrective action, but also by adaptation of the boundaries or structures of the social system. These often occur through processes of negotiation and "remedial ritual work" (p. 365) -- apologies and requests, and other forms of conveying a willingness to keep one's place in the social order. When viewed through this frame, containment is a much more nuanced process not simply reserved for those who exhibit deviant behaviour:

> Without self-control, without containment of our emotions, psychological states, and actions, “society” would no longer function. A society without containment is a society…of havoc, one that has become unpredictable or unmanageable from the point of view of one or possibly even all participants. Containment is the necessary effort to restore predictability…(Hancock & Garner, 2011, p. 321)

Similarly, predictability and the containment of emotions, psychological states and actions are necessary for a residential environment to function. Havoc, then, occurs when perceived social offenses are not amenable to neutralisation by concealment, remedial ritual work, withdrawal, or formal or informal means of control (Goffman, 1969). Hancock and Garner define it as:

> the final breakdown of normative interactions…[leading] to the dissolution of a situation and ultimately the social order…[it] names the condition in which individuals are not able to be self-governing or self-sufficient in society (2011, p. 323).

The way that practitioners and young people describe some occurrences leading up to restraint (particularly in publications 5,6,7 & 8) resonates with this definition.

While there are many loci of social organisation where havoc occurs, Goffman focuses most of his discussion on the family. He even touches on issues relevant to physical restraint:

> Sheer manhandling that is not responded to by tacit cooperation requires the full effort of at least two strong adults and even then can only be managed in brief spurts – long enough to remove someone from a house, but not much longer. Even merely to stand watch and guard over a person requires more than a household can usually manage for very long. And the household itself can hardly be run if everything that might be damageable or dangerous must be kept out of … reach (p. 375).

Goffman stresses that it is not the unpleasantness caused by havoc that is of such importance, but the threat to the meaningful existence of the family members. "In ceasing to know the sick person, they cease to be sure of themselves. In ceasing to be sure of him and themselves, they can even cease to be sure of their way of knowing" (p.374). In other words, the individual with 'mental symptoms' no longer enacts self-assumptions that are congruent with family members' definition of him and the family members cannot adjust their definitions so that congruence can be achieved (e.g. an individual who comes to believe he is Jesus Christ). The inability for socially recognised departure makes the family particularly vulnerable to havoc, and families struggling to contain their child are similarly vulnerable. Because the child cannot do remedial ritual work, cannot simply be withdrawn or ejected from the family, and cannot simply be redefined, havoc results and causes complete disruption to the family and the minds of its members. "The family is turned inside out" (p.383). This last phrase reflects the kind of language that intuitively or even metaphorically represents containment (or the lack thereof) and resonates strongly with the way containment has been applied in this portfolio.

While Goffman's illustrative examples tend to be primarily on a micro-level, Hancock and Garner argue that his theorising about containment and havoc is an implicit macro-analysis of social order and links the micro to the macro:

> Havoc and its containment are potentially present in all social relationships and form the foundation of individuals' relationships with each other and to organizations and larger gatherings. Thus the pair havoc/containment links micro and macro processes (2011, pp. 323-324).

Bion (1962) and subsequent related theorists offer a clear frame for understanding havoc and containment at the individual, micro-level (see publications 1, 7 & 8), and there are strong parallels with Goffman's macro-level frame. Both describe containment as an on-going, complex, relational and nuanced process. According to each frame, containment enables

understanding. For Bion, it is the understanding of one's experiences and emotions that is enabled; for Goffman, it is the understanding of "the incoherence, irrationality, unreason, incomprehensibility and unbearableness of social life" (Hancock & Garner, 2011, p. 317). Without containment, the world and our experiences within it become incomprehensible and unbearable.

For Goffman, containment is necessary to prevent the dissolution of social order, but he also concedes the dark side of containment:

> So-called mental symptoms, on the other hand, are made up of the very substance of social obligation. Mental symptoms directly express the whole array of divisive social alignments…These divisive alignments do not – in the first instance – constitute malfunctioning of the individual, but rather disturbance and trouble in a relationship or an organisation…there is a multitude of reasons why someone who is not mentally ill at all, but who finds he can neither leave an organiszation nor basically alter it, might introduce exactly the same trouble as is caused by patients. All the terms I have used to describe the offensive behaviour of the patient – and the term "patient" itself – are expressions of the viewpoint of parties with special interests (Goffman, 1969, p. 386).

Whereas Bion's containment is fundamentally necessary for the cognitive, emotional and social development of the individual, Goffman's containment is necessary for purposes of prevention, specifically the prevention of havoc. There is no explicit promotional benefit, other than the promotion of the status quo – a status quo which is significantly more beneficial for some than for others. The potential stigma and oppression individuals may experience when being contained is the cost of this necessary process.

One of Goffman's significant contributions to sociological thinking, however, has been described as deconstructing the assumptive realities of society (Schieff, 2006); liberation from stigma and oppression, for Goffman, is pursued by illuminating and challenging the frames we use to define our

current realities. Yet, a key component is missing from his frame of containment, one which makes possible a less brutal, macro-level containment. Its absence is likely due to long-standing assumptive realities about individuals as independent, autonomous and self-contained – a trope most often attacked by Goffman (ibid). This missing component is care.

**Care**

Frames for understanding care have been best illuminated by the literature of care ethics. Gilligan's (1982, 1993) critique of Kohlberg's psychological theory of moral development was seminal in articulating much of the early thinking that underpins care ethics. In it, she reframed questions of morality to make "relational realities explicit – how to live in relationship with others, what to do in the face of conflict" (p. xiv). She emphasised the realities of concrete circumstances and interpersonal responsibilities, as opposed to the formal, abstract, impartial applications of universal principles that dominated moral philosophy and theories of moral development at that time. This 'different voice' of morality contributed to a paradigmatic shift towards a plurality of ways of understanding the world.

Tronto (1994) takes the psychosocial formulation of care ethics to a structural, political level, arguing that the current peripheral location of care serves to preserve inequalities of power and privilege. It also serves to oppress and 'other' those who directly give or receive care:

> …how we think about care is deeply implicated in existing structures of power and inequality. As we currently formulate it, care functions ideologically to maintain privilege, but this function is disguised (p. 21).

Tronto focuses on boundaries demarcating care and in doing so, casts light on the current frame of care in Western, industrialised societies. She asserts that these boundaries [which constitute the current frame of care] shape political and moral theory, influencing what kind of society we (think we can)

have and what is considered right and good within it. This frame can be characterised as *private, individualistic care*, and through it, care is understood as the possession and province of the individual. As a result, the possibility that care is able to function at a social and political level is dismissed outright. Outside the private sphere, issues of care are seen as trivial or the problem of the idiosyncratic individual:

> Care is supposed to be provided in the household. Only when the household fails to provide care in some way does public or market life enter. For example, ideologically, mothers should care for their children (p. 119).

This example is telling in its relevance to residential child care. Constructions of why children should require residential care tend focus on problems of children and their families rather than on the structural impoverishment related to care (and related, fundamental aspects of life) that these families have endured – sometimes for generations. The perceived failure of residential child care also tends to be located within the inadequacy of the sector as opposed to structural constraints that obstruct its effectiveness. The media coverage surrounding the recent fatal accident inquiry (FAI) into the two girls who jumped off of the Erskine Bridge (Anderson, 2012b) is a recent and clear illustration. Most of the coverage focused on failings of the unit (a lack of formal risk assessment processes and poor staffing ratios on the night they absconded and took their own lives). Their long, troubled histories for girls of such tender ages (14 and 15) and the structural inadequacies that contributed to their deeply entrenched patterns of self-destructive behaviour remained virtually invisible. Even the summary of the FAI is disproportionate in its focus on the failings of the unit (Anderson, 2012a), despite robust evidence of wider failings in the full report. Some of these same structural inadequacies are discussed in publications 7 and 10; they contribute to the damage done to children by the time they reach residential child care, and they obstruct the potential of group care milieux to provide developmentally enhancing and healing environments.

Historically, care has been seen as the province of women and has been associated with the emotional (Tronto, 1994, see also publication 10 & 11). Intersecting with dominant frames that valorise rationality, independence and autonomy, care is not only made invisible or devalued, it degrades those who require care, and by association, those who directly give care:

> …if we look at questions of race, class, and gender, we notice that those who are the least well off in society are disproportionately those who do the work of caring, and that the best off members of society often use their positions of superiority to pass caring work off to others (Tronto, 1994, p. 113).

Tronto highlights that the association of caring work with bodies further lowers its perceived value, pointing out that the 'othering' of individuals is often done through associating them with bodily terms. Work that involves direct, hands-on care (for instance nursing) is less valued in terms of status and pay than caring work that is done at a greater distance to the body (for instance doctors). The example of surgeons, whose interaction with the body is very hands on, is not addressed by Tronto. However, this potential counter-example is almost completely devoid of an emotional or affective dimension. When a surgeon's work becomes 'hands on', there is little or no interaction with the patient; the 'care' that is performed in surgery is purely instrumental. When the surgeon does have more direct interaction with a (conscious) patient, with the exception of touch involved in the process of diagnosis, there is little expectation of hands on 'caring'. This adds another dimension to the exploration of touch and physical restraint in publication 11. The perception of risk related to touching of young people may reflect a potentially unconscious reticence about further degrading a line of work already undervalued and misunderstood. Further exploration of macro-level fears related to touch will be explored in the *Anxiety and Fear* section in the next chapter.

Tronto terms such discrepancies in how care is valued 'the fragmentation of care' and she illuminates this fragmentation by identifying four separate but interconnected phases of care. The first two, *caring about and taking care of*, involve caring from a distance. *Caring about* notes the existence of a need

and determines that it should be met; *taking care of*, then, is the next step and involves the assumption of responsibility and determination about how that need should be met. The third and fourth phases, *care giving* and *care receiving* involve the direct practices of care. Most of the analysis above about the invisibility and degradation of care actually applies to these latter two phases, with those *taking care of* tending to enjoy greater status and power. Tronto points to this fragmentation of care as complicating the reality about the place of care in society and disguising the way its place preserves privilege and inequality. A further fragmentation can be seen in the way care is understood either as sentiment and located with the individual, or as instrumental and only being valuable to the degree that it supports other ends.

Tronto's project, then, is to realign the boundaries that frame care. By moving it from the individual, private, peripheral and trivial to "the centre of human life" (p. 101), she argues that a more just and caring world is possible. By de-essentialising care as 'women's morality', Tronto

> offers the possibility of effecting greater social and political change by requiring all humans to see and act on their mutual interdependence…if the world is to be made a better place, care must be seen as a human, not a woman's, responsibility (Menkel-Meadow, 1996, p. 284).

By critically examining the organisation of care in society, the way that care delineates positions of power and powerlessness becomes visible. By conceptualising an integrated care in which all of its phases are considered, and by recognising the *practice of care* as a disposition *and* an activity, care can become a central category of social analysis. The broader moral, social and political ramifications of the way care is framed can be understood. Held (2006), building on the work of Tronto, argues that the social and political implications revealed by care ethics provide a "radical ethic calling for a profound restructuring of society."

In reframing care, Tronto offers more than the four phases of care and dual nature of the practice of care; she also identifies four ethical elements of care

which parallel the four phases of care. Combined, they provide a standard by which care can be judged. The first is *attentiveness*, or noticing the needs of others. Through this frame, ignoring need, whether wilfully or by habit of ignorance is seen as moral failing:

> The more serious aspect of inattentiveness is the unwillingness of people to direct their attention to others' particular concerns. No formal improvement in our understanding of reason or communication can direct people's attention. That caring has been so obscured in our current accounts of society helps to explain how the process of inattentiveness operates. But to increase attentiveness will require that caring become more prominent in social life (Tronto, 1994, p. 130).

The second is *responsibility* and is distinguished from the political-philosophical concept of obligation. Responsibilities are embedded in complex networks of relationship and particular cultural and contextual realities. Obligations are wedded to abstract rules or principles. Held refers to the "moral force" of this responsibility, linking it to prospects for human progress and flourishing (2006, p. 10).

The third ethical element of care is *competence;* this element stresses the importance of skills, knowledge and stamina in providing care. Competence applies not only to the level of *care giving*, but extends to the more distant *taking care of*. Such a perspective brings into sharp relief wider spheres of culpability when we look at the state of residential child care in the United Kingdom (and elsewhere) and the use of physical restraint within it. Contextual complexities highlighted in publications 8 and 10 become more than just unfortunate circumstances. Rather, the moral significance of their contribution to the degradation of care and of those individuals involved in giving and receiving care becomes clearer (this will be explored further in the *Policy and Practice* section in the next chapter).

The final ethical element of care is *responsiveness*, and refers to the response of the care receiver to care. By including *care receiving* and

*responsiveness*, Tronto calls attention to conditions of vulnerability and inequality experienced by those receiving care. A consideration of *responsiveness* requires attending to the inequality between individuals' conditions and the inherent potential for abuse in caring exchanges. Rather than an imperative to put ourselves in others shoes, we must consider the other's position by attending to their expression of need. More recent attention to children's perspectives, as discussed earlier in this chapter, would be one example of the influence of this way of thinking.

More recently, Tronto has argued that because the practice of care is essentially relational, good institutional care must robustly maintain three key foci: purpose, power and particularity:

> …care institutions need to have formal practices in place that will create the space for evaluating and reviewing how well the institution meets its caring obligations by being highly explicit about its pursuit of purposes, how it copes with particularity, and how power is used within the organisation (2010, p. 160).

She highlights the lengthy process required for members to come to a common understanding about their purpose and how they strive to achieve it. Creating spaces for this process, and for evaluation, review and evolving understandings, resonates strongly with Ruch's (2007) epistemological facet of containment discussed in publications 1, 7 and 9.

The moral practice of care, then, requires integrity of the four phases, the four ethical elements and the disposition and activities of care. It also requires explicit attention to issues of purpose, power and particularity. This can be analysed at the level of individual organisations or at a wider, political level. Either way, such an integrated way of framing care also allows for clearer deliberation about the moral dilemmas that inevitably accompany care. The phenomenon of physical restraint is a tangible manifestation of the moral dilemmas that accompany caring for troubled and troubling young people, and Tronto's frame of care can assist with addressing them. These dilemmas will

be discussed in the *Order versus Havoc* and *Anxiety and Fear* sections of the next chapter.

**Frame Assemblies**

As set out in this chapter, the frames offered by each of the three key theorists discussed here, Bion (1962), Goffman (1969, 1974), and Tronto (1994), all serve to illuminate physical restraint in residential child care. Their explanatory power to connect the micro to the macro and compel a deeper engagement with the complexities of physical restraint in residential child care is considerably strengthened when combined. Scheff (2006) adopts the term 'frame assembly' to describe the way multiple frames structure the context of a situation [or phenomenon] and contribute to the way the individual defines it. The next chapter will examine the portfolio of publications through a frame assembly of Bion's micro-level containment, Goffman's macro-level containment and Tronto's care, arguing that care and containment are necessary at micro- and macro-levels if we are to effectively address physical restraint.

**Critical Appraisal**
**Chapter 3**
**Frame Assemblies Applied**

In *Insanity of Place*, Goffman argues that the medical model for mental illness and mental symptoms is inadequate, especially if people with such illness and symptoms are to be contained within society (as opposed to total institutions). A sociological understanding of the way people are contained or are not contained within a wider social order is necessary, according to Goffman, for understanding the challenges of what we now call community care.

There are also benefits to be gained from a more sociological understanding of the 'symptoms' endured by those families who experience one of their own being taken into residential child care. Such families display symptoms not just of their own pain and trauma, but symptoms of our society's inability to address supersizing inequality (Chakrabortty, 2012) and social exclusion. Poverty, more than any other factor, characterises these families (Simkiss, Stallard, & Thorogood, 2012). The relationship between macro and micro factors is becoming clearer through more formal, sometimes empirical efforts to hold some sort of 'whole' that encompasses both (see, for example, Bronfenbrenner, 1979, 2005; Wilson & Pickett, 2009). These efforts bring us closer to an understanding that can better inform both our efforts to maintain children in families and to develop residential child care services.

This chapter examines the portfolio of publications through the frame assembly discussed in the previous chapter – Bion's containment (1962), Goffman's containment (1969) and Tronto's care (1994). This frame assembly offers a more integrated way of holding in mind micro- and macro-level dimensions of physical restraint. In so doing, it explores the following two questions: What can be understood further about the relevant topics discussed in these publications by examining them through said frames?; and what can the content of these publications tell us about containment and care at the macro-level? These questions are explored through the following themes, which were identified during the conceptual work of the preceding

chapter, and then modified and refined during a close, methodical reading of each publication in the portfolio – a not dissimilar process to that of content analysis:

- order versus havoc
- anxiety and fear
- policy and practice

They are discussed in turn.

**Order Versus Havoc**

Similar to psychiatric hospitals, residential child care is seen as a last resort (Milligan, 2009; The College of Social Work, 2012) – a last resort container into which those children and young people who cannot be contained by families are deposited. The havoc caused in the lead up to their placement into residential care also parallels that described by Goffman (and discussed in the previous chapter). This portfolio diverges from Goffman's argument, however, by championing the potential (and sometimes actual) role of residential child care as an ameliorative container for those who cannot be contained within a family.

Central to residential child care being able to realise this role is the capacity to manage the consistent tension between order and havoc. For Durkheim, social order is rooted in the influence of social integration and social regulation, from societal to individual level (Thorlindsson & Gunnar Bernburg, 2004). A lack of integration and regulation, both at interpersonal level and in terms of social groups, often characterises families for whom residential child care becomes a necessity. It can often be the case that social links no longer attach these individuals to social groups or to society more widely, with both the young person who becomes resident as well as other members of the family who do not feel part of a larger whole (Ward, 2007). Indeed, many

struggle to even feel part of a family of any kind (Barton et al., 2012). Such lack of integration and regulation creates anomie, with a resultant sense of meaninglessness, hopelessness and injustice (Thorlindsson & Gunnar Bernburg, 2004).

In residential child care, this disintegration and dysregulation are more often understood at a psychological, or micro-level, where there is an emphasis on creating environments that promote a sense of psychological safety and recovery (Barton et al., 2012; Trieschman, Whittaker, & Brendtro, 1969). Some of the necessary elements for creating psychologically safe and restorative environments at micro-level parallel elements associated with social order at macro-level. They are often referred to as the need for structure, predictability, safety (Barton et al., 2012) – paralleling social regulation, and the need for a secure base (Daniel et al., 2011) – paralleling social integration. At micro-level, care must infuse the process of establishing these elements. For reasons identified by Tronto in the previous chapter, there is no such parallel at macro-level. Moreover, the discrepancy between culturally defined goals (and the pressures they exert) and the socially acceptable means of achieving them (and their inaccessibility to many young people who find themselves in residential care) – a key dimension of anomie (Merton, 1938) – is rarely addressed at micro-level. Perhaps this manifestation of power at this macro-level is too overwhelming or intangible. This is likely one of the more unacknowledged obstacles to creating ordered, safe and restorative residential environments, as there is an awareness (on varying levels by all involved) that however great the effort at micro-level, it does not affect the wider social structures that necessitate and perpetuate the requirement for residential child care in the first place. Thus, residential child care practitioners may indeed experience their own version of related anomie.

Whether in extreme or milder forms, havoc or disorder can sometimes be the norm in some establishments, especially when compared to established norms outside the residential environment. While in some instances such havoc may be indicative of organisational dysfunction, it is always related to the pain, rage and chaos young people carry with them into the care

environment and the way it manifests in ‘disordered’ and ‘disordering’ behaviour. In a large, grounded theory study aimed at offering a theoretical framework for residential child care practice, Anglin (2002) identifies the primary challenge of residential practice as responding to the pain and pain-based behaviour of young people. He coins the term *pain-based behaviour* to emphasise the deep-seated and often long standing pain that is manifest in challenging behaviour, but often glossed over in practice and in the literature. The way social order is established and maintained, and the way it is re-established when havoc erupts must be informed by an understanding of this pain for it to be ameliorative. When effective, the micro-level social order is a caring response. The danger is that order itself (often in the name of safety) becomes the aim, cultivating the kind of conditions that corrupt care (Levy & Kahan, 1991; Wardhaugh & Wilding, 1993). As argued in publications 1 & 7, a settled shift is not necessarily indicative of a good shift. For order to be containing rather than constraining, there must be space for the disorder that can result from the need to ‘poultice out’, rather than always succumbing to the urge to ‘dampen down’.

To ‘poultice out’ involves the healing (re)creation of meaning, and allowing space for such processes is not only influenced by individuals’ anxiety and/or tolerance related to order and havoc, but has to do with deeper meanings. As previously stated, for Goffman havoc is less about the unpleasantness brought about by disordering behaviour, but about how it disrupts meaning. Yet it is not only the disordering behaviour that threatens meaning. The deep ambivalence towards residential child care, as discussed in publications 8 and 10, affects the way it is framed and the meaning made of attempts to create order and respond to havoc within it. Even how order and havoc are experienced is influenced by this wider ambivalence, which obfuscates efforts to manage the tension between them. For example, the degree of damage done to children before they are finally placed in residential care (due to it being seen as a last resort) often compounds the original difficulty that necessitated their looked after status in the first place (publication 8). On the one hand, there is a macro-level expectation that staff control children’s behaviour; at the same time due to current frames around abuse in

institutional settings, there is an suspicion towards care staff as inherent abusers (publications 7 & 11, see also Smith, 2009). This affects staff confidence in exercising power – not only in setting firm and effective boundaries, but in developing therapeutic relationships which can reduce the need for more extreme forms of control, including physical restraint (this latter dynamic will be discussed in more depth in the next section). At times, control is conflated with abuse; at others it is closeness and abuse which are confused (see publication 11). A vicious cycle can manifest in which anxiety or ambivalence drive efforts not to be (seen as) controlling or abusive, necessitating more extreme forms of control (some of which can become abusive). This, in turn, creates greater levels of anxiety and ambivalence. The problem is not with the desire to avoid unnecessary control, misuse of power or any form of abuse, but with the drivers. Hence, the space designated for establishing a kind of order is itself disordered by the continuing threat to its own meaningful existence.

Perhaps what is most disordering and uncontainable for many children and young people in residential care (and perhaps for staff, vicariously) is the experience of parental rejection, whether through abuse, neglect or abandonment.

> *…**all*** children need a specific form of positive response – *acceptance* – from parents and other primary care-givers. When this need is not satisfactorily met, children worldwide and regardless of variations in culture, gender, age, ethnicity or other such defining factors tend to report themselves to be hostile and aggressive, dependent or defensively independent, impaired in their self-esteem and self-adequacy, emotionally unresponsive, mostly unstable, and holding a negative worldview … In short, we now know that parental rejection, abuse and neglect not only cause grievous developmental harm, but also grievous *bodily* harm (Cameron & Maginn, 2008, p. 155 & 159, authors' emphasis).

The pain Anglin (2002) discusses is directly relevant to the catastrophic damage wrought by significant and/or pervasive experiences of parental

rejection. He highlights how difficult it is to avoid contributing further to children's experiences of rejection:

> Perhaps more than any other dimension of the carework task, the ongoing challenge of dealing with such primary pain without unnecessarily inflicting secondary pain experiences on the residents through punitive or controlling reactions can be seen to be the central problematic for the carework staff (Anglin, 2004, p.178).

The use of the word 'controlling' here is telling and reflects a necessarily negative framing of control. Moreover, taking control is conflated with 'exacting compliance' by Paris in her rejoinder (publication 9), and the element of control very likely contributes to staff's experiences of guilt, doubt and defeat in the study (publications 5 & 8). Yet, exercising control can also be a fundamental act of care. Both staff and young people spoke of the need for adults to sometimes take control in publication 8. The use of control in the face of threat and imminent danger, however, is no easy feat:

> Some out of control behaviour indeed requires intervention and the experience of being out of control can be distressing for young people. How staff make sense of and manage the related, absorbed anxiety from the young person, the other young people present and their own triggered anxiety will impact on the degree to which their intervention is proportionate and based on an assessment of need, or simply a reaction (or overreaction)…Containing and making sense of out of control feelings and resultant anxiety are crucial if staff are to create safe spaces to explore and work through difficult feelings and behaviour; the alternative is simply the provision of controlling reactions to alleviate their own and/or others' anxiety (publication 8, p.126).

The disruption of the meaning of control within the social order of the residential environment can also be seen in the study's findings related to property destruction and absconding (publications 5, 6 & 7). In other literature as well as the publications that constitute this portfolio, there is a general consensus that physical restraint is only justified when there is an imminent

risk of harm and when other, practicable means to address that risk have failed or are not possible (see publications 2 & 3). Even young people, both in my study and elsewhere, have identified physical restraint as necessary under these circumstances (see publications 3, 5 & 6). Interestingly, young people in my study (and in Morgan, 2005, 2012) were more liberal than staff in their views about which circumstances should warrant a restraint. In publication 6, staff views about the acceptability of restraint in situations of property destruction reflected uncertainty and ambiguity and in publication 7, a staff member is cited who

> …spoke with pride about how she and her colleagues did not physically stop a child who proceeded to wreak devastating damage to all of the communal areas of the home – pride because she felt it demonstrated their commitment to avoiding physical restraint. She showed no insight as to the impact this may have on the child's relationships with the other children living in the home, nor how it may have affected the child's own sense of self-control or self-worth (p.9).

In her account, there is no appreciation for the relevance (or not) of social integration and regulation, and this was often the case when staff discussed absconding and property destruction. Yet most children and young people conveyed certainty in their views that restraint should be used to stop a young person from damaging property (publications 5 & 6) and some were clear that it should be used to stop absconding (publication 7). An understanding of micro-level complexities was offered in publication 5 as one way of explaining the differing views of staff and young people, but the macro-elements discussed here are also relevant. Children's rights discourses, combined with "the 'dark shadow' cast by the 'unremitting nature of the focus on institutional abuse'" (p.121 publication 8) can have the unintended consequence of disrupting clear thinking about the roles of power and control in the provision of good care. Understanding these roles requires that anxieties are contained so that related ambiguities and complexities can be addressed, and responses to absconding and property destruction are highly illustrative of this point. Both tend to disrupt the social order of the residential environment and

in their more extreme forms, they can breach its containing function. At the same time, absconding and property destruction can be part of some young people's process of working through underlying pain. The sense of whether restraint is warranted on such occasions can be skewed away from an assessment of imminent risk of harm towards one of two extremes: order for order's sake or a laissez fair, abdication of responsibility. An integrated care, one that encompasses *attentiveness, responsibility, competence* and *responsiveness* (Tronto, 1994, and as discussed in the previous chapter), is necessary within the assessment process.

For it not to be oppressive, social order within a residential child care environment must serve (and be subservient to) the wider aim of creating therapeutically containing environments, and it also must be developed and maintained through robustly caring relationships. At the same time, it is not possible for an environment to be therapeutically containing without a social order that integrates, regulates and holds its members. This requires the exercise of power, subtle and explicit, and the attention to how power operates on both a micro- and macro-level. One of the most extreme responses to restore that order is physical restraint, and the components reflected in this portfolio (and touched on in all of the publications) that appear necessary for a restraint to be part of an overall therapeutically containing experience – trust, respect, knowing the other, help in making sense of the incident – are all central to caring relationships. Care must remain central rather than peripheral to processes of maintaining social order. These publications tangibly contribute to our understanding of the skill and fortitude necessary to maintain the disposition and practice of care in such processes.

**Anxiety and Fear**

One of the chief contributions offered by Bion's containment theory (1962) is an understanding of the impact of anxiety on thinking and how this might be addressed. In this critical commentary (and often in psychodynamic literature), 'anxiety' is used as a sort of short-hand for undesirable feelings,

partly for purposes of readability and also because undesirable feelings tend to provoke anxiety. The portfolio clearly establishes the presence and impact of anxiety on the way physical restraint is thought about, experienced and practiced in residential child care (publications 3, 7, 8, & 11). A model for the containment of anxiety such that practitioners and organisations can think more clearly about policy and practice is also offered (publications 8, 10, 11). This section discusses anxiety's parallel at the macro-level – fear – and explores the impact of a similar lack of containment on physical restraint in residential child care.

While fear has long been used to entice television viewers and sell newspapers, the subject of fear itself has more recently become the focus of academic analysis in areas of sociology, human geography, cultural studies and politics (Pain & Smith, 2008). According to Bauman (2006), the ubiquity of fear characterises our current, 'liquid modern' times:

> The most technologically equipped generation in human history is the generation most haunted by feelings of insecurity and helplessness…we – at least in the developed countries – 'live undoubtedly in some of the most secure (*sûres*) societies that ever existed', and yet, contrary to the 'objective evidence', we – the most cosseted and pampered people of all – feel more threatened, insecure, and frightened, more inclined to panic, and more passionate about everything related to security and safety than the people of most other societies on record…(Bauman, and Castel cited in Bauman, 2006, p. 101).

Bauman's work on fear is criticised for potentially overstating the scale and (global) sources of fear, as well as for overlooking the everyday foci, patterns and experiences of fear by individuals (Pain, 2009); it nonetheless highlights important aspects of fear that reveal a lack of containment at a macro-level and reflects (and likely affects) the similar deficiency (discussed in this portfolio) at a micro-level.

The protection of human beings from natural disasters has been a central focus of the modern project (Bauman, 2006; Beck, 1992); yet it is the moral/social catastrophes with their attendant fears which, according to Bauman, have proven to be more fear-invoking.

> Evil and fear are Siamese twins. You can't meet one without meeting the other…We call that kind of wrong 'evil' for the very reason that it is unintelligible, ineffable and inexplicable. 'Evil' is what defies and explodes that intelligibility which makes the world liveable…Above all – the evil caused by the immoral actions of humans appears ever more unmanageable *in principle*…(2006, p. 55 & 86, author's emphasis).

Bauman's language, i.e. 'unintelligible', 'inexplicable', 'intelligibility that makes the world liveable', strongly resonates with Goffman's description of havoc and containment (Goffman, 1969; Hancock & Garner, 2011); the latter phrase chimes with Bion's emphasis on thinking to manage emotion and experience (publication 1). Whether at a micro or macro level, the inability to make sense of our world interferes with containment; it exacerbates and is exacerbated by our fear.

As discussed in chapter 2, for Goffman (1969) an understanding of containment comes about through an understanding of the havoc created by individuals who actively disrupt the social order. Yet just like at micro-level, a lack of containment at macro-level also manifests more subtly than always at a level of havoc, and more collectively than always at the level of the individual. The uncontained nature of two, deeply felt, collective fears – child death and the sexual abuse of children – can be seen in publications 10 and 11. Stroud describes the longstanding incomprehensibility of child death and the simultaneous belief in the possibility [or even desirability] of zero risk childhoods – "if only social workers properly used their professional skills, followed procedures and exercised legal powers" (2011, p. 47). Managerialism as critiqued in publication 10, with its overriding emphasis on risks and protection at the expense of relationships and growth, can be seen as stemming from this uncontained fear. While there appears to be growing

consensus that developing more protocols, procedures, tick boxes and targets is not going to make things better and in fact is likely making things worse (Munro, 2011), we do not seem to know how to stop ourselves (for a recent example, see the emphasis on protocols and procedures in the recommendations of the FAI into the deaths at Erskine Bridge in Anderson, 2012b).

Other fears (identified in publication 10) add to the mix at micro and macro-levels, including fear of dependency (Tronto, 1994; Ward, 2007), fear of groups of young people (Cohen, 2002, 1972; Emond, 2002), and fears around the nature of the relationships between adult carers and the children they care for. This latter fear manifests in its most extreme form as the moral panic about the touching between adults and children, as discussed in publication 11.

While the term 'moral panic' now regularly appears in the media, its utility – at least in its original form – has been contested. McRobbie and Thornton (1995, p.560) argue that the original and revised models of moral panics, discussed more in depth below, no longer represent the current "fragmentation of mass, niche and micro-media" or the "multiplicity of voices" which create much more complicated representations and meanings of the kinds of issues that are currently considered moral panics. Garland (2008) additionally points out that the label 'moral panic' is applied by outsiders, those who are sceptical or even critical of the disproportionate reaction to a perceived moral threat. Yet disproportionality, especially in relation to the moral dimension of a particular behaviour, does not easily lend itself to measures and so its application is in itself subjective and contestable. However, both McRobbie and Thornton (1995) and Garland (2008) argue that it is precisely the illuminating power and general success of the concept that predicates its urgent need for updating and for more precise approaches to its application.

Cohen (2002, 1972, p. viii), one of the seminal theorists of moral panics, identifies several "familiar clusters of social identity" to which the objects of

moral panics belong. One of these he entitles “Child Abuse, Satanic Rituals and Paedophile Registers” (p. xvi), highlighting the disproportionate public focus on “sexual abuse and sensationally atypical cases outside the family” (ibid). The so called moral panic about touch between adults and children as discussed in publication 11 does not precisely fit Cohen’s definition; there are no objects of hostility and moral outrage, there is less of an overall consensus regarding prohibitions of touch and the panic appears more stable than volatile (see as far back as Ward, 1990, for example). The pervasive concern and disproportionality of perceived risk does relate, however, to Cohen’s “familiar cluster” and is strongly evidenced the literature:

> …the touching of children in professional settings is no longer relaxed, or instinctive, and primarily concerned with responding to the needs of the child. It has become a self-conscious, negative act that requires a mind-body split of children and adults controlled more by fear than by caring (Piper & Smith, 2003, p. 891).

This mind-body split may also be a reflection of Tronto’s (1994) identification of the split between care as an activity and care as a disposition.

Piper and Stronach (2008) explored this trend more deeply in a large-scale study that analysed touch related documentation from over 400 settings involving children. It also included in-depth case studies of five different schools, where pupils and teachers were observed and interviewed. Their analysis of the touch-related documentation revealed a disproportionate response to an exaggerated risk of harm to children by adults touching them. Sexual abuse, or the misperception of sexually abusive behaviour, appears to be the dominant risk addressed by most policies. In the case studies, even schools that described themselves as supporting appropriate touch exhibited self-defensive practices and confusion about legislation and guidelines. Practices were predicated on a presumption of possible guilt. While the importance of touch in the development of children was acknowledged, there was no agreement as to the parameters of its use. “In short, the case studies confirmed that professionals and carers have learned how not to trust

themselves, and to call that damaging condition 'safety'" (p.137). Yet the intimacy of the lifespace, as discussed in publication 10, necessarily requires trust, affective relationships, and even love.

Whether or not this trend can be accurately called a moral panic is probably beside the point. Rather, the uncontained fear can be seen writ large, as a few examples from Piper and Stronach's findings illustrate: in one instance, staff are strongly encouraged to use verbal means of reassurance in place of touch if a child becomes distressed; in another, there is an explicit statement that staff do not place bobbles or clips in children's hair; in yet another, staff are told to ensure that sun cream is applied in view of other staff. There are even prohibitions against touching genitals when holding a young person, or against making physical contact with intent to sexually arouse (Piper & Stronach, 2008). One is left wondering to whom these last two proscriptions are addressed. The acceptance of these and other, similar mandates offers clear illustration of the disruptive effect of uncontained fear on the clarity of our collective thinking. It also strongly reflects the fragmentation of care identified by Tronto (1994) (and discussed in the previous chapter) between those *caring about* and *taking care of* (i.e. those identifying what is needed and determining how that need will be met), and those who do the actual *care giving* and *care receiving* such that the actual related risks and needs of children are not reflected.

The degradation of care associated with bodies (and therefore touch), as highlighted by Tronto (1994) and discussed in the previous chapter may also contribute this uncontained fear surrounding touch between adults and children. It offers a further layer of understanding of the tendencies, as identified in publication 11, to use more technical-rational language to speak about forms of touching and to see women as more capable of (or appropriate for) interactions involving touch.

Ultimately, however, it is perhaps the fear of becoming the object of hostility and outrage that is the most disruptive. Piper and Stronach (2008) identify a 'ratchet effect' of accreting precautions where *the risk of being at risk* shifts

the focus from the protection of the child to that of staff. Deeper and likely unconscious fears of our own pleasures and desires (Piper & Smith, 2003) and of being out of control (Stroud, 2011) may be fuelling a collective projection onto a paedophiliac 'other', simultaneously out there but also in our midst. Yet no matter how much distance we try to place between ourselves and this 'other', no matter how much we try to create and follow the right procedures and protocols, the possibility of becoming the target of hostility and outrage lurks ever round the corner. In his commentary on the impact of hurricane Katrina, Garton Ash (2005, n.p.) highlights what can arguably be referred to as the fragility of macro-containment: "…the crust of civilization on which we tread is always wafer thin. One tremor, and you've fallen through…" While he is referring to the kinds of catastrophic disasters that cause infrastructure collapse, individually falling through that wafer thin crust is no less terrifying:

> …fears of being picked out from the joyous crowd *singly,* or severally at the utmost, and condemned to suffer *alone* while all the others go on with their revelries. Fears of a *personal* catastrophe. Fears of becoming a selected target, earmarked for personal doom. Fears of *exclusion*…fears which haunt the many may be strikingly similar in each singular case, but it is presumed they will be fought back against individually…the conditions of individualized society are inhospitable to solidary action (Bauman, 2006, p. 18 & 21, author's emphasis).

As discussed in publication 11, the identification of touch as risky, the need for related surveillance, and the technical-rational approaches to touch (separating caring activity from a caring disposition) can all be seen as defending against being identified as that paedophiliac 'other' – the consequence of which would be ejection from the container of society into a realm of social exclusion.

There is good reason to fear, however unconsciously, social exclusion. It has been found to cause increases in aggressive and self-defeating behaviour; a reduction in intellectual performance; emotional numbness; reduced capacity

for empathy; and strong and consistent decrements in self-regulation (Baumeister, 2005). Our brains respond to rejection in a similar fashion to pain, shutting down cognitive and emotional systems. Social exclusion "strikes at the heart of what our psyche is designed for" (ibid, p. 732). Seen in this light, the parallels between the destructive and uncontainable impact of parental rejection as discussed in the previous section, and that of social exclusion become more visible. To be completely lost from the container of one's parents' love or acceptance can often be the precursor to being deprived of an included place in the wider container of society.

For those working at the sharp edge of all of these elements – rejected children, socially excluded families, fears of child death and child sexual abuse, and fears of being seen as an abuser – this heady mix is all the more potent in a context that constructs care and the need for care (as Tronto (1994) has highlighted) as private, individualistic and problematic. It is hardly surprising that physical restraint, with its prescribed techniques and documentation, may be legitimised over other forms of physically touching young people (publication 11).

**Policy and Practice**

Part of the potential legitimisation of physical restraint over other forms of touching may be the "feeling of clarity afforded by prescribed techniques and procedures", preferable to the "murky, un-prescribed territory of, for example, embracing a young person who simply wants to be held" (publication 11, p.551). These prescribed techniques and procedures derive, in part, from policy. For the purposes of this discussion, Fox Harding's definition is a useful starting point:

> …policy is understood as the ongoing actions of state organisations which have a degree of stability and which affect many people's lives in significant ways. Policy in Britain includes Acts, statutory instruments, circulars, regulations, codes of practice, directives, reports and

> reviews, plans, statements of intent as in White Papers, and the thinking and principles which underpin these (1996, p. xii).

Many of the contextual difficulties that affect the practice of physical restraint highlighted in publication 8 and discussed in earlier in this chapter are rooted in disjunctures between policy and practice. One of the most apparent is the continued use of residential child care as a last resort. In 1988 in an independent review commissioned by the then Secretary of State for Health and Social Services, Wagner argued for residential care to become a positive choice among many in a range of services. Despite the general acceptance of many of the ideas contained within the review, the positive potential of residential child care is far from being realised:

> Over the years, perhaps on one of the reasons that the positive messages about residential child care have not come to the fore has been a continuing ambivalence in policy debates about the role of residential care. Alongside exhortations to promote the positive use of residential child care and not to use it as a last resort, there have been clear messages about the primacy of the family, the preference for foster care over residential child care and the excessive costs of residential care, and arguments to reduce the use of residential care placements (Kendrick, 2008, p. 8).

Publication 8 highlights the damaging impact this has had on young people, on practitioners, and on the sector more generally – often contributing to the kinds of underlying problems that lead to physical restraint.

As highlighted in publications 3, 5, 6, 8, & 11, inconsistencies and a lack of clarity characterise state-level policy and practice related to physical restraint across the U.K. This includes the concern raised by the U.N. Convention on the Rights of the Child (2002) about a potential lack of compliance with articles 25 and 37 related to the number of children who have sustained injuries as a result of restraint in custody or residential care (see publication 6). It called for a review, which has yet to occur at UK level. In an independent inquiry into the use of restraint, solitary confinement and strip

searching in penal institutions for young people in England (Carlile, 2006), serious instances of misuse and abuse were identified (see publication 3).

Inquiries into abuse in residential child care investigate the most extreme deviations in practice, and as discussed in publication 8, they have significantly shaped practice in subtle and clearly identifiable ways. They have also been central to the development of subsequent policy in residential child care (Smith, 2009). In the most recent independent inquiry, which looked into abuse at a residential school here in Scotland, physical restraint featured prominently (Frizzell, 2009). A "volume of concern" (p. 45) regarding the misuse of restraint was raised that included: poorly executed and purposely painful restraints; restraints that were used as a first response rather than a last resort; and restraints used when there was no imminent danger, despite the introduction of a training package designed to reduce restraints during the period under investigation. These concerns chime with the findings discussed in publications 3, 5, 6, 7 & 8. Despite the intended and actual impact of inquiries (for better and for worse), the report highlights simultaneous impotence of this form of social policy development:

> The unpalatable fact is that most of the factors which contributed to what went wrong at Kerelaw have been identified by Inquiries into child abuse time and again over the years, whether in residential establishments or elsewhere. Recommendations have been made in relation to regulation, recruitment, management, training, supervision, scrutiny, resourcing, systems, policies and procedures which stretch to many pages of print (p. 143).

Again, the chasm between the identification and determination of how need is to be met, on the one hand, and the actual direct practice of meeting need (Tronto, 1994), on the other, is clearly reflected here. This is likely due, at least in part, to the distance (social, economic, educational and experiential) between the former and the latter. This distance is further revealed in the report's recommendations related to physical restraint. Only two are offered: one prescribes that providers (of residential child care) ensure that staff regularly receive 'refresher training' from whichever crisis management

package is being used for behaviour management and restraint. The other states:

> Providers should ensure that residential care staff fully understand the circumstances in which physical restraint may be employed so that staff feel confident that they will be supported by management when they act appropriately. Staff should also be aware that if, following assessment of the context, they are deemed to have acted inappropriately they will be held accountable (Frizzell, 2009, p. 145).

These recommendations neither address the related complexities highlighted in all of the publications that constitute this portfolio, nor promote the kinds of processes necessary for dealing with them. Indeed, the simplistic manner in which these complexities are glossed over into "circumstances in which physical restraint may be employed," leading to confident staff following a formula and inappropriate staff being held accountable does not engender confidence in the report. Furthermore, the key recommendation belies a gross simplification of care:

> Perhaps the most important recommendation the Inquiry can make is one that reflects the key message from past failures: that those who carry responsibility for the welfare of others must always put the client first and simply do their jobs (Frizzell, 2009, p. 143).

If inquiries are to constructively impact residential child care, they need to serve a containing function. Ruch's (2007) model of holistic containment, particularly the facet of *organisational containment* as discussed in publication 1, 7 & 8, offers some direction in this regard. While she is referring to the role of the organisation in providing clarity, the same can be applied to social policy (including inquiries):

> Clarity of organizational expectations, professional roles, responsibilities and identities were identified as of fundamental importance for practitioners. Clear organizational expectations in the form of management structures, procedural

> guidelines and explicit professional roles and responsibilities for teams and individual practitioners appeared to be vital for the development of reflective practice beyond the most basic technical levels (p. 670).

For inquiries to contribute to such clarity, a deeper understanding of care, generally and as applied to looked after children specifically, needs to be reflected in reports and recommendations. I am also left wondering at the potential anxiety provoked by the task of investigating the abuse of children for purposes of an inquiry, and how well that anxiety might have been contained (or merely repressed) during the process. Perhaps notions of containment for the containers should also be applied to those responsible for the various forms of social policy.

It can also be argued that the gaps within policies themselves are as significant as those between policy and practice. A key policy area affecting quality of practice generally and the use of restraint specifically is the professionalization of the sector. The continuing disparity in professional status of residential child care work, despite the CCETSW's declaration in 1968 that residential child care is social work, raises significant questions about macro-level culpability in the misuse of restraint (and about poor outcomes generally). Reports and reviews have consistently called for more and/or better training since the Curtis Report in 1946. In light of the high stakes and complex professional judgement required in situations which may involve restraint, that *any* H.N.C., alongside an S.V.Q. 3 in Health and Social Care, is the minimum qualification to register as a residential child care worker can be seen as a significant policy failure and, when viewed through Tronto's (1994) frame of care, a moral failing.

The appropriateness of type as well as level of training is also of significance. Shaw (2011) questions the usefulness of social work training for residential child care practitioners, pointing out that the key offenders in both the Leicestershire and Pindown Inquiries (Kirkwood, 1993; Levy & Kahan, 1991) were social work qualified. Milligan (1998) and Smith (2003) have similarly argued that social work training and education has not served the

development of the residential child care sector. Plans currently in place for introducing a minimum S.C.Q.F. level nine qualification for registration (Bayes, 2009) may go some small way towards addressing minimum levels of qualification, but only if the curriculum content adequately addresses relevant complexities and facilitates the development of a professional identity capable of exercising highly complex professional judgements in extremely challenging circumstances.

There are also significant gaps in policy specifically addressed to physical restraint. The U.K. has no Act or other statute similar to that of the U.S.'s Children's Health Act of 2000 in establishing the regulation of 'child management' interventions and conditions for the use of physical restraint at state level (see publication 3). There is also no government oversight of the training packages that include physical restraint. Concerns regarding the commercial nature of these packages and a related lack of regulatory framework or state-level system of accreditation are highlighted in publication 3. Hart and Howell's (2004) review of policy and practice related to physical restraint within children's services in England highlights significant inconsistencies (see publication 5), and urgently recommends debate across the four nations of the U.K. about: whether current policy and practices breaches the U.N. Convention on the Rights of the Child, whether national guidance for all settings is possible or desirable, how a more robust evidence base can be developed to inform policy development, and how restraints can be usefully monitored. Nine years on and no such debate has taken place on a national level.

Given the importance of understanding the complex contextual features of restraint in residential child care, government oversight and regulation has the potential to make the situation worse, particularly if it is informed by a managerialist faith in context-free management (Hurst, 2012). Just as inquiries need to be informed by a robust understanding care and carried out within containing contexts, the development of other forms of social policy require the same if they are to serve their containing role related to residential child care practice generally and physical restraint specifically. Instead, there

appears to be a fragmented approach at best within a wider context of avoidance. This is not inevitable and there are alternatives.

*Holding Safely* (publication 2) does not technically meet Fox Harding's definition of policy. However, because it was commissioned and endorsed by the then Scottish Executive (arguably to begin to fill this policy gap), and because it contains relevant, accessibly presented legal and regulatory information and guidance aimed at practitioners and their managers, it is offered here as part of the "ongoing actions of state organisations" (Fox Harding, 1996, p. xii). That it does not carry legal or regulatory authority very likely affects the strength of its influence, though its overall impact is unclear (data for the study at the centre of this portfolio was collected before the guidance was launched). Compared with more managerial approaches to shaping or controlling practice, *Holding Safely* has relatively few pre- or proscriptions, with the latter consistently applied to actions likely to cause serious psychological or physical damage (or even death). The majority of the guidance encourages the kinds of actions and processes conducive to what can be argued as containing care, both for young people and for staff. The three facets of Ruch's model of holistic containment, as discussed in publications 1, 7, & 8, can be identified at various points. For example, associated feelings and the need to voice them and make them manageable (for young people and for staff) are addressed in chapters two, six and seven. The need for organisational clarity is also addressed in chapter two and eight; the importance of spaces for addressing complexity, ambiguity and uncertainty in chapter seven; and an overlap of the latter two in chapter nine.

It is interesting that in both cases (Hart & Howell's review and *Holding Safely*), the kinds of recommendations made, in large part, are not of a technical-rational nature; following them requires a willingness to embrace complexity and 'think outside the [managerial] box', and more sophisticated frames and models are necessary for this to be possible. Paterson (2008) argues for a re-emerging co-creationist frame in understanding violence. A co-creationist frame sees violence arising from the complex interactions between individuals within a complex social system and considers the contribution of each layer of

that system in creating violence. And if violence is co-created, the reduction of violence must be a similar, collective process. The concept of co-creation sits well within the current frame assembly, as it also simultaneously holds the micro and macro, and, like care and containment, is located within relationships.

Paterson et al. (2008) also argue for the application of a public health module in pursing the reduction of violence and physical restraint at policy level. This model comprises three, distinct dimensions: primary interventions, where actions are focused on the prevention of violence generally; secondary interventions, where actions are focused on preventing imminent violence; and tertiary interventions, where actions are focused on addressing violence during and after its occurrence. Individualising frames, as discussed in chapter two, tend to overemphasise secondary and tertiary levels of action and this was indeed evident in the study at the centre of this portfolio (see publication 8).

Primary prevention requires an understanding that the causes of violence are multiply determined. Paterson et al. (2008) identify several of its root causes, including negative organisational climates, power inequalities among staff, and aspects of staff/child interactions. The low value afforded to care and its current fragmentation at macro-level could easily be added to this list. The authors' analysis bears some resonance with (and, in fact, cites) Wardhaugh and Wilding's (1993) seminal exploration of the corruption of care, as well as Tronto's (2010) more recent analysis of institutional care (as discussed in the previous chapter). In addition, content on organisational and interpersonal dynamics that create the conditions for violence (Paterson et al., 2008) can only be prevented if they are addressed and worked with rather than being suppressed or repressed; in other words and as argued in publication 7 & 8, only if they are contained (whether or not this term is explicitly used).

While a focus on violence reduction is more likely help to prevent some of the dangers associated with a focus that is solely on reducing or eliminating restraint (as discussed in publications 3 & 7), a focus on care (particularly in a

service specifically tasked *to care*) may be even more powerful in reducing violence, and physical restraint by association – and in increasing the likelihood that those restraints which do occur are experienced as acts of care. Any organisation-level or state-level policy related to physical restraint must not only be congruent with and facilitative of the fundamental values and activities associated with care, but evaluations of care, at all levels and based on the discussion in the previous chapter, must also be considered highly salient to policy efforts to address physical restraint. To be effective, policy and practice cannot separate physical restraint from care; given the risk-laden, ethically charged and emotive nature of the restraint, containment is necessary for this to be possible.

## Discussion

The analysis in this critical appraisal has been primarily concerned with understanding and applying frames in order to make physical restraint in residential child care more intelligible, and thus our responses to it more effective. Indeed, frames themselves can be seen as a form of macro-containment:

> Frames interpret our experiences and become the regulatory mechanisms of society that are socialised into us – embodied – at a level below consciousness. Frames become the intelligibility structure, in the Durkheiminan sense, through which we negotiate daily and generate the required responses so that society and the social order may continue on in a relatively structured fashion…For Goffman, frames are *enabling* in that we are not constantly faced with interpreting moment to moment interaction, as well as *constraining* in that they define, shape, and determine the forms of social interaction and meaning (Hancock & Garner, 2011, pp. 328-329, authors' emphasis).

Current dominant frames (master and domain-specific) are inadequate in serving this purpose. Physically restraining and being physically restrained

are outside the normal experience of most people, at least in the form they take in residential child care. In addition, because of the emotive and transgressive nature of physical restraint, commonly accessible master frames (as discussed in Chapter 2) are inadequate for enabling interpretations and responses that meet the needs of children, young people and the practitioners who care for them. An understanding of the disruptive impact of anxiety on clear thinking (i.e. on intelligibility) is particularly needed, and micro-level frames of containment offer the potential for an appreciation of the similarly disruptive impact of collective fear on macro-processes of containment.

A better frame of care is also needed. Early processes of micro containment are indistinguishable from processes of care (Bion, 1962) – they are one in the same and they necessarily involving holding and sometimes even restraining. At therapeutic and even organisational levels, care is similarly necessary for processes of containment to be effective. Yet, due to its marginalisation at social and political levels, care is relatively absent from macro conceptualisations and enactments of containment and this can be seen within all three sections of this chapter. As a result, macro-level containment can often be experienced as oppressive, marginalising and silencing. Indeed, those who have experienced inadequate micro-level containment during infant years are at much higher risk of subsequently being subject to extreme and sometimes brutal forms of containment (i.e. forms of restraint and incarceration), as well as social exclusion.

In Chapter 1, meaning making is cited as a key theme running through the publications that constitute this portfolio. Attending to meaning making at micro *and* macro-levels, with the aid of frame analysis generally and the frame assembly of care and containments specifically, offers an expanded world of opportunity to effect positive change (in a similar fashion to the 'expanded world of therapeutic opportunity' afforded by attending to meaning making as discussed in Chapter 1). Hence, a more robust understanding of our individual and collective need for care and containment can begin to challenge the unhelpful way physical restraint is thought about and practiced

– as well as organise and illuminate the myriad of factors that contribute to its continued existence. Just as it is impossible to separate care from containment during infancy, it should be unacceptable (i.e. impossible *ethically*) to separate care from containment at macro-level – whether in how individuals are physically restrained or in how individuals are contained within society.

## Conclusion

> …the name Ananke [the Greek goddess of necessity] contains echoes of "constriction" and also "kinship." The same sort of double semantic meaning is rendered by the word "bonds." An alternative view finds a close relation between the word *ananke* and the phrase "taking in one's arms." This duality, or antagonism even, finds its reflection in the net of Necessity. Inevitably, inexorably it tightens around mankind [sic], as the world atomizes and scurries aside. But the pressure of the net falls as it comes closer, as we discover the bonds linking us with others, and the thread becomes a thread of mutual understanding, sympathy and trust. This can happen unexpectedly, and then it is like a spark jumping between two electrodes, like the flash of a metaphor joining distant worlds together (Szczeklik, 2005, p. 4).

Containment is an apt metaphor for understanding this 'net of Necessity', and perhaps this adds to its intuitive appeal as an organising frame. Processes of containment are enacted through relationships and are shaped in large part by the quality of care within those relationships. It is our relatedness that comprises the micro and the macro, inescapable, necessary and often difficult, but for too long kept invisible or at the margins of public life. The frame assembly of containments and care offer an alternative rendering.

Derived from the largest qualitative enquiry into the phenomenon of restraint, the publications that constitute this portfolio contribute to a process of reframing physical restraint in residential child care such that care, containment and relationships are made visible and central to its consideration. They do so by involving those most directly affected by restraint – not only by including their views and experiences, but by inviting a wider readership (and 'writership') than just the academy. The central argument that emanates from these publications is this: for us to reduce and, where possible, eliminate physical restraint in residential child care, we must create robustly containing environments for children, young people and the residential practitioners who care for them. Such environments are also necessary if we are to increase the likelihood that when restraints do occur,

they are experienced as part of an overall process of therapeutic containment (or, more simply, an act of care).

The work of this critical appraisal supports and extends this argument; for us to reduce and, where possible, eliminate physical restraint in residential child care, our related efforts of research, theory development, consultancy, education, training and policy development must also embody care and containment. Robustly containing environments are necessary, albeit manifest in slightly different forms, for those who are involved in these efforts so that our responses are neither devoid of nor overwhelmed by the emotional, complex, ethically ambiguous dimensions of the issue. Furthermore, serious contemplation of the phenomenon of physical restraint offers a stark illumination of the relationship between the state of care and containment at micro and macro-levels. For in the final analysis, residential child care's struggle to provide restorative, therapeutically containing environments for children and young people is profoundly affected by a deficit of caring, containing processes at macro-level.

**Recommendations**

Practice recommendations emanating from this study are as follows:

- Efforts to reduce or eliminate physical restraint should focus on meeting the needs of children and young people and those who care for them, rather than solely on physical restraint. In seeking to meet those needs, the multi-layered, contextual factors discussed in this portfolio must be acknowledged and addressed, as all incidents of restraint reflect organisational and societal issues as well as the interpersonal dynamics that happen between those individuals directly involved.
- The creation and maintenance of robustly containing environments for children, young people and the residential practitioners who care for them is necessary in order to reduce or eliminate physical restraint while still meeting the needs of child and young people in residential child care.

- Related efforts should attend to all three facets of holistic containment (Ruch, 2007), including:
    - the *emotional containment* of children, young people and staff by developing and/or attending to processes and practices that make feelings related to restraint more speakable and manageable;
    - the *organisational containment* of children, young people and staff by developing and/or maintaining policies and procedures that provide clear guidance and directives and that facilitate the other two facets of holistic containment;
    - the epistemological containment of children, young people and staff by developing and/or attending to processes that facilitate making clear sense of individual incidents of restraint and co-creating collective meanings of restraint that are in the best interest of the children and young people. Contextual factors at individual, organisational and even societal levels should be included in related discussions. There is evidence that this facet receives the least attention and it should therefore be treated as a priority; it should also be noted that emotional containment can also be facilitated within this facet. Formal and informal forums and spaces should be utilised for these purposes, including:
        - post-incident discussions/debriefing sessions (incidents involving restraint and those in which restraint is avoided);
        - house meetings, staff meetings and young people's meetings;
        - supervision sessions;
        - consultancy;
        - impromptu discussions (though there should not be an overreliance on this).
- any policy attempts to address physical restraint or related issues must embrace its multi-layered complexity, address the containment needs of

children and young people and the staff who care for them, and must take place within a process that is itself containing.

As it is becoming increasingly clear that the language and mentality of managerialism does not deliver desired results, an approach focused on the development of habits and practices is desirable (in the main) over one that spawns further procedures.

Finally, further research continues to be necessary to inform our efforts to address issues of restraint, and they must continue to robustly include the views and experiences of children, young people and staff; it is also important to include the views and experiences of care leavers and the families of children in care. Based on the findings of this study, future studies should involve action research that explores the impact of the development of robustly containing environments on the volume, frequency and duration of physical restraints, on participants' experiences of escalating situations in which there is a perception of imminent harm, and on restraints themselves. The use of alternatives to restraint, including multi-sensory rooms, as well as the incorporation of neurobiological understandings of the impact of trauma on children's development (a perspective that has captured the attention of the sector) would enhance such research, as both can be integrated in a way that is congruent with containment theory. Finally, to prevent such research from creating unnecessary anxiety and for it to be truly effective, a participatory approach from the earliest stages of design would be necessary.

**Final Reflexive Comment**

As I look back on the process of this critical appraisal, I realise that part of my motivation to undertake a macro-analysis was an attempt to contain the overwhelm I experience when I look at the 'big picture'. I can see that even my choice to work in residential child care was informed by the despair I felt in doing my political science major; I ended up deciding to work with individuals in the micro-system of the lifespace, implicitly rejecting a career more oriented

towards macro-concerns. From the start, I was attracted to theories and concepts that shed light on what was happening at work; the related language offered a way to get a handle on what was initially overwhelming. It was clear to me that knowledge was vital to our ability to be positive agents of change in the lives of children and their families.

As an American, I brought my 'can do' attitude to my practice in Scotland and was sometimes shocked at the apparently low expectations and aspirations my colleagues seemed to hold for our residents. Over time and with the aid of my studies on the MSc in Advanced Residential Child Care, I developed a far greater appreciation of the impact of elements of the macro-system (Bronfenbrenner, 1979, 2005) on the development and life-chances of children and young people. I came to understand that my Scottish colleagues also had this greater, albeit often tacit, appreciation than I (or my American counterparts) had had. The more I (re-)engaged with knowledge about elements of these macro-systems and their impacts, the less I felt able to be that positive change agent. Paradoxically, I began to wonder whether our American ignorance of one level enabled stronger, though inadequately-informed, optimism and enthusiasm on another. In Scotland, I much more frequently felt a collective sense of pessimism, or at least withering, as we approached our work. This was compounded by the aforementioned lack of therapeutic orientation to residential child care in Scotland. Yet it was not possible or desirable to go back to that former ignorance. Focus on the micro to the exclusion of the macro is problematic; the opposite is true as well.

The experience of working in both countries softened the ground for growing a deep commitment to holding in mind both micro and macro in my approach to teaching, research and other forms of indirect practice. This critical appraisal has been, in large part, an effort to enable this simultaneous holding while resisting overwhelm and despair. It is no surprise, then, to find myself arguing that frames are a form of containment. It is equally unsurprising that the macro-frames I chose for this critical appraisal offer more than just criticisms of our social/political systems, for that would perhaps make things more

intelligible but not necessarily more containable.  These frames, particularly when brought together, offer hope for something better.

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## Appendix A

## Summary of Each Publication

The following selection is presented in ascending order by date of publication so that the trajectories of analytic depth and theoretical development can be charted in their summaries. The selection comprises more publications than the minimum required; the inclusion of articles addressed to both academic audiences (i.e. peer reviewed) and to practitioner audiences is deliberate. In practice-based disciplines, quality of research and publication is not simply about measures of academic impact, but also about improving practice for the benefit of service users (Orme & Powell, 2007). The process of professionalizing the residential child care work force has only recently begun, with current practitioners requiring a very different pitch and voice in order to engage meaningfully with research literature. This poses different (but nonetheless important) requirements for impact and rigour.

1. Steckley, L. (2010-2011). Constrained, contained or falling to pieces?; Containing the containers: Staff containment needs in residential child care & Containing the Containers II: The provision of containing processes for staff in residential child care [Electronic Version] *The International Child and Youth Care On-line Journal*, November & December, 2010; March, 2011. Approx. 4,200 words.

This three part piece is published as part of a monthly column in an online journal aimed at practitioners and managers in residential child care. It offers an expanded discussion of therapeutic containment, its relevance to direct practice, and its vital importance to indirect practice (the practice of supporting and equipping those in direct practice).

2. Davidson, J., McCullough, D., Steckley, L., & Warren, T. (Eds.). (2005). *Holding safely: A guide for residential child care practitioners and managers about physically restraining children and young people*. Glasgow: Scottish Institute of Residential Child Care. 114 pages; my contribution: approx.25%

Beyond the training provided by private companies as part of their own particular methods of physical restraint, there is a gap in the practice literature related to physical restraint in residential child care. In 2004 the then Scottish Executive commissioned the Scottish Institute for Residential Child Care (SIRCC) to fill this gap. The aforementioned interviews were being carried out prior to and during this process, and the early stages of analysis informed much of the development of the document. It was particularly valuable to have a deeper understanding of the challenges and complexity faced by those in direct practice and the raw, vivid accounts by all involved to sharpen our focus on the needs of the intended audience and the primary aim of the document.

3. Steckley, L., & Kendrick, A. (2008). Hold on: Physical restraint in residential child care. In A. Kendrick (Ed.), *Residential child care: Prospects and challenges*. London: Jessica Kingsley. 5240 words; my contribution: approx. 75%

This chapter reviews relevant literature on physical restraint to provide a legal, research and theoretical context for the study. Key areas included legislation, restraint related injuries and deaths, commercial training packages and implications, efforts at reducing restraint and other research that has surveyed the views of staff and young people. Initial findings of the study are offered, comparing them against findings of similar studies and making links to the other literature. The study found greater depth and breadth of experiences and views, offering a more complex, multi-layered account of this difficult area of practice.

4. Kendrick, A., Steckley, L., & Lerpiniere, J. (2008). Ethical issues, research and vulnerability: Gaining the views of children and young people in residential care. *Children's Geographies, 6*(1), 79-93. Approx 8,000 words; my contribution: approx 35-40%.

This article addresses ethical dimensions of carrying out research aimed at gaining the views of children and young people in residential child care and is part of a special issue dedicated to interdisciplinary perspectives on ethical issues and child research. The article draws from three studies, one of which is the study at the centre of this application. Some of the particular ethical issues that arise from researching children in their own living space are identified. An examination of views held by the researchers, particularly related to constructions of childhood and the rhetoric and realities of giving voice to children's experiences, is offered and an account of how these views informed the design and implementation of the studies is explored. Specific examples are offered from the studies.

5. Steckley, L., & Kendrick, A. (2008). Physical restraint in residential child care: The experiences of young people and residential workers. *Childhood, 15*(4), 552-569. Approx. 8,200 words; my contribution: approx. 90%.

This article presents the findings of the study, comparing and contrasting the views of children and young people with the views of staff. Areas of consensus and divergence are explored and analysed. The importance of relationship appears to be central to responses from both groups, both in regard to the context within which respondents experience restraint, but also in the way that its meaning and implications are constructed. Concepts of therapeutic containment and meaning making are introduced and offered as organising frames for making sense of these complexities.

6. Steckley, L., & Kendrick, A. (2008). Young people's experiences of physical restraint in residential care: Subtlety and complexity in policy and practice. In M. A. Nunno, D. M. Day & L. B. Bullard (Eds.), *For our own safety: Examining the safety of high-risk interventions for children and young people*. Washington, D.C.: Child Welfare League of America. Approx. 8,500 words; my contribution: approx 85%.

This chapter focuses on the views and experiences of the children and young people who participated in the study, highlighting the subtlety and complexity of their responses. Children and young people discuss positive as well as negative aspects of physical restraint and offer raw and sometimes deeply reflective insights about their experiences. A broad array of experiences and feelings were relayed. Two dominant concerns emerged: inadequate reasons for being restrained and restraints that were carried out too roughly. Conversely, the existence of strong, positive relationships with staff seemed to positively affect about a quarter of young people's experience of restraint and almost a third spoke of the experience of being physically restrained as having a positive impact on their relationships with staff. The findings are briefly theorised through the lens of therapeutic containment.

7. Steckley, L. (2009). Therapeutic containment and physical restraint in residential child care [Electronic Version]. *The Goodenoughcaring Journal*, 6, n.p. Approx. 6,200 words.

This invited article was published in an online journal aimed at practitioners and managers in residential child care. It starts with a discussion of therapeutic containment before theorising the findings. It is argued that separating out restraint from wider issues—issues of relationships, how behaviour is worked with, and ultimately how the work of residential child care is understood—will be unlikely to produce useful responses to the situations where restraints may be needed. Importantly, the way restraint is thought about affects how much it is used and how its use impacts those involved. In some cases, it appears that individuals and/or establishments have adopted fear-based, self-protective orientations in their efforts to avoid physical restraint, often at the expense of the young people they are meant to serve. Difficult questions are raised, including whether our own beliefs in the necessity of restraint *creates* that necessity, or at the very least, prevents us from making it unnecessary. The sector is challenged to engage with these deeper questions and to consider therapeutic containment as a conceptual frame for increasing the effectiveness of efforts to reduce or even eliminate restraint while still meeting the needs of children and young people.

8. Steckley, L. (2010). Containment and holding environments: Understanding and reducing physical restraint in residential child care. *Children and Youth Services Review, 32*(1), 120-128. Approx. 9,500 words.

This article draws together three distinct threads: an account of the complex context of physical restraint in residential child care, a short literature review of containment theory and the findings of the study theorised more comprehensively through the lens of containment to develop an argument that encompasses both micro and

macro dimensions of this difficult area of practice. Key themes of relationship, touch and control are identified as significant in the micro level of direct practice, and there is evidence of basic yet significant work being done with children and young people that can be reasonably described as therapeutically containing. On a macro level, there is strong evidence for staff's significant and complex containment needs, and the sector's struggle to adequately meet them. These appear related both to the issues arising from direct practice as well as the significant impacts of a wider ambivalence towards residential child care more generally. A model for holistic containment is discussed and offered as an antidote to the more dominant technical-rational approaches to the issue.

9. Steckley, L. (2010). Dispelling the myth. Response to Parris by Laura Steckley and further rejoinder to Parris. *Relational Child and Youth Care Practice, 23*(2), 6-8 & 12-14. Approx. 3,500 words.

This was an invited article by the editor of a practice journal published in Canada. It is a four part piece, consisting of an opening argument (by Paris), an invited response (by the applicant), an invited rejoinder (by Paris) and an invited rejoinder to the rejoinder (by the applicant). Key themes and arguments from previous publications are built upon, including evidence of children and young people's use of physical restraint for purposes of catharsis, evidence of physical restraint being experienced as part of an overall therapeutic experience by some, the imperative to better understand and promote this as long as physical restraints are being carried out, and the use of containment theory in achieving this end. The previous publications (and the thinking that went into them) provided clarity in responding to sometimes muddled and often unhelpful arguments put forth by the other author.

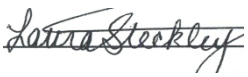
10. Steckley, L., & Smith, M. (2011). Care ethics in residential child care: A different voice. *Ethics and Social Welfare (Special Issue), 5*(2), 181-195. Approx. 6,500 words; my contribution: approx. 50%.

Using a care ethics perspective, this article argues that public care needs to move beyond its current instrumental focus to articulate a broader ontological purpose of residential child care, one that is informed by what is required to promote children's growth and flourishing. Central features of caring in the lifespace are explored, including working with challenging behaviour, physically restraining children and young people and other forms of touch between staff and young people. Complexities related to care in the lifespace, it is argued, are poorly served by the current technical/rational orientations and instead are better considered as a practical/moral endeavour. For this to be possible, practitioners require containing environments in order to develop reflexive, ethically sound practice.

11. Steckley, L. (2012). Touch, physical restraint and therapeutic containment in residential child care. *British Journal of Social Work, 42*(3) 537-555. Approx. 8,000 words.

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. Developing on from threads in previous articles related to touch, this article uses theories of therapeutic containment to illuminate the relationship between touch and physical restraint. 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.

For publications in which I am the only author listed, I have been the sole author and have written all of the word. For jointly authored pieces, I have indicated the approximate percentage of my contribution in the details of each.

Signed;  Date: 08/04/2013