

Steckley, L. (forthcoming). Catharsis, containment and physical restraint in residential child care. *British Journal of Social Work*.

## Catharsis, Containment and Physical Restraint in Residential Child Care

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### Abstract

In residential child care, physical restraint continues to be a contentious and high-risk intervention with potential for physical and psychological harm to all involved. Its relationship to catharsis is poorly understood and rarely addressed in policy, practice and literature. Indeed, there is a paucity of application of catharsis theory to residential child care (or social work generally). This article redresses this gap by presenting findings of a large-scale, qualitative study of children, young people and practitioners' experiences of physical restraint and analysing them through lenses of catharsis and containment theories. It offers evidence of cathartic expression in situations involving restraint, as well as a potential relationship between ongoing, repeated restraints and a drive for catharsis. It is argued that catharsis theory, especially when combined with containment theory, has explanatory power in making sense of physical restraint and how to minimise its use while still meeting the needs of children and direct-care practitioners in residential and other relevant settings.

**Key Words:** physical restraint, catharsis, containment, residential child care

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## Introduction

In residential child care, physical restraint is sanctioned for the purpose of re-establishing safety when a child or young person poses serious imminent harm to self or others. For the purposes of this paper, physical restraint is defined as ‘an intervention in which staff hold a child to restrict his or her movement and [which] should only be used to prevent harm’(Davidson et al., 2005; 2013). It is one of the most complex and contentious areas of practice in residential child care, in the UK and internationally (Nunno et al., 2008). On the one hand, physical restraint can and has been used oppressively as an exercise of power and/or punishment (see Frizzell, 2009 for recent related public inquiry), and children report predominantly negative experiences of restraint (Morgan, 2012; Paterson et al., 2003). It carries serious physical and psychological risks to all involved, including death (Nunno et al., 2008); these risks extend beyond residential child care into other forms of social care, health care and law enforcement, again internationally (Barnett et al., 2012). On the other hand, not restraining a child who causes and or comes to serious harm can be seen as failing one’s duty of care.

Information at national levels is scarce, with the Committee on the Rights of the Child recently criticising the UK for not collecting, monitoring or publishing data on the use of restraint (2016). This is not particular to the UK, however, with similar data unavailable from other national governments as well. An exception, though at provincial level but one that can give some impression of the significance of its use, is a recent report out of Ontario which found that, ‘every day, on average, 40 restraints are used in a children’s residence ... during the period under review’ (Provential Advocate for Children and Youth and Snow, 2017).

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The importance, therefore, of developing policies and practices to reduce or eliminate restraint where possible, while still meeting needs for safety and care, cannot be overstated. This is an extremely complex undertaking, as will be illustrated below, for there are occasions when all available alternatives to restraint in a given moment carry even greater potential for harm. This article casts a multidisciplinary and theoretically innovative light on this complexity by arguing that theories of catharsis, especially when combined with containment theory, have explanatory power to inform the practice of restraint as well as policy efforts to reduce or eliminate it. This analysis of physical restraint also adds new conceptual insights and deepens our understanding of the theoretical perspectives employed.

Previous theory building emanating from the study at the centre of this paper established the utility of containment theory in making sense of physical restraint and informing residential child care practice (Steckley, 2010). A short summary of containment theory is offered, and a foundation for the incorporation of catharsis theory is then laid. The study is introduced and findings analysed through Scheff's theory of catharsis (1979, 2007). Because of the dearth of practice or research literature on catharsis in social work, the aim of this paper, then, is threefold: to illuminate the heretofore unexplored relationship between physical restraint and catharsis, to contribute to the theoretical development of catharsis and containment theories, and to further develop a theoretical understanding of physical restraint internationally and across service settings to inform related policy and practice.

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## Containment and Residential Child Care

Containment theory originated with Bion (1962), who drew parallels between developmental processes between mothers and their infants, and therapists and their clients. It can be thought of as someone absorbing what is unthinkable, unmanageable, *uncontainable* in another, and giving it back in a more thinkable, manageable, *containable* form. Douglas (2007, p. 33) offers one of the few definitions in the literature:

Containment is thought to occur when one person receives and understands the emotional communication of another without being overwhelmed by it, processes it and then communicates understanding and recognition back to the other person. This process can restore the capacity to think in the other person.

In the last decade, containment theory has enjoyed a renaissance in social work (Lees et al., 2011; Ruch, 2007, 2011; Turney and Ruch, 2016) and residential child care (Emond et al., 2016; Steckley, 2010, 2012).

Many children in residential child care did not have 'good enough' early childhood experiences of containment and therefore have underdeveloped capacities to manage experiences and emotions. The basic notion of enabling children to use thinking to manage experience and emotion resonates with the fundamentals of residential child care practice. Containment is provided in seemingly simple ways, through the rhythms, routines, boundaries and activities – and most importantly, within key relationships (including but not always key-worker relationships) and a wider network of relationships within the home (Emond et al., 2016; Ward, 1995).

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Residential child care can offer rich opportunities for such experiences due to the availability of several adults and other children amongst whom a child can feel contained; conversely, related dynamics can make the provision of a containing atmosphere quite challenging (Ward et al., 2003), with occurrences of restraint increasing these challenges further.

Providing containment requires advanced skills, knowledge, personal fortitude and organisational support (Ruch, 2007). In the pressurized environment of residential child care, it is a tall order to receive the intense and coded communications of children, process them and provide an empathic response, all while managing one's own triggers and counter-transference reactions. This is especially challenging in the face of imminent serious harm (i.e. situations in which restraint might be used). Thus, residential child care practitioners also need containing processes in order to manage intense practice experiences and the emotions which are triggered by them.

The most literal and extreme form of containment in residential child care is physical restraint. In Scotland,  *Holding Safely*  (Davidson et al., 2005; 2013) was commissioned by the (then) Scottish Executive to rectify the absence of official guidance. It addresses key related issues, including: criteria for restraint, relevant legislation, related risks, children's rights, practitioner training, conditions necessary to reduce the need for restraint (with an emphasis on relationships), and the importance of debriefing practitioners and young people after restraints. The principles underlying this guidance are consistent with those of containment theory, and physical restraint can be carried out in a manner that contributes to an overall reparative experience for a young person (Steckley, 2010). Conversely, it can also be implemented in a manner that can rightly be named 'crude containment',

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potentially causing physical harm and/or damaging the young person's sense of self and trust in others. Because of the high emotional intensity often associated with physical restraint, the avoidance of 'crude containment' requires significant skills, knowledge, personal fortitude and organisational systems of support. Our current knowledge-base requires development in this regard, and the application and advancement of containment theory offers clarity and direction. Moreover, as the remainder of the article argues, cathartic events can be understood as a form of reparative containment, but only with the application and advancement of a working theory of catharsis.

## **Catharsis**

Catharsis is associated with intense expression of emotions, which are often integral to situations requiring physical restraint. Understanding catharsis offers the potential to make further sense of how to meet the containment needs of children and practitioners so that physical restraint may be rendered unnecessary or experienced as an act of care. Because of the paucity of dedicated literature on catharsis in social work and because of the contention surrounding its therapeutic legitimacy, a brief review of the development of catharsis theory in psychology and the varying arguments for and against its merits are discussed first. Scheff's (1979, 2007) working theory of catharsis, developed from psychology, sociology, neurobiology and drama, is then offered, against which the findings of this study are discussed.

The concept of catharsis has been around at least since the time of Aristotle (Sutton, 1994). In psychology, Freud and Breuer (1940; 2004) are credited with founding a modern theory of catharsis and later abandoning it favour of free-

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association (Nichols and Efran, 1985). In what Nichols and Efran refer to as a 'reactive shift away from rationality' (1985, p. 49), a variety of therapies emerged in the 1960s and 1970s which emphasised the release of emotion almost to the exclusion of cognitive and behavioural dimensions of patients' personalities. Over time, this was found to be deficient in providing lasting positive impact. Klopstech (2005, p. 2) describes a subsequent paradigmatic shift away from catharsis as a therapeutic goal, arguing that 'we are still living out this shift'.

In their re-conceptualisation of catharsis theory, Nichols and Efran argued that viewing people as 'passive recipients or storehouses' of their emotions was inimical to 'the basic analytic goal of expanding the sphere of self-knowledge and personal responsibility' (1985, p. 50). Notwithstanding their mistaken assertions about the non-material nature of emotion (Pert, 1997), their argument regarding the inseparably interconnected nature of thoughts, emotions and actions continues to be supported by subsequent developments in neuroscience (Scheff, 2007). They viewed catharsis as an indicator of previously blocked or incomplete emotional expression, and as a preliminary step in the process of changing one's awareness and actions (Nichols and Efran, 1985). More recently, Klopstech (2005) has argued that catharsis-promoting interventions and cathartic experiences can have an essential role in improved self-regulation and recovery, but only if they are integrated and extended (at reduced levels of intensity) into patients' everyday lives.

Conversely, studies in experimental psychology have been used to argue that catharsis has no lasting therapeutic benefit. Geen et al. (1975), Bushman et al. (1999) and Bushman (2002) found that while there were temporary benefits

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associated with the expression of aggression, increased subsequent aggression was also strongly correlated.

When closely scrutinised, these arguments apply differing definitions of catharsis, which may account for their opposing positions about its value. All definitions involve the expression of emotion, but more recent proponents cited here include a far wider range of emotions; they also incorporate catharsis as part of an overall therapeutic process that goes beyond mere expression. Those arguing against catharsis's therapeutic value narrowly focus on anger and aggression, and omit integral, related processes from their definitions and research designs. Moreover, Klopstech (2005) and Nichols and Efran (1985) highlight the natural and sometimes spontaneous nature of catharsis, which is not replicated in the contrived tasks identified as cathartic in the quasi-experimental studies (e.g. administering a (perceived) electric shock or punching a punching bag).

### **Catharsis, residential child care and Scheff's theory of catharsis**

The pros and cons of catharsis are likely recognisable to most experienced residential child care practitioners: intense expression of emotion is sometimes ameliorative and, on other occasions or with other children, can reinforce problematic feelings and behaviours. Thus, how children are supported in relation to intense emotions is a central concern.

Scheff's (1979, 2007) theory of catharsis, based on a review of case and empirical studies, offers greater utility in informing policy and practice in residential child care and other human services. He defines catharsis as having two parts: a somatic component and a component of optimal distancing. The somatic component is

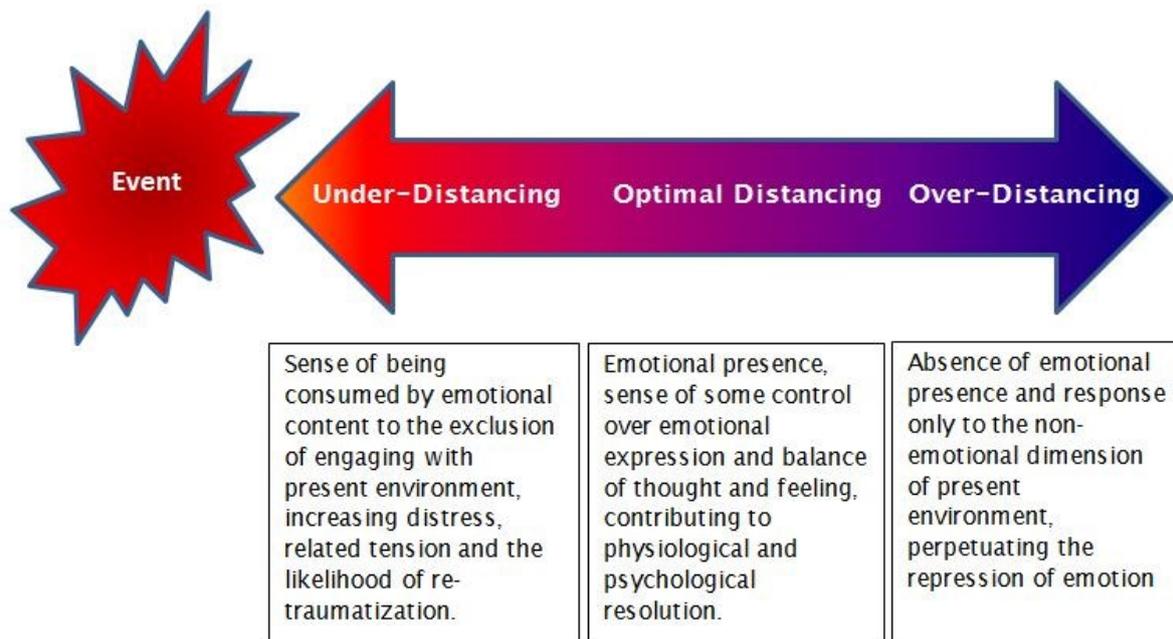
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concerned with dual dimensions of the emotional and the physical. Building on the work of Dewey (1895), Mead (1934) and Shibutani (1961), Scheff argues that human emotions have a physiological dimension that follows a biological sequence. For example, loss triggers grief and the completion of the sequence is the neuropsychological reflex of crying (Scheff, 2007). The more profound the loss, the more sequences are necessary to work through it. For reasons both cultural and individual, these sequences are often blocked and filtered out of conscious awareness (i.e. repressed), but nevertheless remain present in the unconscious and in the body (e.g. in the form of muscle tension).

Catharsis, then, is the physiological, motor-discharge of emotion (immediate or repressed) that provides resolution to related, physiological tension. Examples include the discharge of grief through sobbing, shame through laughter, anger through heat, and fear through sweating and shaking (Scheff, 2007, p. 107). Despite episodes involving their discharge or expression, these emotions and physiological states are sometimes retained, reinforced or even entrenched. Optimal-distancing, the second component of Scheff's definition, addresses this apparent contradiction and is represented below:

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Figure 1: Optimal-distancing



Optimal distancing is concerned with the extent to which a person's attention is consumed by the return of repressed emotion, and the impact this has on the balance between thought and feeling. As represented above, it can be thought of as occupying a position on a spectrum. Extreme under-distancing can be thought of as too close; it is characterised by the experience of being consumed by emotion to the exclusion of engaging with the present environment and can serve to re-traumatise. Extreme over-distancing can be thought of as too distant; it is characterised by an absence of emotional presence and a response solely focused on the non-emotional dimension of the event.

Under-distancing increases distress and its related tension. Over-distancing perpetuates the repression of emotion. Both, according to Scheff, obstruct the

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resolving discharge of emotion. At optimal distancing, then, an individual is emotionally present with intense emotions, but feels considerable control over their somatic discharge in terms of an ability to stop and a sense of not being overwhelmed. The discharge is not necessarily unpleasant and there is a balance of thought and feeling, described by Scheff as 'deep emotional resonance, but also a feeling of control' (1979, p. 61).

Distressing emotions are ubiquitous in residential child care. Abuse, neglect and other forms of trauma feature in the histories of most children who are placed there (Anglin, 2004). For some, their related difficulties are compounded by multiple placement break-downs (Lawrence, 2011) and mental health difficulties (Smith and Carroll, 2015). All must contend with the emotional ramifications of separation and the grief that accompanies not being able to live with their families of origin. Fear, rage, shame and grief can feature in children's daily experience, and intense or even extreme expressions of emotion can be commonplace in some residential child care environments. Emotions can also be deeply repressed.

Often, children may not be ready to directly address the source of distressing emotions. Recall of past events (commonly a feature of other theories of catharsis) is missing from Scheff's definition. This is deliberate. Scheff argues that explicit recall is unnecessary for cathartic discharge of emotion and that most occurrences of catharsis do not involve it. He also argues that in some cases, a series of cathartic events is required to chip away at repressed emotions before access to memories is even possible. This, too, is relevant to residential child care, as much

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of the work is less about recalling past events and more about the therapeutic utilisation of everyday events for development and healing.

## **The Study**

The study's aim was to explore the experiences of children, young people and practitioners related to restraint in residential child care such that the voices of those most directly affected inform policy and practice developments. It was funded by Save the Children, Scotland. The samples were achieved by inviting the participation of all residential child care establishments in Scotland, and then distributing information sheets for practitioners, children and young people, and their parents or guardians via gatekeepers nominated by those establishments that responded. The impact of organisational self-selection and gatekeepers cannot be known; potential participants with highly critical things to say may, in some instances, have been obstructed from taking part. Despite this limitation, respondents did share negative views during interviews.

Inclusion criteria comprised direct experience of or witness to physical restraint. As is sometimes the case, not all establishments that indicated an initial interest ended up participating. In total, 37 children (26 male and 11 female) and 41 practitioners (17 male and 24 female) participated. Interviews took place across 20 different residential child care establishments in Scotland, including secure care (locked) facilities, residential schools and group homes across local authority (10), voluntary and private sectors (10), reflecting the diversity of service provision in Scotland and internationally. Children ranged in age from 10 – 17 years old; practitioners had been working in residential child care between one and 29 years. In-depth interviews comprised four vignettes and a series of semi-structured interview

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questions, and averaged approximately 30 minutes with children and 100 minutes with practitioners.

The study was approved by Strathclyde's University Ethics Committee, and due to the potentially upsetting nature of the subject, extra care was taken in relation to issues of informed consent, ongoing consent, clarity about the limits to confidentiality, and support should participating in the interview cause distress (Kendrick et al., 2008). While there have been other reports of children's views (as cited above), this is the only study of its kind, in terms of its size, scope, depth of exploration and theorisation on this subject. It is also the only one that identifies containment or catharsis as relevant to the data.

All interviews were transcribed verbatim. The vignettes and interview schedules elicited rich descriptions and wide ranging views, experiences, meanings and feelings, producing a voluminous, complex and nuanced body of data. NVivo was employed in an initial, systematic thematic analysis (Miles and Huberman, 1994). This analysis included: applying codes to each transcript; cycling between coding and documenting reflections and insights (di Gregoria, 2003); identifying themes and relationships across the transcripts; and gradually distilling these down to a smaller body of generalisations (Miles and Huberman, 1994) (for a much more in-depth discussion and analysis of general findings, see Steckley and Kendrick, 2008). A 'drilling down' of the data (Rapley, 2016) in relation to containment was carried out, involving further analysis between and within a reduced set of codes, with further systematic interrogation of insights gained using the analytic software's sophisticated search function. This produced the aforementioned theory-building of containment theory as applied to physical restraint (Steckley, 2010) and touch (Steckley, 2012) in residential child care. All of these processes raised significant

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questions about the potential relevance of catharsis for understanding experiences of restraint. This article, then, drills down into the data in relation to catharsis, introducing a previously unapplied theoretical lens and further building an empirically informed theoretical understanding of physical restraint to inform policy and practice development.

### **Findings Related to Catharsis**

Because catharsis-related questions were not incorporated in the data collection instruments and instead emerged via analysis, related data is more limited than it otherwise might be. A model of catharsis, based on questions raised by the analysis to this point and developed from the literature on catharsis (discussed above), informed the further analysis for this article. Findings are organised accordingly, using the focus points of:

- The presence and expression of intense emotion;
- Evidence of cathartic effect of restraint;
- Deliberate use of restraint to dispel emotion;
- The somatic component of emotional expression in restraint;
- Emotional distancing – under, over, and optimal.

For the purposes of confidentiality, pseudonyms have been used throughout.

Interviewer's minimal encouragers (e.g. 'uh hu') are offset by forward slashes and in italics. All other content by the interviewer appears on its own line.

*The presence and expression of strong emotion*

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Strong emotion was reflected in 30 of the children and young people's accounts of being physically restrained (two chose not to give an account, and five indicated that they hadn't been restrained before). More than the naming of emotions, their descriptions included terms that reflected the sensation of building-up or spilling over – phrases including 'escalated', 'going off', 'going mad', 'losing the rag', 'lose it', 'lost the plot', 'off the scale' and 'exploded' – alongside details of their own verbal abuse, property destruction and physical violence. While loss of control is implied in their descriptions, seven directly identified *needing* staff to stop them on such occasions:

Andy (young person): Because a boy had ripped my new shirt that my Mum bought me, [...]I would have hit, I would have hurt that boy very badly[...]they were protecting me from hurting another boy. I don't really like it, but if I lose my temper I can hurt somebody.

All of the practitioners' descriptions also featured intense emotion, sometimes building up over time and sometimes exploding quickly:

Matthew (practitioner): [...]that's generally what happens in cases I've been in, you get the build-up, the build-up, the build-up[...]and then they just lose the plot. And generally when they've lost the plot, that's the actual anger bit out of the way, and then you really need to be looking at the underlying reasons as to why they are that angry, and generally because they are actually so vulnerable at that point, emotionally, you know, everything is opened up[...]dare I say, actually, after I have restrained young people is when you actually get to the issue.

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All but two practitioners also spoke of being impacted by this intensity, whether in terms of their own emotional reactions and/or physiological ones, both of which will be discussed below.

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### *Cathartic effect of restraint*

10 young people spoke of what could be interpreted as a potentially cathartic effect of restraint, including feeling 'calm', 'relief' or generally 'better' after a restraint:

Callum (young person): After a restraint I feel much more like, I don't know how to say it, just more, I feel better because everything's out.

15 practitioners also identified what can be seen as cathartic effects of restraint for the young person:

Tony (practitioner): [...]when the young person has lost it and they're no longer in control /ok/ and that is when I think it's sometimes easier, because sometimes it's not a matter of restraining, it's a matter of a hold /ok/ for the young person to then release what's in it and cry and it sometimes is just a cuddle that you're doing[...]once you touch, you can feel their body relax then because then they know that they're going to be able to sort it out in their own head[...]I have been in situations when you've put hands on, you feel their whole body relax and they're just hanging onto you /yeah, ok/ and sobbing.

### *Deliberate use of restraint to dispel emotion*

Significantly, four young people spoke of the deliberate use of restraint to dispel emotion. Two, Sharon and Helen, spoke candidly about themselves:

Sharon (young person): Some kids just need to be held to comfort them.

*Interviewer: As a comfort thing?*

Sharon: Yeah.

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*Interviewer: So sometimes do they get held when they haven't, when they're not putting anybody at risk, but they just need the comfort of being held?*

*OK.*

Sharon: Well they won't, but like you have [go] to mad before they can do it.

*Interviewer: Oh, I see. So maybe a kid really just needs the comfort, but they have to kind of go into that 'putting at risk' place to be able to get the hold. Aye? That, what do you think about that?*

Sharon: Well I've done it a few times[...]you need to get all your anger out and then you just go mad and then you need to be held[...]I used to want to get held all the time, but now I just can't be bothered with all that stuff.

Helen (young person): I think I just needed a cuddle[...]That's just my way of dealing with anger[...]most of my restraints have been my fault, and it's through drinking[...]

*Interviewer: You said early on in the interview that you felt like you got restrained, sometimes, to be able to cry?*

Helen: Aye.

*Interviewer: Do you think sometimes you get restrained to let your anger out?*

Helen: Aye, that's what gets me angry, and I cry[...]When I'm restrained still, I try and fidget about[...]the staff will sit there as long as until I calm down[...]I'm that much angry with all these people around me and I can't get any

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control, and then I start getting angry and then, my eyes all fill up and then I cry, and once I've cried, then I'm alright again.

One young man spoke in slightly more general terms about how restraint was used to vent off anger:

Jason (young person): [...] there's times where you need to be restrained and you feel yourself, there's some boys in here in the, even, see in [name of establishment] there's boys that speak to each other and, like, say, 'Aye, I feel like I like getting restrained to take my anger out away' [...] when you're in a restraint your anger will just come out /*yeah?* / when you're struggling. That's what a restraint's about.

And one young woman spoke of witnessing a fellow resident whom she believed used restraint to expel anger:

Wendy (young person): When the staff really did get him down and calm and he was on the floor, then he would cry and it would be a painful cry, you know? Not an anger cry [...] he used to, quite a bit when he was really high, uncontrollable anger, I think he used it, as a relief for that.

Within their discussions, three of the four young people spoke also of repeated restraints, the significance of which will be addressed in the discussion section below.

Nine practitioners spoke of young people who appeared to use restraint to release their anger, aggression or frustration, or to cry.

Dorothy (practitioner): I have worked with children whereby they're almost goading you into holding them because they want something but they don't,

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maybe just a cuddle and they don't know how to act it or ask for it. So they keep going until you actually physically intervene[...]And actually helping them deal with those feelings and helping them, sort of, after the cuddle then that's what they need, or kind of, give them a more productive way of venting their anger in that particular situation.

*The somatic component of emotional expression in restraint*

In terms of Scheff's (1979, 2007) identification of the somatic component of catharsis, the most frequent reference to motor discharge made by young people was crying (five), with only one referring to shaking and none referring to laughing or sweating. When referring to young people, 19 practitioners referred to crying, four to sweating and two to shaking. No one mentioned laughing. When practitioners referred to their own physiological reactions to restraint, eight spoke of shaking, seven of crying, and three of sweating. Again, no one spoke of laughing.

Practitioners' accounts of situations involving restraint, as described above, had what can be interpreted as the physiological dimension of emotional build up and release, with feelings portrayed as something that young people vented, got rid of, got out, or got off their chest, often in process of the restraint. It is also significant that all of the young people who spoke of using restraint to release emotions included anger, and three of the four (all girls) also referred to crying (gender is possibly relevant here in how physical restraint is experienced and made sense of, but is beyond the scope of this article). Similarly, nine practitioners' accounts of

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young people crying during restraint reflected a release which was seen as important for being able to open up and talk about their distress.

No one referred to heat in their accounts, and Scheff (2007, p. 106) does suggest that the neuropsychological endpoint of anger may be asymptomatic, 'approaching zero arousal but infinitely slowly'. Certainly, heat is less noticeable, both in terms of its observability (as opposed to crying, for example) and in terms of it standing out as noteworthy.

Finally, of those who spoke of the emotional release involved in restraint, eight practitioners and four young people also made links to the need for a hug, a cuddle or to be held:

Renee (practitioner): while we were in an absolute frenzy /sure/ then I would say that is therapeutic. That is, that's you actually holding them in cos a lot of times when a child is out of control, they're scared still because they're out of control, their, you know their emotions are everywhere[...]Because you're drawing them together again, you're giving them a, you're giving them a chance to feel like they're being held together.

Renee's description reflects not only a tacit awareness of how uncontained children and young people can become during episodes of intense emotion, but also an appreciation of how important the embodied dimension of containment can be.

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### *Distancing – under, over, and optimal*

As might be expected, young people's experiences of being restrained reflect under-distancing. As described above, 30 accounts reflected highly consuming emotional content and a loss of control; 19 indicated further distress as a result of at least one or more experiences of restraint. Also, as described above, practitioners' perceptions of young people's experiences of restraint closely matched those described by young people, with under-distancing similarly indicated. This is unsurprising given the intensity of such events and the related perceptions of imminent harm.

Significantly, of the 14 young people who described positive effects of at least some restraint(s) – effects on how they felt in themselves or their relationships with the practitioners who restrained them – all gave accounts of restraint experiences that were clearly under-distanced (see Sharon and Helen's excerpts above, for example). No account of restraint reflected the characteristics of over-distancing (i.e. an account devoid of emotional content) or optimal distancing (i.e. a sense of control and a balance between thought and feeling), though it must be noted that an interview schedule designed to explore these possibilities might have yielded different results. This is perhaps the most significant limitation of the study in relation to this analysis.

### **Discussion**

That physical restraint involves intense emotions, including their build-up and expulsion, is not newsworthy to anyone familiar with residential child care or the practice of restraint more generally. Understanding them through the lens of catharsis, however, breaks new theoretical ground and offers significant insights

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that should inform policy and practice development. Based on the data collected in this study, children and young people appear to experience what can be understood as intense emotional expression during physical restraint with a clearly somatic component. For some, being able to experience what can be understood as under-distancing in the context of safe, containing relationships appears to have contributed to a wider process of healing and recovery – even if the sense of safety happened when making sense of the event(s) subsequently. The experiences of Sharon and Helen are possible examples; each indicated that they had not been restrained for over a year and both described being in a better emotional place.

The data also indicates that for some young people, the drive to relieve themselves of intense emotions is a key factor contributing to situations involving physical restraint. Catharsis theory brings into sharp relief the bodily dimension of emotions, especially in incidents involving physical restraint. While this may seem obvious – indeed physical restraint is likely the most extreme form of physical contact that takes place in residential child care – the physicality of care more generally remains unacknowledged. Voestermans and Verheggen highlight the absence of the body in psycho-social developmental theory and the challenge associated with the development of ‘bodily techniques and bodily practices’ in care that promote attachment and relationships (2013, p. 175). Their discussion of the abstract, disembodied way that care is described resonates with Jensen’s findings from a comparative study of early childhood practice in Denmark, Hungary and England. She identifies *kropslighed* or embodiment as a critical theme in pedagogic practice in Denmark, with one research participant commenting on how ‘The body is *allowed* to be there’ in Danish practice, as opposed to ‘the way the body has been reduced to a head’ in English practice (Jensen, 2011, p. 150, emphasis added).

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This unacknowledged and often unconscious awareness of the bodily dimension of care and, specific to this paper, emotional distress, has significant implications for practice. Ferguson (2011) argues for 'generous touch' in child protection social work, one that incorporates holding a distressed child in a way that conveys warmth and comfort. A previous analysis of the data in this study found, however, wider anxieties about touch between children and adults (Piper et al., 2006) clearly reflected in practitioners' accounts of risk, precaution, surveillance and techniques in relation to touching young people (Steckley, 2012). These anxieties may inhibit practitioners' ameliorative use of touch when children are struggling with intense emotions. Moreover, the possibility must be considered that some practitioners unconsciously expedite restraint in order to facilitate catharsis – the young person's catharsis and potentially their own vicarious catharsis – again, especially if this dimension of the event remains unacknowledged and poorly understood. Protected spaces for related discussions are necessary to support practitioners and their managers to explore the emotional component of the work and how this manifests physically in practice.

Optimal-distancing, the other component of Scheff's (1979) model, provides an immediately accessible language for making sense of and addressing young people's related emotional needs. The data strongly indicates the majority of young people's experiences of physical restraint as under-distanced. This makes intuitive sense, given the extreme nature of restraint and the accompanying loss of emotional and physical control experienced by the young person. Indeed, it can be argued that, given their histories of trauma and/or chronic stress, young people in residential care are far more likely to experience suboptimal-distancing with greater frequency and severity in their day-to-day lives than young people without such histories. Yet for an emotional event to be cathartic according to Scheff

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(1979, 2007), there must be optimal–distancing. This study raises the possibility that containing responses to under–distancing of intense and distressing emotion has a bodily dimension (with or without restraint) and is a necessary part of a process that leads towards optimal–distancing.

Optimal distancing is far more possible within a robustly containing environment. Indeed, not being overwhelmed features in definitions of both containment and catharsis, and there is benefit in understanding cathartic events as a type of containment. Klopstech (2005) emphasises the relationship between therapist and client as an essential component of catharsis, and in residential child care environments, this must be expanded to the network of relationships between and amongst children and practitioners. Practitioners' own level of distancing directly impacts their effectiveness in providing such containment. An over–distant practitioner is not able to absorb or offer empathic acknowledgement, leaving the child feeling unrecognised or misunderstood and therefore not contained. An under–distant practitioner becomes overwhelmed by the child's emotions and/or his or her own, leaving the child feeling uncontainable and potentially escalating the intensity of emotion. Neither will facilitate optimal distancing for the child. This, then, reinforces the imperative for containing processes for practitioners to maintain their own optimal distancing as part of providing containment for a child's cathartic event.

The phenomenon of multiple restraints is of particular concern. 22 practitioners described being unable to break out of cycles of multiple restraint with one or more young people, and of those, five connected this cycle with a young person losing his or her placement. While this likely represents only a minority of the residential child care population, there is increasing concern over the deeply damaging effects

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of placement breakdown on young people's psychosocial development, educational attainment and ability to develop close relationships (Furnivall et al., 2007; Tomlinson, 2008). Better understanding of this phenomenon is needed to reduce the suffering these children will carry into adulthood.

Repeated restraints will be characterised by multiple, complex factors; viewing them through a combined lens of containment and catharsis theory offers illumination. Some young people may get stuck in their attempts to purge emotions that are more bearable to express (often anger), rather than those which may also be driving the behaviour (often shame, fear and crushing grief). Respondents' association of anger with crying highlights the danger of restraints reinforcing the belief that violent eruptions are necessary before vulnerability can be expressed or tenderness received. Furthermore, if such events (whether or not they involve physical restraint) are only framed in terms of anger, practitioners' ability to provide a containing process for other emotions such as shame, fear or grief may be compromised. Other young people may experience restraint such that their anger gets strongly reinforced rather than relieved through crying; this reinforcement is much more likely when restraints are not experienced as part of an overall caring, containing process that includes good practice before, during and after the actual event of restraint. It is also more likely when practitioners' working environments do not provide containing processes for them (Steckley, 2010).

Theories of containment and catharsis have much to offer not just policy and practice development, but also each other. Catharsis theory's illumination of emotional distancing and the somatic component of intense emotional expression provide a deeper, more embodied way of understanding what it means to be contained. Containment theory's focus on the parallels between client and

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practitioners' needs highlights the imperative of attending to the somatic component and degree of emotional distancing *for practitioners*, thus increasing their capacity to resist its use for purposes of punishment or dominance. It also widens the focus to the environmental processes that support (or disrupt) genuinely cathartic events. Finally, the application of both theories to physical restraint in residential child care moves our understanding beyond the current focus on the relationship between practitioner and child to the far more complex milieu of therapeutic group care. Dedicated research is warranted to explore the extent to which catharsis is a feature of physical restraint and to evaluate its utility to inform practitioner and organisational responses.

## Conclusion

This article forwards the literatures on physical restraint, containment theory and catharsis theory by synthesising the latter two to illuminate a recognisable but rarely discussed dimension of one of the most complex and ethically charged area of residential child care practice. In doing do, it offers a language for such discussions to take place, discussions in the literature and discussions in practice settings. More specifically, this article is a call for a more contextualised understanding of intense emotional expression in order to reduce, and where possible, eliminate the use of physical restraint in residential child care and other settings where it is used. Such an understanding increases the likelihood that when restraints do happen, they are experienced as acts of care rather than brutality. For all of this to be possible, our understanding must also move beyond dichotomising the bodily and emotional dimensions of such experiences. Put simply, some

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children need to be literally held through their most painful moments. Owning up to this reality requires a rethink beyond physical restraint.

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