

A lesser harm? Restraining self and others or holding and being held? An in-depth exploration of restraint and holding in residential child care.

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Abstract

This thesis uses action research through work discussion groups to understand the intra-psychic, inter-personal and systemic factors influencing practitioners' experiences of physical restraint in residential child care. It explores the ethical dilemmas, practice challenges and personal distress evoked in participants by this practice. It also examines their perspectives on how others, including the children involved, witnesses and professionals, experienced or thought about physical restraint. Their reflections on the impact of wider systemic factors on their experience are also considered.

The findings show that physical restraint presents serious physical and emotional hazards for both children and adults involved. Participants all supported attempts to reduce restraint but believed that 'no restraint policies' presented greater risks than restraint itself. Other children who witnessed restraints were recognised as invisible victims as this experience was terrifying and potentially evoked traumatic memories. The level of ethical distress experienced by all participants was very high but previously unacknowledged. The perverse social defence that had enabled restraint to be an uncontested practice despite its clear dangers has been dismantled but the brunt of anxiety is felt by individual workers. This is exacerbated by the climate of suspicion and negativity experienced from external professionals and regulators as well as the public.

The importance of a culture of reflection and curiosity to support staff's capacity to remain connected to children and be able to survive hostile projections from both children and the external world was emphasised and external consultancy identified as helpful in this process. Strong leadership, a model of care and a supportive but

challenging team were identified as key components of such a culture. Without such reflective practice, restraint risks being a gateway to institutional abuse.

Finally, this thesis places the findings in the context of current research and practice and considers the implications for the wider sector.

Keywords: Children and young people, residential care, physical restraint, reflective spaces, holding, containment, social defences, external consultancy, moral distress.

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Chapter One: Introduction

This thesis focuses on what is happening beneath the surface when physical restraint occurs in residential child care (RCC) settings. The aim is to expand understanding of processes within and between adults and what wider systemic factors might influence them. Although there is an emerging literature about physical restraint in RCC, there are no studies that examine these dynamics.

The main site for the research was a long-term therapeutic children's home, the Cedars. **The children were all aged under twelve on admission and all had histories of severe trauma and neglect. Most had also experienced multiple placement breakdowns before they arrived. There was an even balance between boys and girls at the point the research took place.** I met a group of experienced practitioners for five sessions to reflect on their experiences of physical restraint. The material this generated was also used as discussion triggers with a group of house managers from another organisation (Sanctuary), for triangulation purposes. Children resident in this second organisation spanned the age range from early primary aged children to young people in their early twenties. In this organisation there were more boys than girls as it had originally been a boys only resource and girls had only recently been admitted. Children were accommodated in different houses across several small towns and villages and most attended the school provided by Sanctuary. They had experienced similar adversities to those who lived at the Cedars both in their families and the care system. The examples these participants drew upon in their discussion were mostly from children at the younger end of their resident groups.

In both organisations participants described a steady reduction in restraints for most children the longer their placements continued. This was, however, offset by a recognition that as children became older and physically stronger the intensity and

danger of physical restraints often increased though their frequency reduced. This was particularly true for boys as they entered puberty. Different issues arose when girls entered puberty as adults recognised that it became more difficult to physically restrain them without inadvertently creating a situation where the child might feel sexually intimidated.

I acted as an external consultant to both organisations. Whilst this pre-existing relationship eased the process of gaining research access and allowed me to understand references from participants to particular children or adults outside the research room, this insider role did present ethical and practical issues. These included the risk that participants felt pressured to take part in the research because of their relationship with me rather than through a process of fully informed consent. In addition, my pre-existing role is likely to have affected the way participants and I engaged during the research as well as the way I understood and analysed the material that was generated. These issues are fully explored later in this thesis in the methodology section (Chapter 3) and my reflections on the research (Chapter 10).

This chapter outlines the background and rationale for the research and presents the hypotheses that informed my research questions. I then explain some of the language around physical restraint and consider how this complicates the way physical restraint is understood and discussed. Finally, I outline the structure of the thesis.

Background and rationale for the research

Physical restraint was a common and largely uncontested practice in RCC settings until the Hartford Courant (Weiss et al., 1998) exposed child deaths occurring during restraints. A 26 year long study of US child fatalities associated with restraint found that at least 79 children died between 1993 and 2018 (Nunno et al., 2022). Although several adults have died in the UK because of physical restraint (Paterson et al., 2003),

only two child fatalities have occurred, both in custodial settings (Carlile Inquiry, 2006; Gooch, 2015). Many children have, however, suffered injuries ranging from bruising to broken bones (Day et al., 2010; Gooch, 2015).

For a brief period in the US physical restraint was sometimes employed as a 'therapeutic' intervention. In attachment therapy children were forcibly held sometimes for hours to try and create new attachments with adults. Children had to maintain eye-contact and failure to comply or protests about pain meant they were held more tightly. This treatment had no theoretical integrity and several children died when it was used. (Chaffin et al. 2006; O'Connor and Zeanah, 2003; Steele, 2003).

In the UK there has been a significant shift in how physical restraint is perceived. This has been largely led by people who have themselves experienced physical restraint. Increasing disquiet has also emerged within various professional groups whose work has involved physical restraint. Public outrage at the discovery of serious misuse of restraint, for example at Winterbourne View Hospital¹, contributed to strengthening regulatory processes and new guidance.

Two networks focusing on reducing physical restraint have been set up. The Restraint Reduction Network is a UK wide membership body that aims to reduce the use of physical restraint in all settings. The Scottish Physical Restraint Action Group (SPRAG) focuses on physical restraint in children's residential services. They have wide support for their vision of working "*towards making coercive forms of holding less or even unnecessary and, when children are restrained, it is carried out relationally*

¹ 1 Winterbourne View was a private hospital for people with learning disabilities. In 2011 a Panorama undercover reporter found evidence of systematic abuse in particular the indiscriminate use of dangerous and unnecessary restraints. Eleven members of staff were convicted of abuse.

*and with care*²". In addition to influencing policy and practice, SPRAG has developed a reflective model that is being implemented across Scotland.

There are criteria for physical restraint in UK children's homes - restraint must be undertaken as a last resort to prevent harm to people or dangerous damage to property (Davidson et al., 2005; HM Government, 2019). Force must be proportionate, and restraint should last for the shortest possible time. Deciding whether these criteria are met depends on the individual judgement of adults involved in a volatile and fast-moving crisis where everyone may be experiencing high physiological and emotional arousal. Assessment of risk in such situations is contestable, and practitioners face disciplinary action for making the 'wrong' decision. Intervening too soon or too forcefully may be criticised but their duty of care to others means a failure to protect may also be questioned. An unjustified restraint constitutes an assault and might lead to prosecution for the workers involved. Davidson et al. (2005) provide a hard decisions flow chart (Appendix 1) that highlights the consequences of intervening or failing to intervene in a variety of scenarios.

There are psychological as well as physical hazards involved in using physical restraint. Children in RCC have experienced painful losses and most have suffered trauma. Mohr (2006, p.43) argues that "*the act of forcible restraint becomes one more layer of trauma on top of an already wounded psyche*". The negative psychological effects of physical restraint are highlighted in research studies (Strout, 2010), particularly the danger of re-traumatisation associated with earlier abuse (Fox, 2004). During the consultation stage of the Children (Equal Protection from Assault) (Scotland) Bill (Scottish Parliament, 2018), Who Cares? Scotland³ gave evidence in

² Information about SPRAG is available at ([Scottish Physical Restraint Action Group :: Celcis](#))

³ Who cares? Scotland is an advocacy organisation for care-experienced people,

the Scottish Parliament. After consulting their members, they argued that physical restraint often constitutes an assault, as it is currently practised. In Scotland the Independent Care Review (ICR) consulted with over 1000 care-experienced people and physical restraint was continually mentioned. The review's report recommended that "*Scotland must strive to become a nation that does not restrain its children*" (ICR, 2020, p.85).

Failure to intervene may also have adverse effects. 'No restraint' policies may have perverse consequences for individual children and the whole system. Practitioners facing imminent danger, may involve the police, presenting a different, and potentially more serious, danger to the child involved, as a Scottish study suggests.

the calling of the police to take control of out-of-control situations with young people effectively means that other parties are being called on to use methods that the agency has decided are ethically unacceptable (Lindsay and Hosie, 2000, p.13).

Children may be more brutally restrained, arrested and charged, spend time alone in police cells and emerge from the incident with a criminal record. There might also be systemic effects with some providers refusing places to children showing behaviours requiring physical intervention.

When dysregulated children express their pain through aggression, other children and workers are at risk. Failure to protect other children from injury would evoke criticism and, potentially, disciplinary action for workers. Staff may also be attacked, and organisations have a duty of care to employees. Paterson and Duxbury (2007) argue it is ethically questionable to prioritise the safety of one group, such as service-users, over another such as direct care workers. They place this in the context of increased aggression towards care professionals and the negative impact of exposure to violence.

Physical restraint is a hazardous practice that can cause serious harm to all those involved. As outlined above, however, there are also risks if children are not prevented from hurting themselves or others. It poses serious moral dilemmas for RCC workers expected to make complex ethical and practice judgements in intensely difficult situations. When this research was initiated, it was clear little was understood about the conscious and unconscious dynamics occurring in physical restraints and the systemic factors influencing them. The choice of a systems psychodynamic lens to explore these at depth seemed appropriate to the complexity of the interaction between these various processes.

Use of language

This section highlights the various ways physical restraint is defined. It also discusses the differences in how certain terms are typically understood between practitioners in residential care and those in the systems psychodynamic field.

Definitional issues

Physical restraint is categorised under the overarching term 'restrictive practice'. This term also refers to the enforced seclusion of children or the use of chemical control, such as sedation. In the UK physical restraint typically refers to a child being held against their will through the bodily force of adults. 'Safe holding' is an alternative term describing this type of physical restraint. Other physical interventions include guiding a child away from a situation or blocking their access to spaces when an adult stands between the child and the place they want to reach. In some countries, however, 'physical restraint' includes situations where a child is restricted by mechanical restraints such as leather straps, special clothing or constraining chairs. In the research literature different situations are rarely clearly delineated, and terminology is inconsistent (Day et al., 2010). Although chemical control or seclusion are not usually

referred to as 'physical restraint' many accounts show physical restraint being used during these other restrictive practices. Children may be physically dragged to seclusion spaces or held down and medicated if they are resistant to accepting drugs⁴. Some studies only included interventions lasting longer than a specified time as physical restraints. This study focuses on physical restraint in its narrowest sense of adults using their bodies to restrict a child's freedom of movement regardless of the duration of the intervention.

Confused terminology

Two psychodynamic concepts 'the holding environment' (Winnicott, 1964; Winnicott, 1965) and 'containment' (Bion, 1962) were useful in illuminating the processes being described by participants in this research and identifying the mirrored needs of both children and adults. They are particularly relevant in examining residential care as they describe interpersonal dynamics rather than just intra-psychic processes. Holding refers to the everyday experience of attuned care and connection provided by a caregiver. Containment is an active process occurring between infants and their caregivers. Infants project into their caregivers (containers) emotional experiences they cannot process on their own. The caregiver processes these projections and makes them available in a digestible form to the child.

The importance of protective holding environments in which traumatised children can recover was emphasised by Winnicott and Britton (1947) and Dockar-Drysdale (1990) in their descriptions of creating therapeutic residential care environments. A key task of adults in RCC is to contain overwhelming distress and pain that children push into them without withdrawing emotionally or retaliating punitively. These concepts can

⁴ This happened as a regular practice at Hill End Adolescent Unit where children were forcibly sedated with adult levels of tranquilising drugs if they made the staff 'anxious' [Compensation announced for Hill End adolescent unit abuse victims | Herts Advertiser](#)

also be applied to the support adults require to do their work. Without a robustly maintained external boundary and policies and structures that reduce their anxiety, adults may struggle to provide the preoccupation children require. Additionally, they need managers and consultants able to contain the extreme emotions evoked by their work and help them respond sensitively and find meaning in children's behaviour. (Ruch, 2011; Steckley, 2010).

Unfortunately, within RCC, the terms 'holding' and 'containment' often have negative connotations. Containment is usually used disparagingly about practice that merely provides basic needs, rather than being a key plank of therapeutic intervention and emotional recovery. 'Holding' has come to be applied mainly to physical restraint. This not only makes the concept of a 'holding environment' unusual in residential settings but has also contaminated the normal usage of a word describing a natural interaction between people and invested it with the implication of coercion. Although the conscious intent of introducing the terminology of 'holding safely' was to reframe restraint as an act of care rather than brutality, it may have served to defend practitioners against the meaning of their actions. Unusually, however, participants in this research were familiar with the psychodynamic meaning of both concepts and used them frequently and accurately in their reflections. In both organisations there was an investment in continuous training and development as well as regular consultation. This does not reflect the usual experience for RCC practitioners.

Hypotheses and research questions

In developing my hypotheses, I drew on my knowledge of RCC and the wider context in which it is situated, as well as my learning from providing external consultancy. Physical restraint seems to be a space where pressures arising from the external

context interact powerfully with individual anxieties in a complex and at times explosive relational environment.

In my consultancy role I regularly support adults who daily face the stress of working with traumatised and highly dysregulated children. Many seem to have been unconsciously drawn to RCC seeking to resolve issues lingering from relationships with their own caregivers. A few, with very difficult childhoods, find echoes of their experiences in children's histories. Some have also experienced domestic violence or traumatic loss in adulthood. Although this is anecdotal evidence, it is supported by studies showing that care professionals have a higher-than-average Adverse Childhood Experiences Score (Esaki and Larkin, 2013; Lee et al., 2017). Sometimes the behaviour of children or details of their histories trigger unexpected reactions in adults that link to their own adverse experiences. The emotionally volatile experience of restraint is a time when such unsettling responses are likely to occur.

RCC is essentially a group and intergroup experience. Any study of physical restraint needs to examine wider interpersonal dynamics in the service, as well as those occurring in any specific restraint. Although the overt purpose of restraint is to restore safety, other complex dynamics may also be in play that might reflect differences in power and authority, complicated personal relationships or contested perspectives.

RCC is a neglected and undervalued sector and yet services experience intrusive monitoring by regulators. Children looked after away from their families, especially those in residential settings, and the adults who care for them seem to serve as convenient receptacles for the split off negative projections from society. The children are often perceived as victims or villains and those caring for them as potential abusers or incompetent do-gooders.

A culture of enquiry and reflection seems to create resilience in RCC organisations and enables adults to survive the emotional volatility and psychological demand inherent in the work (Kahn, 2004). This seemed likely to be relevant in examining the underlying dynamics at work during physical restraints as well as managing the emotional intensity of the experience.

These were the hypotheses I developed.

- The decision to restrain a child and the process and impact of the restraint are affected by the individual histories of RCC workers and the characteristics and history of the child.
- Interpersonal dynamics within the setting affect the decision to initiate a restraint and the process and impact of that restraint.
- Societal and organisational structures, processes, procedures and dynamics affect the process and impact of restraints.
- Facilitated reflection may provide a holding environment that enables practitioners to survive the emotional maelstrom of physical restraint without being overwhelmed and to retain their capacity to think.

These led to my research questions:

- *How does a focused reflective group affect physical restraint and holding in a therapeutic children's home?*
- *What conscious, unconscious and systemic factors influence physical intervention in RCC?*

Structure of the Thesis

This thesis consists of three parts: Part One contains three chapters outlining the background and aims of the research, reviewing relevant literature and describing the methodology; Part Two contains four chapters presenting findings of the research; Part Three contains three chapters including discussion of the findings and

recommendations, reflections on the research and suggestions for further studies and some concluding thoughts.

Part One

Chapter One Introduction

Chapter two is a literature review in two sections. The first section contextualises the research and identifies the gap in knowledge leading to my research questions. The second identifies concepts and research primarily from the systems psychodynamic field used in framing my research and analysing my data.

Chapter three outlines the methodological and ethical foundations of this research. I explore my motivation for undertaking the research and outline my role and position as a researcher. I explain methodological choices and describe the process of gathering and analysing the data. Throughout this chapter my approach to ethical dilemmas is highlighted.

Part Two

Chapter Four is a brief introductory chapter explaining my rationale for the presentation of data and introducing the results of two exercises undertaken by participants.

Chapter Five identifies the importance of locating any physical restraint in its temporal and spatial context to avoid a simplistic analysis focusing only on the behaviour of the main protagonists.

Chapter Six explores the visceral experience of adults immediately before and during restraints as well as their understanding of children's behaviours and emotions. I examine participants' beliefs about some children's route to self-regulation.

Chapter Seven considers the complexity of the task workers face navigating the challenging ethical and practice dilemmas surrounding physical restraint.

Chapter Eight examines the impact of those external to a restraint on its process and aftermath and the effects on those who directly witness a restraint.

Part Three

Chapter Nine discusses the data and its implications. The chapter ends with a series of recommendations for practice and staff support and development.

Chapter Ten offers my reflections on the research process and suggests areas for future research.

Chapter Eleven offers my concluding thoughts and outlines my contribution to this field. I draw on my extensive experiences as a practitioner and consultant as well as my professional training in social work and consultancy to reflect on issues this research poses.

Chapter 2: Literature Review

Introduction

This chapter comprises two sections. In the first I outline my search strategy and review the research literature about physical restraint, focusing first on those directly relevant to RCC and then on those referring to contiguous fields. Through this I demonstrate the gaps in knowledge. I then review conceptual papers highlighting issues raised by physical restraint and examine the contradictory perspectives these demonstrate. In the second section I discuss the research and conceptual papers helpful in my analysis including key systems-psychodynamic concepts framing my research.

Section 1 The Initial Review

Search strategy

Before formulating my research questions and gathering data I undertook a search of literature using the terms and limiters outlined in Figure 1. I used Suprimo, the search service of the university where I worked. I also used databases to search the fields of social sciences, social services and psychology. Although I set wide parameters to identify as many papers as possible there were not many results and there was substantial crossover between the four sets.

Figure 1 Search Results

| | Suprimo (University search service) | Psych info database | Social science premium database | Social services abstracts |
|--|---|---|--|---|
| Search terms | "residential child care" OR "child and youth care" OR "children in care" OR "children's institutional care" AND "physical intervention" OR "physical restraint" [Searched for in any field] | AB(CHILDREN OR (YOUNG PEOPLE) OR YOUTH OR ADOLESCENTS) AND AB((PHYSICAL RESTRAINT)OR (PHYSICAL INTERVENTION) OR (PHYSICAL HOLDING)) AND AB((RESIDENTIAL CHILD CARE) OR (INSTITUTIONAL CARE) OR (RESIDENTIAL TREATMENT) OR (CARE FACILITIES)) | NOFT(CHILDREN OR "YOUNG PEOPLE" OR YOUTH OR ADOLESCENTS) AND NOFT("PHYSICAL RESTRAINT" OR "PHYSICAL INTERVENTION" OR "PHYSICAL HOLDING") AND ("RESIDENTIAL CHILD CARE" OR "INSTITUTIONAL CARE" OR "RESIDENTIAL TREATMENT" OR "CARE FACILITIES") | NOFT(CHILDREN OR "YOUNG PEOPLE" OR YOUTH OR ADOLESCENTS) AND NOFT("PHYSICAL RESTRAINT" OR "PHYSICAL INTERVENTION" OR "PHYSICAL HOLDING") AND ("RESIDENTIAL CHILD CARE" OR "INSTITUTIONAL CARE" OR "RESIDENTIAL TREATMENT" OR "CARE FACILITIES") |
| Limiters | English 1/1/1995 23/5/2019 Peer-reviewed journals | English 1/1/1995 23/5/2019 Academic journals | English 1/1/1995 23/5/2019 Scholarly journals | English 1/1/1995 -23/5/2019 Scholarly journals |
| Number returned | 67 | 30 | 44 | 17 |
| Number remaining after excluding duplicates, dissertations, non-academic and obviously irrelevant papers | 32 | 17 | 22 | 13 |
| Number remaining after reading all papers | 10 | 11 | 10 | 10 |

I checked all titles and discarded the obviously irrelevant. Where I was unsure, I also read the abstract. I excluded results that were not primary research. Finally, I read the remaining papers and reviewed fourteen that focused specifically on the area of RCC. These informed my research questions. Although I initially excluded interesting but tangential papers such as those focusing on health, criminal justice or education and purely conceptual papers, I revisited and updated these later to contextualise my research.

Identifying the gap

The fourteen papers fall into two groups: seven focused on organisational or systemic factors and seven on the experience of workers and children.

Organisational and systemic factors

Six of the systemic/organisational studies were evaluations of therapeutic models or crisis intervention training (Boel-Studt, 2017; Brown et al., 2013; Crossland et al., 2008; Jones and Timber, 2003; Miller et al., 2006; Nunno et al., 2003) which generally reported reductions in restraints. Most were conducted by researchers involved in developing the models being evaluated which might undermine their reliability. One study found no reduction in restraints before and after the introduction of a trauma-informed model, but this might reflect the low baseline number of restraints prior to the change in practice (Boel-Studt, 2017). All studies argued that reduction in physical restraint demanded a whole-systems approach. This was convincingly demonstrated in a study examining differences in the restraint and seclusion levels among 693 residential treatment facilities (Greene-Hennessey and Hennessey, 2015). Residents' characteristics failed to predict levels of restraint but differences among facilities did. These papers reported on services in the US which differ from those in the UK in their structure and practice. Most operated a behavioural model, although some had

recently introduced trauma-informed care. There was no evidence of psychodynamic practice in the organisations studied or systems-psychodynamic analysis in the research, but the unanimous emphasis on the importance of organisational culture and training was valuable.

Experiences of staff and children

The remaining papers draw on three qualitative studies examining the experience of restraint- two undertaken in Scotland and one in the USA. These vary in their findings, methodology and level of critical analysis.

Bell (1997) explored the effects of introducing Therapeutic Crisis Intervention (TCI) in a Scottish Region. Practitioners reflected upon their most recent restraint. None felt the child had experienced distress with some suggesting that they had benefited. Participants described little fear during the restraint although they expressed concern about restraint in general because of its potential harm. Staff described trigger points for restraint: a child refusing to follow direction; maintaining safety; transition times or hearing difficult news. Their acceptance of restraint used to enforce compliance may be explained by the early date of this research when there was little concern about the practice. Routine debriefing was not available, although some opportunistically used colleagues or managers for reflection.

Hejtmanek (2010 and 2014) focused on physical restraint when reporting on an 18-month ethnographic study in a residential centre for boys in the USA. In her first paper she provided a vivid description of a violent physical restraint and the extreme physical and psychological arousal and distress it entailed. The restraint ended with the boy naked below the waist, sobbing in a foetal ball, alone in seclusion. Workers' clothing was torn and some sustained serious injuries. She powerfully evokes the tension among staff and other children. Her analysis of this event and others she observed is concerning. She uncritically accepts workers' explanations for the violence she

observed. They believed these experiences were an essential part of the therapeutic programme - explaining that their violence to children protected them from extreme community violence they might later experience.

Similarly, her account of the introduction of a new model, 'Counter Response' (Shahbazian et al., 2005), demonstrated unquestioning acceptance of the negative views of staff (Hejtmanek, 2014). She argued that expecting practitioners to reflect on their own internal reactions was an unwarranted exercise of power and implied that this suggested that they, rather than the boys, had emotional difficulties. Her own lack of reflexivity mirrored the resistance displayed by the practitioners at the idea they should consider their own responses. The author appeared to be drawn into the participant role that characterises ethnography and lost sight of the equally important analytic perspective which might have led her to question the workers' beliefs and attitudes (Geertz, 1973; Hammersley, 2006).

The remaining papers drew on an extensive Scottish study exploring views of children and staff about physical restraint. It involved interviews with 37 children and 41 staff from 20 establishments across Scotland. Five main themes were identified (Steckley and Kendrick, 2008).

- Children and staff believed restraint was sometimes necessary.
- The complex nature of physical restraint was clear in the ambiguity expressed about what should trigger physical restraint
- Concern that restraints sometimes occurred unnecessarily with a few children stating that some adults hurt them on purpose.
- The general experience of restraints was negative although a few children felt restraint provided emotional release.

- Restraints should be understood in the context of existing relationships.

Restraints affected, and were affected by, the quality of relationships.

Steckley drew on psychoanalytic theory in later papers. She revisited her original data examining it for evidence of containment (Bion, 1962) or the existence of a holding environment (Winnicott, 1965). She found examples of basic containment for children, but few containing experiences for staff. Most of the epistemological and emotional holding (Ruch, 2005) was provided by colleagues rather than managers, and external consultancy support for managers or teams was rare. She suggested that lack of containing experiences for individuals and groups and the absence of a wider holding environment for the adults prevented the creation of therapeutic experiences of containment and holding for the children (Steckley, 2009).

Her next paper identified a reluctance to use touch to de-escalate heightened situations or even provide comfort. She posited that lack of positive touch may perversely increase coercive touch as some children sought restraint to gain emotional release. She noted the extremity of the touch experience of physical restraint and its association with pain and wondered if this diverted attention from emotional distress and the possibility of psychological recovery. Again, she argued for the importance of adults having space to reflect on their emotional responses and practice complexities and dilemmas (Steckley, 2012).

Her final paper linked the concept of catharsis to therapeutic containment (Steckley, 2018). She used Scheff's (2007) work on catharsis to explore these ideas. He argued that catharsis requires a bodily discharge of emotion and a balanced state of emotional distancing. Descriptions of extreme physiological reactions by both children and adults were identified by Steckley but there was little evidence of optimal emotional distancing. She argued that trauma may leave children existing in a constant state of

under-distancing of emotion – always on the edge of being overwhelmed. Helping children gain optimal emotional distancing of their emotion may require bodily responses including, at times, physical restraint. For such work to be helpful rather than destructive, however, practitioners must work from a position of optimal emotional distance – neither overwhelmed nor cut off. Steckley again argued that this requires containment and holding for the adults.

This initial review of the literature identified little primary research on physical restraint in RCC. Steckley's corpus of work was the most substantive and contributed to an understanding of physical restraint informed by psychoanalytic ideas. A significant gap in knowledge exists, however, as her original study was not designed to capture the complex and multi-layered conscious and unconscious dynamics and systemic factors involved in physical restraint. It supported, however, my hypothesis that a focused and facilitated reflective space might enable staff to stay emotionally regulated and preserve their capacity to think during physical restraints.

Literature from contiguous fields

The rich literature from other settings where physical restraint occurs has informed this study. Although these studies were conducted in settings as different as acute paediatric care and custodial establishments some consistent themes emerged.

Health care research

Most healthcare research was undertaken in adult psychiatric hospitals, but physical restraint has also been investigated in acute hospital care. Strout (2010) undertook an integrative review of qualitative studies focusing on patients' experiences of restraint. Only twelve papers could be identified. The themes identified include negative psychological effects, re-experiencing previous trauma, unethical behaviour from medical professionals and patients feeling their spirit had been broken. Although

medical patients were more likely to believe the restraint was life-saving many still described negative emotions. Knowles et al., (2015) explored the impact of physical restraint on relationships between nurses and patients in a forensic psychiatric hospital. Five themes emerged which appeared to adversely affect therapeutic relationships:

- Power differentials were aggravated
- Restraint was experienced as humiliating and traumatic
- Patients were unwilling to accept restraints they perceived as unjustified
- Some staff were seen as wanting to cause pain to patients
- Patients having to deal with their sense of powerlessness.

The researchers emphasised the importance of allowing patients to express difficult feelings without triggering a restraint and suggested nurses should be more accepting of patients communicating their unhappiness about being restrained.

Several studies explored nurses' and mental health support workers' experiences of physical restraint and what meaning the act held for them. These studies revealed the anxieties, ambivalence and ethical distress experienced by professionals who deeply disliked restraining patients but appeared to accept it as unavoidable. In their study Bigwood and Crowe (2008) identified the over-arching theme: 'It's part of the job'. This acceptance was problematic, however, as nurses also articulated their extreme discomfort about physical restraint. This conflicted acceptance runs through several other studies (Bailey, 2015; Bailey et al., 2021; Kodua et al., 2023; Martin, 2023; Perkins et al., 2012; Wilson et al., 2017). Organisational constraints and structures were felt to contribute to the inevitability of physical restraint in these settings (Bigwood and Crowe, 2008; Kodua et al., 2023; Perkins et al., 2012).

Participants found it hard to ignore the trauma intrinsic to physical restraint, despite accepting it as unavoidable, which caused them deep ethical distress. Martin's study, focusing on support workers, also identified the additional moral difficulty for workers who believed the behaviour of a higher status colleague had provoked restraint but felt powerless to challenge them.

The perceived need for control was articulated in these studies and there was a recognition that individual staff had different thresholds which triggered their need to enforce control through physical restraint (Bailey, 2015; Bigwood and Crowe, 2008; Perkins et al., 2011). Sometimes this was linked to fear generated by patients' aggressive behaviour as well as anxiety about taking part in the restraint. Emotional distancing and dissociation were described as a way of dealing with their own and patients' overwhelming emotions (Bailey et al., 2021). All studies found anxiety about the impact of restraint on therapeutic relationships with patients. Usually this related to the patient's loss of trust in practitioners, however in one study participants acknowledged that they struggled letting go of negativity towards patients, particularly when targeted with hurtful verbal abuse (Martin, 2023). Lack of care for and between practitioners and the absence of space to process emotions were reported in several papers (Bailey, 2015; Bailey et al., 2021; Martin, 2023). Participants expressed appreciation that the research had allowed them space to reflect. In contrast, Bigwood and Crowe (2008) found nurses stating that emotional support and space for reflection reduced the negative impact of restraint. The importance of support from other skilled team members was emphasised and difficulties posed by working with less experienced or agency staff were highlighted.

There is less research on physical restraint in adolescent mental health settings, however Kodua et al. (2023) undertook a phenomenological study across three NHS

trusts examining staff experiences of restraining young people. Findings echoed those of studies conducted in adult facilities – physical restraint was seen as inevitable but very distressing and the importance of working closely with colleagues was highlighted. Interestingly, participants believed no long-term damage was done to the therapeutic relationship, indeed several felt it had strengthened their bond with young people. The authors noted, however, there was no verification of this perception by patients. The perceived external focus on elimination of restraint was found to provoke strong negative reactions from staff and a sense of being misunderstood and blamed. The authors suggested that organisational attempts to reduce restraints need to acknowledge the conflicts and challenges faced by staff. Nielson et al. (2020) in a systematic review of studies into restraint in adolescent mental health settings identified that most research focused on staff experiences and there was little first-hand information about its impact on children and young people.

A few authors have also examined restraint in paediatric hospitals. Bray et al. (2015) provided a narrative review and ethical discussion of the literature on holding children in such settings. They found little literature and an inconsistency in definitions which contributes to the near invisibility of the practice despite its ubiquity. They found ethical issues were rarely considered despite professionals' dislike of restraining children. They also noted the relative absence of children's voices in literature. They argued that current justifications for restraint are too simplistic and called for rigorous research into children's perspectives and greater reflexivity among medical professionals to challenge currently uncontested practice. Lack of ethical consideration about restraint was also found in a later study (Lombart et al., 2019). Researchers argued that nurses experienced 'transient empathic blindness' which allowed them to ignore children's distress and avoid complex ethical dilemmas. They described the way language

shifted during interviews so that the child as a person became disregarded and nurses focused on conducting a particular procedure on a body. They also noticed that when teams conceptualised restraint as an ethical issue it was rarely used, however when it was perceived as a routine inevitability it was a common intervention.

Research in education settings

Most research on physical restraint in schools has taken place in specialist education settings. Similar themes were identified as in previously cited research. A recent systematic review (Hodgkiss and Harding, 2024) of strategies employed to reduce restraint identified the importance of a whole school approach combined with individualised plans for children. They emphasized the importance of positive relationships between staff and pupils and strategies that maximised the autonomy of children, supporting them to develop their own capacity for de-escalation by learning self-regulations skills and making it easy to ask for help when they were upset.

Philips (2025) reported staff concerns about unclear definitions and inconsistency between training providers. Staff described restraint as unpleasant and wanted to avoid it but felt it was sometimes necessary. They were aware of external pressures to reduce restraint and worried about the legal and ethical issues it raised. The importance of positive relationships between adults and children was highlighted not only for averting restraint but also for making the experience less traumatic. The emotional impact on staff and pupils was apparent as was the pervasive experience of shame and guilt for all involved. There was a lack of studies exploring physical restraint from the perspectives of children who had experienced it.

Restraint in secure or custodial settings

In the UK the only child fatalities associated with physical restraint occurred in youth-custody establishments (Carlile Inquiry, 2006; Gooch, 2015). One boy killed himself

after a restraint where a pain compliance technique was used. Although restraint of children is supposed to avoid such techniques there is evidence that children in the UK have been regularly exposed to deliberately painful restraints in custodial settings. The Chief Inspector of Prisons acknowledged that inspectors regularly heard accounts of restraints where techniques were incorrectly applied and excessive force used (Haydon, 2020)⁵. Legal changes came into force in 2024⁶ banning the use of all pain compliance techniques in the children's secure estate⁷ but the impact of this change is not yet clear.

A study examining the views of 111 children across the secure estate found restraint was a regular occurrence (Shenton and Smith, 2021). Although not all children interviewed had been restrained, they had all witnessed restraint. Most accepted restraint was necessary, but all felt that it was often used unfairly or too forcefully. They suggested staff targeted children they did not like for minor reasons. Researchers noted that despite describing restraints that were quite violent and seemed excessive, most children responded with a fatalistic acceptance and a feeling that to some extent they deserved it. The researchers wondered whether the normalisation of violence merely confirmed children's previous life experiences. Interestingly this setting, where the most concerning practice was evident, also produced one of the most in-depth accounts of children's experiences of restraint.

⁵ Annual statistics show there were six incidents where boys suffered a serious injury during the use of force in 2023/24 and 51 incidents where boys or girls suffered a minor injury during use of force in UK youth justice establishments. There were also 208 incidents where a 'warning sign' such as loss of consciousness occurred. Ministry of Justice (2024) Safety in the children and young people secure estate: Update to March 2024. Available at: <https://www.gov.uk/government/statistics/safety-in-the-children-and-young-people-secure-estate-update-to-march-2024>

⁶ [Use of force, restraint and restrictive practices in the children and young people secure estate - GOV.UK](#)

⁷ The Secure Estate includes Local Authority Secure Children's Homes, Secure Training Centres and Young Offender Institutions

Summary of primary research papers

The potentially negative impact of physical restraint for everyone involved is clear from the research literature, yet it remains common across a range of settings. Most professionals using physical restraint see it as an unpleasant but necessary part of their job. There are indications, however, that organisational cultures influence how frequently restraint is used and how it is experienced by staff and service users. Factors mitigating adverse effects include clear guidelines, regular training, promotion of positive relationships between staff and service users and a culture that encourages reflection and the safe expression of emotion. The voice of those experiencing physically restrained is rarely represented.

Physical restraint conceptual papers

Physical restraint of children in residential care has been portrayed in starkly contradictory ways. It has been variously conceptualized as a therapeutic intervention, an unpleasant but necessary intervention, a practice with no evidence to justify its efficacy and as a precursor to abuse. Some of these differences can be explained by the various definitions of what constitutes physical restraint and the different ways it is used in practice.

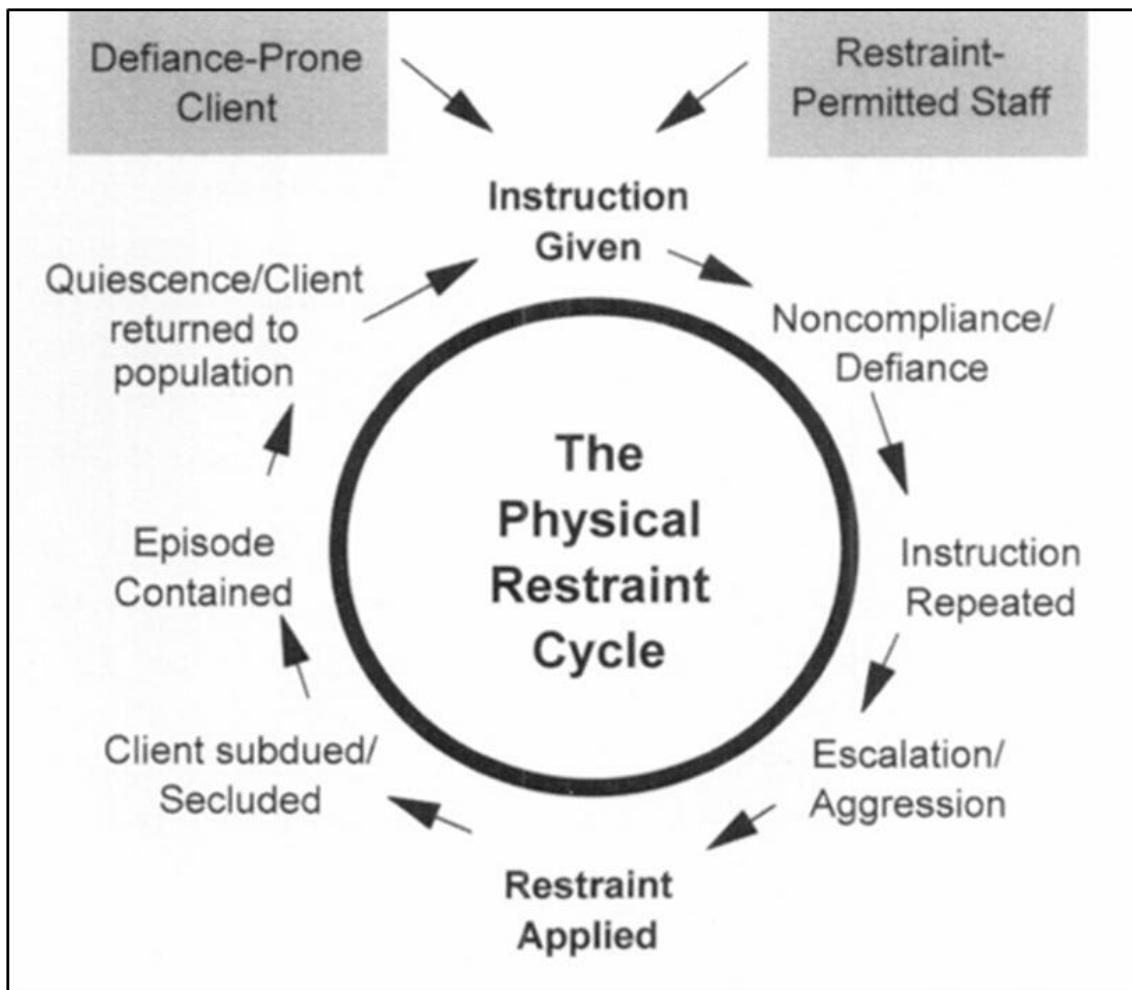
Authors arguing for the use of physical restraint as a therapeutic intervention (Rich, 1997; Ziegler, 2001) are not suggesting that it is without hazards or should be used indiscriminately. They do, however, suggest that properly used it can have therapeutic benefits. Rich pointed out counter transference issues should be recognized as staff may retaliate with anger to hostile projections from the child thereby confirming their worst fears. He also emphasised the importance of high staffing levels to prevent similar behaviour from other children to attract attention. Nevertheless, he suggested that physical restraint allows children to verbally process distress which will reduce

future acting out. Ziegler (2001) compared physical restraint positively against other restrictive alternatives such as seclusion, mechanical restraints, or chemical control (e.g. sedation). Implicit in his work is that forcible control will be necessary for some children. He did not consider this a routine intervention but argued it can be beneficial in dealing with a violent child. He suggested it demonstrates therapeutic limits for the child, protecting them from their impulses in a relational way that helps them to experience touch differently from earlier experiences with hostile adults. He contrasted this negatively with seclusion which leaves the child alone without comfort or reassurance.

Whilst both authors recognise restraint has dangers, they display little of the ethical uncertainty or self-questioning that is apparent in later contributions to the field. In contrast, other authors provide a more critical analysis of physical restraint and question not only its practice efficacy but also its moral acceptability.

Jones and Timbers (2002) conducted a behaviour analysis of restraint in residential care and suggested that a predictable self-perpetuating cycle can happen. (See Figure 2). They identified the various reinforcing factors for both staff and residents and suggested that unless staff receive training additional to restraint techniques then they will employ these, and restraint becomes entrenched in services. Interestingly the trigger identified by Jones and Timbers is children's defiance and restraint is initiated to enforce compliance. The emphasis is on correcting behaviour rather than recognising the underlying distress the behaviour may be communicating. Nevertheless, this is a rare attempt to make sense of the dynamics between adults and children when restraint occurs.

Figure 2 The Physical Restraint Cycle



From Jones and Timbers, 2002

Day et al. (2010) whilst acknowledging the intense emotions on both sides of the debate recognised the legal and policy basis for physical restraint conducted within clear guidelines. They suggested that there was no reliable evidence for therapeutic benefit other than protecting the child or others from serious and imminent harm. They pointed to significant reductions in restraint achieved after appropriate training.

Other authors, however, not only questioned the efficacy of physical restraint they were concerned that it could quickly become the precursor to abusive cultures. Mohr (2006) argued that in the absence of the right training and organizational structures overt or covert abuse might flourish. Mullen (2002), in response to the public outcry to

the deaths reported by the Hartford Courant, wondered whether staff counter aggression might have occurred to allow them to ignore evidence of children's physical distress. He was concerned about the lack of leadership and supervision that allowed such practices to continue unchecked. He advocated for organisations to provide regular training, coaching and reflection.

More recently Paterson et al. (2025) have suggested that cultures can easily become corrupted, and that the misuse of restraint contributes to the development of institutional abuse. Their focus is on the education system, but it is relevant to residential care. Such a corrupted culture can be prevented by strong leadership that creates a clear model for practice that looks below the surface of behaviour to understand its meaning and sets compassionate relationships at the heart of the organisation's ethos. Though they recognised the need for regular training on physical restraint, they argued this is not enough and insist that it must be accompanied by compulsory debriefing and time for reflective supervision.

Section 2 Using literature to make sense of the data

I framed this research to explore the overt and covert dynamics occurring in incidents of restraint and anticipated that the themes that emerged would be best understood by examining them through a systems psychodynamic lens. This section presents the key concepts and papers I drew from this paradigm. I also used concepts from the wider conceptual literature where relevant, and this is also discussed in this section.

Containment and holding

Bion's (1962) concept of containment and Winnicott's (1964) work on holding environments were useful in developing my research questions and analysing my data. Although these concepts were originally created to explain aspects of infant

development, they have proved helpful in understanding interactions between individuals and in groups and organisations.

Winnicott (1964) described the primary preoccupation of the main caregiver with an infant which provides the attuned physical and psychological care that allows healthy development and supports the child towards independence. He highlights not only the relationship between caregiver and child but the essential role of supportive adults around them in protecting this dyad from destructive impingement from outside. The intensity of connection between caregiver and child and the protective function of other adults together constitute the holding environment.

Bion (1962) developed the concept of containment to refer to the capacity of a caregiver to accept hostile projections (Klein, 1946) from a distressed infant without being overwhelmed. He suggested that these serve a communicative function from infant to caregiver allowing them to experience the infant's emotions. He described a state of 'reverie' in which the caregiver processes these projections by feeling and thinking about them and returning them in a more manageable form. He suggested this enables the child to develop early capacity for thinking and finding meaning rather than just experiencing raw emotion.

Children in RCC have often missed out on these key early experiences. Adults need to provide compensatory experiences to fill these developmental gaps in a way that is sensitive to the child's chronological age. Dockar-Drysdale (1990) argued adults should provide individual children with appropriate primary preoccupation and holding and emphasised the role of other adults in ensuring this is not breached by external demands. This is difficult to achieve in RCC, but Winnicott and Britton (1947) described the creation of a complex web of interacting individuals and groups providing an

environment mirroring the experience of healthy infancy that allowed children to recover from early adversity.

Such an enabling environment allows children to develop the capacity for communicating their distress safely. Dockar-Drysdale (1998) identified violence as a communication breakdown and highlighted the importance of residential practitioners maintaining connection with children to avert aggressive outbursts. She also emphasised that workers need to be aware of their own violent emotions to avoid unconsciously influencing children to act them out on their behalf. Her main concern was prevention, but she was clear that a child who has collapsed into violence should be held and reassured while their dysregulation continues. She suggested that children left alone with such overwhelming emotions will feel abandoned and be anxious about their very survival.

The concepts of containment and holding help in understanding what RCC practitioners need to manage the painful challenges intrinsic to their work. Kahn (2001, p.264) described the positive impact of holding environments when people face “*work-related situations they find disturbing, upsetting or anxiety provoking*”. He suggested that when workers feel held and contained by their environment, they move toward difficult issues rather than away from them. He suggests that these are key components of resilient organisation

Ruch (2007) in her work on supporting child care practitioners proposed a development of Bion’s idea of containment that had focused primarily on emotions, to a form of containment which she terms ‘holistic’. She suggested that in addition to emotional containment, this requires a context of thoughtful managerial relationships that can contain organisational and practice uncertainty (organisational containment) and one that promotes a multi-level culture of learning and enquiry (epistemological

containment). She argued that holistic containment is particularly suited for practitioners and organisations facing the challenges inherent in work with children and families in adversity.

The Ailment

Main's (1957) classic paper offered insights into the impact on health staff of dealing with the patient who fails to recover and, despite their best efforts, seems to deteriorate. He describes the realization that these patients were medicated not because of clinical need but when nurses became emotionally overwhelmed by their voracious but unmeetable needs. Although these patients were frustrating and overwhelming, they were seen as special. Nurses felt gratified to have special relationships with them and often patients were provided with additional treatment sessions or extra attention. Envy and competition were rife among staff favoured in this way about who was most important to the patient. Staff not involved in this dynamic challenged it but were often silenced by the 'ingroup' and became resentful and disparaging about the situation with others who shared their 'outgroup' status. Main suggests that the source of these relationship patterns may be very primitive object relations difficulties. The patients find splits within the staff group and use them to project their own primitive struggles between sadism and masochism into the staff for them to enact on their behalf. Staff try to meet the patients' insatiable demands at huge cost to themselves and suppress any resentment or dislike of the patients, but patients still cannot trust them and expect attack. Those in the outgroup become increasingly irritated and slide into a punitive response. This pattern repeats and splits become intensified until a patient's deterioration provokes movement to a more secure environment. Main emphasizes that suppression of hatred and the inability for staff

members to talk openly both about their feelings and patients' needs exacerbate the patients' difficulties rather than helping them. His final advice is this

If at any time you are impelled to instruct others to be less hostile and more loving than they can truly be - don't (Main, 1957).

Gairdner (2002) used Main's ideas to explore similar dynamics within health and residential care settings for children. Particular children evoke wildly divergent feelings in the adult team, and everyone believes that their perspective is correct. She highlights that sharing different emotional reactions towards children enables adults to gain a unique insight into their internal worlds. Adults need to feel able to acknowledge their negative feelings towards children without judgement. This allows the splits in the child and the team to be recognized and integrated.

Social defences against anxiety and the need for reflective spaces

Menzies Lyth (1959) postulated that individuals in organisations unconsciously create shared social defences that protect them from primitive anxieties evoked by the nature of the work. She argued that when professionals must deal with the messiness of providing primary care for people or survive the primitive terror and rage evoked in pain-soaked environments, they unconsciously collude to build organisational defences that protect them from the full anxieties these experiences generate. She suggested that reflective discussion might help people deal with the anxieties inherent in their job more effectively and diminish some of the negative effects of social defences.

Canham (1998) gave the example of children's information being lost or not passed on to relevant care providers because it is too unbearable to contemplate and suggested this defends professionals from the enormity of children's histories. He pointed out that for residential care workers to be effective they must be able to face the full extent of children's trauma and that alternative more functional ways to survive

the unbearable must be found. He suggested that facilitated space to discuss children's histories and the impact children have on individual adults and the group, can help process these uncomfortable responses and make them bearable. In a later paper (Canham, 2000) he described using work discussion groups in this way.

There is general agreement that well-facilitated reflective spaces are key to remaining open and connected to children's pain and increasing the possibility of positive outcomes.

The need for external consultancy and reflective opportunities for staff and managers in children's homes is not only apparent in systems-psychodynamic literature, but it has also been continually recommended in social work papers (Berry, 1975; Davidson, 2010; Kendrick, 2005; Whitwell, 1998). Consultancy alone, however, is not sufficient to create a positive culture. Some staff feel consultancy creates rather than reduces anxiety. This may be because their existing defences are challenged, leaving them feeling exposed and judged or because the consultant does not understand the RCC context (Hodgson, 2016). The enduring nature of the role must also be understood. Bolton and Roberts (1994) described the emotional 'toxins' inherent in the tasks undertaken by practitioners who work consistently with people in severe distress. They suggest that external consultancy and facilitated reflective spaces can act like dialysis to remove these. Finally, my own experiences of consultancy would suggest that without a culture which is open to some level of honesty, consultancy is likely to be ineffective.

No consultant can rescue an establishment which is totally dysfunctional. Consultation is not about rescue but about empowerment (Furnivall, 1991 p.145).

The perverse defence (Long, 2002) is a complicated form of social defence where a reality that challenges previously assumed certainties is simultaneously recognised

but denied. This builds on the idea of turning a blind eye described by Steiner (1985). He questioned the typical assumptions in the story of Oedipus - rather than being unaware of the tragic set of relationships that is being played out, he argued that everybody knows the truth but turns a blind eye to the reality because it is easier. He suggested that this process is neither fully conscious nor fully unconscious but requires a collusive denial to be able to retain the unknowing state. Several examples of this process relating to care-experienced children have been identified, such as the professional failure to acknowledge the impossible expectations placed on care-leavers compared with their peers (Furnivall, 2018).

The persecutory impact of inspection

The UK regulatory bodies that inspect RCC were set up to provide uniform standards and regular inspection. The articulated intent was to keep children safe and well cared for. Evidence from research, however, suggests that inspections are experienced as persecutory and inconsistent in their assessments (Hodgson, 2016; Ibitoye, 2025). Moreover, there are many accounts of inspections distorting practice as practitioners' focus shifts from providing care to children to trying to obtain a good grade to ensure their continued survival (Burton, 2016). The context in which these bodies were set up was one of panic at the discovery of widespread institutional abuse, and this seemed to have contaminated the primary task of both the regulators and RCC settings. The destruction of trust in and denigration of RCC leads to a suspicious approach which is experienced as searching for deficit rather than seeking to celebrate and share good practice. Dartington (2010, p.120) highlighted the persecutory controlling nature of inspection and contrasts it with the containment that might be achieved by consultancy:

What is spontaneous, idiosyncratic, uncertain in its outcome does not fit with an agenda of national standards. If you allow carers to have relationships of

any significance with service users, things will become messy. We need the remarkable competence of ordinary people to care for others, but then we become frightened of that competence and impose control rather than, in the supportive psychological sense, containment.

Purcell et al. (2025) reviewed the impact of regulatory reforms on RCC across the UK. They identified four themes: the importance of balancing control and support; improving practitioner autonomy and relationship building; resolving issues with minimum professional qualifications and a stronger focus on organisational culture in inspections. Apart from the professional qualification theme, these would challenge current inspection regimes as they focus on what is easily measurable which as Dartington suggests may not contribute to quality. There is a sense that grades do not necessarily reflect quality and that high grades may be achieved by organisations who know how to meet evidential requirements but may not provide a high quality of care and might be successfully concealing problems (Hodgson, 2016).

The personal cost of inspections and the persecutory way in which they were experienced is clearly described by Ibitoye (2025) in her examination of the role of registered managers in RCC settings. She highlighted the institutional and personal risks of a poor inspection and the shaming experience of the process whatever the outcome. She also pointed to the difficult position of managers who are accountable for a home's performance although they may have no authority to institute changes that require decisions from people higher in the hierarchy.

Moral distress

Ethical or moral distress has mainly been explored in health care settings. Morley et al. (2019) in their synthesis of the literature concluded that moral distress occurred when a moral event directly led to psychological distress. This could be the result of being constrained to do something against one's moral code but could also occur from

experiencing ethical confusion in one's professional role. The incompatibility between professional ideals and the maintenance of a safe and therapeutic environment was explored by Jansen et al. (2020). They found that nurses experienced shame and guilt both when they chose to restrain a patient but also when they failed to safeguard others by not initiating a restraint. Nurses also described feeling misunderstood or vilified in society or by other professionals for their use of physical restraint. Moral distress has been shown to contribute to burnout and problems with staff retention not only in health care settings (Eder et al., 2025) but also in RCC (Brend, 2020).

Summary

This chapter reviewed the literature relevant to my research. First, I demonstrated the gap in the literature by identifying the dearth of primary research focusing on physical restraint in RCC and the absence of any studies focusing on my particular research interests. I then reviewed the research on restraint in contiguous fields and conceptual papers about the issue. Finally, I discussed the concepts and research that illuminated my findings. I was continually struck by the variety of views that were implicitly held as well as explicitly stated and the passion that underlies them. This may reflect the polarised nature of the debate within the sector and the ethical discomfort that the issue evokes. In this research, including this review, I have attempted to hold on to a nuanced perspective that avoids retreating into simplistic and defensive perspectives about right and wrong. In approaching the literature, however, I was often reminded of the comment from an earlier writer about papers focused on physical restraint:

In professional literature, there are many more strong opinions than strong research findings (Ziegler, 2001).

In the next chapter I will outline my motivations for undertaking this research and explain the methodology I chose to adopt.

Chapter Three: Methodology and Research Methods

Introduction

This chapter outlines the methodological approach I used in this study. I begin with a reflexive examination of my personal reasons for focusing on physical restraint in RCC. I then discuss the complexities involved in my researcher role and provide an explanation of my ontological and epistemological positions. I next examine ethical issues I identified and explain how these were addressed. I then explain why I chose my methodology. Finally, I describe the phases of the study, using a reflexive approach to explain my decision making.

My Position

The Impact of Personal and Professional Experiences

I have been involved with RCC for over fifty years and throughout this time physical restraint has affected the lives of children and workers. As a student, I saw harsh and controlling restraints used to enforce compliance in a secure setting but also witnessed what appeared to be courageous and thoughtful physical interventions in a therapeutic school. For several years I restrained young people when working in a therapeutic community. Whilst recognizing that restraint was hazardous and could be abused, I believed it was a proportionate response when children lost control and became aggressive. Moreover, I believed that it usually improved my relationship with the child, as I imagined they recognized my positive intent and were relieved that they had hurt no-one. I realised, however, that the balance between the impulse to protect and the desire to retaliate was shaky. I knew that the experience of restraint depended on relationships between practitioner and child as well being affected by the wider context and any triggering events. I believed, however, that intense and reciprocal

relationships within the community seemed to mitigate adverse effects of restraint. Reflective spaces existed for both individuals and groups, and the children could and did challenge staff about their behaviour in the daily meetings. These spaces were regularly used to explore and share difficult experiences, including physical restraint, but there was no real questioning of its efficacy or moral justification.

Contrary to my previous easy assumptions, most care-experienced adults I have discussed this issue with found restraint terrifying, painful and damaging to relationships, regardless of the harm that may have been prevented. A few described more positive outcomes, but these usually occurred while being cuddled and having space to talk with adults after the incident rather than from the restraint itself. Most RCC practitioners state that they generally experience physical restraint as deeply unpleasant and believe that they only use it as a last resort.

As I began to prepare for this research, I had a vivid memory of an experience I had repressed. Aged ten, I had a short stay in hospital where I daily witnessed medical staff and nurses holding children down to administer medication. After a few days, I was mildly resistant to having yet another injection in my already painfully bruised thigh. Immediately I was surrounded by several large adults and held down. There were no warnings and no conversation with me. I remember the shock and helplessness I felt and how quickly I gave in and complied. I then became desperate to get out of hospital. This memory of a brief moment in my life with people I would never see again, in a place I was going to leave imminently, cannot compare with the intensity and terror that many care-experienced people suffer through restraint, but if I had recalled it sooner I believe I would have been less sanguine about restraining children.

The complex issues involved in physical restraint led me to explore it through my doctoral research. Understanding the dynamics of physical restraint demands an examination of the connections between the individual and wider systems, a consideration of the thoughts and feelings of children and adults and an exploration of conscious and unconscious processes. I also wanted to engage with the moral dilemmas that any exploration of physical restraint raises.

My position as a researcher

These personal and professional experiences explain my motives for undertaking this research. Many researchers choose to examine issues that have meaning for them (Berger, 2015; Letherby, 2000; Scott, 1998) and highlight the importance of openly sharing their own story. I believe that total objectivity is unattainable and that research with personal resonance for the researcher can uncover different, but equally relevant, findings from that undertaken from a more distant position (Letherby et al., 2013). This, however, required that I adopted a rigorously reflexive approach to ensure that my personal involvement and interest did not contaminate the meaning of my participants' experiences.

Even without a personal reason for undertaking research, individual histories can affect how researchers interpret and retell the stories of others. As Katz-Rothman (2007, p.15) says:

... we take the personal and place it in the context of the social; we face troubles and consider issues. Our work of sense-making is a basic human job, done traditionally through storytelling... Our ethical obligations go beyond what we owe our subjects ...We owe something too, to our readers and to the larger community ...we owe them an honesty about ourselves: who we are as characters in our own stories and as actors in our own research.

In approaching this research, I had to consider my own ontological position and epistemological approach. My various roles in RCC and my existing knowledge

affected how I understood physical restraint. I do not consider consistent observable truths about physical restraint exist - indeed I know that perceptions and interpretations in this area have already changed and may shift again over time or in other contexts. Yet some objective realities do exist – physical restraint does occur, there have been fatalities, people have been injured, and several children became involved with the criminal justice system because of restraints. The position I take is that of critical realism – I recognise the existence of a real world (a realist ontology), but I believe our understanding of the world is constructed through our previous experiences and assumptions (a constructivist epistemology).

Ethical considerations

Formal ethical approval for this study was granted by the Tavistock Research Ethics Committee prior to the data collection phase of the research. Using guidelines set out by the Social Research Association (SRA, 2003 and 2021), I identified several ethical issues that required continuous attention throughout the course of the research.

Participant and researcher distress

Discussing sensitive material always holds the potential to cause distress particularly when the research is designed to explore close relationships, ethical dilemmas and unconscious dynamics. Both organisations have support systems firmly embedded in their structures and have continuing relationships with external therapy organisations. Although the research did evoke painful emotions and uncomfortable insights, participants stated that they found the overall experience of the groups positive and stressed the importance of exploring such issues in depth. I also recognised that as a researcher with experiences and deep feelings about restraint I was opening myself up to the possibility of considerable distress. I have support systems at my work and at home where I could discuss my own responses whilst maintaining the confidentiality

of my participants. I also felt safe to explore issues fully with my supervisor. I reflect more fully on the impact of the research on me in chapter ten.

Confidentiality

Conducting research within small organisations raises difficulties in protecting confidentiality. The existence of the group and its membership was well known within the Cedars and attracted considerable interest among the team. Although participants were pseudonymised it is likely that anyone from the home could recognise the 'voice' of particular individuals. This was discussed with participants who felt comfortable that others might recognise them. In Sanctuary the group was less visible, and participants were known in depth by only a few colleagues but the possibility their contributions might be recognised was acknowledged and they also accepted this. Preserving confidentiality externally was also problematic as RCC is a relatively small sector and, despite endeavouring to disguise them, participants or their organisations may still be identifiable. This was fully discussed with all participants and the directors of the organisations, who accepted these constraints and were happy with the arrangements to safeguard their material. No children were interviewed, and I had no direct access to any information about them for this research. The children were all pseudonymised and could only be recognised by adults in the home who already knew details of the incidents described. All data has been stored on password-protected computers and audio recordings were uploaded immediately and deleted from the recording device.

Consent

Although I knew participants were likely to experience some distress during the research, I believed they all had the capacity for informed consent. I ensured that the issue of consent was reviewed throughout the process as the implicit power of a researcher can interfere with participants' choices. I reiterated that they could withdraw

at any point during the data collection process and their individual data would not be used. I needed to make clear that I could not withdraw data from the group discussions though I guaranteed not to use any direct quotations. In the event nobody wished to withdraw from the process.

Impact of my role

As well as acknowledging the impact my existing role in these organisations may have on the research, it is essential to consider the ethical issues it raises. My relationship with participants may have affected their decision whether and how to participate in the process. They might have felt pressure to volunteer through a wish to help me or gain my positive regard which might also have influenced their contributions. I had considerable influence and authority within the organisations and it was impossible to completely divest myself of that power when adopting a researcher role. I addressed this with participants directly in individual interviews and group sessions. Their response, however, was that knowing and trusting me in my consultancy role freed them to speak openly and without fear of judgement. This may of course mean that they shared more than they were comfortable with, but they also denied this. In their review of qualitative social work research articles, Gringeri et al. (2013) found that few authors reflexively examined their own positionality or power issues. Recognising the inadvertent harm that such lack of reflexivity can cause made me focus on this with my participants.

Choice of methodology

Research in social care and health usually adopts a quantitative approach which offers widely generalizable findings (Milner, 2014). This provides important data to develop robust guidance and protocols to inform clinical or care practice. It fails, however, to capture the nuanced richness of lived experience.

Qualitative research asks different questions than those posed by the positivist approach behind most quantitative methodology. It asks '*about process, understandings and beliefs*' rather than searching for '*outcomes or associations*' (Barbour, 2013, p.26). It explores lived experience and is interested in the meaning ascribed to this. An essential assumption in qualitative research is that no single truth exists and that people find diverse meanings in the same events or interactions that are connected to their personal biographies, internal experience, and environment. My research questions are most appropriately answered by a qualitative approach.

I could have used a hermeneutic phenomenological approach to understand and make sense of the phenomena of physical restraint. Such research attempts to identify lived experience and the meaning individuals impose on it, without fitting it into the researcher's existing perspective. I intended, however, to move beyond describing phenomena and use the research to promote change.

Other methods I might have adopted could have included gathering data through interviews, focus groups or document analysis. I could have undertaken an organisational ethnographic study focusing on restraint which would have enabled me to collect deep and rich data through participant observation. Although there have been several ethnographic studies in RCC (Emond, 2000; Fowler, 2018), I judged the topic was too sensitive and might have triggered dysregulation or even unnecessary restraints.

I decided to use action research through the process of a work discussion group to answer my research question. Rustin (2019) suggests that work discussion groups are a promising psychoanalytic research method in organisational research. I also drew on McIntosh's (2013, p.61) work who sees action research as '*less about a cycle and more about periods of sustained transformation through engagement in focused*

reflection'. He argues for the importance of seeing beyond what is immediately apparent in action research. This fitted with my wish to take an approach that allowed me to explore the subterranean processes involved in restraint. I was also drawn to the collaborative nature of action research. I asked my participants, and the organisations they work for, to make a serious investment of time, emotional energy and cognitive effort in this research, I hoped it would directly benefit them as well as generating findings relevant to the wider sector. It also seemed important that the bulk of the research should be conducted in a group setting as physical restraint always involves more than a single person and I wanted to adopt a data collecting process that depended on interaction between people.

Research Design

Context

The research was mainly conducted in a small therapeutic children's home that cares for four children. The children arrive with few regulatory skills and often communicate their distress through explosive rage. As a result, the home has a level of physical restraint which varies depending on the characteristics of the children and how long they have been in placement. Children all seem to have warm and secure relationships with the adults who care for them. The secondary site was a large provider of RCC where I conducted a single focus group comprised of managers from different houses. In both organisations adults were well supported and the practice of reflection, both individually and in groups, was embedded in the culture. I had offered weekly consultancy to both organisations for several years and knew my participants well. All participants had some familiarity with basic psychodynamic theory⁸.

⁸ Both organisations have accredited crisis and physical intervention training. The Cedars uses CALM and Sanctuary TCI.

Clearly my existing role and relationships posed questions about my capacity to remain objective in this research. As discussed earlier many feminist writers have questioned the mirage of value free research suggesting that membership of a community of interest may enhance the richness of research material (Letherby, 2000; Letherby et al., 2013; Scott, 1998; Stanley and Wise, 1990). I believed that by working reflexively and addressing the complications inherent in this position I could bring additional value to this research.

Although it poses methodological and ethical questions there are positives to undertaking research in from an insider stance (Brannick and Coghlan, 2007). This research benefited from the pre-existing trust between me and participants. I also understood both organisations in depth. This allowed me to recognise processes occurring below the surface in group discussions; however, it might also have left me unaware of occasions when my assumptions prevented me from noticing new information. However, although I possess some characteristics of an insider researcher, my boundary position as an external consultant means I am less enmeshed in the everyday life of the organisation than a regular employee.

All qualitative research requires reflexivity from the researcher, but this is intensified when undertaking research from such a close position. I have striven to work in a 'value-explicit' way as described by Letherby (2003, p.71) using her concept of theorised subjectivity (Letherby et al., 2013). This involves the researcher accepting the inevitability of subjectivity whilst making a conscious commitment to work to interrogate it.

Recruitment of participants

My intention was to have the widest representation of different roles. I would have liked to include anyone expressing interest, but the needs of the service restricted the

numbers possible, so I recruited five people. The home forwarded an email from me to all practitioners outlining the project and inviting them to contact me if they wished to participate. Only five people responded, and I sent them copies of the research information and consent form and offered to discuss any questions they had. They all decided to participate. The eventual group included all relevant roles, but all participants had considerable experience. This had the advantage that they understood the organisation and physical restraint well, but more recent employees might have offered alternative perspectives. It would, however, have been unethical to exert pressure on practitioners to participate. The recruitment of the second group of participants was organized through Sanctuary's training manager who sent invitation emails to the service managers on my behalf. After reading the information and consent form six people agreed to participate. All recruitment documentation is available in Appendix 2.

Data collection

Initially I conducted brief semi-structured interviews with participants from the Cedars. This gave me the opportunity to revisit consent and ensure that they were clear about their right to withdraw. The interviews also allowed them to discuss any concerns or initial thoughts they had about the research and to explore how their individual histories affected their experience of restraint and holding. They were keen to be involved and raised issues they later revisited in the group discussions.

We then had five group meetings, each lasting 90 minutes, on a monthly schedule. The first three groups allowed participants to share their experiences, discuss their understanding of the issues and explore the meaning of restraint for them. In the fourth group participants engaged in a drawing exercise. They were invited to draw a picture focusing on restraint that had meaning for them drawing on themes from previous

groups. Two participants drew actual incidents, the others created images symbolising important aspects of restraint for them. Participants were asked to respond to the images before they knew what the artist had intended them to represent. Participants found this to be very powerful and were surprised by the different perspectives evoked by the images.

In the final group participants drew on their discussions and insights from previous groups to try and identify or imagine the experiences and perspectives on restraint from different stakeholders. They were asked to consider themselves, the child in the restraint, other adults in the restraint, other children in the home, the wider team or organisation and the external world. This was helpful in drawing together the different strands from the previous discussions and exploring their perspectives on how individuals and groups at different systemic levels affected or were affected by restraint.

I re-interviewed all participants for debriefing and reflections on the process. I also wanted to give them space for comments they might have been reluctant to share publicly. Finally, I asked whether my other role had interfered with their experience of the groups. All felt it had helped rather than hindered their engagement. They reflected on the experience and were surprised at the useful insights they reached. They also valued the opportunity to reflect with others about restraint.

This was also an action research project and areas for improvement were fed into the wider team at regular points and led to changes in training and practice.

The pictures from Group Four and other key findings were shared with the focus group of six managers from Sanctuary. The purpose of this was to check for resonance with practitioners beyond the Cedars. The two organisations were located in different UK

jurisdictions, subject to differing legal requirements and regulatory bodies, yet the Sanctuary group found the findings relevant. Their discussion strengthened the wider applicability of the findings

All interviews and meetings were audio recorded and transcribed by the researcher. The images from group four were photographed. The interview schedule is available in Appendix 2.

Analysis

Some level of analysis had already taken place with the group as part of the action research process which highlighted the issues they found most helpful and surprising. This was shared formally in a letter to the directors of the Cedars (Appendix 3). I also, however, needed to conduct a fuller formal analysis of all the data. The analytical process I used in this process was reflexive thematic analysis (TA) This involved identifying codes across all the data to develop themes. These are described as - *patterns of shared meaning underpinned or united by a core concept* (Braun and Clarke, 2019, p.594). This requires immersion in the data over time and is an iterative process that enables the researcher to develop their narrative of what the data represents.

Familiarisation and coding

I transcribed all interviews and group sessions which allowed me to re-experience the material at depth The initial process of coding was already starting as I listened and transcribed. I attempted to code without specific assumptions, but I recognise that my pre-existing knowledge will have influenced subjective coding decisions I made. In my analysis and writing I have returned continually to both the transcripts and the original audio recordings to check that I have only used material that was either explicitly or implicitly mentioned by participants. Similarly, I continually needed to check that my

professional knowledge of RCC, especially physical restraint was not affecting my conclusions. It is important, however, to recognise that completely letting go of such fore-structures of understanding (Heidegger, 1927) is impossible. It is therefore important to be open about their existence and remain rigorously aware of their potential impact.

Developing, reviewing, refining and naming

The process of coding allowed a provisional development of themes, but these initial themes had to be refined through further review which required considerable analytic work.

Themes are analytic outputs developed through and from the creative labour of our coding. They reflect considerable analytic 'work,' and are actively created by the researcher at the intersection of data, analytic process and subjectivity (Braun and Clarke, 2019, p.595).

This stage involved modifying or letting go of some themes. At times this was because I realised I was imposing my own assumptions on the analysis in a way not warranted by the data. The process of writing contributed to the clarification and sharpening of my themes. Braun and Clarke suggest that this is a fundamental part of the analysis. The results of this TA are presented in Appendix 4 and form the structure of the data chapters.

Summary

This chapter outlined the methodology I adopted in this project. It explained the complexity of being an insider researcher as well as the ontological and epistemological positions I adopted. It explored the ethical issues posed by the research and how I addressed these. It explained the decisions I made about which methods to use and describes the different stages of the research process.

The next chapter introduces the data chapters.

Chapter Four: Introduction to findings

This short introductory chapter offers a rationale for the way the research findings are organised. It also presents the results of the exercises from the last two groups: the images drawn by participants about what restraint meant to them; and the Post It notes from the final group where they gave their sense of how various people or groups might view physical restraint.

Rationale

The research process produced a mass of rich and powerful data. The analytic process helped to identify and organise themes in a coherent manner, but it then became important to create a framework for the presentation of these themes within the thesis. Although there were many ways this could have been undertaken, it seemed useful to organise the chapters by mirroring the processes described by participants from the personal and visceral experience of the actual restraint incidents through their practice and ethical struggles to the effects of the external world on their experience. This structure also fitted well with the research questions that focused on how intra and interpersonal dynamics as well as systemic factors influence residential workers' decision making and practice in physical restraints. The substantive data chapters offer the findings of the research, but these are complemented by the inclusion of supplementary material in Appendices 5 and 6.

Some of the themes identified in the data are specific to only one of the following chapters but there are others such as the importance of relationships and the meaning for participants of the use of power that cut across all the chapters.

Chapter Five considers the importance of being aware of the temporal and spatial context of any physical restraint rather than seeing it as a discrete event.

Chapter Six explores the intense physiological, emotional and psychological experience of the immediate build up to a physical restraint and the incident itself.

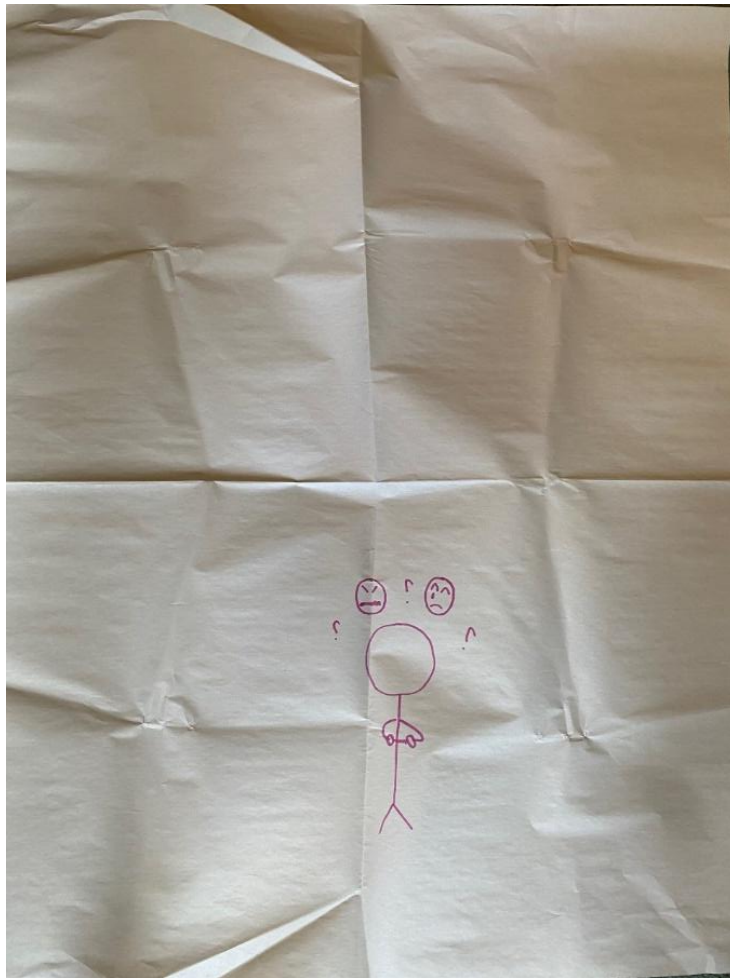
In Chapter Seven the focus is on the struggle participants experienced in navigating an appropriate path between apparently opposing options.

Finally, Chapter Eight considers the impact of the external -witnesses and regulators- on the restraint itself and any aftermath.

Pictures

This section introduces the pictures drawn by participants from the Cedars which were also used as trigger material in the Sanctuary group. Participants were asked to create a picture representing something important to them about restraint. Every image below is accompanied by a text box which is the reflection from the artist. Other significant comments and observations from discussions in both the Cedars and Sanctuary are summarised in the text. Although the images reflected themes from previous groups, they also evoked unexpected but powerful insights not apparent earlier.

Figure 3 Kitty's Picture



I am highly emotional today. But yeah, they were handcuffs...it was the restriction that we have in PIs from the restriction that we put on them. And then the emotions at the top is how they can feel or how obviously we can feel because we're trying to, we're trying to, we're holding this child preventing them from violence, but we may have been hit ourselves. And then the question marks is just the morals of PI and how you can question yourself. You know you're doing the right thing because you've stopped them from hurting themselves or hurting others or damaging but then you are restricting a childlike you are physically holding this child where they can be screaming and telling you that you're hurting them and even though we do everything right and we follow the CALM principles there's always still those question marks about the morals and the ethical reasons for PIs (Kitty Group 4)

^{9 9} PI is used by participants from the Cedars as an abbreviation for physical intervention.

Other participants picked up on the loneliness and emptiness of the tiny image in a sea of white paper. It was also noted that this could be a child or an adult as the confusion and mixed emotions were shared experiences. The blank face masking internal emotions was a repetitive theme across some of the other images that had not emerged in previous discussions. They recognised the individual was handcuffed and felt it was a powerful portrayal of restrictions their children suffered. Their discomfort about the use of power and the ethical conflicts they experienced were revisited.

Figure 4 Sarah's Picture



where we were... we were in a circle and everyone was around as well with their own benches in a circle. And like just it's just bizarre to me how like a kid can be screaming like "someone help me call the police", blah, blah, blah. We were like, This is the worst place we can physically be holding him right now. But we're not gonna try and walk off with them because that looks like we're kidnapping him. At least if we're sat still people aren't gonna think "oh they're kidnappers" because kidnappers don't just sit down. But yeah, the thought of I wish someone would ring the police and then like, at least then people would know we're not doing anything wrong. And it could calm down the situation. But when I was drawing the faces I was able to do Max's first really easy because he was screaming and shouting but I didn't know what to put on our faces because I don't know what my face looks like. When I'm in a restraint I feel like to smile would be weird to be upset would probably match the situation best but you kind of got to keep that I am calm and cool Yeah, I think we just look a bit like robots in that picture just like right we're just going through the motions (Sarah Group 4)

Participants found the staring eyes disturbing and dangerous. It aroused a sense of being judged and condemned and evoked situations where they had felt desperate while restraining a child but faced indifference or morbid curiosity. They also reflected on the lack of expression that Sarah mentioned. They recognised this might be experienced by the child or witnesses as robotic or emotionless but felt it allowed them to regulate their own internal state. They reflected on the impact of a blank face on children whose survival had depended on reading facial cues but were unsure what expression would be helpful.

Figure 5 Faye's Picture



...looking at now in my head, I want to add more, because I want to add the girls on the side, and them being alone and Hermione having to step up, I want to add the cars rushing past the literal feeling of this is, this is a life or death literally, if he gets out of this car, he's running on the dual carriage way. And that's kind of why I put his feelings or what he was saying in red, because it was just anger it was just all his emotions and then the blue trying to be calming and the green was trying to recognise the feelings but the feelings at the top were not only his but it was ours at the time. The glasses on the side as you say taking away all the sight - the arms were jolty because that's where I'd just been bit. And my arms are absolutely killing. And we do that all the time. Where we end up getting injured. So difficult to hold. You're hurt but then they're hurting everywhere else which is why he's then all jolty because he's hurting everywhere. And as I said, that's why the car goes round like that, because I can exactly fit all the sort of chaos in it was all just enclosed in one place...And then in my head, I've still got the image of the girls on the side and what they're feeling what they're seeing how Hermione literally came up and picked my glasses up off the floor and put them in the front to make it safe. And how she went "Do you want me to call home?" (Faye Group 4)

All participants were powerfully affected by this image which reminded them of the primitive terror of situations where if they got it wrong a child might die. They commented on the hot sweaty chaos compressed in the car and felt the image represented a situation that might explode at any moment. It evoked the embodied nature of restraint with pain, tension and desperate holding on but also the sensory chaos of distorted vision, thundering traffic and a shaking car. They recognised the intense helplessness of not being in control of the safety of the other children and not knowing how the situation could be resolved. Finally, they acknowledged how difficult it was to accept help from the public because they struggled to explain the situation and were unsure they could entrust the other children to a stranger.

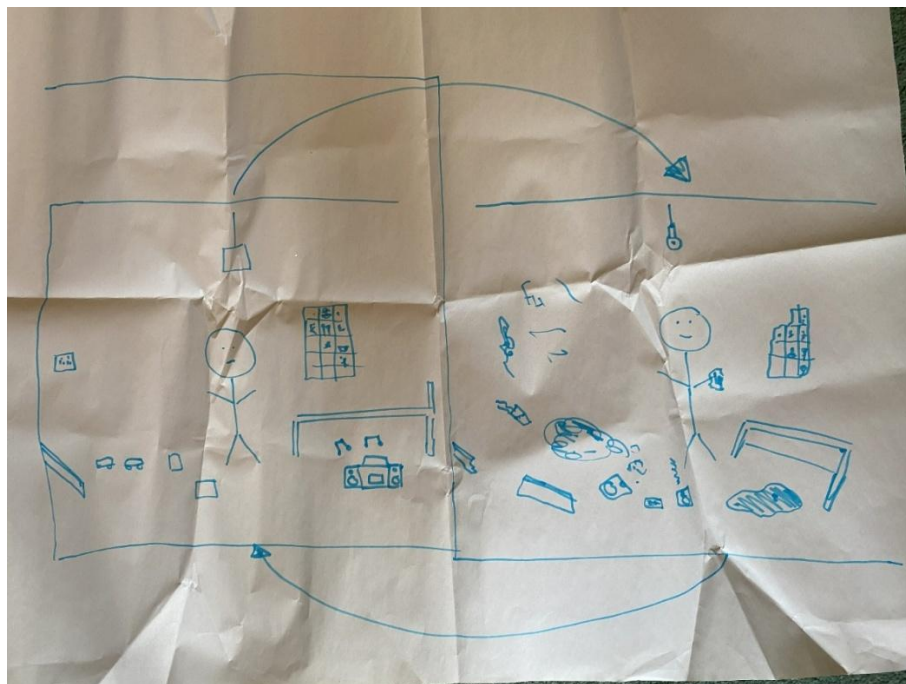
Figure 6 Sally's picture



When they're heightened and they're becoming violent ...it's like they become all consuming and our main focus is them and I thought of the triangle with the victim the abuser and the perpetrator and it's like one side that the child's like the victim but then the child can also become like the abuser as well when they're hurting us or hurting the other children. And the other kids are just watching ... not watching as in like see but sometimes they're in the room when we're having to take a hold or when stuff starts. So they see that like element of it. You have the sadness and like tears including the children and the adults. The squiggles are just like chaos because I feel even when you're deescalating there's chaos - they will be throwing stuff around screaming and shouting and when they're in the PI obviously there's definitely chaos. I put the sun and the grass for like a happy place I try and think of something that you can focus on like when we say like "this will end". I kind of think this will end, it will and I think of somewhere sunny to try and motivate me but it was supposed to be moon and stars because at the end of the night everything does end - they all end up in bed and they do all end up safe and tucked up and secure. And the love hearts just like Kitty said we love them either way like whether they're getting cuddles off us or whether they're screaming or shouting at us or they're punching us or they're kicking us and I was like that love for them like that's what guides us to where we need to be for them (Sally Group 4

This image evoked the switch between the vulnerable child and the terrifying monster that emerges when the child falls into panic. There was an acknowledgement that despite the chaos they had to accept and love the whole child, including the scary monster they could become, for them to be able to recover from their trauma. It also provoked further discussion of the other children hovering on the sidelines affected by the experience but unnoticed by anyone. Although the faces were yet again represented as emotionless, participants recognised the chaos and distress that was swirling throughout the image but also the importance of love, hope and relationship that enabled them all to survive the intensity and terror of the experience.

Figure 7 Antony's picture



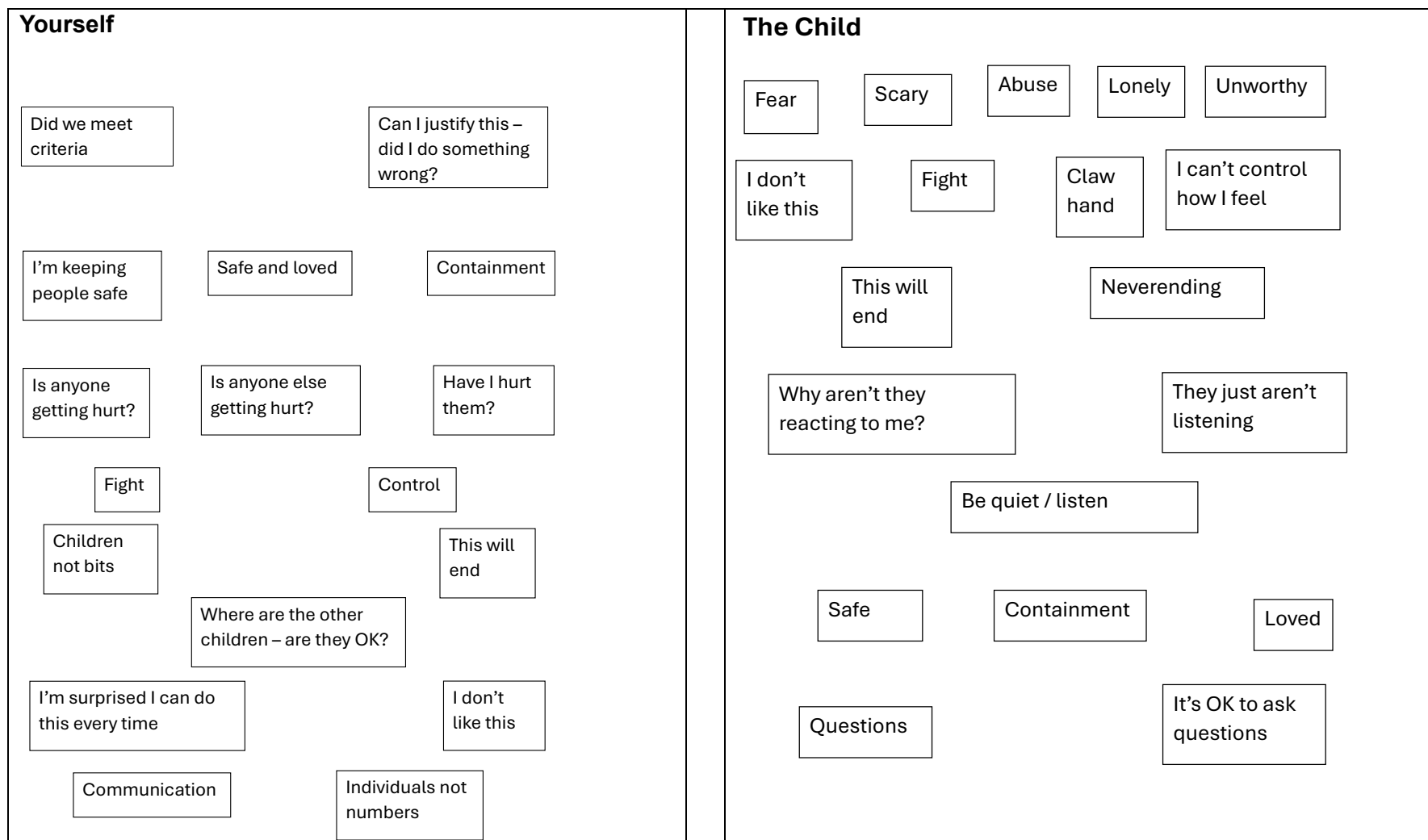
I wanted to do something that was like the cycle... there's a difference in emotions and the chaos. And although I tried to generalise it was based on it was Liam and being stuck in that cycle with Liam...and it would be the whole room and you'd end up stepping into the chaos. And there was a point where my photo would be in there and it was a lovely one of us together on holiday dancing, and he took it off and he ripped it in front of me. And that got through more than anything else. And he stood in that chaos. And when, when he was ready, put it back together. But there was nothing there was like literally nothing left. So, if I kept on going in the cycle, it would have been like drawing the room and then it didn't have a bed and it didn't have sockets and it didn't have walls and didn't have skirting boards. And somewhere in my psyche, it's just that war of attrition of it, it takes something out of you each time. And you'd steel yourself and you go back in. But there's less and less there's like physically less or there's emotionally less there's just like it drains and then there's change but I didn't feel that I could represent the change it was just the cycle. Different children at different times I feel like you get into that this is how this is what we need to survive this is what will end but how it will end what the end will look like. And when it happens you won't even know it'll just be a point that you refer back to once it has ended but when you're in it, it's just round and round. I didn't put any adults in - there's only the child that was the kind of emptiness and the loneliness not to take away from the - I didn't draw the restraints aspect- but it was just the I don't think that in that period of time- I don't think the restraint touches the sides of how the feeling is the chaos and the emptiness so not wanting to take away that role but it's just it's not the central theme at that time. (Antony Group 4)

Participants recognised the chaotic cycle and the level of destruction that a child can create but the focus for the discussion was the slight smile on the child's face in the wrecked room. They wondered whether the state of the room accurately reflected the child's internal state and they felt more comfortable there than in the neat, ordered space. They reflected that if the destruction was a communication about how bad a child felt, then they might feel unheard when their room was tidied and straightened and given back to them like a parcel. They also recognised that their hope that repairing the room would help the child to sort out their feelings was probably out of step with the child's own readiness to process their emotions. The cyclical nature of the experience and the consequent erosion of hope also resonated with some participants.

Post Its Exercise

All participants completed post it notes with their reflections on how people in each of the categories might experience or perceive restraint. As I reviewed them in my analysis the comments seemed to fall into clusters within each category, and this is how I have presented them in this chapter. The exercise proved helpful in reprising the issues covered in previous groups and encouraged participants to be curious and speculate about the variety of attitudes and perspectives that exist about physical restraint.

Figure 8 Post Its Exercise



Other adults involved in the restraint

Are they OK?

Can I help?

How do you feel?

Do you trust me?

Do you feel the same?

I'm relying on you to keep me safe

I don't like this

Just keep hold

Tired

Stressed

Safe

Bonded

Cared for

Different perspectives

The other children

What's that noise?

What's happening?

What are they doing in there?

Why?

Fear

Anger

Pain

Why did this happen to me?

I don't like this

Who's hurt?

When will it stop?

I'm still me

Safety

Don't be scared to ask questions

The wider team/organisation

Anticipation

Stress

Guilt

Pain

Hurt

Tired

Full

Was anybody hurt?

Do they need support?

Support

Relief

Take your time

You did your best

You do such a good job of keeping everything contained

External world

How do they see what we are doing?

Why are they doing that?

That's just a naughty kid – call the police

I couldn't do that job

Naughty

Choice

Ignorance

Blind?

Uninterested

Are they hurting that child?

Child abuse

Behaviour as communication

Trauma

Numbers

Safety

I never thought about how this all looks like to OFSTED

I'd like the world to understand what it is and why it's needed

Summary

This chapter provided a rationale for the organisation of the main data chapters and provided a brief outline of them. It also presented the results of the two exercises completed by participants from the Cedars in their final groups – the pictures and Post Its.

The next chapter places physical restraint into a temporal and spatial context using an extended timeline. This timeline is expanded in Appendix 5 with quotes from participants to illustrate each factor.

Chapter Five: Time and Space- present, past and future

Introduction

This chapter explores the importance of viewing physical restraint in its temporal and spatial context. Participants seemed conscious of the different factors influencing any one restraint as well as recognising that restraints have long lasting and powerful effects on everyone, whether participants or witnesses. This contrasts with bureaucratic requirements that frame each incident as a discrete event and focus on immediate triggers and consequences for the child as well as demanding appropriate written justification for physical intervention and an explicit account of techniques used. Participants suggested these processes risked creating a situation where a deeper understanding was sacrificed to provide a justification for the restraint that could satisfy external scrutiny.

the difference between how an event can feel and then when you read what will be the lasting record, or one aspect of the lasting record, how it can be completely different ... it's not that they're, they're not accurate - but it's very rarely where I think 'that's what I experienced' (Antony, Group 1).

The timeline presented in Figure 9 is constructed from the individual interviews and group discussions – an expanded version in Appendix 5 provides direct quotations to illustrate the findings. It highlights factors that were perceived by participants to have meaning for them in their experiences of restraints. Far from seeing a restraint as a discrete explosive event, participants used their knowledge of children and adults' lives, as well as the emotional and physical environment, to understand why restraints occurred and their long-term negative and positive consequences. The timeline does not describe a single pathway but identifies processes that may be in operation at different points during restraint-associated activities. Although the timeline presents

the data in temporal sequence, the following sections focus first on participants' descriptions and reflections about actual incidents, next on past influences affecting restraints and finally on their aftermath

Participants also identified the importance of space in understanding restraints. This included, but was not confined to, the direct impact of the space in which an incident occurred. Participants also identified that visiting significant places could increase the probability of physical restraint happening. Transitions from one space to another were also associated with increased dysregulation for many children and a consequent risk of restraint. Physical restraints also directly affected the physical environment not only for the child involved but also for others in the home. Participants believed the emotional aftermath for all children could inject anxiety into spaces which should have been a safe haven.

Figure 9 Extended Timeline

Potential antecedents of incidents of restraint

| Distal factors | Current personal/family factors outside the home | Current emotional/ social factors within home | Immediate Triggers |
|---|--|--|--|
| <div data-bbox="219 488 495 620">Social attributes eg class, disability and gender</div> <div data-bbox="219 647 506 807">Changing personal characteristics: age, size, injury</div> <div data-bbox="219 818 461 914">Children's histories</div> <div data-bbox="219 927 461 1034">Personal Anniversaries</div> <div data-bbox="219 1042 461 1137">Shared key events/rituals</div> <div data-bbox="219 1158 461 1254">Adults' histories</div> | <div data-bbox="607 520 943 663">Children's current family, school and community experience</div> <div data-bbox="595 951 981 1090">Adults' current home, family, community and personal experiences</div> | <div data-bbox="1055 464 1339 571">Children's group dynamics</div> <div data-bbox="1043 659 1391 786">Children's and adults' relationships with each other</div> <div data-bbox="1055 863 1339 986">Adult group dynamics</div> <div data-bbox="1048 1031 1373 1145">Management support/ expectations</div> <div data-bbox="1043 1174 1384 1289">Impact of external pressures or scrutiny</div> | <div data-bbox="1518 440 1821 571">Sensory or environmental triggers</div> <div data-bbox="1518 611 1821 786">Child's extreme response to distress/ excitement</div> <div data-bbox="1529 818 1832 898">Adults' anxiety /fear</div> <div data-bbox="1541 946 1821 1010">Adult insensitivity</div> <div data-bbox="1529 1094 1809 1182">Communication breakdown</div> |

Different processes that may be involved in incident of restraint

| De-escalation | Beginnings | Middles | Endings | Overall Feeling |
|---|---|---|--|--|
| No attempt at de-escalation. Restraint becomes first option | Signalling to colleagues to initiate | Pain, distress, discomfort, physiological arousal for children and adults | Violence escalates – police called | Primitive terror. Life, death and survival |
| Sometimes leave it too long to intervene | Losing a sense of child and self as whole individuals | Child's terror may be expressed through screaming and violent struggle | Bodily changes. Child begins to relax | Control / compliance achieved through coercive power |
| Child seems to be 'asking' for restraint | Sometimes feels like a fight | Individual adults appear to be violently targeted | Sounds change - screaming turns to sobbing | Unsatisfying – underlying distress remains hidden |
| Understanding children's individual emotional and sensory needs | Difficulty getting into and maintaining hold | Adults may have range of internal responses: concern, care dissociation, anxiety, anger, but likely to display 'blank face' | Child may seek hug/cuddle | Part of a repetitive cycle |
| Attunement through relationship | Impact of environment | 'Change of face' - adults swap to attempt to reduce tension | Occasionally child may be able to express and explore their feelings | Milestone experience linked to change / cathartic |
| Co-regulation | Good technique and experience make a difference | Adults use repetitive mantras – 'this will end' 'you will be ok' to calm themselves and child | | |
| Physical and psychological preparation | | | | |

Aftermath

| Perceived impact on child | Potential impact on other children | Impact on adults | Impact on relationships | Creating the narrative | Impact on organisation |
|---|---|--|--|--|---|
| <p>Re-traumatisation/ re-enactment of trauma</p> <p>Eroded trust</p> <p>Injury</p> <p>Guilt/shame</p> <p>Normalisation of restraint</p> <p>Release/ catharsis</p> <p>Feeling safe and contained</p> <p>Helped to regulate</p> <p>Knowing their destructiveness can be managed</p> | <p>Re-traumatisation</p> <p>Rupturing relationships with adults and Interruption of their day/routine</p> <p>Anger with child involved in restraint</p> <p>Normalisation of restraint</p> <p>Awakening the capacity for concern/empathy</p> | <p>Traumatisation</p> <p>Resigning</p> <p>Injury</p> <p>Feeling like an abuser</p> <p>Guilt/shame</p> <p>Anxiety about other people's perceptions</p> <p>Seeking absolution</p> <p>Erosion of hope</p> <p>Belief that restraint can be therapeutic</p> | <p>Can permanently shape the relationship negatively</p> <p>Can help build relationship</p> <p>Can strengthen bond with child</p> <p>Can strengthen bonds with other adults</p> <p>Can reduce the likelihood of future incidents</p> | <p>Adults' perspective becomes the accepted reality</p> <p>Difference between how an event feels and the written record</p> <p>Difficulty in ensuring children's views are heard</p> | <p>Can lead to downgrading or requirements from regulatory body and reputational damage</p> <p>Staff leaving or off sick</p> <p>Bureaucratic requirements</p> <p>Improves possibility of containing traumatised children and maintaining placements</p> |

Immediate time and space – the restraint itself

The actual processes and environmental issues involved in restraint are examined fully in Chapter 5, so this section provides only a brief outline of the discussion to centre data relevant to past and future time and the implications of different spaces.

Participants were clear that adults usually made strenuous attempts to de-escalate difficult situations without resorting to physical restraint. They also, however, described situations where an immediate reaction was necessary because a child was at imminent risk of serious injury or a child had attacked or was about to attack someone. Many however, described other settings where physical restraint was used to enforce compliance or demonstrate superior strength. They believed that, in such situations, physical restraint was the immediate reaction of staff to any difficulty.

a large issue with them is the unrealistic sense of power that some people get after being trained... it's once you're trained in PI, that's their 'go to'. It's not de-escalation, it's not trying to understand and make things safe, it's a "Well just restrain them" (Faye, Group1).

Several examples of effective de-escalation were provided usually linked to the quality of relationship between adults and children. Additionally, participants reflected on the importance of understanding individual children's needs and described strategies for responding sensitively to children and supporting them by attunement and co-regulation. Usually such de-escalation worked, however participants acknowledged that sometimes adults were so reluctant to restrain a child they left it too long to intervene increasing risk for everyone.

but sometimes we don't do it when we should, as soon as we should. So, we let it go on ... in hopes of them regulating themselves. And maybe that is because of the fear of holding them and us not wanting to do it. But there's times where we've probably just let this scenario go on for a little bit too long and not held them (Kitty, Interview 1).

Although participants were committed to de-escalating situations where children were heightened and distressed, there were occasions when it felt that the child was determined to be restrained as Sarah describes.

...there's times where Max like will, he will just say, "Just hold me just hold me. I just want you to hold me. I'm doing this cos I want you to hold me" (Sarah, Group 2).

The actual process of restraint generally seemed to consist of three stages. Participants also seemed to have an overall sense of the whole restraint.

Beginning

This stage includes the agreement between the adults to initiate a restraint. When adults knew each other well this usually involves a non-verbal communication rather than the type of conversation suggested by training providers. This type of unspoken connection and understanding was considered important, and participants acknowledged that being with less experienced workers in their first restraints was anxiety-provoking because trust was not yet established.

The initial task in a restraint is to get the child into a secure hold appropriate to the level of resistance they show which will keep both the child and those around them safe. Usually, techniques learnt in training enable this to happen but participants also described situations when this was impossible to achieve using 'appropriate' holds. Constraints imposed by environmental situations, for example being in a confined space such as a car, made it difficult to successfully get a grip quickly. Similarly, a child's physical attributes or psychological distress could make the initial stage feel more like a fight than a skilfully managed intervention as Kitty recounts.

It's becoming that power struggle in a restraint because he is literally fighting you. Like you - he can literally, can spin you round, and he can do like a 180 while you've got hold of him, he can be kicking you, it is, it comes down to you can look at it and it can look like a fight (Kitty, Group 3).

A few participants described at times losing a sense of the child and self as whole individuals in the very early moments of particularly dangerous restraints. Some described the need to suppress emotion and switch into instrumental thinking to ensure their own and others' safety when a restraint begins although they recognised that this might interrupt their connection with the child.

Middle

The longest stage is usually where a child is being held but is actively resisting. Participants described intense physiological and psychological arousal both for themselves and the child. Although neither of the crisis interventions used by participants are intended to use pain compliance, it was acknowledged that the experience was always uncomfortable and unpleasant.

It's that kind of sweaty, uncomfortable, wanting to move in frustration, versus like an open touch where someone comes for a hug and you share a hug. It's worlds away from, from even if you do a hold which resembles a hug. They don't have a choice to then shrug out of it, it continues until you've decided. It's like having it forced upon you (Antony, Group 1).

Although participants understood the extremity of emotions experienced by children, they also shared the difficulty of dealing with the behavioural expression of these feelings. They described chaos, violence and screamed accusations of abuse from the children as they were held. Sometimes the anger and violence seemed to be targeted towards one adult more than others – often a key worker or other significant adult. Despite being able to understand the possible reasons behind such behaviour, being the focus of a child's rage in this way could evoke powerful emotions in the adult.

I'm able to realise that it's to do with the attachment and stuff and the trauma and stuff. So, that's the reason because I'm the closest person I get targeted the most, but it does just ...like it just makes, it makes me feel every different kind of feeling, I'm angry, I'm upset, I'm confused, I'm just everything (Sarah, Interview 1).

Adults might have a wide range of emotions during a restraint but during their discussions they realised that their facial expressions were unlikely to reflect their internal state, and children were likely to encounter a blank face. They reflected on the implications of this for children who had survived traumatic experiences by learning to read minute changes in adults' faces, but questioned what emotion might be appropriate to the situation. Participants also explained that the use of repetitive mantras such as "this will end" helped them to stay regulated and contributed to the children becoming more regulated.

Ending

Participants described a common pattern indicating the child was moving into a different state where it would be safe to end the restraint. This included a reduction in the tension held in the child's body and a shift in the quality of their screams from terrified rage to sadness and pain. Adults described feeling most connected to the child then as they moved from ensuring protection and safety to a deep concern for the child and their pain as Kitty vividly describes.

I think when I first go into it ... I'll go into a mode where it's I've got to protect them, protect myself, protect other people. And I think that is very much my mindset of going into it until we can start coming to the end and they can... I think probably when they can start letting that that pain out is when I can start to just feel more relaxed and feel their pain and know what they're going through because in the midst of it me head just goes to protect them us everything else (Kitty, Interview 1).

Often children sought hugs and cuddles from the adults who had held them and sometimes were able to verbalise their distress and explore the triggers for their outburst.

On rare occasions, however, no safe ending is possible, and the situation can only be stopped through external support from the police. Some participants described situations where the police had intervened that had been deeply distressing for them

and traumatising for the child and most usually went to extreme lengths to avoid such involvement.

I had to ask police to leave because they were bending his wrist up his arm. He was seven at the time, he was seven. And it got to the point Michael, and I just went, "just go" (Kristy, Sanctuary).

Overall Feeling

Participants rarely felt positive about a restraint in its immediate aftermath. Several recalled experiences where the situation felt extremely dangerous and people's very survival depended on a 'successful' outcome. They highlighted the importance of being able to trust colleagues in such situations, as Sarah explains.

It can feel like life or death. Like if I, if we don't get in now and get in at the right moment as quick as possible and with the best technique, people are going to die and there's the kind of feeling it's linked with survival, because like, literally, like, there's been times where I thought, "God, he's gonna kill me," like, so it is literally linked with survival and I know like anyone in this room can save my life (Sarah, Group 3).

Often participants felt that although a child had become calmer the underlying distress remained unsoothed and its roots unclear. They described trying to make sense of the incident through individual reflection or in debriefs but acknowledged that a cathartic breakthrough for the child was rare. More frequently they recognised a repetitive cycle that over time reduced in frequency and for some children eventually stopped. This cyclical process was often powerfully linked to the destruction of spaces such as a child's bedroom that participants felt should be a place of safety and comfort. Figure 8 provides an image of this cycle and Antony's comments about his picture describe the depth of destruction that he had observed. In retrospect, participants could identify specific restraints that seemed to instigate a positive change in their relationship with a child, but this was rarely apparent at the time.

Time and space past

Participants all agreed that the immediate precipitant of physical intervention was to prevent imminent harm to people or serious damage to property. They also, however, articulated their belief that the emotions underpinning those behaviours usually had their roots in early traumatic experiences often involving parental abuse and/or neglect. Moreover, they noted that most children had experienced continued loss of relationships and places through their disrupted care journey. They suggested that such experiences left children hyperalert and reactive to apparently minor negative cues as well as often mistrusting of and resistant to adult support. Sarah, for example, described her sense that children's previous trauma was often present in the physical restraints she experienced.

I have been involved in physical interventions that have been like, to the extreme level and that's the child in complete fight and flight and you're dealing with the trauma right there (Sarah, Interview 1).

Although such early trauma was understood to make children physiologically and psychologically more reactive, difficult experiences in their current lives and anniversaries of previous losses were perceived as contributing more immediately to incidents where physical restraint occurred. Often these were within their family, however, difficulties or loss in school or the home also seemed to trigger powerful responses:

There's been changes to one of our children...his key worker was leaving. so, she left, and then she came back, but not as his key worker. And we had several restraints over the fact that he felt like he had no one because another one of his key workers is a manager (Sally, Interview 1).

It was also suggested that some children's sensory difficulties left them acutely responsive to sensory or environmental triggers and that restraint was a way they could restore some physiological and psychological equilibrium.

Although there was a strong focus on the children's histories and current experiences in their understanding of how physical restraint occurred, participants acknowledged adults' own histories and responses might also contribute this.

it's all our bits come into play with that as well as the kids' bits. Like how we react and stuff (Sarah, Group 5).

This might be due to violence or loss in their childhood or adult lives which were reactivated by the children's extreme responses. They also reflected on the possibility that their own behaviours might sometimes have triggered intense anxiety and distress in children leading to restraint. Some powerful examples involved situations where an adult was different from the way a child usually experienced them. These might be physical changes such as different haircuts or perfumes, but an adult's response to the child could also be different and unexpected, because of something from the adult's own life, which evoked a fearful reaction. Kristy, for example, described a worker behaving in a way that was so uncharacteristic that she had found it disturbing and was unsurprised that the child's distressed reaction led to a physical restraint¹⁰. Participants also reflected that their own anxiety or expectation of difficulties might lead to physiological changes – increased heartbeat, different smell etc – that alerted children to their heightened arousal evoking memories or anxiety that could tip a child into dysregulated and threatening behaviour. They also recognised that their own history with a child might lead them to anticipate a restraint which could create just such a dynamic. There was also an acknowledgement that adults' own insensitivity or failure to understand a child's communication could lead to distress and behaviour that led to a restraint.

¹⁰ It is possible that their earliest experiences had interrupted these children's capacity to reliably achieve 'object constancy', where they were able to internalise a caregiver's '*predictable emotional participation*' (Mahler, 1974).

Environmental triggers associated with previous experiences could also contribute to physical restraints. This might be associated with returning to places which confronted children with earlier loss or trauma such as the family home or the localities of previous placements. Interestingly, children most often showed their distress once they had returned to the relative safety of the children's home. Participants also, however, described environmental triggers that seemed to be shared between adults and children. This could occur when places were associated by them with previous visits that had ended with a collapse into dysregulated behaviour. It was highlighted that such anxieties needed to be challenged rather than avoided.

Transitions also seemed to be strongly associated with physical restraint particularly when this involved moving from one space to another. Sometimes this appeared to relate to anxiety provoking situations such as school or night times. On other occasions, however, it appeared to be associated with the ending of an enjoyable activity and children's inability to regulate not only distress but also excitement and enjoyment as Sarah describes.

Me, Riley and Max had a lovely day out that day. We spent so much time together. We had loads of fun. And looking back on it. How exciting was it, but it was like that different excitement... It was like like it wasn't like super dangerous, ...but was a "We need to stop you from hitting us. And the only way we can do that is by sitting here all day (Sarah, Group 3).

Other factors that were seen as contributing to the likelihood of restraints were changes in the organisation. The disruption of relationships when adults left or were absent through illness was considered significant. Similarly, changes in the children's group could increase or decrease the likelihood of restraint because the children expressed their distress in very different ways. Sarah, for example, pointed out that with a different group of children Max (who at the point of the research taking place was most involved in restraints) might not respond in the same way.

Participants also reflected on the ways different experiences of management support and external scrutiny affected their practice. Antony explained that he had left a previous job because he felt compromised by the organisation's decision to adopt a 'no restraint' policy which he felt left children physically and psychologically at risk. He contrasted that with the supportive nature of his current managers. Others described cultures where restraint was the norm and competence was judged by a practitioner's ability to control children physically and be emotionally unaffected. In neither the Cedars or Sanctuary did this reflect current practice, but participants from both acknowledged that the perceived pressure to justify and reduce restraints had affected the way they and their colleagues responded to children in distress.

Time and space future

Participants gave numerous examples of the continuing effects of physical restraints. One concern expressed by participants was how easily restraint could become normalised. Sally for example reported a poignant conversation with Max:

... he said to me 'When I leave here, who's gonna hold me?' And I said, 'What do you mean' and he went like, 'Well, when I'm angry, and I hit youse, youse hold me.' I said, 'Yeah'. And he said, 'So, who's gonna do that when I'm grown up?' (Sally, Group 2).

There was also a sense that other children who witnessed or heard a restraint going on could quickly come to accept this as a normal part of their lives and might make sense of it through the lens of their own trauma. Even as they reflected on the dangers of restraint becoming normalised participants expressed their own sense that some incidents of restraint, whilst not normal, were inevitable when caring for highly traumatised and dysregulated children

One anxiety expressed by all participants was that by restraining children against their will they were further traumatising them or retriggering previous trauma. Participants

also worried that it was easy for a child to fall into unhelpful shame that reinforced their sense of themselves as bad. In some cases, they believed that the experience of restraint undermined the child's trust in the adults. As well as these psychological risks, they were also clear that restraint was always uncomfortable and could leave the child bruised and in pain. Most participants believed these negative effects were generally balanced by the positive impact when children felt safe and contained and knew their violence and destructiveness could be managed.

The research process led to an important realisation that the significance of physical restraints for those children not directly involved was unrecognised. Participants continually referred to this insight in subsequent sessions, and it was equally thought provoking for the Sanctuary Group. Not only were participants aware that the experience might trigger traumatic memories from children's early lives they reflected on how much their own responses of hiding or minimising their injuries might replay the dynamics of domestic violence. Participants reflected on the experience of children alone in their bedrooms hearing screams and crashes. They believed that not only did this compromise their often already tenuous sense of their bedrooms as safe places it also potentially echoed previous experiences of domestic violence.

As well as reactivating early trauma, participants recognised that children experienced a rupture in important relationships with adults in the home as time and attention could be abruptly withdrawn to deal with a child in crisis. This might result in anger from the other children towards the child involved and a wish for them to leave the home. Although participants were concerned about the unrecognised impact of restraint on the other children, they also suggested these incidents sometimes provided them with opportunities to develop and demonstrate empathy towards both the adults and the child involved.

The research demonstrated that the risk of psychological trauma and physical injury was not confined to the children but a constant danger for adults as well. Participants described numerous injuries ranging from bruises to broken bones. They also described the traumatising impact of physical restraints where they felt that either they or somebody close to them was in danger of serious injury or death. As well as the primitive terror evoked by some of the most extreme restraints, participants also highlighted the more insidious emotional effects of being involved in restraints where they might be left feeling like an abuser as Antony describes.

The emotional impact – how it feels to be in particular situations or how you can be embodying the feelings of an abuser and, and how it feels to be called names or told that you're hurting. And then, a situation is resolved ... but something lingers (Antony, Group 1).

Participants frequently alluded to their guilt and shame even when they were sure a restraint had been necessary. This was linked to anxiety about other people's perceptions of them, both immediate colleagues and those in the external world. Some participants described their desire to seek forgiveness or absolution for the restraint from colleagues who were not involved in a restraint.

Despite the difficult emotions and experiences associated with restraint, most participants also achieved a state of acceptance that restraint was sometimes inevitable and could at times have benefits. Some, however, described long lasting negative implications of restraints on their relationships with individual children. For some their first physical interaction with a child was a restraint which shaped their ongoing relationship, for others there were unresolved issues from the restraint that lingered for the child. Despite these negative effects, some participants also believed at times restraints had strengthened relationships because children felt safely contained by an adult. They felt such experiences could reduce the likelihood of future

incidents. They also explained that physical restraints strengthened the trust and bonds with colleagues because of the need to depend so closely on them for their own and others' safety.

Anxiety about the exercise of power was a continuing theme throughout the research. Although this was mostly focused on the ethical dilemmas of exercising coercive physical control over young children, participants also identified another area where adult power was exercised, often with little awareness. They realised that the narrative of a restraint was created by the adults involved and that it became the accepted written record and important emotional realities were left unrepresented. Although attempts were always made to seek out children's views and perspectives, children were often reluctant to revisit an experience that had been painful, humiliating and shameful. Moreover, their previous experiences of disclosing painful experiences may have led to loss of relationships and home.

It was clear that physical restraint also had organisational consequences. Adults could be absent from work through injuries or stress and the experience of physical restraint could contribute to people leaving the profession. The heightened scrutiny of physical restraint by regulatory bodies and referring authorities could lead to criticism or downgrading for organisations. Requirements to change practice or modify reporting were sometimes imposed and participants felt these reflected a lack of understanding about the needs of the children and the challenges faced by adults attempting to create safety. In contrast, some participants felt that using physical restraint had allowed them to keep children whose level of distress had previously wrecked numerous placements. Finally, participants reflected on the future implications of physical restraint as it might be presented in virtual spaces. This included the representation of residential care by children who had experience of physical restraint. Even more

concerning was the fear that a child might be videoed in an external space while being restrained and how that might be used on social media.

Summary

This chapter examined participants' perceptions that both time and space are important factors that should be acknowledged in understanding physical restraint. They suggest that current reporting practices and external scrutiny risk focusing attention away from the complexity and depth of such exploration and lead to a simplistic and narrow consideration of incidents as discrete explosive events.

The next chapter will explore the physical and psychological processes involved in restraint at greater depth.

Chapter Six Getting a grip

Introduction

This research showed the act of physical restraint is not only an intense embodied experience, but one that can evoke extreme emotions requiring effortful cognitive control to regulate successfully. Adults described the need to get and maintain a safe grip on the child to prevent injury to anyone, but they also highlighted the importance of getting a grip on their own emotions to help the child through their distress so that they too become more regulated.

I think you're fighting your natural fight or flight instinct because - depending on which one you are- if a child goes to hit you, you either fight or flight - you know you can't fight a child but at the same time you can't flight because you need to make sure that you're safe, your colleague's safe, and that child's safe (Sally, Group 5).

This chapter presents the themes identified from the data that focus on some of the physical, emotional and cognitive processes occurring during restraints. It begins by considering participants' views and experiences about the actual holds they employ as well as examining their accounts of the embodied nature of restraint. The impact the adults' capacity to contain a child, both physically and emotionally, can have on the outcome of a restraint is then considered. This includes an examination of the disintegrative experience described by participants that can occur for both adults and children, especially early in the restraint. It also explores the powerful psychological processes occurring between adults and children and the importance of being able to survive these. The significance of a holding environment for adults as well as children is also considered. This leads into an exploration of participants' accounts of how the repeated experiences of processes such as attunement and co-regulation have contributed to the development of self-regulation in children in their care.

Technique

The importance of technical competence was frequently highlighted by participants, and it was associated with fewer injuries and less distress for both children and adults. Only Antony had worked in a residential setting, albeit with a different client group, which had no physical restraint training. He described the vulnerability to physical injury this involved, and the lack of support staff received. The fact that both the Cedars and Sanctuary worked to clear models of physical interventions seemed to provide a degree of structural containment.

Although the training and continual practice sessions were considered essential, participants questioned their artificial nature. Adults warmed up before training sessions; there were mats on the floor, and those volunteering to be 'restrained' were not allowed to resist. This provided a stark contrast to the actual experience of physically restraining a seriously dysregulated and terrified child. It also raised ethical questions about why they learnt these techniques within a highly protected environment, yet used them in volatile, highly charged situations. This focus on potential harm reinforced their sense that physical restraint should never become normalised.

When you're in a PI, it's like last resort, the only way to keep things safe. And you keep it as safe as you can. And like it's a danger to you; it's a danger to them as well. So, like, it's not like, "Oh, you adults are so important... don't do it to each other because you might get hurt" because they'd say, "don't do it to the kids" ... (Sarah, Group 2).

Although their shared understanding and competence provided them with containment and comfort, participants shared scepticism about aspects of the model they felt were unrealistic with their children. Participants explained that technique alone could not help in every situation. The unpredictability of children meant a restraint might be initiated in less-than-ideal circumstances particularly outside the home.

They also recognised that sometimes the techniques were not effective. Antony described the impact of this realisation on him when working with a very dysregulated girl who was also strong and well built.

[I believed that] CALM is the way and had a complete belief in the security of it, the holds. And that saw me through to Soraya... might take more people, but the right technique at the right time by trained practitioners and it will be safe ... that was like one of my, you know, personal wakeups ... it was not safe to establish a CALM hold... that was like my first experience of that, and it feeling like a tussle and a fight... everything I've been taught would not help keep that situation safe. And that was scary (Antony, Group1).

Restraints usually involve more than one adult, and participants highlighted the importance of being confident in the competence and courage of other adults. They emphasised the power of repetition for embedding techniques in crisis situations. The trust they described was not only gained through shared restraints but from knowing each other and the culture and practice of their organisation well. All participants were very experienced and acknowledged they felt less comfortable in restraints with new colleagues even though they had been trained and accredited. They emphasised the difference between the experience gained in situations of real crisis and that from training. They believed that injuries to adults increased when such experience was lacking. Although they welcomed the reduction in restraints, they felt this impeded the acquisition of skills and thus made restraints less safe. Kitty explained her feelings going into a restraint with an inexperienced colleague.

You do think I'm gonna get hurt, someone's gonna get hurt. Yeah, even though you know, they've got that level...it's that repetition. And even though they've got that level of training... our PIs are so low at the minute, and they're dropping every year- their opportunity to be in PIs is a lot more limited (Kitty, Group 3).

Embodied experience

Physical restraint is an embodied experience. A child and one or more adults are involved in an intimate, body-to-body struggle. This can vary in intensity and duration but at its heart it is a physically controlling act designed to impose the adults' will on

the child. The greater the child's panic or resistance the more force is required to control them. Where this unwanted forceful touch was the first physical connection with a child, this was particularly troubling for the adult and could have longer term implications for their relationship with them.

...that would be something throughout a career in residential care where the first time I'm touching someone is against their will to hold them. And that shaped the relationship.... It feels massively invasive on every level and that's where you feel closest to being an abuser (Antony, Group 1).

Participants' accounts highlighted the physicality of the experience at every stage of a restraint. Even the initiation of a restraint usually involved non-verbal communication. As well as the looks exchanged between adults, this could also include actions that are almost like stripping for battle, for example, tying hair back or removing watches

During their discussions participants recognised that this non-verbal communication was likely to be recognised by the child in crisis. They realised that this might inadvertently escalate a difficult situation as children notice the adults' behaviour and start to prepare for a conflictual encounter. Participants also reflected that the children might also respond to basic physiological reactions beyond the adults' conscious control.

The descriptions provided by participants emphasised the level of physiological reactions involved in restraints. They talked of being flooded with adrenalin and having intense bodily responses such as increased heart rate, sweating and shaking. These were mirrored in the reactions they observed in children. They also highlighted that most restraints involved skin on skin contact and that in a prolonged physical struggle such contact was marked by becoming increasingly sweaty and slippery as Faye vividly recounted:

This was a summer's day, I was sweating. And we were in a car where the windows were closed, doors were closed. The car was off so there was no aircon or anything you were just getting sweatier and sweatier, he's getting slipperier (Faye, Group 4).

Participants also described the frequent exposure to other bodily fluids such as saliva (from spitting or bites) or blood (from injuries) and occasionally, in more extreme situations, faeces, vomit or urine where a child lost complete control of their body as well as their emotions. These experiences took place in everyday life, not in clinical spaces so there were no protective barriers for adults or children such as gloves or masks. Interestingly, however, one participant mentioned that when police were dealing with a crisis, spit masks might be used even with young children. In rare instances these situations were exacerbated when a child had removed their clothing but were still behaving in an extremely dangerous way. Some participants described how they managed such extreme situations. Antony, for example, explained how he had coped when dealing with a naked child covered in faeces.

My approach ... was quite businesslike - was the that part was cut off. So, I could deal with you know, the nakedness and faeces everywhere and the colleague who was a little rabbit in the headlights with what was going on, because part of me shut down and stopped responding – I've done this before. So, you know, I can - survival kicks in (Antony, Interview 2).

He also reflected on this action's lasting implications as it was a long time before this child wanted a more positive physical interaction from him. The encounter itself was brief- a matter of minutes - and from Antony's perspective the actual intervention was essential. His reflections from the research group experience were that in a similar situation he would deal with the aftermath differently by looking for opportunities to talk about it at the time with the child.

Participants also reported injuries to both children and adults that occurred in restraints. The children's injuries they described were bruises or scratches that

occurred inadvertently. These had continuing significance for both adults and children even when an adult was also injured.

I don't think it ever fully really goes, like the one where I ended up accidentally leaving a bruise on Stephen sticks in my head and it's never gone. It's still there. Even when I see him it's still there. I think that everything that he'd done, I ended up having a black eye, split lip and a concussion ... there's loads of different things in that one PI, but I still mainly zone in on the fact that I left a bruise on his arm and his elbow (Faye, Group 3).

Adults also sustained injuries – a few requiring hospital attention. Although some were accidentally sustained during a restraint, others were inflicted by the child in their distress and attempts to get out of a hold.

These injuries created an additional stress while trying to manage the emotional demands of a restraint and its aftermath. Paradoxically, however, many participants stated that they would rather they were injured than a colleague, particularly a less experienced one. Not only was there a desire to protect others in such situations there was an acknowledgement that dealing with their own physical injuries was easier than dealing with managing the guilt when others were hurt.

The physical and sensory connections between adults and the child also allowed the progress of the restraint to be monitored. Participants explained how the changing levels of bodily tension and the volume and tone of a child's cries allowed them to judge when it was possible to relax their hold on a child or shift to a reassuring hug rather than a controlling grip as Kitty illustrated:

... there are screams from the beginning, but there's just something about them changes ... it's no longer a fight scream, it's more a wail ... obviously there's wails all the way through, but ... you just feel it is now so different and it's more like that breakdown cry than the fight cry (Kitty, Interview 1).

Many restraints ended in a child clinging to an adult who had physically restrained them and being hugged and soothed. Although adults were relieved when a child was

able to accept nurture and care they also recognised the complexity and emotional confusion involved in such total shifts in responses. Sally used the idea of the drama triangle (Karpman, 1968) in her discussion of her picture (Figure 6). She emphasised the repetitive nature of the experience and the constant flipping of roles.

The physiological impacts of restraint continue beyond the actual event and participants described other children's awareness of their bodily state.

Isobel used to always smell me. And no matter how, like, however, I came back, and would think I'm calm now, I'm okay, and you know, the situation was over, she would come and sniff my armpits and, and the stink, wouldn't lie, it would say you've been in a sweaty restraint (Antony, Group 2).

Providing containment

Participants regularly used the term 'containment' to explain what they hoped to provide through a restraint. They distinguished between the act of physical containment, when a child was prevented from causing harm, and emotional containment, when adults connect to and accept the child's fear and pain and help them to regulate. Early in a restraint physical containment was usually all that was possible. Indeed, some participants described a disintegrative process where their sense of the child and themselves as whole people could almost disappear.

in that first moment of initiating a PI - I'm not attuned to the child, or thinking about a child, it's hands that hit, feet that kick and teeth that bite. Once we're in, then I open up again, but I haven't got the headspace to consider them as an individual, it's just like, in this equation that's my arm, or that's my leg, or this is a technique going in for, and so that becomes broken down into those elements (Antony, Group 1).

As well as the physical struggle, participants described some of the psychological processes they experienced and how they managed to make sense of and survive them.

Most participants described situations where a child had reacted to them as though they were their abuser either through verbal accusations or by their expressions of terror. Such experiences were difficult and conflicted with their internal sense of themselves as good people concerned with making children's lives better. These feelings were most acute once the restraint was over. Antony described early in his career feeling unclean after such experiences and needing a shower once he was at home. Some participants had their own difficult childhood experiences which made these feelings even more painful. For almost all of them, however, their emotional responses were exacerbated by their own ethical questions and uncertainties about physical restraint.

Participants often actively suppressed their feelings during the restraint to cope with these powerful projections from the children. Antony suggested that it was not just adults experiencing this type of dissociative response, sometimes so were the children, particularly at the end of a restraint.

I have to fight that temptation each time to go to my happy place, and then I'll come back down afterwards and feel this hasn't touched me. And for the child, sometimes it can feel like that they're not there. They've let it all out, and it's gone. And then you're hanging on to the "But you've broken this window and these things happened." And for them actually it's done...there's not a neat ending, not a great moment of truth ...just an "I feel better now". And then you move on to something different (Antony, Group 5).

Some participants also described ways in which the adults involved in a hold could at times be split. This could be directly in response to a child's behaviour or words as Faye described when Max made her feel incompetent by negatively comparing her strength to Kitty's. More often they explained that they found themselves performing very different roles in the restraint as though they were holding fragmented parts of the child.

Participants reflected on the frequency with which in the research they described the thoughts rather than the emotions they had during restraints and suggested this was a way of dealing with the enormity of the experience. They explained that this type of thinking allowed them to monitor and manage the process of the restraint and the safety of everyone involved. As well as suppressing their emotions at times they also cut themselves off from the experience of physical pain as Faye illustrated:

I don't think about myself during the restraint at all. I could have blood running down my arm from an injury that I've got. And I still wouldn't even have that as a thought it would be purely is everyone else, okay, have I hurt this kid? What's going on with the other adults? All right? How can we get through this, this will end, this will end (Faye, Group 5).

Interestingly, however, in several of the images that participants drew they visually represented emotions such as fear, anger and sadness, and, acknowledged that these emotions belonged to them as well as the children. It appeared that their conscious effort was to suppress their emotional response to cope with the immediate situation but unconsciously they were deeply in touch with the children's emotions and indeed mirroring them. In situations that were life-threateningly dangerous such as the restraint in a car represented by Faye in Figure 5, the effort to prevent the emotions overwhelming them and exacerbating them becomes clearer. When a motorist stopped to check on them the emotions rushed to the surface but still had to be managed because there was nothing he could do to help. His presence merely added to the child's distress and his shock increased the complexity of emotions that Faye and her colleague were dealing with.

... he came, like " Are you okay? I thought you'd broken down" ... it's just the feeling of you want the help but you're helpless...when someone comes to go, "You alright?" You just want to scream. "No. I want help..." You're also screaming "I am so thirsty. I am so hot" (Faye, Group 4).

Participants believed that their capacity to survive physical struggles and psychic assault without abandoning the child or retaliating with anger were essential aspects

of providing containment for distressed and dysregulated children. Catriona, for example, suggested that Callum was finally able to settle at Sanctuary because the adults caring for him had survived his distress without being overwhelmed

...with Callum, and the amount of movements he'd had prior to being with us, we have, you know, we're still here - because that was him every hour... I don't know where the change happened, but it did happen. And he's just going, "Okay I know these people here.... No matter what I throw at them, they're still coming back" (Catriona, Sanctuary).

Participants also, however, reflected on the ways in which their own responses could contribute to a child's distress rather than soothe it. There was a clear recognition that it was important that adults not only needed to monitor children's emotional and physical state but also their own and that of other adults involved. It was understood that if an adult was struggling to maintain a safe grip or could not control negative emotional reactions, wherever possible they should swap with someone more regulated to ensure that the situation did not escalate. This could require courage to challenge a colleague or humility to accept feedback on one's own state. As Kristy described, this could easily be interpreted as undermining a colleague and allowing a child too much control.

I had to swap and ask them to leave, and they were raging, that I'd ask them to leave, like raging. That's that was the child had all the power (Kristy, Sanctuary).

Participants reflected on how training and practice had developed over several years to reflect greater understanding of the most effective ways to manage crisis situations. What had once been standard practice was now recognised as unhelpful as Antony explained.

We used to talk about ...what was on their mind whilst it was happening. So, it wasn't unusual for these restraints to be longer and the roller coaster be driven by us talking about it in that exact moment...not, not, you know, not intentionally creating guilt or shame but now the training is very different around the length of the, the actual physical side of things, ... like how the adrenaline's affecting you, what, what you're capable of hearing what you would or wouldn't discuss,

and kind of always de-escalating ... it's very different... at the time, that was how you did it, that was a template for, for restraints, you got into the nitty gritty of- find out what it was to make sure it didn't happen the next time. And it was like then you saw it through to the bitter end because it was yours (Antony, Group 1).

They also explained there could be an urge to explain or justify a restraint to a child to protect a sense of oneself as a good person -effectively placing the blame and shame on the child- whilst recognising that this exacerbated the situation. Participants, however, reported a gradual shift in practice by which it was increasingly possible for adults to be alongside a child in their distress, communicate acceptance of their pain and express a conviction that everyone would get through the situation with less focus on searching for interpretations, explanations or justifications.

Participants were also able to acknowledge that sometimes they misread a situation and failed to really hear a child's communication about their need. Antony provided a poignant example of a restraint in which he responded to the aggression a child was displaying by holding him and failed to recognise his desperate need for a soothing cuddle from his other keyworker.

Despite the physical and emotional distress involved for everyone in restraints and their recollections of times when they or others had got it wrong most participants believed that for some children physical restraint provided necessary emotional as well as physical containment. Their experience was that at times children's experience of total psychic disintegration was so intense that only a physical intervention could reach them. This resonated strongly for several participants in the Sanctuary group who expressed concern that failing to hold physical boundaries for a child could leave them unsafe and totally dysregulated and be worse for them than experiencing a physical restraint. They highlighted the importance of trying to ensure that any restraint was undertaken as a caring action.

...he needed the adults to contain emotionally and physically...and I think not doing it would have been worse for him.... But how do you make sure people are confident? Because it's exhausting for everyone, and how's it done? Caringly? Yeah, with love, affection, not for power, not for control, but at the same time you are going, "No, we're not doing that. That's not okay, and that's not safe" (Kristy, Sanctuary).

All participants highlighted the importance for adults of formal debriefing and informal peer support after incidents of restraint as a form of containment for themselves. The participants in Sanctuary, who all had many years' experience in RCC, commented on the shift in the response to difficult incidents which had previously evoked little or no concern or care. They described deliberately creating a culture where negative emotions and tears were acceptable and the expectation was that talking about difficulties was important and helpful. They acknowledged that accepting or asking for help was not easy as they had been socialised into a belief that showing emotion was a sign of weakness.

I think we're getting a lot better at how you manage it because of the changes in reflections, debrief, what you're asking, recognition of emotions... I think that's a culture shift ...of that whole vulnerability's a strength...by the way I put myself in - it's taken me a long time to learn that, and I've got better because I remember an incident that we had in December, and I actually said can you debrief me because I need to talk that through ... I don't know if, years ago, I would have done the same (Kristy, Sanctuary).

Participants from the Cedars, which had a more established culture of reflection and an awareness of the importance of accepting adult distress, also highlighted the value of the multiple opportunities provided to reflect on incidents of restraint. At the end of the research, however, they commented on how important it had been to reflect on their more general experiences of and perspectives on restraint rather than focusing on single incidents. They felt they had never done this before as Kitty stated:

It's the one time we've genuinely been able to sit down and be able to talk about PIs in depth. And really, when you think about that process, like the process of physical intervention, and what it entails, and the emotions that you go through

to think the in-depth conversations about it really don't take place it's quite crazy (Kitty, Interview 2).

During the Sanctuary group's discussions, they considered using the pictures exercise with their own staff groups to facilitate a similar space for a more general reflection on restraint. Even within these two organisations where opportunities for reflection were embedded within the structure and culture, this suggests that participants identified an important gap in the holding environment. Within the Cedars the realisation of the importance of creating a time for shared reflection about physical restraint has resulted in restraint being discussed on a regular basis within the weekly reflective space.

The journey to self-regulation

Participants were clear that providing external physical and emotional containment should always be a process leading to children developing the internal capacity to self-regulate. They worried that the normalisation of restraint risked the child becoming dependent on others to manage their emotions which could seriously interfere with their capacity to lead successful adult lives. In most cases they described a pattern of restraints reducing over time and eventually ceasing, but a few children displayed such overwhelmingly dangerous behaviour that they could not be contained and had to be moved, often to more secure environments.

Often children expressed their need for this type of external regulation through their heightened arousal and threatening behaviour. Participants described ways in which practice had shifted in their organisations with a consequent reduction in the frequency of restraints in such situations. Jeannie described a lengthy de-escalation with a child in the middle of the night and her constant need to assess the balance of risk between intervening physically or just continuing to talk to him.

I got called out at four in the morning and he's kicking about the room, and what actually helped was the hole that he kicked in the wall, because then I could

actually talk to him through the wall and then he's up at the window... When do you go in? How long do you give him? How long do you try? Right? Okay, we'll try a wee bit longer, right? He's not quite put himself at risk... He's down, right. Let's start something else. It's constant, and then eventually, about two hours later, he lay down and went to sleep (Jeannie, Sanctuary).

The discussion in the group around this event highlighted the level of anxiety Jeannie had to contain about the risk the boy posed to himself and the impact on other children.

There was a recognition that previous practice would have been to go in and restrain him from the outset which, while reducing Jeannie's anxiety and removing any immediate risk, would have prevented the boy having the experience of emotionally supported self-regulation.

Sally also explained how a focus on identifying clear strategies with individual children that helped them to calm down had reduced restraints in the Cedars over the previous year.

The more we've focused on de-escalating the children and what works for them.... it helped us get to know the children better and, know that if like Hermione's putting her shoes on, it's not because she's going to do a runner and abscond - you're like, ah, you know that she's going to go, "I'm gonna go for a walk". And it might be she'll walk to the bottom of the street, and she'll come back, or she'll say can we go for a walk around the block (Sally, Group 2).

In both these examples it was the adult behaviour that changed rather than the child's because the adults were striving to attune to the needs of a child rather than react precipitately when criteria for restraint were reached. Antony reflected that undertaking a restraint can act as a defence against unbearable feelings.

When you stop and just take that step back, or just have that moment to reflect, I think it's often there with the children that, like they're giving you this feeling that is often, sometimes overwhelming. So, it's easier to think well I'm trained to deal with this, so you do this, and they do this (Antony, Group 3).

Despite their recognition that many restraints could be avoided if adults were fully attuned to the child's distress and prepared to engage with it, they also gave examples where restraint seemed inevitable because it was meeting some deep need in a child.

Participants explained that they were now also more aware of the interaction between the effects of trauma and neurodiversity. They shared their growing awareness of children's sensory needs and believed that children sometimes sought both the safety that physical restraint could provide and the sensory pressure that they could not ask for directly.

My understanding is a lot of the children need that restriction, they need the comfort, they need tightness. Because they can't ask for a hug. And yes, we're protecting them and we're protecting staff and we're protecting damage, but they are needing that containment, they need us at that moment in time to say, ... we are going to hold you but it's not, it's not in a malicious way...I just see it as another form of giving them that pressure and that comfort (Kitty, Interview 1).

Participants from both organisations gave examples where children had asked adults to lie on top of them to get the pressure they wanted. The importance of physical pressure in supporting some children to regulate was a relatively new understanding in both organisations and clarity about the most appropriate strategies for children was best achieved through specialist occupational therapy (OT). Max, for example, had been assessed by OT and had a special sensory diet created for him. This enabled adults to offer appropriate levels of deep pressure to him when he was dysregulated and on occasion this could avert a distressing restraint. It was clear, however, that this type of intervention caused discomfort to the adults involved – it did not fit easily into established forms of physical restraint, but neither was it a reassuring hug. Being so responsive to a child's needs came with risk of external criticism or unexpected reactions from the child.

Participants shared situations where they were prepared to make risky judgements to enable children to experience a measure of self-regulation. For example, an adult with a strong relationship with a child might decide to manage the child's distress by themselves without recourse to a restraint despite the criteria already being exceeded.

Such choices required deep trust between the adults and until the situation was resolved it generated far greater anxiety for all those involved than undertaking a restraint. Such anxiety is based on a realistic assessment of the danger that dysregulated children can pose. Participants had described some of the serious injuries sustained by themselves or colleagues, and, arguably, choosing to engage alone with a child in this way could be perceived as reckless. They suggested, however, that the experience of regulating without being restrained demonstrates to a child that they have alternatives even when overwhelmed by intense emotions.

Alongside this intense attunement to children's needs some participants described experiences of coregulation with a child. This involved authentically acknowledging their own internal state to enable the child to learn more about bodily responses to stress and ways of managing them. Rather than the adult taking responsibility for managing both their own and the child's emotional state this seemed to provide a way for them together to work through a difficult situation. Participants also described children being able to communicate just how hard they were working not to be violent even if they were behaving aggressively or destroying property. Noticing and encouraging children's attempts to use words rather than behaviour to express their emotions was seen as a crucial step in the development of self-regulation even when their words were threatening.

When he's saying "I'm going to, I'm going to kick you and I'm going to break your head". And I'm you know, "I'll be two steps further away, then", you know, we have conversation at that level. And when it comes down, talking to him about like "You were strong enough to put that into words and some people couldn't, some people would have done it by now. And by saying it you've said that's how strong you felt" (Antony, Group 3).

Most children were desperate not to lose control and be restrained and at times it was possible to avert a restraint by reminding them how well they had been managing and

encouraging them to find a different way to react. As well as expressing their feelings verbally rather than through behaviour, children also need to learn to tolerate feedback from others without exploding in shame or denial. One space in which participants described this happening was in the children's meeting.

Participants recognised that the adults' ability to tolerate difficult emotions had also needed to improve. Rather than responding to distress by attempting to control it and separate the dysregulated child from others, they felt they were becoming better at remaining in touch with the emotion and processing it in the moment. This seemed at times to have shifted their perspective of where the point was reached that a restraint became necessary. In the final group Antony explains the position he had arrived at in understanding his part in helping children to arrive at the point of self-regulation:

It's the listening but not talking, or the listening and hearing what's being said or like with someone who uses a lot more symbolic communication like Hermione you'll think that she has told me something... the effort is to try and keep showing that you're trying to understand, rather than understanding, for me personally, I don't think she ever intends for me to know what's going on or to tell me. It's just that you'll keep trying to understand (Antony, Group 5).

In both organisations the number of restraints has reduced dramatically but the histories of the children they care for are as traumatic as ever and their behaviour just as challenging. What participants described were changes in understanding and practice that have enabled adults to attune more deeply to their children and support them in their journeys towards self-regulation.

Summary

This chapter considered the techniques involved in physical restraint and explored the embodied nature of the intervention. It also examined the internal and interpersonal physiological and psychological processes that occur during such events and how these are managed by the adults involved. Despite the distressing and traumatising

nature of physical restraint, participants generally believed that they were sometimes inevitable to create safety. In addition, participants drew attention to some of the psychological and sensory needs that might at times be met through physical restraint. They were, however, aware of the danger of children becoming dependent on external regulation of their distress and described a variety of ways in which they attempted to support children to develop their own self-regulatory skills. There was a recognition that attitudes, practice and knowledge had changed, and this had resulted in fewer restraints. It seemed, however, that the psychological burden of this was an increase in anxiety held primarily by front line practitioners. The importance of providing a holding environment for adults so that they could contain children's distress was emphasised by participants.

The next chapter will focus on the challenges encountered by adults in navigating several ethical and practice dilemmas around physical restraint.

Chapter Seven Between Scylla and Charybdis – finding their way

Introduction

In the *Odyssey* Homer describes the journey through the Strait of Messina where Odysseus and his crewmates had to navigate between two monsters – Scylla who lurked on cliffs snatching sailors from passing ships and Charybdis a whirlpool that swallowed whole boats and their crews. Facing this dilemma, Odysseus chose to steer the ship closer to Scylla and lose some, but not all, of his sailors. The continual need to make choices between different problematic options was a strong theme throughout the research. Participants described situations where there was no good option, only one that was less harmful. Moreover, the different histories of the children, the complex web of relationships and the swiftly changing context of any children's home prevented the development of definitive instructions or even guidance for adults facing these situations. Whatever decision they made had the potential for negative outcomes and they were accountable to themselves and others for this. Whilst there was a practice component to all the issues raised, they also presented profound ethical dilemmas. Participants were fully aware of some of these prior to the research but others emerged during their discussions. Although exploring below the surface in this way was uncomfortable for participants, it seemed to help inform their decision making and practice.

To hold or not to hold – that is the question

The most obvious question facing participants was whether to engage in physical restraint of children. This was discussed at two levels: firstly, whether and when to intervene physically in a particular crisis and secondly, what are the ethical issues

raised by physical restraint more generally and how did they personally engage with these.

Crisis decision making

Participants described continually wrestling with the implications not only of physically restraining a child but also the consequences of failing to intervene physically.

I think it's a very fine line, isn't it? Is it a restraint culture? If we didn't restrain? What injuries would staff have? What injuries may children have? How much of the house would be left intact? (Kitty, Group 2).

In their discussions participants continually returned to the complexity of these decisions and, reflected on how practice had evolved, partly due to the focus on reducing restraint.

Those with many years' experience in RCC, particularly within the Sanctuary group, described a previously reactive culture where restraint had been endemic and there was little opportunity for reflection. They described a fundamental change in their organisation: physical restraint was no longer considered a routine practice but an experience with a significant impact on everyone involved. Although all participants were committed to creating a culture where restraint was used as little as possible and reflective practice encouraged, several expressed concern that at times failing to intervene quickly compromised safety. Kristy explained the minefield practitioners and their managers must navigate.

*...what's quite difficult is that you are trying to do reflection and learning when people have guilt, concern, "Are we doing the right thing", where I have had reflections of they've let things go too long, you know? So, what is last resort for one's not for another. And last resort doesn't mean that you've gone through all the de-escalation techniques before...So, on one hand, you're trying to say, let's reduce this. Let's **not** do it as much as we can. But the other hand, you're going uh oh, because that child was really not feeling very safe. And it's a pure minefield (Kristy, Sanctuary).*

Participants highlighted that terms such as 'last resort' used in policy and guidance are open to interpretation which can be different not only from person to person but even from day to day. They reflected on situations where their own or others' tolerance of difficulties was affected by stress in their personal lives or anxiety in the workplace. These differences could affect practitioners' choices not only by making them too ready to leap into a restraint but also by leading them to avoid necessary physical intervention. In the Sanctuary group Kristy vividly described adults being paralysed by the presence of an inspector from the regulatory body and failing to intervene in a situation of rising chaos and danger.

Even without the physical presence of an inspector, some participants believed that adults had internalised a fear of judgement that was expressed in a need to justify their actions not only to colleagues, managers and the external world but also to themselves.

I think the whole, the perception of PIs and stuff is ... they're like apologetic, "I had to go into it", as if I've done something wrong. "I did the PI, I wasn't able to do anything else" you know you've got to justify it. But at the point when they hit you once -that's, that's the criteria met. But we will let it go more. And it's sometimes it's about, can I justify that I've done enough? (Sarah, Group 1).

While at times this reluctance to intervene physically reflected anxiety about external judgement, some participants, also explained that their own uncertainties about the positive outcomes of physical restraint meant they sometimes delayed till the last possible moment before initiating a hold. To avoid dealing with the lingering negative feelings for themselves and the child, they would prefer to spend hours de-escalating a situation rather than engage in a short physical restraint.

In contrast, others stated they were unwilling to tolerate any actual violence without stopping a child, physically, if necessary, partly for their own protection but also because of the emotional damage a child might experience from causing harm to other

people. Moreover, some participants felt that the prolonged emotional distress and lack of containment experienced by children when adults are unwilling to intervene might be more harmful for them than a physical hold.

Emotional distress is just as harming as physical. I think if you see a kid, physically hurt it's a bit more visual. But if you see a kid is - I just think you know, would you allow that to continue if that kid is so distressed (Catriona, Sanctuary).

The complexity of the decision-making process involved is reflected in the discussion where these apparently contrasting views were not held as fixed positions by participants. Whilst they had all at times experienced the reluctance to intervene, they had also all made swift decisions to initiate a hold when they believed it was necessary.

Participants described some extreme situations where the difficulty of decision making was exacerbated by external advice that physical intervention for a child should be avoided because of the danger of re-traumatisation. They could find themselves caught between replaying the neglectful parent or the abusive adult. For example, faced with a newly arrived child who was unwilling to come out of their room even to use the toilet but who became physically aggressive if anyone came in to try and clean up after them, adults eventually had no choice but to protect them through a physical intervention.

Most participants described a feeling of guilt and shame after a restraint even if they believed it was the right decision and often questioned their own competence and relationships. They also suggested that these emotions had intensified because of the increased scrutiny of restrictive practices.

I do think at times, because there's so much of a sort of lens on that we need to reduce this, this needs to get better, that that feeling of guilt and failure is worse (Kristy, Sanctuary).

Ethical dilemmas

Throughout the research participants emphasised that they wanted to care for the children with love and compassion and to help them recover from the trauma they had experienced. Their involvement in physical restraint sat uncomfortably with their identity and self-concept as caring human beings. In Fiona's response to the image of the lonely individual in handcuffs in Figure 3 she contrasted the hope she has that children would have better experiences in their care with the reality of physical restraint.

Most participants expressed considerable discomfort about using power to control a child against their will even if they were able to justify it. They recognised that many of their children had already experienced adults using physical force to control or abuse them, and these adults had also justified this to the children.

That's probably what adults done when they were hurting them and did that adult then justify why they hit them? So we say "Oh, we're holding you because you've hit me or you've hit so and so or you've caused damage", but that adult will have said "Oh, well I've hit you because didn't eat your tea or I've hit you because you backchatted me or something" like it's justification but for different things (Sally, Group 4).

Participants also recognised the possibility of professional misuse of power. They were all aware of reports in the press of the abusive use of physical restraint and felt that public assumptions about restraint were negative. Some participants acknowledged that before working in RCC this would also have been their perspective. Others recounted experiences of working in settings where they had witnessed the misuse of power exercised in unnecessary physical restraints. This exacerbated their own discomfort and uncertainty. Faye described a constant wrestling in her own mind about the morality of physical restraint:

Is this right? Half the time I don't - I know it is because it's to keep people safe. So, keep them safe is obviously what's needed - But I am constantly thinking is

this right? But this isn't right you're hurting them you're stopping... but power is the thing we talked about in the in one of the other ones about power and control - and this just doesn't feel right when you are doing it, because you're restraining a kid, you're holding them, potentially hurting them and yes, you're stopping them from hurting you and others but... (Faye, Group 5).

As well as discussing the direct use of power involved in these interventions, participants also explored the power adults had to create the narrative around physical restraint. The bureaucratic requirement to record every incident of restraint and provide a justification risked creating a history that represented only a partial truth. They also recognised that it was easy to come up with post hoc rationalisations for their intervention and emphasised the importance of continual self-questioning.

Although children were given the opportunity to share their views if they were restrained, this was rarely taken up. Often, they had no wish to think about the experience because it caused them further distress. Moreover, participants questioned whether it was realistic for young children with a history of traumatic relationships and loss to know whether a restraint had been a proportionate reaction. They also felt that children might be reluctant to challenge adults they were completely dependent upon.

Participants also explored their sense that occasionally children might stop struggling and become compliant through fear rather than through feeling safe. This might be fear of losing or damaging their relationship with people who were important to them but might also be fear of injury and pain.

*I've previously felt that fear and whether it's just kind of compliance through fear...it was typified by me coming into a room and him having hit or bitten someone, and then him apologising to **me**, for you know, and it would be not quite as formal as I remember it. "I'm terribly sorry. Sorry you have to see that" he said, and then it kind of stopped (Antony, Group 3).*

This posed a particularly uncomfortable problem for men involved in such situations.

Antony describes his ambivalence about knowing that his own body and perceived

strength might evoke additional anxiety in children, whilst recognising that this had also created safety in crisis situations. Although Antony was the only man in the group where this was discussed, it was recognised that children often responded to adults based on their previous experiences of men and women. In contrast to Antony's experience of being uncomfortable about his perceived power, sometimes women felt forced to demonstrate their power and strength to challenge children's assumptions about female weakness.

Participants knew the children had histories of severe trauma and were constantly aware that physical restraint might trigger memories or flashbacks of previous physical or sexual abuse. This was particularly acute when children were new, and adults had not yet developed a relationship with them that was different from those they had experienced in the past.

As well as the risk of evoking traumatic memories, adults also acknowledged that there were times when physical restraint did hurt children, and they were concerned that might damage trust and affect future relationships. Sometimes the impact of physical restraint lingers for years even when adults assume the rupture in the relationship was repaired.

... sometimes we do get it wrong, and we do hurt the children, you know. There was a really difficult restraint two years previous, it came up during this really difficult period of change and he was shouting at the top of his lungs that I had strangled him... although the repair, the repair had been done, I suppose the biggest part of that learning is just because it looks repaired - because I had went back, right? We're okay. We've done this, we've done some nice things together, so we're okay, we're cool - but actually, two years later, that had triggered in his mind, and I was devastated for him, holding that for that length of time, and his opinion of me, that I had intentionally tried to hurt him...But when children are hurt, just making that conscious effort of repair - repair without the assumption that it takes just one time (Fiona, Sanctuary).

The potential negative effects of restraint and their ethical distress about it meant that at times participants questioned whether restraint was ever justified. Kitty voiced the continual internal moral struggle she experienced about physical restraint during the discussion of her picture (Figure 3). This was not simply a philosophical or intellectual issue it caused real distress – Kitty was in tears throughout that discussion. Others shared their emotional upset when they had witnessed the pain of children during and after restraints or felt that they or others had failed to recognise children's communications or been overly forceful.

In the Cedars group, although they described the constant ethical and emotional struggle they faced around restraint, there was a consensus that the appropriate use of physical restraint was a lesser harm than the potential physical and psychological effects of not using it. Antony shared his perspective that there are times when the danger to a child or others is so severe that there is no alternative:

The stakes are so high, there are some ways that feel like it's life or death. There are some where it is literally life and death... if you don't get it, right, someone could die. And there's, you know, like, there's not many other... can't think of any other aspects of my life where, you know, the stakes are that high. And it's, it's part of what you have to do and like, it's never ideal (Antony, Group 1).

Antony also provided an interesting perspective on what can occur when a policy decision is made to stop restraints. Rather than the adults having a responsibility to protect children from the consequences of their actions when they are in a state of terror and dysregulation, the children can be left alone in their distress and must carry the burden of any adverse outcomes from their behaviour.

I was involved when we stopped restraints because restraints were too high. It had been national press... And so, it just became blame the kids, leave them to it. And if something goes wrong, it's their fault, because nobody stopped them... They need to learn self-control and they'll do that by not being stopped. And that was terrifying (Antony, Group 5).

Although Antony found that terrifying, he perceived that for some practitioners it meant they could avoid the difficult moral and emotional struggle that participants in this research all described, as the responsibility for and anxiety about managing emotional distress and difficult behaviour shifted from adults to children.

The discussion in the Sanctuary group was profoundly affected by the policy context in Scotland. The report from the ICR – The Promise – has forced the issue of physical restraint into the spotlight across all RCC settings in Scotland. It calls for Scotland to '*strive to become a nation that does not restrain its children*'. Participants agreed with that as an aspiration and were aware of organisations that had adopted 'no restraint' policies, but most were unconvinced that restraint could be eliminated completely. Whilst in agreement that restraint had been used far too freely in the past and that the focus on restraint reduction was to be welcomed, the discussion highlighted differences in their perspectives.

Donald felt that the previous professional consensus was broken and anticipated that in a few years, even people who were currently suggesting that elimination was impossible would be shocked that they had ever accepted restraint as a practice. He acknowledged that on a personal level he would prefer never to use restraint and did not believe that it ever promoted positive change, whilst also accepting the organisational expectation that he would use restraint in certain situations.

It became clear in the subsequent discussion that this was an issue that he and his colleagues wrestled with continually and although the other participants disagreed with his stance they understood and shared his ethical reservations. Similarly, he recognised the practical and ethical difficulties involved in adopting such a policy.

I fully get all the complications. If someone's going to jump on a rail track, if it was my daughters I wouldn't want anyone to put them in a prone position, but I'd want to pull them off the train track, right? I just, I just wonder sometimes, if it wasn't there, what would we do and we'd be forced to use all our de-escalation skills more - would we feel safer?... the police might come, and they might, they might put a child in handcuffs and might put a spit mask on them, and it might be horrific. But then again, those same police officers don't have to be there that next morning and repair that relationship (Donald, Sanctuary).

It seems from Donald's comments that he could envisage situations in which he would feel it was right to intervene to protect a child or others from risk of imminent death or maiming. His concern, however, was the profound damage that physical restraint could do to adults' relationships with children and he was unsure that even harsh police involvement caused greater harm. The importance of creating a relationship of trust also underlay the opposite perspective of his colleagues. They argued that without the use of restraint children's omnipotent rage would never be contained which could contribute to multiple placements and children's sense that they were overwhelmingly dangerous. Curiosity about organisations that operated with 'no restraint' policies had led Kristy to explore how such organisations managed difficult behaviour.

Their policies aren't really any different from ours, other than they don't use restraint. But one woman said they were advised to lock themselves in the office. How does that create a sense of safety for a child ...if you think, again from an attachment point of view, that, you know, children will become scary, frightening, because that's my survival - that's how I'm going to keep myself safe. And yet, adults then go, well, actually, do you know what? you are - so we're just going to back off and lock ourselves in our office (Kristy, Sanctuary).

All participants in the discussion took seriously the negative feedback care-experienced young people had given about restraint through consultative processes across the residential sector and within their own organisation. They were deeply aware that these voices had been neglected in the past and that practitioners had engaged in physical restraint practices that had hurt and frightened children without fully considering their impact. They felt that this heightened awareness had increased

anxiety for practitioners in caring for the children because they now had to face these ethical issues directly but recognised that these emotions were probably appropriate.

...It adds to that guilt, guilt and worry about when it does happen, but then, in the same hand, I would be hugely concerned if I had a member of the team who was involved in a restraint and didn't feel some emotion. Do you see what I mean? So you actually you're wanting people that actually care, so you would be expecting them to have feelings around it (Kristy, Sanctuary).

The various discussions centring around the ethical issues involved in physical restraint highlighted the emotional and moral distress experienced by participants. They described their guilt, uncertainty and discomfort about restraining children even when they believed on balance it was a necessary intervention.

... it doesn't matter where you are or how many restraints you've had, it takes you that takes you back to the most difficult and the ones that's been the hardest, and they all should feel hard to let go of. But that's, that's how I feel - it's that pit in your stomach about fucking doing it to other people's weans (Fiona, Sanctuary).

Although the question of whether to use physical restraint and its associated ethical issues was the most frequently mentioned dilemma, participants also highlighted other issues where they had to try and navigate a path that caused children and themselves the least harm.

Balancing risks

Risk assessment is a constant task in RCC, and participants explained how this was particularly acute when considering the possible options that might or might not lead to a physical restraint. They described balancing the risk of dangerous behaviour against the risk of children never learning to develop the capacity for self-regulation. They described two quite different situations where this could occur.

The first was when they could predict that a child might struggle to manage a particular experience such as a trip out or a combination of adults working together. They

explained that it would be easy to act in a risk averse way by never allowing such events to occur but that this would prevent opportunities for growth as well as curtailing children's opportunities for learning and enjoyment.

If it's always the last resort, and we don't want to set them up to fail, you could look at it saying "Well, there's two adults on - that always leads to restraint at this particular time. So, they'll not be on, we'll just avoid it, it'll never happen again". But like part of the opportunity led work is that each time there was an opportunity for it not to happen (Antony, Group 5).

The vivid example provided by Faye in Figure 5 of a physical restraint in a car by a busy dual carriageway demonstrated the level of risk that participants routinely faced in their work. All the participants were able to give examples of similar situations but believed that avoiding all such risks would leave the children with a seriously impaired quality of life. Although they had general support and guidance from managers, such decisions about the balance of risks were made on a moment-by-moment basis by the adults caring for children.

A different and rarer example provided by participants was when an adult, with the agreement of colleagues, decided to support a very distressed child who was aggressive and destructive on their own, without resorting to physical restraint. Participants suggested that the easy decision in such a situation would be to intervene physically to make everybody safe. They recognised, however, that supporting a child to manage their anger and distress without being restrained was an important step on the route to self-regulation. They were clear that such a decision depended on the relationships between the adults as well as that with the child. They described the intense anxiety they all experienced but were clear that where successful it was an important emotional development for the child.

Seeking congruence – managing secrets and shame

During the research in The Cedars, participants began to explore the implications of the ways they presented themselves during and after physical restraints. The drawing exercise in Group 4 made them realise that the blank expressions on their faces during a restraint failed to reflect their internal state. This was noticed first in Sarah's picture (Figure 4) but was apparent in some of the other images too. This was a new realisation for them, and they were unsure about the meaning of such incongruence. In their discussions they considered the possible impact on children if they allowed their internal emotions to be displayed.

But then you can't show emotion in other ways... if you were sat in a PI with him and you were you were sad or you got upset, he wouldn't be able to manage like he wouldn't be able to tolerate you being upset because he is already a child that would put it on himself or he would then be like I've made you upset because I've hurt you (Kitty, Group 4).

There was concern that if they were open about their distress that this might compromise safety by feeding the child's sense of their own power and control and intensify their struggle against the hold. They also believed, however, that once children were regulated, they might also suffer shame for having upset the adults. Although they could rationalise their need to suppress the expression of their emotions in this way, they also began to examine the meaning for their children of being confronted by a blank face at moments of extreme distress.

There's safety in being able to read the gestures and understand and then you know where you're positioned in relation to somebody else. And to have someone giving you nothing back would be like really precarious. Like, I think Max reads every gesture, every nuance of the face... you could have someone screaming "Listen to me" I think seeing it laid out like... the child's it's raw, it's screaming, it's, it's "I need that, help me!" and then you're met with the curtain down (Antony, Group 4).

The advice from organisations that provide training can contribute to this emotionless presentation. Participants explained guidance suggested engaging in neutral

everyday conversations such as discussing the weather to reduce the intensity of the experience. For some children with severe sensory difficulties, it was also considered that any response could become a stimulus and exacerbate the situation, so adults were advised to remain silent. Whilst accepting that these responses could help the immediate situation, participants expressed concern about the meaning for the children of this lack of connection in the context of their earliest experiences. Their use of mantras such as “This will end” seemed to be a way of staying connected with the child and managing to self-regulate whilst avoiding becoming entangled in an emotionally escalating situation. Sally, however, highlighted that although they thought they were successfully concealing their emotional state their suppressed emotions might still be evoking a response in the child. She suggested trying to tap into these hidden communications by checking each other’s faces during restraints.

If it's safe enough to... actually look at the other person's face and see what they're actually like and what that then invokes in you, to feel what that invokes in that child - because sometimes you might think you stay safe but you really could be angry - like I might have something in my head and try and then not let my face show (Sally, Group 4).

The emotions most frequently expressed about the children throughout the research were love, concern, and a desire to understand their behaviour as communication. Participants were also in touch with their own sadness and fear and how this connected to the children’s despair and terror. Although anger or hatred towards the children was much less commonly expressed there were glimpses of these too. Sally, for example, acknowledged that though she loved the children there were times when their behaviour or responses meant that she did not like them very much. Interestingly, the shift in culture that has permitted the feeling and expression of love towards the children seems also to have made it more possible to acknowledge the co-existence of negative emotions towards them as well. Sally continued by saying she felt it would

be impossible to do the job if she did not love the children she cared for. Sarah was able to acknowledge the full gamut of emotions (p.85) she could feel for the children and was clear that although she could bring her theoretical knowledge to bear to understand children's behaviour that did not always make it emotionally easier to cope with.

I understand it therapeutically - I understand it but fucking hell. Just give us a break (Sarah, Group 5).

Antony described being able to acknowledge with Max during a de-escalation the accuracy of his perception that he (Antony) was angry and using it as a therapeutic interaction. This intervention highlighted to Max that there were alternative ways of managing anger that challenged his earlier perception of how devastating and dangerous anger, particularly male anger, had to be.

I am angry, but that anger is not going to lead to me attacking you. But you're right, you've read that right, that's why I am over this side of the room and you're over there (Antony, Group 5).

Alongside the complexity they described about recognising, managing and using the emotions aroused in them by dysregulated behaviour and physical restraint, participants also reflected on the meaning of their tendency to minimise or mask their physical injury and pain. They were particularly concerned about messages their behaviour might be conveying.

...some of us do hide our injuries from restraints from the other kids and from the child who has done them... what does that show as well, in the sense of again, we're hiding? That it's okay? We're saying it's okay cos we're not showing you what's going on? (Faye, Group 2).

Participants made sense of the dysregulated behaviour leading to restraints by recognising its source in previous unresolved traumatic experiences often from early childhood. They also explained children were vulnerable to falling into states of shame

and the urge to hide their injuries came from a wish to avoid shaming the child who had hurt them. They also began, however, to recognise that they were in danger of colluding with a pattern of domestic violence that might be familiar to all the children from their experiences at home. This incongruence was highlighted as one of the most revealing experiences from the research by Kitty in her final interview:

We never think about how it impacts the children who aren't involved in them. Yeah. And that was something that never ever crossed my mind... And it's like, we, we isolate it into that incident, and we get on with the rest of the night, or the day. But we don't think about the other children who've heard the screams, heard the shouts, seen the bruises. And actually, from the possible backgrounds that they come from, and what they've experienced, we can potentially put them back in that space. And then again, we're just pushing over it like, potentially family members did. So, we try to say to them, we don't hit people, this is the wrong thing. But then if we ignore it, and just push it off, then we're just pushing it off like a woman or man in a domestic violence situation (Kitty, Interview 2).

The difficulty of acknowledging the impact of a physical restraint appropriately, is exacerbated by the constrictions placed on communicating effectively with the other children by the demands of maintaining confidentiality. Adults are left with trying to be open without shaming a child or risking them becoming a scapegoat for other children yet unable to provide an explanation for the distress and violence. It was not only the role of the adults involved in restraint that emerged as difficult in this discussion. Participants highlighted how often it is the least experienced members of staff who are left with the other children who are not involved in the incident but who can hear the sounds of what is happening. They suggested that this can mean that the stress of the situation is managed by denial of the meaning of what is happening.

Even in the immediate aftermath of restraint where all the physical signs of injury are still apparent there was often an urge to deny the impact. As Sally indicated it was at

times impossible to manage to respond to a child's concerns in an honest way because the adult was still trying to process the experience.

You walk into one of the kid's bedrooms after being in restraint and like, "Are you hurt?" my first instinct is to be like, "Nah". But like, sometimes like you have been bitten and you've got like an ice pack or like your shirt's been ripped so they can see the visible bite mark or you've got a scratch on your neck or your face or summat and you're stood there like "Nah, no, I'm fine." But it's visible and it's like it's not because you want to lie to them ...but at that point, I'm like, part of me's like, "I just don't need to get into it with you" ...and you're like, "It's all right, let's carry on with bedtime" (Sally, Group 5).

As well as the risk of an implicit collusion with the dynamic of domestic violence participants recognised that their denial of their own injuries could have an impact on children's own ability to acknowledge their pain.

Finally, there was a recognition that the bureaucratic recording and accountability procedures required after a physical restraint also contributed to the process of minimising the emotional impact of the experience. Although the requirement to justify every incident reflects the seriousness with which restraint is viewed, paradoxically the format expected by OFSTED stripped the emotional meaning from the event and served to provide a defensive distance from the pain and distress involved.

We process it, it becomes an incident and then it gets referred to as an incident at each step it becomes removed from the, the traumatic experience of going through it and feeling like an abuser, it becomes a "Can you just have a look at this PI?" - And it's very separate from the visceral experience of it (Antony, Group 5).

Summary

This chapter outlined the ethical and practice dilemmas described by participants around physical restraints that required them to choose between courses of action, any of which might cause serious harm to children or adults.

They described a constant struggle about whether it was right to engage in physical interventions with children. This included the decision to initiate any specific restraint

but more widely whether their ethical concerns about the harm caused by forcibly controlling children against their will were balanced by the safety such restraint could provide. Their discussions highlighted the complexity inherent in any consideration of the ethics of restraint. They could all recount situations where people had been at immediate risk of death or serious injury without intervention but they also all recognised the terror, distress and physical risk involved in physical restraints. Most participants believed that, when used appropriately, physical restraint was the lesser of two harms but the alternative view that restraint should be banned was also expressed and considered. Participants also described other situations that required them to make complex and difficult decisions. They recognised that some restraints could be avoided by removing the conditions that made them possible but were concerned that this could reduce the possibility of children learning to self-regulate or enjoy normal childhood experiences. They highlighted the constant need to balance the risk of creating situations children might be unable to manage with ensuring that they had the chance to have as full a life as possible. They also recounted times when adults took the risk of serious injury to themselves and did not restrain an aggressive and dysregulated child but relied on the strength of their relationship to help the child work through their emotions. Finally, participants recognised and discussed the difficulties they experienced in being able to be fully congruent in their behaviour and interactions about restraint. Being transparent and open about their emotions or injuries was difficult because of the potential harm and shame for the child involved, yet they were also aware of the negative impacts of modelling a dynamic of concealment and secrecy that was associated with domestic violence. They also described the constraints of confidentiality on openness and the impact of some reporting processes on the minimisation of emotional impact.

The next chapter will examine participants' perspectives of the attitudes, assumptions and experiences of people aware of a physical restraint but not involved in it. This includes actual witnesses, whether within the home or external to it, as well as those who hear or read an account of the incident. It will explore how and to what extent these affect the decision making and practice around restraint.

Chapter Eight: The External Eye

Introduction

All physical restraints take place in a social and spatial context that affects the process of the incident and the way those involved experience it and its aftermath. This chapter explores participants' reflections on the ways other people reacted to or were affected by restraints both within the home and the outside world. They also shared their feelings and thoughts about these responses and explained how this affected their practice.

Children as witnesses

One of the most surprising realisations for participants was the lack of attention paid to other children who were nearby during a restraint. Although they were always kept as physically safe as possible the emotional and psychological impact on them was largely unnoticed. Antony drew the group's attention to this during a discussion about the reactions of people in the external world, when he realised that the same behaviours that they were criticising in adults who ignored restraints were exactly what they were asking their children do.

thinking about the other witnesses ... the children ... we'll ask them to do that same range of things. "Can you just ignore it?" "Can you walk past?" "I'll close this door" - we can still hear someone shouting, 'you're killing me'. or you're doing this (Antony, Group 2).

This began the exploration of how children uninvolved in a restraint made sense of it and what early life experiences it might evoke. This was a major theme throughout the discussions in the Cedars and resonated strongly with the Sanctuary group. The three tiny figures in Sally's picture (Figure 6) represented the other children on the edge of the chaos watching or listening, but unnoticed as the drama and its resolution played out.

In their discussions, participants reflected that children might have a very skewed perception of restraints – simultaneously seeing them as a form of abuse and also an everyday part of their experience, often at school as well as at home.

Usually, the other children did not actually see the restraint but only heard the screams, banging and accusations. Participants from both organisations acknowledged that hearing a physical restraint was often more difficult for them to deal with than participating in one. They recognised that the horror and helplessness that they experienced was likely to be even greater for the children who were forced to hear another child screaming in distress.

Sometimes it's worse hearing it cos your mind goes to other places - if it's like that for us, it must be awful for the other children (Catriona, Sanctuary).

Participants recounted their experiences of talking to children who seemed to imagine the adults were in fact deliberately hurting another child. They also reflected on the situation children then found themselves in as they were dependent on potentially abusive adults to provide all their physical and emotional needs.

They felt it was important to help children make sense of what was happening by exploring their understanding of what had happened and helping them to place it in some kind of context. Participants recognised that the best time to provide emotional containment and safety was while a restraint was happening but acknowledged that this rarely occurred. Most restraints took at least three people, as wherever possible, there should be an observer to check that the hold was safe. This meant that often only one person was available for the remaining three children who was often the least experienced adult.

Quite often you end up with the most experienced people being the ones in the PI and the least experienced one being with the other three kids... Whereas if

there's someone more experienced with them, it's easier to talk through like - "Wow, like so this is happening, this is what happened to lead to this, but you know, they're okay" (Sarah, Group 2).

Participants explained that children often became most dysregulated at bedtimes when they faced being alone with fears and memories and that this anxiety might evoke such dangerous behaviour that a restraint occurred. Antony described vividly how frightening this might be for children alone in their own bedrooms with only one adult available who might also be experiencing intense anxiety.

*...the one with Katy with lots of trauma and a child screaming for help from next door for him to get a knife to come and slash another child's throat... and even just hearing it described was... but you know, he wasn't **doing** those violent things - he was showing something about his fight or flight. But that was a newer member of staff left with three children who were equally traumatised, upstairs, in the place that would normally be their safety, their bedrooms, being told, "This could be the only safe place in the house. So, you need to stay there" (Antony, Group 2).*

During their discussion they recognised that this was an area where there was little formal guidance, and they felt that they might be role-modelling denial and repression to cope with difficult emotions. Even those who did attempt to name what was happening, if they were with the children when a restraint was happening, felt that they did it simplistically, explaining just that the child had done something wrong and the adults were keeping everybody safe. They felt that the need to protect the confidentiality of the child in the restraint prevented them from helping the other children to really understand what had happened and why. They explained that when a community meeting was called to manage a difficult situation this often provided an opportunity to explore the experience at greater depth which provided children with more understanding and supported the child involved in the restraint more effectively.

Participants also recognised that there was no formal way that the impact on the other children was gathered and recorded. The child involved in the restraint was always

given a chance to put their views forward or to talk to someone outside the home, although this was rarely taken up. The other children who were affected repeatedly by such experiences had no such opportunity and the truth of their experience was entirely absent in the formal record as Antony reflected:

if one of the children was able to put in their diary about what actually happened... if that was about a particular incident, from their perspective of listening to what went on, it would be very different from the PI neatly, numerically, archived away (Antony, Group 5).

As well as being aware of how frightening it was to see and hear such violence on a regular basis, participants also reflected on the previous experience of the children and considered what might be evoked in them by a physical restraint. Some of them might have been restrained themselves and most of them would have been affected by abuse in their past.

Many of the children had parents who were in domestically violent relationships, and participants also reflected that memories and anxieties about this might be reactivated by listening to the sounds of a physical restraint, particularly at nighttime. As Antony (Group 2) commented '*Even if they are asleep, it's all going in and informing a nightmare or something*'. Participants recognised that when they resumed an interrupted bedtime routine, they were unable to conceal the physiological signs of heightened arousal or the injuries and torn clothing they might have sustained during a restraint. As discussed in Chapter 7, this meant that they often inadvertently found themselves repeating a previous pattern of domestic violence where a parent pretended nothing had happened.

So many times, I've been taken out of Sam's bedtimes for a PI - and afterwards, you go back in, you tuck her back in, you say you're okay - that's what her Mum did. It doesn't sit right (Faye, Group 2).

In his final interview Antony reflected not only on the potential re-traumatisation of children but also the lost opportunities to help them to recover from their earlier abusive experiences by working directly with the feelings that were evoked.

I guess it minimises the chance to heal. And like, if it's opportunity-led work it's the, it's okay that this can bring up and dredge some of the really horrible feelings - it's what we do with the feelings, to let them go. Because I think previously, inadvertently, it was mostly just pretend they're not there and carry on (Antony, Interview 2).

This discussion brought to the surface aspects of their own and the children's experience that participants had known but which had never been given the significance they required. Even before the research had been completed this had been fed back into the system in The Cedars and practice had been modified. The needs of the other children were highlighted in the physical restraint training, children were given space within their community meeting to discuss their thoughts and feelings about restraint, and plans put in place to identify with each child how they might best be supported during and after a restraint taking place.

It was not, however, only the retraumatising aspects of restraint that participants discussed in relation to the other children. They recounted multiple examples where children had been essential supports to the adults in particularly difficult situations. Often, they were ambivalent about the need for children to be involved in this way and at times uncertain whether they would join in with the dangerous behaviour particularly where the child was a friend of theirs.

I think of the night of me and Jonny when he was struggling, I literally just had to hold him myself. And I was like, I don't know how, where to go, or what and I had to say to Callum, "Can you please go get some help?" And he just ran. It must have been minutes, but it did feel like a lifetime. When you heard the door open. I thought, because at that point I'm thinking, is he going to hit me here? Is he? Because he's going to see like me, and they had an all-right relationship, but all that stuff came through your head... Like for a kid at that age watching that... Oh, it's horrific. I'm thinking now you think back, you probably don't

realize how difficult that must have been for him to see as well (Catriona, Sanctuary).

Participants in the Sanctuary group had previously worked in a large house with several children accommodated together and they had experienced situations where one restraint provoked others. The Cedars group had also experienced some of this type of contagion where children seemed to merge into a delinquent mass, but in most cases, they described children being helpful, particularly in situations outside the home.

Not only did participants describe situations where children had contributed to calling for help or keeping themselves and others safe, they also recounted instances where a child was able to demonstrate empathy and concern for an adult who was hurt or upset. Although they were appreciative of such support and impressed by the children's capacity, participants remained concerned that such expectations should not be placed on children who may have had to care for adults in the past.

Sam slammed my hand in the door and Hermione could tell, like I was in so much pain, and she was amazing. She got me ice; she'd seen to me. And she really calmed me down because like, I was like, I was up there and like she was like "Do you want to talk about something? What do you want to do? Do you want to come and have a cuddle?" like, she was amazing (Sally, Group 2).

Finally, Sarah raised the possibility that the child involved in the restraint might seek access to their records in the future and read accounts of the incidents. She wanted to be sure that such an adult witness would be able to make sense of what had happened to themselves as a child. She recognised that as well as wanting any child in the future to understand what had happened, she also saw such recording as a way to protect herself. Physical restraint is a contentious and contested subject, and she recognised the need to be transparent and accountable if the child had any questions or concerns as an adult or if any investigative process was initiated.

Other adults and managers

Participants were clear that they were accountable for every restraint that they participated in, and a formal process was in place to ensure that incidents were recorded and that they were individually debriefed. They frequently referred to criteria laid down in national guidance to guide their decisions. If they deviated from holds, they had been trained to use, they had to be able to explain their decision making.

... it's trying to justify why we like had to, like had to hold him that way, or hold her, when that's not always what we've been trained (Sally, Group 1).

Although they emphasised their constant awareness of the requirement to justify their interventions, participants from both organisations also described a supportive culture from managers and colleagues that helped them to deal with the physical and emotional impact of restraints. Some contrasted this with previous experiences where this had been missing.

They highlighted the importance of regular opportunities for debriefing after difficult situations. Participants from the Cedars explained that at the end of every shift there was time built in to discuss the experience where they were encouraged to express emotions, share concerns and ask questions of each other. This could be a valuable opportunity to deal with the residual distress from a restraint. It was not only through such structured spaces that adults gave and received mutual support. Participants described the importance of informal personal care and connection provided by their colleagues in the aftermath of a restraint. This was highlighted by Sally (Interview 1):

If I've had a bad restraint and I'm on with say like Kitty, she'll come through and give me a hug and that's kind of like enough to get that kind of contact, that warmth because after you can feel quite disconnected because you're trying to process everything and you try to still be on shift and you know you need to take care of yourself but the prime focus is the child.

Participants all felt their organisations provided space for reflection for individuals and small groups about specific incidents of restraint. Antony, however, identified a gap in provision that he felt the research had uncovered, as he realised that there was no opportunity for the whole staff group to reflect and learn together about the issues and practices associated with restraint.

In the Sanctuary group, which was composed completely of managers, there was a strong emphasis on the importance of appropriate challenge as well as support. They suggested that this was an essential component of a well-functioning team and was of particular importance when considering physical restraints where the volatility and anxiety of the situation was so intense. They recognised that achieving this level of honesty was not simple. When Kristy was describing her experience as a manager of confronting an adult who she felt had lost control of his emotions in a damaging way during a restraint, she explained that the recent introduction of a prescribed set of prompts for reflection had been very helpful. The requirement to focus on these enabled the adult to recognise that he had escalated the intensity and distress of the incident.

Overall participants felt their colleagues and managers were supportive and that the culture of their organisations encouraged reflection and learning and provided challenge without blame. Some of their reflections and discussions, however, suggested that there were other less comfortable dynamics in play. Several participants described feeling apologetic or guilty when they had to pass on to an incoming shift that a restraint had taken place. Often, they seemed to experience the restraint as a personal failure and implicitly suggest that someone else might have been able to avoid it. Alternatively, some shared their annoyance after an extremely difficult shift and a very distressing restraint with a child, when someone with a different

relationship with the child comes in and the child's behaviour radically improves. Although they understood why such a dynamic might occur it was not easy to tolerate when exhausted and sore.

Underlying these responses seemed to be participants' unresolved guilt and anxiety about engaging in any physical restraint. Kristy described the constant battle in her mind between her professional and theoretical understanding of why some children may at times need to be restrained and her sense of failure and ineffectiveness whenever she was unable to help a child to regulate without resorting to a physical hold. She referred to Antony's depiction of the continual cycle of restraint and destruction that some children get caught in (Figure 7) and felt that she was trapped in a similar cycle of self-doubt. Again, although she understood it, she too found it particularly galling when a child responded more positively to a different adult coming into the situation.

I'm shite. I've got no skills. But then you go in a cycle. So, seeing like that, recycle of the room -that's probably a cycle of your thought process, because you go through, "I've got this, I know this. I know training tells me this, and I know that I think of the brain and the vagal nerve, and that needs this, and children need this". but you then go in, "I'm shite, I'm rubbish. Why could I not use my skills. Why did that not work?" And then you see other people, who'd just come in and he was like a different child, like, he was like a completely different child, like, "Come on in, bedtime" and then you'd be like... (Kristy, Sanctuary).

Responses in the External World

A repetitive theme throughout the research was the impact on participants of the responses and attitudes towards restraint of people they encountered outside their workplaces. The image in Sarah's picture (Figure 4) of a restraint taking place in a public space surrounded by a ring of staring eyes and speech bubbles vividly portrays her sense of being scrutinised and judged by onlookers. Almost all participants shared

their experiences of having to restrain a child in public and how exposed they felt and also how baffled they were by some of the reactions they received.

The only one I've ever done out of the house was at SeaWorld. And literally, I was mind blown that people were just watching me and Sarah hold Max and he's screaming that we're hurting him, like that we're abusing him, that we're paedophiles. And when you're trying to like contain Max just to see, either people just didn't care, didn't show any expression or anything towards it - it was as if they'd seen it day to day in everyday life, or you'd have them people that would sit there and like, watch in like entertainment. And it just it makes me wonder what they think that we're actually doing to him. Can they see that we're actually trying to hold to help him? Or are they thinking oh, well, they're just throwing him around? And, like hurting him? But they're not going to help at the same time? Like it's, it's, it's weird (Sally, Group 2).

This was the type of reaction most frequently experienced by participants, and it left them confused and anxious. They were shocked that people would ignore a child screaming and in obvious distress while being held down by adults or in some cases being carried struggling into a car. They felt that the lack of response was further damaging to their children's trust in adults and the world in general. Sarah also pointed out that if a child was in fact being abducted then the lack of adult response to their pleas for help could be catastrophic

They were, however, able to recount some examples where passers-by had checked out what was happening or asked if they needed help but in most of these situations the person had a background in residential care or education. On other occasions people did acknowledge the situation but tried to fit what was happening into their own schema, denying the reality of what was happening.

It was on a footpath... the reason was to stop the girl, who was in some distress running onto the road. And it was kind of a very real risk, and it was just me... she was quite calm, and quiet. Someone on a horse went past and said, 'Have you fallen off your horse?' So, they tried to explain it based on what they were doing. And there was no horse around, no riding helmet. You know, what kind of first aid am I giving... But people saw what they wanted to see (Antony, Group 2).

There was a similar situation where people assumed a child had broken his leg even though he was kicking and screaming accusations as he was carried out of a play park into a car. Antony, however, was also able to share an important example of how helpful an intervention from an unexpected source had been, not only in making the situation safer but also for providing further opportunity for exploration and learning.

... there was one with Isobel, it was at a pub, and it was the drunks, who didn't accept what was happening, and stayed and called the police. And that meant a lot for the work that we then followed up with, - alcohol is not the excuse to make poor choices. And actually it was those people that yes, they'd had a drink but then they stopped what they were doing, to make sure that you were okay (Antony, Group 2).

Many of the most frightening restraints took place in public spaces. These were situations where adults were forced to intervene to prevent a child causing significant harm to themselves or even risking death. These usually happened near major roads or railways and in such situations, participants described intense relief when someone was concerned enough about their behaviour to call the police.

In most cases where the police had been aware of a restraint taking place, however, participants experienced them as unhelpful. They recounted several occasions where the police completely ignored what was happening even though the adults were hoping they might be helpful in de-escalating a situation. Kitty shared an experience early in her career where she felt a police officer actively undermined her when she was restraining a child.

...one of the biggest ones - I was very inexperienced at the time and right now, I would have told him exactly where to go- but a police officer told me to stop holding Max because I wasn't helping him and then bought him a toy to calm him down. And I let that happen. Because he's a police officer (Kitty, Group 1).

Although participants expressed anger and frustration at the lack of response that they perceived from people to the disturbing situations they were describing, they could also recognise how difficult it might be for people to know what to do and had some

understanding of their reluctance to become involved. Sarah was even able to acknowledge that she thought her response would probably have been similar before she began her career in RCC.

I think though, like I always say, I don't know how people, don't say anything, don't do anything. But before I was in this job, I don't know what I would have done... yeah, I don't know if I would have stopped to ask, "Are you ok?" or just kind of accept it. Like, they don't need me interfering (Sarah, Group 2).

When the group began discussing Sarah's picture (Figure 4) their underlying expectation of judgement from those observing restraints began to emerge. The image of staring eyes and muttered comments put them in touch with their assumptions that they and the child were being viewed negatively by those watching.

These assumptions re-emerged in the final exercise in Group 5. They believed that from the perspective of many members of the public the child would be dismissed as naughty and themselves viewed as abusers or incompetent. It seemed that when restraints occurred in these open spaces their expectation of judgement coincided with their own ethical uncertainties and discomfort about such physical interventions. These were also the times at which they were least able to rely on support from managers and colleagues which made the experience tolerable. Faye shared her anxiety about observers' judgements and linked it to what she believed she would have felt before she took up this work.

Do they think I am an abuser? Do they think that I'm not doing this for the right reasons?... restraints do leave you feeling shitty, really shitty after... and you do sometimes think that I've done this to look after the child... but what have I done to this child? So, I do think it is a sense of that. But it's also I feel like if I didn't know any form of restraint, and I never had an experience with restraint, if I saw someone restrain a child in the middle of the shopping centre, or in a pulled over car, or in a car park, at a park. I think you would sort of look and go "What? What the fuck is going on there?"... I don't think you'd think, "Ah, they're keeping them safe". I think my brain would go to "What the fuck is going on there?" (Faye, Group 2).

Participants also contrasted the covert judgements and reactions of people observing restraints directly to the responses they saw online. Sarah shared her experience of hearing about an incident of restraint on TikTok and described her reaction to the comments people made about the incident suggesting that the girl had been abused:

The perception is we are such terrible people. Some people were like, "They're not allowed to take hold of you." "What? That's illegal!"... people just think it doesn't make sense (Sarah, Group 5).

The outrage and disgust expressed online was completely different from the indifference or amusement they had experienced when they had restrained children in public spaces, and some participants found this dissonance upsetting. Others, however, recognised that an online forum was a space that invited comment, and people could express horror and indignation there without negative consequences for themselves. This discussion also raised anxieties about what would happen for them and the child if a physical restraint was videoed and posted online. Although participants were upset by the attitudes this story demonstrated they were also able to recognise that some of their distress was because they mirrored their own internal struggles.

It also like, it doesn't help that's what we kind of think about ourselves, when we're in it anyway. We're hurting them or abusing them (Faye, Group 5).

Participants also shared that as well as the lack of understanding they faced from the public, they also had to deal with friends and family that had no idea about their work in general but particularly restraints. They struggled to explain the injuries and distress they sustained, and those close to them were often angry and could not understand why they continued to tolerate such a work situation. In some cases, they even faced pressure to charge the children who had hurt them. In the Sanctuary group two of the

participants had partners who also worked in residential care which they felt made a difference to the support they received at home.

I think I'm quite fortunate that when I go home, if it's been, say, a difficult night, Daniel understands it, so he knows. Whereas, I think sometimes, if maybe your partner doesn't work in this line, they don't realize how exhausting - they don't well, I don't know - but I feel fortunate that mine does get it (Catriona, Sanctuary Group).

The overall experience reported by participants was a feeling of being misunderstood and judged by those outside their sphere of work. This seemed to exacerbate the ethical struggles they already experienced. One of the comments recorded in the Post Its exercise poignantly expressed the wish that the additional stress of such external negativity could be removed.

I'd just like the world to understand what it is and why it's needed (Group 5).

Reporting and inspection processes

Although such attitudes and judgements from the public could be distressing and exhausting, the views of external professionals, particularly referring agencies and regulatory bodies, had more power to directly affect participants' workplaces and futures. Participants were all aware that their organisations' survival was to some extent dependent on positive inspection reports as these were regularly consulted by social workers seeking appropriate placements. They also knew that physical restraint was becoming a focus of increased concern for regulatory bodies. This heightened their sense of responsibility particularly in ensuring that incidents were recorded appropriately.

It's about justifying what... specifically stating what the criteria was, making sure that the individual strategies have been followed so that it is justified as a last resort and your, your thought process... There's that part where you feel responsible, because the stakes are so high with, you know, with, personally,

professionally and you know, for the organisation as a whole. I don't want mine to be the one that lets us down for describing it wrong (Antony, Group 1).

This need to justify every restraint and provide a clear account of the incident contributed to the distancing effect of recording that was described earlier (p.130). Participants also described the pressure to complete the recording of an incident within the prescribed time frame but explained that this often meant that they had been unable to process the experience properly.

Participants had experienced criticism from regulatory bodies during past inspection visits about the volume of restraints which they felt reflected a lack of understanding about the realities of their experience. This contributed to their anxiety about the way they represented their decision making and actions although overall they stated that this had little impact on whether they initiated a restraint other than being clear that they had met the necessary criteria to intervene. Participants were not unwilling to accept criticism or suggestions but felt that the response from the inspectors had lacked context and nuance. They felt their success in dramatically reducing the volume of restraints had been unrecognised and this made it harder to accept critical feedback even though they recognised that it had been instrumental in improving practice.

OFSTED, for me, look at it as numbers. So, we'd had years where we'd had like, two hundred restraints in a year, then they came down and they came down. And they came in and picked fault when we've had like seventy restraints, and it's, you've just looked at it as a number, you haven't looked at all the work we've put in with this child, that this child, yes, is still getting restrained but look at the progress they've made. You've just come in and gone seventy, seventy odd, restraints, that's too many do something about it, and you've not looked and gone. "Actually, you've done really good work with this child, because we can see that you've brought them down from that amount of restraints to this amount of restraints. Yes, your paperwork might need a little bit of tweaking, and you need to add more detail and be more factual but well done! Well done for supporting this child and seeing them as a child and not a number... and helping them to start to regulate themselves" (Kitty, Group 5).

Participants were also aware of the need to account for every restraint to children's social workers. Early in a child's placement there was usually understanding and support from the local authority because the child's history and difficulties were well known and understood. Most children, however, experienced multiple changes of social worker and this context and understanding could quickly become lost, and the level of restraints might begin to be questioned. This caused frustration, particularly when a child's difficulties were such that they had been unable to sustain any previous placement. Despite their frustration at having to continually build new relationships with social workers and explain the work they were doing, participants also understood and accepted the importance of being open to question.

The flipside, if she just had notifications and said nothing, then we'd think she's a bit of a blasé social worker. So, it's that kind of scrutiny you want from them - until you're bitten - because when they're coming in, it's building up relationships so that she understands what we do. And then like, part of the "Where else would he be?" – "Who else could keep him safe?" Like there's just us (Antony, Group 5).

Despite their acceptance and understanding of the importance of external scrutiny and accountability, participants felt that often there was no awareness of, or interest in, the factors that contributed to an individual restraint or pattern of restraints. This left them feeling exposed to the judgement of others who based their assessment on an incomplete picture of the child and their environment as Kitty expressed.

So, they don't want to know the context, but yet we get judged on them, we still get a judgement based on a lack of context that they don't want to know (Kitty, Group 5).

Summary

This final data chapter focused on the way that people who witnessed or learned about a restraint responded. Participants realised that there was almost no serious consideration of the impact on other children present of seeing or hearing a physical

restraint taking place. This was one of the most important discoveries for them of the research and they were shocked by their own and the sector-wide failure to recognise the significance of this. They were keen to ensure that the implications of this realisation were translated into rapid modifications of practice in their own setting. The remainder of the chapter explores participants' negative experiences of the way that physical restraint was understood and responded to both by the public and external professionals who were involved in placing children in the home or inspecting practice within it. Although there were examples of helpful responses from people in the community and supportive social workers, overall, the reactions they described suggested a lack of understanding about restraint. They also shared how some of these responses exacerbated their own discomfort about restraining children against their will even when they believed it was necessary to keep them safe.

The next chapter discusses the data and its implications, before identifying recommendations for practice

Chapter Nine: Discussion and implications

Introduction

This chapter discusses the implications of the data through a systems psychodynamic lens. It became obvious through the course of the research that incidents of physical restraint occur because of a concatenation of factors. Although they are explosive powerful events in themselves, they occur in a context where individual histories and triggers, group and organisational dynamics, professional scrutiny and societal projections combine to create a failure of containment that seems to be impossible to manage without physical intervention.

The interlinking nature of these various factors explains the repetitive appearance of particular themes in the preceding chapters. This chapter attempts to disentangle and address these factors separately whilst recognising that this is a somewhat artificial process that risks oversimplifying the complexity of the dynamics surrounding physical restraint in RCC.

It begins by discussing how a children's home can provide a space where past traumas are unconsciously recreated and considers how this was explored in the research. It then moves on to examine from participants' perspectives the dangers inherent in physical restraint as well as some of the potential positives associated with its use. It also explores the factors that seemed to exacerbate risks or enhance the possibilities of recovery. Next, it examines the unrecognised complexity of the residential workers' task particularly in relation to restraint, then it moves on to consider the impact of the changing external context. Finally, some recommendations for practice and policy are offered.

The nightmare of re-enactment or a dream of change?

Setting the stage

A children's home brings together a group of children with difficult and, in many cases, horrific histories to be cared for by several adults who may carry their own psychic wounds whether from childhood experiences or events in their adult lives. All the children mentioned in the research had histories of severe trauma, neglect and multiple losses often beginning prenatally. Some participants openly referred to their own difficult family dynamics, and they all carried their experiences of the distress and trauma of children they had cared for and the complicated emotions these evoked in them. These conditions created the arena for the re-activation of intensely powerful and painful experiences through transference and counter-transference processes. Participants' accounts suggest that children unconsciously communicated the awfulness of their early experiences through projection into all those around them. The ghosts of the past can wander through the physical spaces of a home and often insinuate themselves into the everyday routines where children must rely on adult care or manage the threat of competitive pseudo-siblings. Every interaction can carry the echoes of previous relationships and evoke the terror of repeated pain and abandonment whilst simultaneously offering the hope that something here might be different.

...ghosts suggest the presence of our unremembered pasts made real in the present. Ghosts indicate the hidden, beneath the surface, ways in which our early history influences our current emotions, thinking and behaviour and makes us act out the past. Ghosts may appear in many different guises, but they are all a projection into the conscious world of daylight from the shadows of our unconscious (Waggett, 2012, p.450).

Participants vividly portrayed the times when they and the children became caught up in the unconscious dramas imported into the group from previous experiences. Complex histories that often included both abuse and neglect as well as multiple

rejections within their care journey seemed to have left the children intensely mistrustful of adults. Close relationships had often been the site of their worst experiences of betrayal and abandonment, and participants believed that they communicated both their terror of and desire for closeness through their behaviour and responses towards the adults.

Participants described children, at times, presenting their need for care physically, in ways that simultaneously evoked disgust such as urinating or defecating inappropriately. As well as communicating their unmet infantile needs and sense of themselves as bad or unworthy this also seemed to be a way to keep people at a distance. They also described a pattern where children would physically attack the adults with whom they had the closest relationships. Participants understood this as not only a way in which children could test the strength of the relationship but also an attempt to regulate the emerging closeness that was both yearned for and terrifying.

Participants also told of being filled with distressing emotions that they felt had been projected into them by children. They believed they were in touch with the kind of fear, powerlessness and shame that children had suffered in previous relationships. It was not, however, just the children's feelings they experienced, they also recounted a sense that sometimes they were embodying the neglectful or abusive adult. As well as these internal psychic responses, participants also described ways in which children seemed to unconsciously recreate dysfunctional parental relationships by splitting the adults caring for them. This was often seen when they offered different parts of their fragmented selves to different adults making it hard to create a coherent picture of a whole child.

Although participants talked most about the children's trauma and their experience of children projecting their distress into them, they also acknowledged aspects of their own countertransference which contributed to the intensity of the interactions. Some participants had experience of domestic violence or abuse in childhood or adulthood and recognised that this not only contributed to their motivation for working with traumatised children but also affected their responses to them. Most participants had also worked with children earlier in their careers whose behaviours or responses seemed to have echoes, whether positive or negative, in the behaviour of the children currently in their care.

The effects of all these processes seemed most apparent when participants were describing the impact of children's physical and verbal attacks on them. Their own expressed identities as good people who loved children and would never hurt them sometimes seemed to be under relentless attack. They described how the feelings of being an abuser could linger well beyond any actual incident particularly when it evoked their own difficult childhood experiences. They acknowledged their wish to defend themselves against such feelings and described the corrosive emotional experience of being caught up in a repetitive cycle with a child when they were used as a receptacle for all their bad feelings. They explained that occasionally it was difficult for themselves or colleagues to overcome their negative responses to a child and repair the rupture in their relationship. They identified that the fact that they had spaces available to express negative emotions about children and explore individually or in a group their own triggers was essential in recovering their capacity to reconnect to children. In both organisations vulnerability and acknowledgement of adults' own countertransference responses were seen as strengths rather than weaknesses.

The restraint drama

One of the most extreme expressions of these unconscious processes for both children and adults occurred when children's heightened behaviour culminated in physical restraint. This might be because a child was putting themselves at risk but more often it involved physical aggression to another child or an adult. Canham (2004, p.122) described his experience of such severely traumatised children communicating their distress physically in the therapy room.

... the communication is not confined to psychic states. It is not just what it feels like emotionally to be abused, one is also being kicked, spat at, hit etc. It can feel as if the abuse is really happening again.

Canham pointed out that this type of communication is one to which residential workers may have massive exposure which leaves them and the child in a precarious position unless they also have well established support mechanisms that preserve their capacity for thinking. Participants described times when it appeared as though the whole of the child's trauma was present in the interaction between them and the adults caring for them. They also discussed the rapid shift in their experience between their feelings of being abused or an abuser (See Figure 6).

All participants expressed a strong belief that all behaviour, however, difficult and challenging it may appear, has a communicative function. The challenge they faced in situations of physical restraint was that often an unbearable feeling shattered the available containing relationships and structures in a physical outburst that required immediate action. Maintaining the capacity for reflective thought in such moments was almost impossible -the focus was on regaining safety and at times merely surviving. Some participants described initially losing a sense of themselves or the child as whole people. They also described the extreme physiological arousal, intense physical effort and verbal bombardment of accusations and threats from children they experienced

in these incidents, all of which temporarily interfered with their capacity to connect with and think about the child involved. In most restraints, however, participants described a process of reconnection and recovery of their capacity to process the overwhelming feelings projected by the child. This mirrors the containment, described by Bion (1962) that an attuned caregiver can provide to a distressed infant by accepting and processing their painful feelings and returning them in a more manageable form. Most of the children discussed by participants had little or no consistent experience of such containment in their previous relationships.

The process of containment requires that the adult experiences the feelings projected by the child - if they are emotionally insulated and unaffected then the child is left alone to manage their unthinkable anxiety and distress. Equally problematic is a situation where the adult is unable to cope with the child's projections and either withdraws or retaliates with an angry attack.

Participants recognised in themselves the impulse to cut off or to retaliate verbally by justifying their own behaviour and pushing the badness back into the child. Several participants described a feeling of dissociation or numbness whilst holding a child. Although they experienced this as a defence against the feelings projected into them, they realised that they might also have been embodying the neglectful adult the child experienced as an infant. Such cut off responses seemed most frequently to occur when another colleague was deeply engaged with the child and in touch with their rage and pain, as if the child was splitting the transference between the adults involved in the restraint. Participants were also aware that too much verbal interaction with the child could feel retaliatory and silence could be experienced as persecutory. Their practice had evolved to respond to the children with simple mantras such as "This will end" or "We will all be ok" that reassured them of continued connection and the belief

that their feelings and behaviour were survivable. More problematic reactions of physical roughness or verbal insensitivity, and even cruelty, were described by participants in previous settings where they had worked. They believed that they were only able to manage to respond differently most of the time because of the containing structures and relationships in place for them within their organisations.

Changing the script

Although all restraints carry considerable risks which will be considered more fully below, this research suggests that when adults are able to provide a consistently containing experience, even in such extreme incidents, then the internal world of the children begins to be modified and their need to communicate their distress in this way lessens. Participants described a consistent pattern for most children where the frequency of restraints reduces over time which seems to strengthen this hypothesis. This is not to argue that physical restraint is in itself therapeutic, indeed it constitutes a breakdown in connection and communication.

Participants also shared their experience of the rare occasions when a child's behaviour and distress was such that it was impossible to restore safety without the involvement of the police. They described this as being emotionally destructive to everyone involved and made the process of repairing the ruptures in relationships very difficult. When, however, the adults involved managed the situation without becoming overwhelmed by their own emotions and withdrawing or retaliating, the act of physical restraint seemed to restore safety and provide sufficient emotional recovery to allow a child to remain open to the therapeutic milieu and relationships. It can help to overcome the distancing processes by which children try to regulate intimacy and challenges their trauma- framed assumptions about the world, relationships and their future.

Balancing the risks

Introduction

Participants described experiencing a constant struggle between the dangers of restraint and the moral issues it poses and the requirement to keep children, colleagues and themselves safe. Forcibly restraining another person against their will can constitute an assault and some advocates and campaigners have argued that much physical restraint in residential care should be categorised in this way¹¹. Equally, however, practitioners have a duty of care and can be judged to have failed in this responsibility if they do not intervene to protect others from physical or emotional harm. The legal and professional consequences of getting this wrong is outlined in the 'hard decisions' flow chart from the Scottish Government guidance presented in Appendix 1 (Davidson et al., 2005). In addition to managing the tensions between these two positions, when practitioners judge that intervention is justified, they also must be sure that this is the last resort and that any force they use is proportional to the threat posed by the child.

The apparent clarity of these criteria conceals the reality that they involve individual judgements by practitioners, with varying levels of experience and physical strength, about children who all have diverse life stories and trauma triggers as well as different capacities for violence and destruction. Participants in this research explained that this struggle to balance two opposing drivers in their decision making is complicated by their constant awareness that the multiplicity of factors they are juggling means that every choice they make is likely to cause harm. The rest of this section examines the

¹¹ For example, Who Cares? Scotland responded to the consultation phase of the Children (Equal Protection from Assault) (Scotland) Bill by arguing that most physical restraint in residential care was for the purpose of behavioural management and this should be classified as assault.

risks and potential benefits involved in physical restraint and factors that exacerbate or mitigate these.

Risks of restraint

It was clear from the research that there are serious dangers associated with the practice of physical restraint however well-trained and supported the adults are. These dangers include physical and psychological harm to those involved in the restraint, but participants also highlighted the possible risks to all children and adults in the home as well as the organisation itself.

Negative impact on those involved in the restraint

Physical restraint is always uncomfortable, but even when adults use good technique children will also often be left with injuries such as bruises and minor scratches after being restrained. All participants in the research were also aware that restraint could also cause much more serious harm and that a few children in secure settings in the UK had died because of poorly executed holds or failure to check on children's vital signs. From the accounts of participants in this research, however, it seems that these adults were more at risk of serious physical injury than the children. It also appeared that, paradoxically, the risk of injury to the adults seemed to increase as the number of restraints reduced, because adults lacked familiarity with the holds and were less in tune with each other during a restraint.

Although participants described their guilt when they saw physical marks on children and often gave vivid accounts of their own injuries, they seemed more concerned about the psychological rather than physical damage associated with restraint. They were aware that the experience of physical restraint in some ways mirrored children's experiences of physical or sexual abuse and were all concerned about the possibility of re-traumatisation. They also recognised that occasionally the experience of restraint

could feed a child's arousal and excitement and even their enjoyment of causing pain, which risked reinforcing the pattern of domestic violence they might have observed in their families.

Participants also expressed concern that some children could become trapped in a pattern where physical restraint became the only way they knew to manage their distress and anger. When there was a pattern of frequent restraints, they acknowledged that the emotional tone of the home shifted and there was a risk of restraint becoming normalised. They recounted examples of hearing children shouting whilst doing paperwork and assuming that a child was beginning to become dysregulated, only to discover that what they had heard was children having fun. They also acknowledged that this constant awareness might at times contribute to a physical restraint as children might be alert to tiny physiological changes or non-verbal communications that indicated adult anxiety which in turn could trigger a child's fear and dysregulation. They also recognised that one side effect of restraints for the other children in the home was that their own relationships and time with adults could be continually interrupted. There was concern from some participants that the unconscious message could become that the best way to get adult attention was to provoke a physical restraint.

Participants also shared the emotional impact that physical restraint had on them and on their colleagues. They described feeling a wide range of negative emotions including fear, sadness, anger, shame and guilt both during and after the incident. Although they also described relief when a restraint ended with the restoration of safety, they stated that they never felt positive about the experience. In retrospect they could point to a few individual restraints that seemed to be turning points for a child, and they also felt that for some children the experience of being restrained seemed to

serve as a step on their journey from external to internal regulation of emotions and behaviour. Nevertheless, their overall experience of restraint was negative and, in some cases, traumatising when they had believed that the child, themselves or other colleagues were at risk of serious injury or death. They also shared their experience of other adults leaving the profession because they were unable to deal with restraining children.

Invisible victims

The pace of life in a children's home is rapid, and key information must be passed on succinctly between shift teams. In this context it is easy for children who have presented no obvious problems to be largely absent from handovers¹². One of the most troubling realisations for all participants had been their sense that they were complicit in turning a blind eye to the impact of physical restraint on the other children. They recognised that their avoidance meant that children were at risk of being re-traumatised as they witnessed (by seeing or hearing) scenes that resonated with earlier experiences of domestic violence. They were concerned that this echoed the collusive secrecy that characterises domestic abuse when parents often assume their children are unaware of the violence in their relationship or too young to be affected by it. Moreover, the adults' tendency to deny the impact of their injuries or emotional distress compounded this dynamic.

Participants also recognised that children were at times unsure whether the adults were abusing the child who was being restrained as they heard repeated accusations of violence and screams of pain. For some children this might also evoke their own

¹² A handover is the transfer of key information from one shift of residential workers to the next. It involves any significant details of what has happened with the children; any important communications about health, education, family or social workers; housekeeping issues; tasks that need to be undertaken by the next shift; and overall emotional experience of the shift.

experiences of being abused at home or restrained whilst in care. They explained that often the most experienced adults were involved with the child in the restraint, and the other children might be left with an adult who was also highly anxious about what was happening. They also said this issue was not dealt with in their training. Concerns about protecting confidentiality also meant that children were rarely provided with any explanation about what was happening despite being profoundly affected by it. Participants were shocked that despite their detailed knowledge of all the children's past trauma they had failed to make a conscious connection to what this might mean for them when they witnessed restraints. It appears that by 'turning a blind eye' (Steiner, 1993) to their 'unthought knowns' (Bollas, 1987), practitioners were able to avoid the additional anxiety and ethical distress of facing the potential harm being done to the other children.

Ethical distress

All participants in this research described moral distress in relation to physical restraint. Their own abhorrence at overpowering a child by physical force, particularly when that child had already suffered abuse and trauma, was balanced by a recognition that failure to intervene could also cause serious harm to the child or others. Although the fundamental ethical dilemma about the use of restraint is inescapable in whatever setting it occurs, the guilt and the shame that participants experienced was exacerbated by the current strong external demand for the reduction or elimination of restrictive practices.

Participants believed that the challenges they faced in caring for dysregulated and traumatised children were unrecognised by those outside RCC. Although both organisations in this research offered practitioners multiple opportunities for reflection, the level of moral distress caused by physical restraint to participants was unexpected.

Imbalance of power

Threaded through participants' reflections was an awareness of the level of power they had over the children in their care. Although they accepted their authority as adults responsible for the children in their care, the potential for the misuse of power caused them anxiety. This was in part due to their awareness of historic abuse within residential care, and, in some cases, having personally witnessed physical restraint being used to enforce compliance rather than to restore safety. Even though none of the participants described such crude uses of force they did suggest that a significant imbalance in power existed that could still affect the children's experiences. They felt that differences in size and strength, particularly when working with younger children, meant that inadvertently adults could be experienced as frightening, and children might become compliant through fear of being hurt rather than experiencing a sense of containment. Moreover, they acknowledged that at times adults could also fail to regulate their emotions and this could be expressed within the restraint whilst they were holding a child. They explained that being alert to this possibility and ensuring that the adult involved was moved out of the restraint was a shared responsibility. Without such clarity, however, they recognised that restraint could easily slide into an abusive intervention that was actively harmful to the child.

Participants also recognised that adults created the written narrative of every restraint and that it was possible, consciously or unconsciously, for an adult to minimise or exclude any of their own responses that contributed to the escalation of difficulties that culminated in a restraint. Although children were always given opportunities to share their view of any incident where they were restrained, they were usually unwilling to revisit an experience that was painful, shaming and humiliating so their voice was usually missing from the record. Participants were also aware that the children were

totally dependent on the adults for every aspect of their care, and that their life experiences might have created an expectation that, if they complained about the way they were treated, they might be moved and lose all their relationships.

The recognition displayed by participants from both organisations of these power dynamics seemed to mitigate the dangers of the misuse of power in restraint situations. In less reflective cultures, however, it seems likely that some incidents of restraint continue to be experienced by children as brutal and abusive.

Potential positive effects of restraint

Alongside the clear risks involved in restraint, participants identified some of the positive effects that they believed balanced these risks.

Restoring safety

The primary justification for physically restraining a child was the prevention of imminent harm. Participants gave examples of situations where they believed that without an immediate physical intervention a child would have been in danger of very serious injury or death. These often occurred outside the home in proximity to busy roads or railway tracks and could be terrifying for everyone involved. More usually, however, they described situations where a child's behaviour became heightened and aggressive and despite attempts at de-escalation, they attacked adults or other children. In these cases, the intervention was primarily to protect other people from the child's aggression. Occasionally, children caused very serious damage to property and were intent on continuing this destruction which could also lead to a physical intervention. The avoidance of injuries and damage meant that both children and adults felt safer. Participants suggested that it was important for all the children to learn that contrary to their previous experiences, adults can manage violence, aggression

and distress without hurting them in retaliation or rejecting them as being too dangerous.

The path to self-regulation

Participants suggested that a secondary effect of restraint for some children is that it can contribute to them developing the capacity for self-regulation. Early neglect and trauma can leave some children reactive to minor stressors and they can quickly become very dysregulated. They believed that when adults can respond to their distress by providing physical and emotional containment, they are not only able to provide a compensatory experience for gaps in children's earliest care but also model self-regulatory capacities. They suggested that over time these experiences enabled children to react differently when stressed. Participants, for example, described times where adults were able to engage a child in a process of co-regulation by acknowledging the accuracy of the child's perceptions of the adult's emotions but demonstrating how they were managing them safely. They also provided examples of children being able to voice their precarious hold on their emotions by expressing their need for adults to stay away or not talk because they were trying so hard not to hit them. Although participants felt this was a pattern they could identify for some children, they were clear that many other factors could contribute to such development and they in no way used it as a sufficient justification for physically restraining children. It seems that for some (but not all) children in RCC the provision of external regulation of distress through physical restraint can be an important step towards the development of self-regulation. It is, however, important that adults are prepared to allow children the opportunities to develop this internal control by appropriate and managed risk taking. The dangers of children becoming dependent on external controls is important to recognise.

Maintaining placements

Another secondary effect of physical restraint, suggested by participants, was its contribution to the stability of children's placements. Most of the children discussed in the groups had a history of multiple placements. Previous carers had been unable or unwilling to accept the distressed behaviour that the children had displayed and placements frequently broke down. Participants believed that without the use of restraint many of the children they cared for would have been moved again. Instead, most children were able to remain in the same home for several years and form trusting relationships with adults and other children. They also suggested that the level of danger that some children presented meant that without physically intervening themselves the only alternative would be to involve the police. Not only would this involve a different and more brutal form of physical restraint, but children would also become criminalised. Some participants also questioned what the impact of no restraint policies had been on the availability of placements for children who displayed particularly difficult behaviours. They suggested that there was an increased reluctance to accept these children, particularly as the intensified focus on reducing restraint means that an organisation may suffer adverse grading from regulatory bodies if they are perceived to use restraint too much.

The importance of relationship

The quality of relationships between adults and children affects the way physical restraints are experienced. Some children seem to target their aggression and violence during a restraint towards the adults with whom they have the strongest relationships and appear relieved when the adult demonstrates a capacity to survive this assault whilst remaining available to the child and connected to their pain. Several participants felt that sometimes their relationship with children had been strengthened after a restraint. They believed this was the result of the child realising that the adult

could keep them safe and prevent them hurting themselves or other people. They also suggested that some children were later able to reflect on the experience of being held as an act of care rather than coercion.

The experience of restraint can, however, have negative effects on the relationships between children and adults. Participants described how restraints that take place early in a child's stay may contaminate the future relationship with an adult and it may take many months or even years to build a safe connection. Even when a child has established a positive relationship with an adult a difficult restraint may have negative repercussions. In most cases this is because the child's trust in the adult has been damaged, but occasionally an adult may have experienced such physical or emotional distress during the restraint that they struggle to overcome their reluctance to repair the rupture in the relationship.

A high level of trust between adults can make the act of restraint safer for everyone. Conversely, where adults are uncertain about the competence or experience of others involved in the restraint, there seems to be a greater risk of injury for both adults and children. When adults have the experience of working together effectively in a restraint to provide safety for a child, this can develop trust and strengthen their future working relationship.

Positive relationships appear to mitigate some of the risks inherent in physical restraint although a negative experience of restraint can also damage relationships.

A lesser harm?

Physical restraint is a hazardous process physically, psychologically and morally. For some children in RCC, however, the risks it poses seem less than the damage caused by failing to intervene physically to prevent harm to them or to others. Not only can

such intervention provide immediate protection from harm to children and adults, for the child involved there may be other significant benefits such as avoiding criminalisation or being able to retain their placement. Although the current focus on reducing restraint where possible is important, the elimination of restraint would be likely to have unforeseen negative consequences.

It is also important, however, to consider the impact on others beside the child involved in the restraint. The effects on other children are often overlooked despite the potential for re-traumatisation. The physical injuries and psychological distress sustained by the adults who are involved in restraints are also rarely considered. This research suggests that the negative impact on these groups is considerable, and it is important to develop ways to mitigate this.

The unrecognised complexity of the RCC worker's task

Introduction

RCC workers are often unqualified and poorly trained but are expected to deal with complex situations fraught with anxiety and danger where the consequences of 'getting it wrong' can be immediately life threatening and may have long term physical, psychological and legal ramifications. This is particularly apparent in relation to physical restraint. Unusually for this sector, however, many of the participants in this research were graduates and the two organisations where they worked provided regular training and external consultancy. Reflective practice was embedded in the culture of the organisations and practitioners had opportunities for making sense of the children's and their own behaviour and responses in a variety of fora at individual, small group and whole team levels. This contributed to the depth of exploration that participants were able to engage in when reflecting on the demands of their role in physical restraint during this research.

In the moment

Participants gave vivid accounts of restraints they had been involved in, and it became clear that this aspect of their work challenged them physically, emotionally and cognitively. They needed to make rapid assessments of the risks both of intervening physically or attempting an alternative strategy whilst also weighing up the ethical implications of their decisions. In addition, they had to communicate effectively with their colleagues to ensure they were able to synchronise their response. All restraints took place in response to escalating and dangerous behaviour which evoked intense anxiety in all those involved. They described having to override their natural physiological responses of fight/flight/freeze when being faced with frightening and at times life-threatening situations. Whilst regulating their own emotions they needed to maintain their focus on the child being restrained and, at the same time, be alert to everything that was happening in the physical and social environment whether they were outside in the community or within the house. Once a restraint was in progress they needed to try and attune to the child and provide them with a sufficiently containing experience that they could begin to return to a more regulated state. In the aftermath of an exhausting and frightening event they were expected, within a restricted timeframe, to write a comprehensive and balanced account of it that explained why the restraint occurred and what process it followed and documented any injuries or concerns.

Understanding the children

When they discussed their decision making and responses to children becoming so dysregulated that a restraint seemed likely, it became clear that participants were drawing on a detailed understanding of them and were strongly motivated to make sense of the meaning of their behaviour rather than just control it. As well as knowing

every child's history, they were aware of their current stressors and could recognise the triggers or sensory difficulties that might tip them into distressed behaviour. They also understood the most effective ways to de-escalate individual children and help them to become regulated again. As well as informing their direct practice with children this depth of knowledge enabled participants to tolerate the physical and psychic assault they sometimes experienced from children without retaliation.

The struggle to keep thinking

The primitive nature of the traumatic experiences that are ubiquitous in residential care settings and the needs of both children and adults to protect themselves against their overwhelming feelings of badness, shame and terror can lead to the development of dysfunctional social defence systems. In many settings this is demonstrated by the continual use of projection and splitting (Kahn, 2005; Klein, 1946) to avoid dealing with the unbearable feelings that children and some adults bring with them from their earliest relationships. This can create a toxic culture within the adult group where factions form and competition and backbiting is common. Instead of providing traumatised children with the experience of containment where their unbearable feelings are accepted, processed and returned to them in a more manageable form, adults react to the children's projective communications by withdrawal or punitive anger. Such defences undermine the adults' capacity to think about the children and make sense of their pain-based behaviour (Anglin, 2002).

Participants recognised those pressures and acknowledged that they were affected by them. Nevertheless, they demonstrated a capacity to survive and be curious about their own and others' unconscious processes at both the individual and group level. They were also generally able to tolerate their own difficult emotions and ambivalence. Their reaction to the overwhelming stress they sometimes faced was to turn towards

each other for support and explore the issues rather than avoid them. These were the responses described by Kahn (2004) that characterise resilient caregiving organisations. Participants described the constant struggle to attain and maintain a position where they were able to accept the children and their colleagues as whole people who were both good and bad and where they were able to resist the temptation to identify with the idealised good parent or torture themselves with their uselessness. They identified the reflective spaces they were offered as crucial in providing containment for them in their task of managing the constant emotional demand of caring for a group of traumatised children. Despite these existing opportunities, however, all participants felt that the experience of the research group had provided an important additional holding environment which had enabled them to explore the particular challenges posed by physical restraint. It was the first time they had explored restraint without focusing on a specific incident and despite the painful nature of the experience they believed the opportunity for such focussed reflection should be available to the whole team on a regular basis.

An impossible task?

The participants in this research were unusually well qualified, trained and supported residential workers, yet the emotional difficulty, intellectual complexity and ethical confusion they experienced in their work were palpable. It may be that in other settings practitioners can do their work without being overwhelmed because, lacking the support described in this research, they remain blind to anything below the surface. This, however, risks creating the type of corrupted culture described by Paterson et al. (2025, p.5) which '*can include the othering, depersonalisation and deindividuation that may underpin the development and institutionalisation of abusive practice*'.

Outcomes for many care leavers can be catastrophic often due to their histories of neglect and abuse. Unless, however, practitioners are provided with the training and support to fully connect to the pain of children and remain hopeful for their futures, then children's experience of care becomes at best a temporary respite and at worse confirms their negative expectations of themselves and others.

Effects of a changing context

While the increased accountability around restraint is important and provides necessary protection to children, it is clear from the participants in this research that this changing context has had some complicated and difficult effects for organisations and individual staff. It was apparent from some of their descriptions of practice in the past that physical restraint was a routine event that was used as much for behavioural management as to restore safety. Deaths and serious injuries of individuals in other settings such as custodial and health care settings has heightened the awareness of the dangers of physical restraint. The voices of care-experienced adults expressing the terror and trauma they experienced whilst being restrained has also been heard in various fora.

The consequent increased awareness and scrutiny of physical restraint have dismantled the perverse social defence that allowed adults to use their superior physical strength to forcefully hold children against their will until safety was restored or compliance achieved whilst denying the potentially damaging and retraumatising impact of restraint. Hoggett (2010, p.209) described the perverse social defence occurring when something is known but its meaning denied and thus can be ignored in practice

...knowing remains abstract and disembodied and is therefore a form of knowing which has no motivational consequences.

The horrific histories of many children were known to everyone but the implication of physical restraint as a re-traumatising experience was denied.

None of the participants viewed restraint as a routine event and all expressed their internal struggles and ethical distress about the need to intervene physically to control children, but they all continued to use physical restraint and despite their reservations most believed that it was less harmful than alternative strategies. Scrutiny from the external world, however, has resulted in an increase in bureaucratic monitoring and reporting requirements that participants seemed to experience as persecutory. Policies and procedures designed to reduce restraint appear to increase rather than decrease individual anxiety. Such external scrutiny combines with powerful projective processes from the children to exacerbate the internal discomfort participants were already experiencing. They felt judged and misunderstood by external professionals who did not seem to recognise the conflicting ethical and practice demands they faced daily. They expressed frustration that one of their primary responsibilities was to create safety for everyone as this is the prerequisite for recovery from trauma, but they felt that their professional authority was continually undermined by this failure of understanding.

Cooper and Lees (2015, p.243) described a pernicious dynamic where internal anxiety associated with the pain of the work interacts with the persecutory anxiety from external regulatory demands, to reinforce the 'ritualised task performance' which undermines genuine connection and care. Although participants showed deep concern and connection to the children they cared for, they acknowledged that some of the bureaucratic recording requirements served to distance them from the visceral reality of a restraint so that the meaning of the incident for the child and adults involved

could become lost. In organisations with less well-developed support mechanisms this dynamic may be unrecognised and more likely to have negative consequences.

Participants were not only affected by the attitudes and demands of professionals external to the home, but they were also disturbed by the societal attitudes and responses they encountered. Sarah's image of restraining a child (Figure 2.), whilst being surrounded by a circle of staring eyes, evoked strong responses in participants. They described their confusion about the prurient, almost voyeuristic, curiosity they had often experienced when restraining a child in public, combined with the apparent lack of concern shown for the screaming, distressed child. They also, however, had a sense that they and their children were being judged negatively by those watching. Facing the scrutiny of the outside world they found their own internal doubts and shame about physical restraint reflected in the gaze of the other. They also felt that negative mass media reports about the misuse of restraint, as well as personal experiences shared on social media, had constructed a social perception that physical restraint was an unnecessary brutal act and those that used it were abusers. This contributed to their sense that no one outside the RCC sector, including their own friends and families, could understand the challenges of their role.

Organisations that provide care for individuals whose needs cannot be accommodated by typical familial or personal relationships often become the receptacles for the split off societal feelings of fear or aggression. Not only are practitioners expected to achieve impossible outcomes, but they are also often required to '*protect and purify society from the negative and disruptive dynamics that these clients inevitably bring with them*' (Cardona, 1999, p.250). Participants described the restricted roles available for them and the children to inhabit from this perspective – they were either abusers or incompetent and children either victims or bad. The nuanced reality of them all being

unique individuals with their own strengths and flaws was easily lost in the distorted public representation of children looked after away from their families and the adults who care for them.

Impact of the provision of a focused reflective space

In addition to exploring the underlying psychological processes and systemic factors that seemed to be involved for these participants in incidents of physical restraint, this research also sought to examine the impact of providing a holding environment through a facilitated reflective space focusing specifically on restraint. All participants in the Cedars welcomed being able to explore this issue at depth and were clear that the opportunity should be extended to the full team on a regular basis. They described feeling relieved that they could share their experiences with others and realising that they were not alone in their confusion and anxiety. They also surprised themselves with some of the insights they achieved together which have now begun to affect their practice. The group of managers from Sanctuary who took part in a single group as part of a triangulation process to assess the resonance of the data beyond a single home, echoed the value of the experience and some were considering replicating the pictures exercise within their own teams.

Participants also, however, acknowledged that the experience was emotionally powerful and at times intensely distressing. Experiences such as reflecting on their ethical confusion or remembering times when they felt that their intervention had been actively unhelpful, laid bare the hazardous nature of restraint for themselves and the children. Both groups of adults emphasised that exploration at such depth was only possible because of the supportive relationships with others in the group. They also commented on the importance of the facilitator having personal experience of working in RCC as well as being known to them all and feeling known by her.

Whilst there are obvious potential dangers of collusion and avoidance within this type of insider research, the pre-existing connection seemed to allow participants to trust that I would not judge them. This meant that they avoided the type of rejection of me as a persecutory alien described by Moylan and Jureidini (1994) in their failed attempt to provide such a reflective space to health colleagues engaged in very distressing work. These insights from participants suggest that the provision of reflective opportunities around physical restraint are unlikely to be perceived as helpful without the creation of a wider supportive and reflective culture within a RCC setting.

Recommendations

- Physical restraint has too often been an habitual exercise of power designed to enforce compliance rather than a measured response to ensure safety. As far as possible when a physical restraint takes place it should be experienced as an act of care rather than an act of brutality. For this to be possible
 - Incidents of restraint need to be understood within an extended timeframe rather than as isolated occurrences.
 - It is helpful for adults and children together to develop a shared understanding of children's individual triggers of distress and most effective de-escalation strategies.
 - It is important that adults examine their own behaviours and responses to consider whether they provoked or exacerbated the violence that led to restraint and take responsibility for this with the child and other adults involved. Managers modelling this behaviour can be very helpful in creating a reflective culture.

- Children's voices should systematically be sought both in relation to individual incidents of restraint and to the issues raised by physical restraint more generally. This needs to be done with sensitivity and creativity as revisiting a restraint can be experienced as shaming for the child concerned.
- Adults need support to make sense of children's behaviour and to deal with their own distress and difficult feelings after restraints. Opportunities for individual and group reflection through supervision, debriefing and full staff meetings can contribute to this process. Cultures that provide the type of 'nested containment' described by Ward (1995) across every aspect of the work are most likely to be able to safely hold and contain the otherwise overpowering experiences of restraint.
- It is important for organisations to regularly review whether systemic or institutional factors, either within the home or located in the wider system, are contributing to children's distress or dysregulation and consequent use of restraint.
- The impact on adults involved in restraining children has received little attention despite physical injury, emotional/psychological distress and moral confusion appearing common.
 - Residential childcare providers need to create robust support mechanisms that recognise these adverse outcomes and enable their staff to recover and sustain their commitment to the children they care for.

- As well as the provision of immediate crisis care this should include regular reflective opportunities that enable adults to voice and explore their moral and practice dilemmas.
- It is important that provider organisations and regulatory bodies should examine practice, policies and procedures to ensure that these do not inadvertently exacerbate practitioners' distress.
- Children who witness physical restraint are unrecognised victims. Many have witnessed domestic violence and their exposure to physical restraint may reactivate their previous trauma and confirm a dysfunctional dynamic of denial and silence.
 - Physical restraint training needs to be expanded to include focus on the needs of the children not involved in the restraint
 - It is important that children and adults work together to develop an understanding of the impact on every child of witnessing a physical restraint, and what might be most helpful to them.
 - Concerns about confidentiality need not preclude children being given a simple explanation about their peer's distress and why a restraint was felt to be necessary – it is their business too!
 - If asked by other children about the impact of a restraint on them, adults need to be supported to find effective ways to manage the tension between denial and shaming the child involved in the restraint.
- Changes in the wider sector could support the creation of cultures of enquiry and care
 - All practitioners should have access to continuing professional learning that incorporates the importance of understanding the meaning of

behaviour and the necessity of hearing children's voices, however, they are expressed.

- External consultancy should be available in all RCC provider organisations to support managers and practitioners to create and maintain a containing culture where reflective practice and staff support is embedded.
- It would be helpful if employers supported higher and further education opportunities to deepen the knowledge and skill base for the sector as well as aiding in staff retention. Few opportunities exist for post graduate study that focuses on RCC with the notable exception of The MSc in Advanced Residential Child Care at Strathclyde. Existing post-graduate courses, however, could provide relevant learning for talented RCC practitioners and managers but cost and course requirements make these largely inaccessible. Courses such as those provided by the Tavistock (D10, D10C and D10D) could strive to be more accessible to this sector as they provide a unique approach that is particularly suited to the complexity of the RCC environment. There is currently a dearth of people with appropriate levels of sophisticated understanding to provide supportive leadership, helpful inspection or containing consultation.

Summary

Using a systems psychodynamic lens in this research allowed some of the unconscious processes occurring beneath the overt behaviour and responses of all those involved in a restraint to be seen more clearly. It also highlighted the impact of wider systemic factors on the process of restraints.

The research highlighted that restraint is a hazardous intervention, not only for the children being held but for others involved in or witnessing the incident. It also suggested that some situations can become so unsafe that the dangers of not intervening counterbalanced the risks of restraint. This challenges the simplistic perspective that physical restraint can be reduced or eliminated by legislative or policy changes alone.

The research took place in environments that provided all the requirements that Paterson et al. (2025) suggest can protect against the misuse of restraint, and the depth of reflection and level of understanding demonstrated by participants was impressive. The creation of such cultures, however, requires time, resources and a stability of key staff that is hard to achieve. Even among these participants there was a recognition that the culture could be affected by internal changes in the staff or children's groups as well as external pressures or demands. The recommendations from the research outline ways in which children's residential care can become places where the negative impacts of physical restraint are mitigated. In a context where the work of RCC is devalued rather than recognised as the intensive care of children's services, such changes are unfortunately unlikely to be implemented. Instead, individual workers will continue to bear the psychological and moral burden of engaging in physical restraint and be the focus of blame when harm occurs and children's complex needs will remain largely unmet.

The next chapter will provide reflections on the research process, identifying strengths and weaknesses as well as suggesting future areas of research.

Chapter Ten: Reflections on the research

Introduction

As well as attempting to cast a dispassionate and critical eye on the design and process of this research, this chapter will consider the impact of the experience on both participants and the researcher. It will also highlight the strengths and weaknesses of the research whilst recognising that at times its greatest strengths are simultaneously its most serious weaknesses. Finally, it will suggest future areas of research that might strengthen or challenge the findings discussed here.

Insider research (lost in familiar places)

This study benefited from my knowledge about the research topic accumulated over a lengthy career. This was more than a theoretical understanding – I had personally restrained children and on one occasion, as a child in hospital, I had experienced being restrained myself. Not only did I have a professional and personal interest in the topic I also had longstanding and continuing relationships with all the participants. This seemed to enable participants to reflect at depth about the physical intensity, emotional distress and ethical and practice dilemmas they experienced when restraining children. They expressed a sense of being known and accepted which they felt would not have been possible with an unfamiliar researcher. Despite the richness of the material that participants shared, being so close to the subject of the research and having enduring relationships with participants also presented challenges.

Letting go of the known

One of the difficulties in undertaking this research was managing the knowledge that I brought from my position as consultant in both organisations. I knew the stories and current situations of all the children mentioned as well as being privy to important personal information about all the participants. This posed a challenge for me in

untangling what was data that was present in the group discussions and what I might be importing into my analysis through my knowledge from outside the research process. This was complicated by the reality that in their discussions all the participants made implicit rather than explicit references to this shared knowledge. For example, some participants mentioned their own histories or current situations in a shorthand way that assumed a shared knowledge amongst everyone in the room including me.

A further issue arose as I completed my analysis and began the writing process – as some time had passed since the data collection phase of the research, my continuing contact with both organisations meant that I knew what had happened to both my participants and the children they had discussed. At times this made it difficult to remain focused on the data as it was presented at a particular moment in time.

Facing up to the findings

The topic of physical restraint is contentious and the organisations and individuals who took part in this research took a courageous decision to be as open as they were. Moreover, the systems-psychodynamic lens through which the material was analysed can uncover unconscious processes which might be disturbing for participants to confront or consider. These realities might always have made the process of writing up the research uncomfortable, this was exacerbated, however, by my continuing professional relationships with those involved. It was at times hard to avoid the desire to protect them and sidestep difficult issues. With the support of my supervisor, I was able to recognise these reactions in myself and strove to address the implications of the data fully but with respect.

The previous connections I had with participants seemed to allow the depth of exploration they achieved which was a definite strength of the research. This was to

some extent counterbalanced, however, by the various implications of these relationships which may have distorted the analytic process and the writing up of my findings. A less involved researcher may have arrived at different conclusions.

Generalisability

The research questions demanded a qualitative approach as they were posed to explore the processes involved in restraint and examine reflections of RCC practitioners. The research was conducted with very few participants and therefore not generalisable beyond the context it took place. The adoption of an action research focus, however, meant that the immediate impact of the study was intended to be on the participants' own organisation. The findings have affected their practice and continue to do so as the research is alive in participants' minds and is frequently referred to in staff meetings. The research design, however, did include a process of triangulation through a discussion group in a separate organisation, focusing on key findings from the original group. The congruence between the two groups was considerable and suggested that the findings have meaning beyond the original organisation. Material was also shared with participants as part of a national training programme for facilitators of reflection and action learning groups across Scotland. Again, the feedback suggested that the material resonated strongly for them.

Missing voices

The research focused only on the experiences and reflections of RCC practitioners and managers. This study therefore represents only a partial perspective on restraint. Although participants were trying to understand the experience of the children they cared for – both those involved in restraints and those witnessing them – the actual voice of children is completely missing. It would not be possible within the scope of a study such as this to expand the focus beyond practitioners without risking

superficiality in the findings. Nevertheless, their inclusion would have strengthened the study as their views and understandings might have contrasted with or confirmed the findings. Other stakeholders who might also have provided different or complementary perspectives on the issue include parents and families, referring agencies, regulatory bodies and other external professionals.

Impact on researcher

This is the second time within a short timespan that I have written up a major research study focusing on troubling and painful issues in the RCC sector. In my reflections on the previous study, I commented on the profound emotional impact of recognising the systemic and structural failings of the sector that affected so many care-experienced young people.

What was more difficult to manage was some of what was revealed in the data-analysis and writing process which forced me to question my optimistic professional assumptions and shook my sense of myself and the professional sphere I have worked in for more than forty years (Furnivall, 2023, p.257).

This experience has been replicated during this research. Although the focus was on a very specific area of practice – physical restraint – the research cast a stark light on the conditions necessary to provide a therapeutic experience for distressed children in a residential setting. The complexity and challenge of physical restraint is extreme, but it cannot be considered separately from the context in which it occurs. Without a culture that supports practitioners' capacity to understand and manage their own responses and values their curiosity and ability to hold on to meaning, it seems likely that much residential care will be at best sub-optimal and at worst frankly abusive.

Although the importance of a containing culture seems clear from the data it is also likely that some of my emotional response to the material was a counter transference response. I noticed my emerging despair as I was engaged in writing up the findings

of this study and recognise that I was probably experiencing some of the pain and despondency that my participants were projecting. I also have relationships with other academics and practitioners who are trying to develop a reflective culture around physical restraint more widely and they are encountering practical barriers and emotional resistance. Their discouragement may also have exacerbated my emotional reaction. As a consultant, accepting and attempting to process these painful projections is part of the role I perform for the organisations I support. Perhaps at some level this is also happening in this research for the wider sector.

Areas for further research

- This study deliberately adopted an in-depth model of work group discussion. Whilst this provided very rich data that highlighted important issues about the practice of physical restraint, these could benefit from further exploration using a wider range of qualitative methods. It would, for example, be interesting to conduct a documentary analysis of young people's records and physical incident reports or to develop case studies around individual staff or young people.
- This study has only examined the perspectives of one group of people affected by or concerned about physical restraint. It would be helpful to consider how other stakeholders experience restraint particularly those who were themselves restrained or who witnessed their peers being restrained.
- Participants in this research were working on a hypothesis that there were negative effects on children when organisations operated 'no restraint' policies. They were concerned that some children might be denied placements as their behaviour would be too dangerous to manage without the option of physically

restraining them. They also believed that these policies might have an adverse impact on placement stability and lead to greater police involvement and children becoming criminalised. Research that tested these assumptions would helpfully illuminate this contentious area.

Summary

This chapter offered my reflections on the research, considered its strengths and weaknesses and made suggestions for future research.

Chapter Eleven: Summary and concluding thoughts

In this final chapter I look again at the questions I sought to answer through this research and consider how far I succeeded in my aims and briefly restate my key findings. I then draw on my own professional experience to consider to what extent changes in policy and practice have led to improvements in the quality of care for children and in what ways they have posed new challenges. I suggest that the continuing thread that underlies good practice and positive outcomes is the creation of a reflective culture preferably supported by external consultation and which also places children's voices at the centre of practice.

Returning to the research questions

The two questions posed in my research were:

- *How does a focused reflective group affect physical restraint and holding in a therapeutic children's home?*
- *What conscious, unconscious and systemic factors influence physical intervention in RCC?*

The effects of a reflective group

Participants from the Cedars were unanimous that their experience of the reflective group had been positive and had led them to understand the processes underlying physical restraint at greater depth. As stated earlier they had never had an opportunity to explore their experiences and attitudes to physical restraint that was not focused on a particular incident. They shared the overwhelming physiological and emotional impact of restraint and their ethical distress about restraining children against their will. Participants had felt held by the experience and as a result the weekly whole team reflective spaces now regularly include sessions focusing on physical restraint. Their discussions highlighted issues that had been previously overlooked such as the

distress of children who witnessed restraints. These insights were incorporated into training and led to changes in practice. The opportunities for discussion in the staff group seemed to have been mirrored in the children's group where there have been tentative explorations between the children about the meaning and impact of restraint from the perspective of those being restrained and those witnessing it.

Whilst the benefits of the group were clear for participants it would be impossible to link this directly to any change in the frequency of restraints or the way these were experienced by children or adults as these can be affected by so many other variables. It is also important to stress that the depth of thought achieved with this group of practitioners cannot be separated from the wider organisational culture of reflection and supportive holding that enabled them to engage with courage and honesty. Participants in both the Cedars and the Sanctuary groups noted how powerfully the experience had affected them and acknowledged that it was painful as well as growthful. In an environment that did not encourage reflection, and which devalued vulnerability as weakness, a reflective group such as this might be actively harmful. Defences against thinking and feeling may be the only way to survive in some environments, and this type of reflective experience can dismantle such defences as occurred at points during this research.

Understanding the processes affecting restraint

The research seemed to be effective in illuminating the multifarious factors affecting physical restraint in RCC. Although the main research was undertaken in a single children's home, when findings were shared more widely, they resonated strongly with other practitioners and managers. The research highlighted the complexity of the experience and the challenges posed to practitioners in managing the ethical and

practice dilemmas involved in responding safely to children's terrified and terrifying behaviour.

It became clear that no incident of physical restraint can be viewed in isolation. Although it is possible at times to identify a particular trigger, the antecedents to the incident may stretch far back to early events in a child's or adult's life as well as being found in current personal and interpersonal stressors. The experience of restraint is also influenced by the place in which it occurs which affects how frightening it may be and how difficult to manage. The effects of restraint, both positive and negative, reverberate far beyond the actual incident. There can be long term effects on relationships and people only peripherally involved may suffer harmful consequences from being aware of the incident. Bureaucratic policies and reporting requirements and the rapid pace of life in RCC, however, combine to mean that restraints tend to be perceived and dealt with as single discrete events.

The intensely embodied experience of restraint for both children and adults was clear in participants' accounts. They described deeply frightening and uncomfortable experiences, most had suffered injuries, some serious, and all had witnessed the physical and emotional pain of the children. The task for adults in this situation is to achieve enough regulation of their physical and emotional state to be able to offer a safe and containing experience for the child, which over time may support the development of their own self-regulatory capacity. Whilst training can support this, it is not sufficient without a wider containing framework of supportive structures. These include policies that liberate good practice rather than constrain it, a clear philosophy of care, leadership that emphasises positive values and embedded opportunities for exploring feelings and finding meaning.

It was clear that the participants in this research approached their task with an awareness of the ethical and practice dilemmas entailed in their work. They recognised the potentially hazardous nature of physical restraint and consciously engaged in dynamic assessment of the risks of intervening in this way. This allowed them to notice when their own defences had led to the avoidance of difficult considerations such as the impact of restraint on other children. They conceptualised the role of a residential worker as a complex and ethically demanding one which required continual self-examination and a preparedness to be curious and questioning about the behaviour and responses of others, both adults and children. They recognised that as well as the observable behaviours displayed by children and adults there were unconscious processes occurring within and between people. They displayed a capacity to tolerate uncertainty and ambivalence without being driven to react and could accept hostile projections without retaliating. Such a stance is not always apparent in RCC, and practice is often more simplistic and reactive without a theoretical framework to make sense of the behaviour and interactions of children and adults.

Participants also identified wider systemic factors affecting restraint. They recognised the additional vulnerability and exposure associated with restraints that occurred in public. They described feeling simultaneously judged and ignored on such occasions and linked this with the negative perceptions of children in care and adults who looked after them. Although they recognised that at some level their assumptions about the level of judgement may have reflected their own internal ethical discomfort, these feelings exacerbated the anxiety inherent in any incident of restraint. Physical restraint confirms the negative perceptions of RCC held by many professionals in social work and regulatory bodies. The scrutiny and suspicion participants sometimes encountered contributed to a sense of not being understood and being responsible for

keeping children safe but not being trusted with the authority to do so. They suggested that the awareness of such scrutiny at times led adults to intervene too slowly even when a situation was becoming progressively more unsafe.

A personal response to the findings

In examining the data from this research, I brought my own experience and insights from a career immersed in RCC that has spanned over fifty years. The provision of residential care has changed almost beyond recognition in this time¹³. Whilst many of these changes have provided more oversight of the care that children receive and have improved the working conditions of staff, they have also brought challenges.

Arguably the reductions in working hours and lack of physical proximity to children have diminished opportunities for the development of attuned and enduring relationships between adults and children that could enable recovery from neglect, trauma and loss. This has been compounded by the increased demand for extensive recording and other administrative tasks that removes adults from direct contact with children. Awareness of the existence of physical and sexual abuse in some settings also led to the development of defensive and risk-averse practice that meant adults were discouraged from affectionate physical contact or close relationships with

¹³ More children were then looked after in residential settings than foster care, usually in large groups of ten or more. Foster care is now considered the preferred option for children unless their level of emotional or behavioural difficulty is unmanageable in such a setting and residential care is perceived as a poor last resort. There is evidence that this policy has increased instability for children and contributed to the level of emotional trauma among children who are finally placed in residential care after a series of failed placements (Cronin 2019). The structure of residential care has also changed. Many children placed in residential care now live alone or with only one or two peers. Adults caring for children would previously have lived on site, working long hours and often being expected to be available outside their formal hours when necessary. Residential workers' hours of work are now similar to those of the general population and a strict separation between home and work is expected to be observed (Shaw and Kendrick 2017)

children. This practice has only been effectively challenged in the past few years largely through the voice of care-experienced people (ICR, 2020).

As identified in the literature, social care providers in the past operated as quasi-closed systems which meant that some became sites of unchallenged appalling abuse. In the RCC sector lack of external accountability and an unwillingness to listen to children's voices meant that often abusive practice became embedded at a systemic level. This was even represented as a cutting-edge practice, as occurred in Staffordshire with Pindown and Leicestershire with Beck's regression therapy (Stein 2006). Despite this, other organisations were able to develop transformative practices in this context which are still considered to be the foundations of high-quality care. This was particularly evident in many of the children's therapeutic communities. These were characterised by a culture of enquiry and reflection and almost all had regular external consultancy. The function that consultants can perform to protect against abusive practice was vividly described by Whitwell (1998, p.300) in his description of Menzies Lyth's consultancy in the Cotswold Community.

Residential institutions are especially prone to redefining bad practice as good practice, hence many of the abuse scandals that have come to light in the last few years. Consultants can play an important part in helping to prevent this because they are less likely to get drawn into a collusive system. Their job, in my view, is to be a continuous irritant in the sense that the equilibrium is disturbed by fresh insight and feedback, which the staff group, by themselves, may not see because they are too defended or can't see the wood from the trees.

External consultancy provides more, however, than the safety of an external eye, it can also make it possible to survive frightening and painful experiences such as those identified by participants in this research. I recognise this detoxifying function of consultancy both from my own experience of receiving high quality consultation as a member of staff in a therapeutic community but also as a consultant to RCC

organisations. I regularly feel that I am carrying away an almost overflowing rucksack of pain and confusion when I leave after a day with RCC workers and the frequent requests for my time suggest that this is providing some essential release for practitioners.

Therapeutic communities also led the way in placing children's voices at the centre of their practice. In the community where I worked adults and young people alike were held to account for their behaviour during the daily community meetings. If an adult had physically intervened too forcefully or without what the young person or others believed was reasonable cause, it would be dealt with in this space. I experienced this after a restraint in which I allowed my irritation to be expressed by a slight change in the way I held the child. They immediately recognised the difference and knew that what had begun as a caring intervention had flipped to one driven by anger. The fact that such interactions were open to discussion and reflection preserved the sense for young people that their voices were heard and that adults could accept responsibility for their actions. The risks of abusive practice becoming embedded were mitigated by this culture of openness and reflection that was mirrored across the whole organisation.

After the exposure of widespread institutional abuse in RCC I was involved in arguing for the adoption of a more rigorous and standardised approach to regulation and inspection (Anderson et al., 1998) which should include Local Authority provision rather than just the voluntary and private sectors. The two major investigations into abuse in RCC (Kent, 1997; Utting, 1997) also recommended greater external scrutiny to keep children safe. Unfortunately, the regulatory bodies created in the wake of these very real concerns, have at times had the perverse effect of taking attention and time from the children themselves as Burton (2016, p.43) suggests.

Compliance with externally set standards and quality benchmarks corrupts the core task.

The focus in children's homes can easily shift to providing measurable evidence of meeting care standards to regulatory bodies rather than providing therapeutic and thoughtful care to children.

Undertaking a therapeutic task in an atmosphere of mistrust and scrutiny is difficult and this attitude from inspectors risks evoking a bureaucratic response from practitioners and managers. Across the UK I have witnessed the anxiety of managers and practitioners at the prospect of inspections which are often experienced as persecutory rather than supportive, particularly as a negative report can realistically compromise the survival of a home. The external scrutiny that was developed as a response to the recognition of widespread neglect and cruelty, now seems to risk stifling creativity and innovation and distorting practice. Moreover, some organisations appear to have become adept at providing inspectors with the bureaucratic evidence they require which may not reflect the actual care that children receive. This may only become apparent at the point when a serious failure occurs in an organisation previously rated highly, and the underlying systemic problems are 'discovered' by regulators.

I had personal experience a few years ago of how easily dangerous practices can elude the current inspection process. I and a care-experienced colleague were asked to review a children's home after a complaint was received. It became clear that the culture of the home was based on stringent control of all the children. We heard very disturbing accounts of clearly abusive restraints being used to enforce compliance with staff demands and examples of children being criminalised when they resisted. Most of the staff were qualified, some to higher degree level, yet they had failed to question

the coercive control exercised by the manager. Eventually several staff were dismissed and the home closed but previously the home had received positive inspection reports. This is not to suggest that all or any staff set out to abuse children but does demonstrate the corrupting impact of toxic cultures.

Although children's homes are not such closed systems as they were, they cannot function effectively if their boundaries are too permeable – they must be robust enough to contain the pain and behaviour of traumatised and distressed children. This relatively closed environment combined with the complexity of the emotional dynamics in RCC settings increase the likelihood of abusive practices, such as the misuse of physical restraint, emerging. This tendency cannot be resolved by inspection and regulation alone. Preventing this type of abuse seems to require a culture where pain and distress, whether that of the children or adults, can be heard, accepted and responded to with compassion and care. In such cultures children's communications, whether through behaviour or words, are respected and acted upon while adults have their own distress contained by robust leadership, a rigorous theoretical base and embedded opportunities for reflective practice. Some residential childcare providers, most noticeably those adopting a therapeutic community or trauma informed approach, use external consultancy to support the establishment and maintenance of such therapeutic and reflective cultures. Although such external consultancy has continually been highlighted as an essential resource in RCC for the last fifty years it is still rarely available to managers and practitioners.

As I was concluding my research a disturbing memory emerged. I come from a family where curiosity was nurtured, debate encouraged, and challenge welcomed. These skills and attributes were honed in school and university - I prided myself on my ability to question everything and resist the crowd. Early in my social work training I had a

four-week placement in a secure unit. It was a harsh and punitive environment. One incident, however, stands out. Towards the end of my time there, a young boy was found to have matches on him when he was searched on his return from a visit home. The result of this was that every boy's room was searched and all the boys strip searched. The search was done without care and with the intention of demonstrating control – for example some of the boys had Christmas presents wrapped, ready to give to their families, and the paper was ripped off these and flung to the floor. My involvement was peripheral but some of the boys included me in the screaming rage they expressed. Instead of compassion I found myself feeling anger with them and a sense of justification for what was happening. Fairly quickly I was in touch with the awfulness of this incident and was shocked not only by the treatment of the boys but also by how easily I was drawn in to colluding with an oppressive act. Within this setting the ethos was one of control and domination and vilification of the boys. There was no space to think and no capacity to make sense of the meaning of behaviour or the unconscious group and intergroup dynamics occurring. The memory of this brutality and my part in it emphasised for me that while restraint may at times be intended and experienced as an act of love and care, it holds within it the potential to be an abusive expression of hatred. Although the stark brutality of the environment I describe is unusual, when adults have to continually absorb stress and pain and have no place to safely express and examine their negative emotions then love and good will become steadily eroded. In the absence of protective structures such as value-based leadership and externally supported reflective spaces, the distress and despair that swirls below the surface of most RCC settings may too easily become enacted through a slide into abuse.

Bibliography

Anderson, W., Furnivall, J. and Lindsay, M. (1998). *Slipping Through the Net? A study of issues of safeguarding in the inspection process*. Glasgow: The Centre for Residential Child Care.

Andersson, P. (2022). Secure units as emotional sites: Staff perceptions of fear and violence at secure units for young people in Sweden. *Residential Treatment for Children and Youth*. Vol. 39 (4): 387 – 415. <https://doi.org/10.1080/0886571X.2022.2041533> [Accessed 16 June 2023].

Anglin, J. P. (2002). *Pain, Normality, and the Struggle for Congruence: Reinterpreting residential care for children and youth*. New York: Routledge.

Armstrong, D. (2005). *Organization in the Mind: Psychoanalysis, group relations and organizational consultancy*. London: Karnak.

Bailey, J. (2015). *A Hermeneutic Inquiry into Adult Acute Mental Health Nurses' Experience of Physical Restraint Procedures and their Intervention using Forced Touch with Patients*. Doctoral Dissertation. Portsmouth: University of Portsmouth. https://pure.port.ac.uk/ws/portalfiles/portal/5753148/JILLIAN_BAILEY_COMPLETE_THESIS_FINAL_25.03.16.pdf [Accessed 16 June 2023].

Bailey, J., Nawaz, R. F. and Jackson, D. (2021). Acute mental health nurses' experience of forcibly touching service users during physical restraint. *International Journal of Mental Health Nursing*. Vol. 30 (2): 401 – 412. <https://doi.org/10.1111/inm.12799> [Accessed 16 June 2023].

Baker, J., Kendal, S., Berzins, K., Canvin, K., Branthonne-Foster, S., MacDougall, T., Goldson, B., Kellar, I., Wright, J. and Doxbury, J. (2022). Mapping review of interventions to reduce the use of restrictive practices in children and young people's institutional settings: The CONTRAST study. *Children and Society*. Vol. 36 (6): 1351 – 1401. <https://doi.org/10.1111/chso.12581> [Accessed 16 June 2023].

Barbour, R. (2013). *Introducing Qualitative Research: A Student Guide to the Craft of Doing Qualitative Research*. London: Sage.

Bell, L. (1997). The physical restraint of young people. *Child & Family Social Work*. Vol. 2 (1): 37 – 47. <https://doi.org/10.1046/j.1365-2206.1997.00030.x> [Accessed 16 June 2019].

Berry, J. (1975). *Daily Experience in Residential Life: A study of children and their care givers*. London: Routledge & Kegan Paul.

Berger, R. (2015). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*. Vol. 15 (2): 219 – 234. <https://doi.org/10.1177/1468794112468475> [Accessed 16 June 2019].

Bigwood, S. and Crowe, M. (2008). 'It's part of the job, but it spoils the job': A phenomenological study of physical restraint. *International Journal of Mental Health Nursing*. Vol. 17 (3): 215 – 222. <https://doi.org/10.1111/j.1447-0349.2008.00526.x> [Accessed 16 June 2019].

Bion, W. R. (1962). *Learning from Experience*. London: Karnac.

Bitton, M. and Rajpurkar, S. (2015). Therapeutic crisis intervention system in residential care for children and youth: Staff knowledge, attitudes, and coping styles. *Children and Youth Services Review*. Vol. 56: 1 – 6. <https://doi.org/10.1016/j.chidyouth.2015.04.009> [Accessed 16 June 2019].

Boel-Studt, S. M. (2017). A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents. *Research on Social Work Practice*. Vol. 27 (3): 273 – 282. <https://doi.org/10.1177/1049731515614401> [Accessed 16 June 2023].

Bollas, C. (2005 [1987]). 'The Shadow of the Object: Psychoanalysis of the unknown thought,' in: Armstrong, D. (Ed.). *Organization in the Mind. Psychoanalysis, Group Relations, and Organizational Consultancy*. London: Free Association Press.

Bolton, W. and Roberts, V. Z. (1994). 'Asking for help: Staff support and sensitivity groups re-viewed,' in Obholzer, A. and Roberts, V.Z. (eds). *The Unconscious at Work: Individual and organizational stress in the human services*. Hove: Routledge. pp. 156 – 165.

Bondi, L. (2014). Understanding feelings: Engaging with unconscious communication and embodied knowledge. *Emotion, Space and Society*. Vol. 10: 44 – 54. <https://doi.org/10.1016/j.emospa.2013.03.009> [Accessed 23 October 2022].

Bowen, B., Privitera, M. R. and Bob, V. B. (2011). Reducing workplace violence by creating healthy workplace environments. *Journal of Aggression, Conflict and Peace Research*. Vol. 3 (4): 185 – 198. https://doi.org/10.1108/17596591111187710?urlappend=%3Futm_source%3Dresearchgate [Accessed 23 October 2022].

Brannick, T. and Coghlan, D. (2007). In defense of being "native:" The case for insider academic research. *Organizational research methods*. Vol. 10 (1): 59 – 74. <https://doi.org/10.1177/1094428106289253> [Accessed 18 March 2021].

Braun, V. and Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*. Vol. 11 (4): 589 – 597. <https://doi.org/10.1080/2159676X.2019.1628806> [Accessed 6 June 2023].

Bray, L., Snodin, J., and Carter, B. (2015). Holding and restraining children for clinical procedures within an acute care setting: an ethical consideration of the evidence. *Nursing Inquiry*. Vol. 22 (2): 157 – 167. <https://doi.org/10.1111/nin.12074> [Accessed 22 October 2022].

Bray, L., Carter, B., Ford, K., Dickinson, A., Water, T. and Blake, L. (2018). Holding children for procedures: an international survey of health professionals. *Journal of Child Health Care*. Vol. 22 (2): 205 – 215.

<https://doi.org/10.1177/1367493517752499> [Accessed 22 October 2022].

Brend, D.M. (2020). Residential childcare workers in child welfare and moral distress. *Children and Youth Services Review*. Vol. 119: 105621. <https://doi.org/10.1016/j.childyouth.2020.105621> [Accessed 3 August 2025].

Brend, D.M. and Collin-Vezina, D. (2022). Stronger together: Workplace social support among residential child welfare professionals. *Child Abuse and Neglect*. Vol. 130: 105302. <https://doi.org/10.1016/j.chiabu.2021.105302> [Accessed 3 August 2025].

Brend, D. M., Collin-Vézina, D. and Daignault, I. V. (2025) Claiming the edge as central: what residential childcare workers need to better serve children and families. *Residential Treatment For Children and Youth*. Vol. 42 (3): 459 – 484. <https://doi.org/10.1080/0886571X.2025.2467106> [Accessed 3 August 2025].

Briggs, A. (2012). *Waiting to be Found: Papers on children in care*. London: Karnac Books.

Brown, A. D., McCauley, K., Navalta, C. P. and Saxe, G. N. (2013). Trauma Systems Therapy in Residential Settings: Improving Emotion Regulation and the Social Environment of Traumatized Children and Youth in Congregate Care. *Journal of Family Violence*. Vol. 28 (7): 693 – 703. <https://doi.org/10.1007/s10896-013-9542-9> [Accessed 16 June 2019].

Burton, J. (2016). *Leading Good Care: The task, heart and art of managing social care*. London: Jessica Kingsley.

Bryson, S.A., Gauvin, E., Jamieson, A., Rathgeber, M., Faulkner-Gibson, L., Bell, S., Hazelton, J., Russel, J. and Burke, S. (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *International Journal of Mental Health Systems*. Vol. 11: 36. <https://doi.org/10.1186/s13033-017-0137-3> [Accessed 10 August 2023].

Canham, H. (1998). Growing up in residential care. *Journal of Social Work Practice*. Vol. 12 (1): 65 – 75. <https://doi.org/10.1080/02650539808415133> [Accessed 16 June 2019].

Canham, H. (2000). Exporting the Tavistock model to social services: Clinical consultative and teaching aspects. *Journal of Social Work Practice*. Vol. 14 (2): 125 – 133. <https://doi.org/10.1080/02650530020020528> [Accessed 10 August 2023].

Canham, H. (2004). Spitting, kicking and stripping: technical difficulties encountered in the treatment of deprived children. *Journal of Child Psychotherapy*. Vol. 30 (2): 143 – 154. <https://doi.org/10.1080/00754170410001727013> [Accessed 10 August 2023].

Cardona, F. (1999). 'The team as a sponge. How the nature of the task affects the

behaviour and mental life of a team,' in Vince, V. and French, R. (Eds.) *Group Relations, Management and Organization*. Oxford, Oxford University Press. pp. 239 – 250.

Care Inspectorate. (2023). *Restrictive Practice*. Edinburgh: The Care Inspectorate. <https://www.careinspectorate.com/images/documents/7856/Restrictive%20practice%20statistical%20bulletin%202023.pdf> [Accessed 16 June 2022].

The Carlile Inquiry. (2006). *An Independent Review into the use of Physical Restraint, Solitary Confinement and Forcible Strip Searching of Children in Prisons, Secure Training Centres and Local Authority Secure Children's Homes*. London: The Howard League for Penal Reform.

Children's Homes Regulations (England). (2015) [The Children's Homes Regulations 2015](#)

Cooper, A. and Lees, A. (2015). 'Spotlit: defences against anxiety in contemporary human service organisations,' in Armstrong, D. and Rustin, M. (Eds.) *Social Defences Against Anxiety: Explorations in a Paradigm*. London: Karnac Books. pp. 239 – 255.

CRAE. (2013). *Speaking Freely. Children and Young People in Europe Talk about Ending Violence Against Children in Custody*. London: Children's Rights Alliance for England.

Cronin, M. (2019). Looked after children: The reluctant state and moral salvation. *Genealogy*. Vol. 3 (2): 16. <https://doi.org/10.3390/genealogy3020016> [Accessed 10 August 2023].

Crosland, K. A., Cigales, M., Dunlap, G., Neff, B., Clark, H. B., Giddings, T. and Blanco,

A. (2008). Using staff training to decrease the use of restrictive procedures at two facilities for foster care children. *Research on Social Work Practice*. Vol. 18 (5): 401 – 409. <https://doi.org/10.1177/1049731507314006> [Accessed 16 June 2019].

Dartington, T. (2004). In defence of inefficiency. *Organisational and Social Dynamics*. Vol. 4 (2): 298 – 310. [Accessed 16 June 2022].

Dartington, T. (2010). *Managing Vulnerability. The underlying dynamics of systems of care*. London: Karnac Books.

Davidson, J. C. (2010). Residential care for children and young people: Priority areas for change. *Child Abuse Review*. Vol. 19 (6): 405 – 422. <https://doi.org/10.1002/car.1137> [Accessed 10 October 2025].

Davidson, J., McCullough, D., Steckley, L. and Warren, T. (2005). *Holding Safely: Guidance for Residential Child Care Practitioners and Managers about Physically Restraining Children and Young People*. Glasgow: Scottish Institute for Residential Child Care.

Day, A., Daffern, M. and Simmons, P. (2010). Use of restraint in residential care settings for children and young people. *Psychiatry, Psychology and Law*. Vol. 17 (2): 230 – 244. <https://doi.org/10.1080/13218710903433964> [Accessed 20 July 2023].

Davidson, J., Wilkinson, C., Docherty, B. and Anderson, M. (2009). *Higher Aspirations, Brighter Futures: National Residential Child Care Initiative Workforce Report*. Glasgow: Scottish Institute for Residential Child Care. <https://www.celcis.org/application/files/3114/3878/4504/NRCCI-workforce-report.pdf> [Accessed 24 August 2024].

Department of Health. (2014). *Positive and Proactive Care: Reducing the Need for Restrictive Interventions*. London: Department of Health. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/300293/JRA_DoH_Guidance_on_RP_web_accessible.pdf [Accessed 16 June 2022].

Dockar-Drysdale, B. (1990). *The Provision of Primary Experience: Winnicottian Work with Children and Adolescents*. London: Free Association Books.

Dockar-Drysdale, B. (1998). The management of violence. *Residential Treatment for Children and Youth*. Vol. 16 (3): 61 – 74. https://doi.org/10.1300/J007v16n03_05 [Accessed 4 November 2021].

Duxbury, J. A. (2015). The Eileen Skellern Lecture 2014: physical restraint: in defence of the indefensible? *Journal of Psychiatric and Mental Health Nursing*. Vol. 22 (2): 9 – 101. <https://doi.org/10.1111/jpm.12204> [Accessed 4 November 2021].

Dyregrov, A., Solomon, R. and Bassoe, C. F. (2000). Mental mobilization processes in critical incident stress situations. *International Journal of Emergency Mental Health*. Vol. 2 (2): 73 – 82. <https://pubmed.ncbi.nlm.nih.gov/11232176/> [Accessed 16 June 2022].

Eder, N., Nordenberg, K., Långström, N., Rozental, A. and Moell, A. (2025). Moral distress among inpatient child and adolescent psychiatry staff: a mixed-methods study of experiences and associated factors. *Child and Adolescent Psychiatry and Mental Health*. Vol. 19 (1): 1 – 12. <https://doi.org/10.1186/s13034-025-00868-7> 20 [Accessed 20 August 2025].

Emanuel, L. (2002). Deprivation. *Journal of Child Psychotherapy*. Vol. 28 (2): 163 – 179. <https://doi.org/10.1080/00754170210143771> [Accessed 4 November 2021].

Emond, H. R. (2000). *Survival of the Skilful: An Ethnographic Study of Two Groups of Young People in Residential Care*. (Doctoral Dissertation). Stirling: University of Stirling. <http://hdl.handle.net/1893/2397> [Accessed 29 April 2023].

Esaki, N. and Larkin, H. (2013). Prevalence of adverse childhood experiences (ACEs) among child service providers. *Families in Society*. Vol. 94 (1): 31 – 37.

<https://doi.org/10.1606/1044-3894.4257> [Accessed 4 November 2021].

Esser, F. (2017). Touch in residential child care: staff's bodies and children's agency. *European Journal of Social Work*. Vol. 21 (2): 285 – 295. <https://doi.org/10.1080/13691457.2017.1289898> [Accessed 16 June 2019].

Etherington, K. (2007). Ethical research in reflexive relationships. *Qualitative Inquiry*. Vol. 13 (5): 599 – 616. <https://doi.org/10.1177/1077800407301175> [Accessed 4 November 2021].

Felver, J.C., Jones, R., Killam, M.A., Kryger, C., Race, K. and McIntyre, L. L. (2017). Contemplative Intervention Reduces Physical Interventions for Children in Residential Psychiatric Treatment. *Prevention Science*. Vol. 18: 164 – 173. <https://doi.org/10.1007/s11221-016-0720-x> [Accessed 16 June 2019].

Fieller, D. and Loughlin, M. (2022). Stigma, epistemic injustice, and “looked after children:” The need for a new language. *Journal of Evaluation in Clinical Practice*. Vol. 28 (5): 867 – 874. <https://doi.org/10.1111/jep.13700> [Accessed 20 July 2023].

Fogt, J., George, M., Kern, L., White, G. and George, N. (2008). Physical Restraint of Students with Behavior Disorders in Day Treatment and Residential settings. *Behavioral Disorders*. Vol. 34 (1): 4 – 13. <https://doi.org/10.1177/019874290803400101> [Accessed 16 June 2019].

Fowler, N. H. (2018). *An Ethnographic Exploration of Relationships in Residential Child Care*. (Doctoral Dissertation). Stirling: University of Stirling. <https://www.storre.stir.ac.uk/handle/1893/30280> [Accessed 7 March 2019].

Fox, L. (2004). The impact of restraint on sexually abused children and youth. *Residential Group Care Quarterly*. Vol. 4 (3): 1 – 5. https://www.researchgate.net/publication/237110301_The_impact_of_restraint_on_sexually_abused_children_and_youth [Accessed 16 June 2022].

Furnivall, J. (1991). ‘Peper Harow – Consultancy – A consumer’s view,’ in Raza Silveira, W. (Ed.) *Consultation in Residential Child Care Establishments*. Aberdeen: Aberdeen University Press.

Furnivall, J. (2018). Reclaiming complexity: Beneath the surface in residential child care. *Journal of Social Work Practice*. Vol. 32 (4): 373 – 390. <https://doi.org/10.1080/02650533.2018.1503164> [Accessed 18 June 2022].

Furnivall, J. (2023). *Exploring the Meaning and Impact of the Suicides of Young Residential Care-Leavers, from the Perspectives of those who Worked and Lived Alongside them in Residential Child Care*. (Doctoral Dissertation). Stirling: University of Stirling. <https://dspace.stir.ac.uk/handle/1893/36031> [Accessed 12 March 2024].

Furnivall, J., McKenna, M., McFarlane, S. and Grant, E. (2012). *Attachment Matters for All. An Attachment Mapping Exercise for Children's Services in Scotland*. Glasgow: Centre for Excellence for Looked After Children. <https://www.celcis.org/knowledge-bank/search-bank/attachment-matters-all>

[Accessed 24 August 2024].

Gairdner, W. (2002). 'The Ailment' – 45 Years Later. *Clinical Child Psychology and Psychiatry*. Vol. 7 (2): 288 – 294. <https://doi.org/10.1177/1359104502007002014> [Accessed 11 October 2025].

Gansel, Y. and Lézé, S. (2015). Physical constraint as psychological holding: Mental- health treatment for difficult and violent adolescents. *Social Science and Medicine*. Vol. 143: 329 – 335. <https://doi.org/10.1016/j.socscimed.2015.04.005> [Accessed 3 August 2025].

Geertz, C. (1973). *The Interpretation of Cultures*. New York: Basic Books.

Goethals, S., Dierckx de Casterlé, B. and Gastmans, C. (2012). Nurses decision making in cases of physical restraint: a synthesis of qualitative evidence. *Journal of Advanced Nursing*. Vol. 68 (6): 1198 – 1210. <https://doi.org/10.1111/j.1365-2648.2011.05909.x> [Accessed 16 June 2019].

Gooch, K. (2015). Who needs restraining? Re-examining the use of physical restraint in an English young offender institution. *Journal of Social Welfare and Family Law*. Vol. 37 (1): 3 – 20. <https://doi.org/10.1080/09649069.2015.997999> [Accessed 16 June 2019].

Green-Hennessy, S. and Hennessy, K.D. (2015). Predictors of Seclusion or Restraint Use Within Residential Treatment Centers for Children and Adolescents. *Psychiatry Quarterly*. Vol. 86: 545 – 554. <https://doi.org/10.1007/s11126-015-9352-8> [Accessed 3 August 2025].

Gringeri, C., Barusch, A. and Cambron, C. (2013). Epistemology in qualitative social work research: A review of published articles, 2008–2010. *Social Work Research*. Vol. 37 (1): 55 – 63. <https://doi.org/10.1093/swr/svs032> [Accessed 29 July 2019].

Hammersley, M. (2006). Ethnography: problems and prospects. *Ethnography and education*. Vol. 1 (1): 3 – 14. <https://doi.org/10.1080/17457820500512697> [Accessed 16 June 2019].

Haydon, D. (2020). Detained children: Vulnerability, violence and violation of rights. *International Journal for Crime, Justice and Social Democracy*. Vol. 9 (4): 16 – 30. <https://doi.org/10.5204/ijcjsd.1687> [Accessed 12 August 2023].

Heidegger, M. (1962[1927]). *Being and Time* (trans. J. Macquarrie and E. Robinson). New York: Harper.

Hejtmanek, K. (2010). Caring through restraint: violence, intimacy and identity in mental health practice. *Culture, Medicine and Psychiatry*. Vol. 34 (4): 668 – 674. <https://doi.org/10.1007/s11013-010-9195-6> [Accessed 23 October 2019].

Hejtmanek, K. (2014). Practicing and Resisting Constraint: Ethnography of

"Counter Response" in American Adolescent Psychiatric Custody. *Culture, Medicine and Psychiatry*. Vol. 38 (4): 578 – 596. <https://doi.org/10.1007/s11013-014-9403-x> [Accessed 23 October 2019].

Henriksen, A-K. and Øye, C. (2023). The ambiguities of coercion: Mapping adolescents' experiences of coercion in institutional everyday life. *Children and Society*. Vol. 37: 1376 – 1391. <https://doi.org/10.1111/chso.12699> [Accessed 7 October 2024].

HM Government. (2019). *Reducing the Need for Restraint and Restrictive Intervention*. London: Department of Health and Social Care.

Hodgson, S. (2016). *The emotional experience of children looked after in residential care and care staff: Internal and external home or homelessness*. (Doctoral Dissertation). London: Tavistock and Portman NHS Foundation Trust/University of East London. <https://repository.tavistockandportman.ac.uk/2754/> [Accessed 16 June 2023].

Hodgkiss, B. and Harding, E. (2024). Exploring views of physical restraint in schools: pupil experiences, relationships with staff, and alternative strategies. *Educational Psychology in Practice*. Vol. 40 (1): 59 – 73. <https://doi.org/10.1080/02667363.2023.2258788> [Accessed 16 October 2025].

Hoggett, P. (2010). Government and the perverse social defence. *British Journal of Psychotherapy*. Vol. 26 (2): 202 – 212. <https://doi.org/10.1111/j.1752-0118.2010.01174.x> [Accessed 23 October 2019].

Hollins, L. (2016). Physical interventions: hiding in plain sight. *Learning Disability Practice*. Vol. 19 (10): 28. <https://doi.org/10.7748/ldp.2016.e1771> [Accessed 25 June 2024].

Hughes, L. (2019). *'WC?S Evidence for EHRiC on Equal Protection from Assault*. Glasgow, Who Cares? Scotland. <https://www.whocaresScotland.org/what-we-do/policy/briefings/wcs-evidence-for-ehric-on-equal-protection-from-assault/> [Accessed 16 June 2019].

Ibitoye, K. (2025). *Shame on YOU and YOU and YOU! An Exploration into the Experiences of Registered Managers, the Opportunities and Challenges faced in Residential Childcare within the Context of Change*. (Doctoral Dissertation). London: Tavistock and Portman NHS Foundation Trust/University of East London. <https://doi.org/10.5526/ERR-00040897> [Accessed 10 October 2025].

Independent Care Review. (2020). *The Promise*. <https://www.carereview.scot/wp-content/uploads/2020/02/The-Promise.pdf> [Accessed 20 April 2021].

Izzo, C.V., Smith, E.G., Holden, M.J. Norton, C. I., Nunno, M. A. and Sellers, D. E. (2016). Intervening at the Setting Level to Prevent Behavioral Incidents in Residential Child Care: Efficacy of the CARE Program Model. *Prevention Science*.

Vol. 17 (5): 554 – 564. <https://doi.org/10.1007/s11121-016-0649-0> [Accessed 7 October 2024].

Jansen, T.L., Hem, M.H., Dambolt, L.J. and Hanssen, I. (2020). Moral distress in acute psychiatric nursing: Multifaceted dilemmas and demands. *Nursing Ethics*. Vol. 27 (5): 1315 – 1326. <https://doi.org/10.1177/0969733019877526> [Accessed 15 July 2025].

Jaques, E. (1955). 'Social systems as a defence against persecutory and depressive anxiety,' in Klein, M., Heimann, P. and Money-Kyrle, R. (Eds.) *New Directions in Psychoanalysis*. London: Tavistock. pp. 478 – 498.

Johnson, B. and Clarke, J. M. (2003). Collecting sensitive data: The impact on researchers. *Qualitative Health Research*. Vol. 13 (3): 421 – 434. <https://doi.org/10.1177/1049732302250340> [Accessed 23 October 2019].

Jones, J. (1995). Institutional abuse: Understanding domination from the inside looking out. *Early Child Development and Care*. Vol. 113 (1) : 85 – 92. <https://doi.org/10.1080/0300443951130108> [Accessed 7 October 2024].

Jones, R. and Timbers, G. (2002). An analysis of the restraint event and its behavioral effects on clients and staff. *Reclaiming Children and Youth*. Vol. 11 (1): 37 – 41. <https://eric.ed.gov/?id=EJ646799> [Accessed 16 June 2022].

Jones, R. and Timbers, G. (2003). Minimizing the need for physical restraint and seclusion in residential youth care through skill-based treatment programming. *Families in Society*. Vol. 84 (1): 21 – 29. <https://doi.org/10.1606/1044-3894.81> [Accessed 16 June 2019].

Joseph, B. (1998). Thinking about a playroom. *Journal of Child Psychotherapy*. Vol. 24 (3): 359 – 366. <https://doi.org/10.1080/00754179808414824> [Accessed 20 September 2025].

Kahn, W. A. (2001). Holding environments at work. *The Journal of Applied Behavioral Science*. Vol. 37 (3): 260 – 279. <https://doi.org/10.1177/0021886301373001> [Accessed 20 July 2024].

Kahn, W. A. (2004). *Holding fast: The Struggle to Create Resilient Caregiving Organizations*. London: Routledge.

Katz-Rothman, B. (2007). Writing ourselves in sociology. *Methodological Innovations Online*. Vol. 2 (1): 11 – 16. https://www.researchgate.net/publication/269958627_Writing_Ourselves_in_Sociology [Accessed 18 June 2022].

Kendrick, A. (2005). 'A different way to look at things': the development of consultancy in a residential service for children and young people. *Scottish Journal of Residential Child Care*. Vol. 4 (1): 67 – 79. <https://pureportal.strath.ac.uk/files/270942187/Kendrick-SJRCC-2005-A-different-way-to-look-at-things-the-development-of-consultancy.pdf> [Accessed 8 October 2025].

Kent, R. (1997) *Children's Safeguards Review*. Edinburgh: Scottish Office.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis*. Vol. 27: 99 – 110. <https://psycnet.apa.org/record/1948-02558-001> [Accessed 16 June 2022].

Klein, M. (1959). Our adult world and its roots in infancy. *Human Relations*. Vol. 12 (4): 291 – 303. <https://doi.org/10.1177/001872675901200401> [Accessed 16 June 2019].

Knowles, S. F., Hearne, J. and Smith, I. (2015). Physical restraint and the therapeutic relationship. *The Journal of Forensic Psychiatry and Psychology*. Vol. 26 (4): 461 – 475. <https://doi.org/10.1080/14789949.2015.1034752> [Accessed 20 August 2024].

Kodua, M. and Eboh, W. O. (2023). "It's not a nice thing to do, but": A phenomenological study of manual physical restraint within inpatient adolescent mental health care. *Journal of Advanced Nursing*. Vol. 79 (12): 4593 – 4606. <https://doi.org/10.1111/jan.15742> [Accessed 3 August 2025].

Kodua, M., Duxbury, J., Eboh, W. O., Asztalos, L. and Tweneboa, J. (2023). Healthcare staff's experiences of using manual physical restraint: a meta-synthesis review. *Nursing and Health Sciences*. Vol. 25 (3): 271 – 289. <https://doi.org/10.1111/nhs.13045> [Accessed 3 August 2025].

Kristin Duppong, H., Ingram, S., Czyz, J. D., Juliano, N. and Wilson, E. (2006). Treatment for Youth in Short-Term Care Facilities: The Impact of a Comprehensive Behavior Management Intervention. *Journal of Child and Family Studies*. Vol. 15 (5): 615 – 630. <https://doi.org/10.1007/s10826-006-9040-2> [Accessed 16 June 2019].

Langeland, R., Bayes, K. and Davidson, J. (2009). *Higher Aspirations, Brighter Futures: Overview of the National Residential Child Care Initiative*. Glasgow: Scottish Institute of Residential Child Care. <https://www.celcis.org/knowledge-bank/search-bank/higher-aspirations-brighter-futures> [Accessed 20 August 2024].

Lawrence, D., Bagshaw, R., Stubbings, D. and Watt, A. (2024). The Maintenance Model of Restrictive Practices: A trauma-informed, integrated model to explain repeated use of restrictive practices in mental health care settings. *Issues in Mental Health Nursing*. Vol. 45 (10): 1006 – 1021. <https://doi.org/10.1080/01612840.2024.2369594> [Accessed 3 August 2025].

Leadbetter, D. (2007). Millfields Charter finding the middle ground. *Learning Disability Practice*. Vol. 10 (3): 34 – 37. <https://doi.org/10.7748/ldp2007.04.10.3.34.c4264> [Accessed 3 August 2025].

Lee, B., McMillen, J. and Fedoravicius, N. (2007). Use and views of physical restraint in select residential treatment programs. *International Journal of Child and Family Welfare*. Vol. 10 (3-4): 139 – 149. <https://cyc-net.org/profession/readarounds/ra->

[lee.html](#) [Accessed 22 June 2023].

Lee, K., Pang, Y. C., Lee, J. A. L. and Melby, J. N. (2017). A study of adverse childhood experiences, coping strategies, work stress, and self-care in the child welfare profession. *Human Service Organizations: Management, Leadership and Governance*. Vol. 41 (4): 389 – 402. <https://doi.org/10.1080/23303131.2017.1302898> [Accessed 16 June 2019].

Letherby, G. (2000). 'Dangerous Liaisons: auto/biography in research and research writing,' in Lee-Treweek, G. and Linkogle, S. (Eds.) *Danger in the Field: Risk and Ethics in Social Research*. London: Routledge.

Letherby, G., Scott, J. and Williams, M. (2013). *Objectivity and Subjectivity in Social Research*. London: SAGE.

Lindsay, M. and Hosie, A. (2000) *The Edinburgh Inquiry-Recommendation 55: The Independent Evaluation Report*. Glasgow: University of Strathclyde and the former Centre for Residential Child Care.

Lombart, B., De Stefano, C., Dupont, D., Nadji, L. and Galinski, M. (2020). Caregivers blinded by the care: A qualitative study of physical restraint in pediatric care. *Nursing Ethics*. Vol. 27 (1): 230 – 246. <https://doi.org/10.1177/0969733019833128> [Accessed 20 August 2025].

Long, S. (2002). Organisational destructivity and the perverse state of mind. *Organisational and Social Dynamics*. Vol. 2 (2): 179 – 207. <https://pep-web.org/search/document/OPUS.002.0179A> [Accessed 22 June 2023].

McIntosh, P. (2010). *Action Research and Reflective Practice: Creative and Visual Methods to Facilitate Reflection and Learning*. London: Routledge.

Mahler, M. S. (1974). Symbiosis and Individuation—The Psychological Birth of the Human Infant. *Psychoanalytic Study of the Child*. Vol. 29: 89 – 106. <https://search.ebscohost.com/login.aspx?direct=true&AuthType=shib&db=pph&AN=PS C.029.0089A&authtype=shib&site=ehost-live> [Accessed 8 June 2025].

Main, T. (1957). The Ailment. *British Journal of Medical Psychology*. Vol. 30: 129 – 145. <https://doi.org/10.1111/j.2044-8341.1957.tb01193.x> [Accessed 25 June 2023].

Martin, J. (2023). 'You have to be a certain sort of person': An interpretative phenomenological analysis of mental health support workers' experiences of physical restraint in inpatient settings. *International Journal of Mental Health Nursing*. Vol. 32 (6): 1691 – 1700. <https://doi.org/10.1111/inm.13195> [Accessed 8 June 2025].

Meek, H. W. (2003). The place of the unconscious in qualitative research. *Forum: Qualitative Social Research*. Vol. 4 (2): 38. <https://doi.org/10.17169/fqs-4.2.711> [Accessed 3 August 2025].

Menzies Lyth, I. (1959). The functioning of social systems as a defence against anxiety: a report on a study of the nursing service of a general hospital. *Human Relations*. Vol. 13 (9): 95 – 121. <https://doi.org/10.1177/001872676001300201>

[Accessed 8 June 2019].

Menzies Lyth, I. (2003). 'A psychoanalytic perspective on social institutions,' in Bott, E. and Spillius, E. (Eds.) *Melanie Klein Today, Volume 2: Mainly Practice*. London: Routledge. pp.235 – 247.

Miller, J. A., Hunt, D. P. and Georges, M. A. (2006). Reduction of Physical Restraints in Residential Treatment Facilities. *Journal of Disability Policy Studies*. Vol. 16 (4): 202 – 208. <https://doi.org/10.1177/10442073060160040101> [Accessed 3 August 2025].

Milner, K. (2014). 'Evidence-Based Practice,' in Stewart, J. and DeNisco, S. (Eds.) *Role Development for the Nurse Practitioner*. London: Jones and Bartlett. pp. 177 – 215.

Mohr, W. K., Mahon, M. M. and Noone, M. J. (1998). A restraint on restraints: The need to reconsider the use of restrictive interventions. *Archives of Psychiatric Nursing*. Vol. 12 (2): 95 – 106. [https://doi.org/10.1016/S0883-9417\(98\)80059-9](https://doi.org/10.1016/S0883-9417(98)80059-9) [Accessed 3 August 2025].

Mohr, W. K. and Anderson, J. A. (2001). Faulty assumptions associated with the use of restraints with children. *Journal of Child and Adolescent Psychiatric Nursing*. Vol. 14 (3): 141 – 151. <https://doi.org/10.1111/j.1744-6171.2001.tb00305.x> [Accessed 3 August 2025].

Mohr, W. K. (2006). Reflecting on tragedy: a commentary on deaths of children in restraints. *Child Abuse and Neglect*. Vol. 30 (12): 1329 – 1331. <https://psycnet.apa.org/doi/10.1016/j.chiabu.2006.10.003> [Accessed 3 August 2025].

Mohr, W. K. and Nunno, M. A. (2011). Black boxing restraints: The need for full disclosure and consent. *Journal of Child and Family Studies*. Vol. 20: 38 – 47. <https://doi.org/10.1007/s10826-010-9375-6> [Accessed 3 August 2025].

Morgan, R. (2012). *Children's Views on Restraint: reported by the Children's Rights Director for England*. London: OFSTED.

Morley, G., Ives, J., Bradbury-Jones, C. and Irvine, F. (2019). What is 'moral distress'? A narrative synthesis of the literature. *Nursing Ethics*. Vol. 26 (3): 646 – 662. <https://doi.org/10.1177/0969733017724354> [Accessed 15 July 2025].

Moylan, D. and Jureidini, J. (1994). 'Pain tolerable and intolerable: Consultations to two staff groups who work in the face of potentially fatal illness,' in Erskine, A. and Judd, D. (Eds.) *The Imaginative Body: Psychodynamic Therapy in Health Care*. London: Whurr. pp. 222 – 240.

Mullen, J. (2000). The physical restraint controversy. *Reclaiming Children and Youth*. Vol. 9 (2): 92 – 94. <https://eric.ed.gov/?id=EJ625992> [Accessed 15 March 2023].

Nielson, S. (2022). *What children tell us about their experiences of being physically restrained in inpatient Child and Adolescent Mental Health Services: An Interpretative Phenomenological Analysis*. (Doctoral Dissertation). Ormskirk: Edge Hill University.

https://research.edgehill.ac.uk/ws/portalfiles/portal/49559420/Simon_Nielson_PhD_The_sis.pdf [Accessed 16 June 2023].

Nielson, S., Bray, L., Carter, B. and Kiernan, J. (2021). Physical restraint of children and adolescents in mental health inpatient services: A systematic review and narrative synthesis. *Journal of Child Health Care*. Vol. 25 (3): 342 – 367.

<https://doi.org/10.1177/1367493520937152> [Accessed 3 August 2025].

Nunno, M. A., Holden, M. J. and Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review*. Vol. 25 (4): 295 – 315. [https://doi.org/10.1016/S0190-7409\(03\)00013-6](https://doi.org/10.1016/S0190-7409(03)00013-6) [Accessed 3 August 2025].

Nunno, M. A., Smith, E. G., Martin, W. R. and Butcher, S. (2015). Benefits of Embedding Research into Practice: An Agency-University Collaboration. *Child Welfare*. Vol. 94 (3): 113 – 133. <https://www.jstor.org/stable/48623531> [Accessed 3 August 2025].

Nunno, M. A., McCabe, L. A., Izzo, C. V., Smith, E. G., Sellers, D. E. and Holden, M. J. (2022). A 26-Year Study of Restraint Fatalities Among Children and Adolescents in the United States: A Failure of Organizational Structures and Processes. *Child Youth Care Forum*. Vol. 51: 661 – 680. <https://doi.org/10.1007/s10566-021-09646-w> [Accessed 3 August 2025].

O'Connor, T. G. and Zeanah, C. H. (2003). Attachment disorders: Assessment strategies and treatment approaches. *Attachment and Human Development*. Vol. 5 (3): 223 – 244. <https://doi.org/10.1080/14616730310001593974> [Accessed 13 August 2020].

Office of National Statistics. (2023). *More Adults Living with their Parents*. [More adults living with their parents - Office for National Statistics](https://www.ons.gov.uk/peoplepopulationandcommunity/healthandcare/mentalhealth/articles/more-adults-living-with-their-parents-2023) [Accessed 28 September 2025].

Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D. and Allen, D. (2003). Deaths associated with restraint use in health and social care in the UK. The results of a preliminary survey. *Journal of Psychiatric and Mental Health Nursing*. Vol. 10 (1): 3 – 15. <https://doi.org/10.1046/j.1365-2850.2003.00523.x> [Accessed 3 August 2025].

Paterson, B., Leadbetter, D. and Miller, G. (2005). Beyond zero tolerance a varied response to workplace violence. *British Journal of Nursing*. Vol. 14 (15): 811 – 815. <https://doi.org/10.12968/bjon.2005.14.15.18598> [Accessed 3 August 2025].

Paterson, B. and Duxbury, J. (2007). Restraint and the question of validity. *Nursing Ethics*. Vol. 14 (4): 535 – 545. <https://doi.org/10.1177/0969733007077888> [Accessed 4 August 2023].

Paterson, B., Stirling, C. and Taylor, J. (2025). Bad apples or bad barrels? Preventing the misuse of restraint and seclusion with vulnerable children. *British Journal of Special Education*. Vol. 00: 1 – 9. <https://doi.org/10.1111/1467-8578.70057> [Accessed 25 September 2025].

Perkins, E., Prosser, H., Riley, D. and Whittington, R. (2012). Physical restraint in a therapeutic setting; a necessary evil? *International Journal of Law and psychiatry*. Vol. 35 (1): 43 – 49. <https://doi.org/10.1016/j.ijlp.2011.11.008> [Accessed 4 August 2023].

Petti, T. A., Mohr, W. K., Somers, J. W. and Sims, L. (2001), Perceptions of seclusion and restraint by patients and staff in an intermediate-term care facility. *Journal of Child and Adolescent Psychiatric Nursing*. Vol. 14: 115 – 127. <https://doi.org/10.1111/j.1744-6171.2001.tb00303.x> [Accessed August 3, 2025].

Phillips, N. (2025). “I hate it. However, I recognise that there are times that I have to.” *Exploring the use of physical restraint in schools in Wales: staff experiences, evaluating approaches and informing future practice*. (Doctoral Dissertation). Cardiff: Cardiff University). <https://orca.cardiff.ac.uk/id/eprint/181300> [Accessed 20 September 2025].

Polvere, L. (2011). Youth perspectives on restrictive mental health placement: Unearthing a counter narrative. *Journal of Adolescent Research*. Vol. 26 (3): 318 – 343. <https://doi.org/10.1177/0743558410391257> [Accessed 4 August 2023].

Purcell, C., Elliott, M., Corliss, C., Baginsky, M., Playle, R., Rees, A. and Robling, M. (2025). Understanding the impact of regulatory reforms in children’s residential care: Findings from an evidence review. *Scottish Journal of Residential Child Care*. Vol. 24 (1): 123 – 147. <https://doi.org/10.17868/strath.00092783#> [Accessed 23 September 2025].

Riahi, S., Thomson, G. and Duxbury, J. (2020). A hermeneutic phenomenological exploration of ‘last resort’ in the use of restraint. *International Journal of Mental Health Nursing*. Vol. 29: 1218 – 1229. <https://doi.org/10.1111/inm.12761> [Accessed 4 August 2023].

Rich, C. R. (1997). The Use of Physical Restraint in Residential Treatment: An Ego Psychology Perspective. *Residential Treatment For Children and Youth*. Vol. 14 (3): 1 – 12. https://doi.org/10.1300/J007v14n03_0110.1300/J007v14n03_01. [Accessed 4 August 2023].

Roy, C., Morizot, J., Lamothe, J. and Geoffrion, S. (2020). The influence of residential workers social climate on the use of restraint and seclusion: A longitudinal study in a residential treatment center for youth. *Children and Youth Services Review*. Vol. 114: 105035. <https://doi.org/10.1016/j.childyouth.2020.105035> [Accessed 4 August 2023].

Ruch, G. (2005). Reflective practice in contemporary child-care social work: The role of containment. *British Journal of Social Work*. Vol. 37: 659 – 680.

<https://doi.org/10.1093/bjsw/bch277> [Accessed 15 July 2022].

Ruch, G. (2011). Where have all the feelings gone? Developing reflective and relationship-based management in child-care social work. *British Journal of Social Work*. Vol. 42 (7): 1315 – 1332. <https://doi.org/10.1093/bjsw/bcr134> [Accessed 15 July 2022].

Ruch, G. (2014). Beneficence in psycho-social research and the role of containment. *Qualitative Social Work*. Vol. 13 (4): 522 – 538. <https://doi.org/10.1177/1473325013497390> [Accessed 15 July 2022].

Rustin, M. (2019). *Researching the Unconscious: Principles of Psychoanalytic Method*. London: Routledge.

Shaw, J. and Kendrick, A. (2017). Reflecting on the past: Children's Services Workers' experiences of residential care in Scotland from 1960 to 1975. *British Journal of Social Work*. Vol. 47 (2): 375 – 391. <https://doi.org/10.1093/bjsw/bcw021> [Accessed 15 July 2022].

Scheff, T. J. (2007). Catharsis and other heresies: A theory of emotion. *Journal of Social, Evolutionary, and Cultural Psychology*. Vol. 1 (3): 98 – 113. <https://doi.org/10.1037/h0099826> [Accessed 2 July 2022].

Scheuermann, B., Peterson, R., Ryan, J. B. and Billingsley, G. (2016). Professional practice and ethical issues related to physical restraint and seclusion in schools. *Journal of Disability Policy Studies*. Vol. 27 (2): 86 – 95. <https://doi.org/10.1177/1044207315604366> [Accessed 3 August 2025].

Scott, S. (1998). Here be dragons: Researching the unbelievable, hearing the unthinkable. A feminist sociologist in uncharted territory. *Sociological Research Online*. Vol. 3 (3). <https://doi.org/10.5153/sro.189> [Accessed 5 October 2019].

Scottish Government. (2024). *Included, Engaged and Involved (Part 3): A Relationships and Rights-Based Approach to Physical Intervention in Schools*. Edinburgh: Scottish Government.

Scottish Parliament. (2018). *Children (Equal Protection from Assault) (Scotland) Bill 38*. Edinburgh: Scottish Parliament.

Shahbazian, M., Taglione, P. and Paull, L. R. (2005). The Conflict Cycle-It's Not Just About the Kids. *Reclaiming Children and Youth*. Vol. 14 (1): 32 – 36. <https://eric.ed.gov/?id=EJ713672> [Accessed 16 June 2023].

Shenton, F. (2015). *Even if it is Legally Defensible, does that make it Morally Right? Children Explore the Use of Physical Restraint in Custody*. (Doctoral Dissertation). Durham: Durham University. <http://etheses.dur.ac.uk/11320/> [Accessed 3 August 2025].

Shenton, F. and Smith, R. (2021). Behaviour management or institutionalised

repression?

Children's experiences of physical restraint in custody. *Children and Society*. Vol. 35 (1): 159 – 175. <https://doi.org/10.1111/chso.12410> [Accessed 3 August 2025].

Skelly, A. (2016). 'Maintaining the bond: working with people who are described as showing challenging behaviour using a framework based on attachment theory,' in Fletcher, K., Flood, A. and Hare, J. (Eds.) *Attachment in Intellectual and Developmental Disability: A Clinician's Guide to Practice and Research*. Hoboken: John Wiley and Sons. pp. 104 – 129.

Slaatto, A., Mellblom, A. V., Kleppe, L. C. and Baugerud, G. A. (2021). Safety in Residential Youth Facilities: Staff Perceptions of Safety and Experiences of the "Basic Training Program in Safety and Security." *Residential Treatment For Children and Youth*. Vol. 39 (2): 212 – 237. <https://doi.org/10.1080/0886571X.2021.1978035> [Accessed 3 August 2025].

Smith, M., Nursten, J. and McMahon, L. (2004). Social workers' responses to experiences of fear. *British Journal of Social Work*. Vol. 34: 541 – 559. <https://doi.org/10.1093/bjsw/bch065> [Accessed October 5 2019].

Smith, M. L. (2005). *Necessary evil or painful experience? perceptions of the use of physical restraint with children*. (Doctoral Dissertation). Kansas: Kansas State University. <https://www.proquest.com/openview/166d42331eae1944120b0bcaad6443b8/1?pq-origsite=gscholar&cbl=18750&diss=y> [Accessed 22 June 2023].

Smith, M. L. and Bowman, K. M. (2009). The Restraint Spiral: Emergent Themes in the Perceptions of the Physical Restraint of Juveniles. *Child Welfare*. Vol. 88 (3): 57 – 83. <http://www.jstor.org/stable/45390170> [Accessed 3 August 2025].

Stanley, L. and Wise, S. (1990). 'Method, methodology and epistemology in feminist research processes,' in Stanley, L. (Ed.) *Feminist Praxis: Research, Theory and Epistemology in Feminist Sociology*. London: Routledge. pp. 20 – 60.

Steckley, L. and Kendrick, A. (2007). 'Hold on: Physical restraint in residential child care,' in Steckley, L. and Kendrick, A. (Eds.) *Residential Child Care: Prospects and Challenges*. London: Jessica Kingsley. pp. 152 – 165.

Steckley, L. and Kendrick, A. (2008a). Physical Restraint in Residential Childcare: The experiences of young people and residential workers. *Childhood*. Vol. 15 (4): 552 – 569. <https://doi.org/10.1177/0907568208097207> [Accessed 5 October 2019].

Steckley, L. and Kendrick, A. (2008b). 'Young people's experiences of physical restraint in residential care: subtlety and complexity in policy and practice,' in Nunno, M. A., Day, D. M. and Bullard, L. (Eds.) *For Our Own Safety: Examining the Safety of High-Risk Interventions for Children and Young People*. Arlington, Virginia: Child Welfare League of America. pp. 3 – 24.

Steckley, L. (2010). Containment and holding environments: Understanding and

reducing physical restraint in residential child care. *Children and Youth Services Review*. Vol. 32 (1): 120 – 128. <https://doi.org/10.1016/j.childyouth.2009.08.007> [Accessed 5 October 2019].

Steckley, L. (2012). Touch, Physical Restraint and Therapeutic Containment in Residential Child Care. *British Journal of Social Work*. Vol. 42 (3): 537 – 555. <https://doi.org/10.1093/bjsw/bcr069> [Accessed 5 October 2019].

Steckley, L. (2013). *Understanding Physical Restraint in Residential Child Care: Juxtaposing Frames of Containment and an Ethic of Care*. (Doctoral Dissertation). Glasgow: University of Strathclyde. <https://doi.org/10.48730/468g-jp37> [Accessed 5 October 2019].

Steckley L. (2015). 'Care ethics and physical restraint in residential childcare,' in Barnes, M., Brannelly, T., Ward, L. and Ward, N. (Eds.) *Ethics of Care: Critical Advances in International Perspective*. Bristol: University Press. pp. 195 – 206.

Steckley, L. (2018). Catharsis, Containment and Physical Restraint in Residential Child care. *British Journal of Social Work*. Vol. 48 (6): 1645 – 1663. <https://doi.org/10.1093/bjsw/bcx131> [Accessed 5 October 2019].

Steckley, L., Hollins, L., Deeley, S. and Bettencourt, M. (2023). *An Appreciative Inquiry into Holding in Residential Child Care: Pilot Report*. Glasgow: University of Strathclyde. <https://strathprints.strath.ac.uk/85908/> [Accessed 3 June 2025].

Steckley, L., Deeley, S. and Watson, G. (2025). *The Reflection and Action Learning Forum (RALF): Full Report*. Glasgow: University of Strathclyde. <https://strathprints.strath.ac.uk/92932/> [Accessed 10 July 2025].

Steele, H. (2003). Holding therapy is not attachment therapy: Editor's introduction to this invited Special Issue. *Attachment and Human Development*. Vol. 5 (3): 219 – 219. <https://doi.org/10.1080/14616730310001594009> [Accessed 5 October 2019].

Stein, M. (2006). Missing years of abuse in children's homes. *Child and Family Social Work*. Vol. 11 (1): 11 – 21. <https://doi.org/10.1111/j.1365-2206.2006.00381.x> [Accessed 10 July 2025].

Steiner, J. (1985). Turning a blind eye: The cover up for Oedipus. *International Review of Psycho Analysis*. Vol. 12: 161 – 172. <https://tcf-website-media-library.s3.eu-west-2.amazonaws.com/wp-content/uploads/2021/09/21110724/Steiner-J.-1985.-Turning-a-Blind-Eye-The-Cover-Up-for-Oedipus.-International-Review-of-Psycho-Analysis.-121.-pp.-161-171..pdf> [Accessed 12 March 2022].

Strout, T. D. (2010). Perspectives on the experience of being physically restrained: An integrative review of the qualitative literature. *International Journal of Mental Health Nursing*. Vol. 19 (6): 416 – 427. <https://doi.org/10.1111/j.1447-0349.2010.00694.x> [Accessed 10 July 2025].

Utting, W. (1997). *People Like Us: The Report on the Review of Safeguards for Children Living Away from Home*. London: Stationery Office.

van Gink, K., Visser, K., Popma, A., Vermeiren, R. R., van Domburgh, L., van der Stegen, B. and Jansen, L. M. (2018). Implementing non-violent resistance, a method to cope with aggression in child and adolescent residential care: Exploration of staff members experiences. *Archives of Psychiatric Nursing*. Vol. 32 (3): 353 – 359. <https://doi.org/10.1016/j.apnu.2017.11.025> [Accessed 3 August 2025].

Van Loan, C. L., Gage, N. A. and Cullen, J. P. (2015). Reducing use of physical restraint: A pilot study investigating a relationship-based crisis prevention curriculum. *Residential Treatment for Children and Youth*. Vol. 32 (2): 113 – 133. <https://doi.org/10.1080/0886571X.2015.1043787> [Accessed 3 August 2025].

Waggett, N. (2012). Ghosts in the care home: the nature of relationships in a home for people with learning disabilities. *Journal of Social Work Practice*. Vol. 26 (4): 443 – 457. <https://doi.org/10.1080/02650533.2012.678819> [Accessed 10 May 2024].

Ward, A. (1995). The impact of parental suicide on children and staff in residential care: A case study in the function of containment. *Journal of Social Work Practice*. Vol. 9 (1): 23 – 32. <https://doi.org/10.1080/02650539508413986> [Accessed 23 June 2023].

Ward, A. (2014). *Leadership in Residential Child Care: A Relationship-Based Approach*. Norwich: Smokehouse Press.

Warwick, L. (2022). “Depends who it is”: Towards a relational understanding of the use of adult-child touch in residential child care. *Qualitative Social Work*. Vol. 21 (1): 18 – 36. <https://doi.org/10.1177/1473325021990875> [Accessed 4 August 2025].

Weiss, E. M., Altimari, D., Blint, D. F. and Megan, K. (1998). Deadly restraint: a Hartford Courant investigative report. *Hartford Courant*. pp.11 – 15.

Whitwell, J. (1998). The experience of external consultancy in a therapeutic community for children. *Therapeutic communities*. Vol. 19 (3): 201 – 210. <https://www.johnwhitwell.co.uk/about-the-cotswold-community/the-experience-of-external-consultancy-in-a-therapeutic-community-for-children/> [Accessed 22 June 2022].

Williams, M. (2013). ‘Situated Objectivity in Sociology,’ in Letherby, G., Scott, J. and Williams, M. (Eds.) *Objectivity and Subjectivity in Social Research*. London: SAGE. pp. 59 – 77.

Winnicott, D. W. (1964). *The Child, the Family, and the Outside World*. Harmondsworth: Penguin Books.

Winnicott, D. W. (1965). *The Maturation Process and the Facilitating*

Environment. London: Hogarth Press.

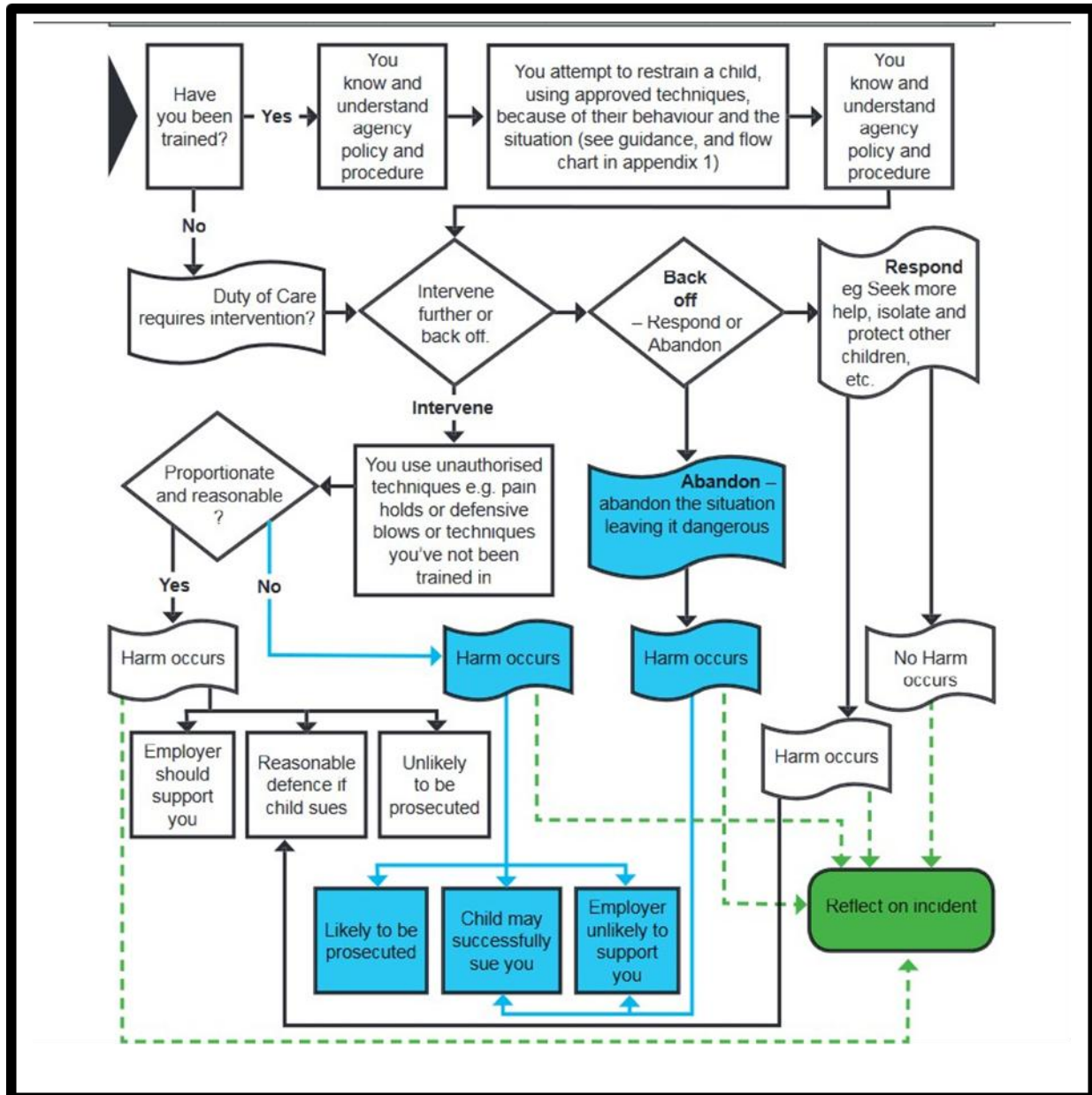
Winnicott, D. W. and Britton, C. (1947). Residential management as treatment for difficult children: The evolution of a wartime hostels scheme. *Human Relations*. Vol. 1 (1): 87 – 97. <https://doi.org/10.1177/001872674700100106> [Accessed 22 June 2022].

Wilson, C., Rouse, L., Rae, S. and Kar Ray, M. (2017). Is restraint a ‘necessary evil’ in mental health care? Mental health inpatients’ and staff members’ experience of physical restraint. *International journal of mental health nursing*. Vol. 26 (5): 500 – 512. <https://doi.org/10.1111/inm.12382> [Accessed 3 August 2023].

Ziegler, D. (2001). To Hold, or Not to Hold ... Is That the Right Question? *Residential Treatment For Children and Youth*. Vol. 18 (4): 33 – 45. https://doi.org/10.1300/J007v18n04_04 [Accessed 3 August 2023].

Appendix 1 Hard Decisions

Figure 10 Hard Decisions Flow Chart



From Davidson et al. (2005)

Appendix 2: Research Documentation

Participant Information Sheet1

The Tavistock and Portman 
NHS Foundation Trust

Information Sheet

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Research Project: *Restraining self and others or holding and being held? An in- depth exploration of restraint and holding in residential child care.*

Researcher Details: Judith Furnivall, Part-time Professional Doctorate student at the Tavistock and Portman Trust

Address: Flat 2, 56 Bentinck St, Glasgow, G3 7TT

Email and phone number: info@judyfurnivall.co.uk 07843017945

Supervisor Details: Dr Simon Tucker

Address: Directorate of Education & Training, Tavistock Centre, 120 Belsize Lane, NW3 5AB

Email: drsimontucker@icloud.com

This project has been approved by the Tavistock Research Ethics Committee

Project Description

Physical restraint in residential child care is a distressing event for all concerned. It can involve injury to children and adults and can cause lasting psychological harm. Many children, in residential settings, however, are severely dysregulated and emotionally reactive which can lead to outbursts of physical aggression and destructiveness where adults have to intervene physically for their own and others safety. This research is seeking to explore the various factors, conscious and unconscious, that affect how physical restraint occurs in residential care settings for children, as well as examining the impact of a focused opportunity for reflection on the issue.

If you decide to participate, I will interview you individually to provide an opportunity for you to ask questions and raise any concerns you have, as well as to explore how your own experiences, both professionally and personally, affect the way you view and participate in restraint. You will then attend five group meetings with other colleagues, once a month for five months. We will use the group to explore the experience of physical restraint through reflection and creative methods to try and identify and understand the various processes happening in and between people (adults and children) before during and after incidents of restraint. Whilst maintaining the confidentiality of the detailed content of the group, participants will be encouraged to discuss the insights achieved with colleagues outside the group and bring their reflections into the next meeting. These feedback loops allow a continuing interaction between research and practice. After the final group I will then interview you individually to allow you to reflect and debrief on the group experience as well as to discuss anything that you did not wish to share more publicly. Both your individual interviews will last a maximum of 45 minutes.

All the interviews and group sessions will be audio recorded and transcribed. Any creative productions will be photographed and stored digitally.

It is likely that this experience will have some direct impact on practice that is specific to your organization, but there are also likely to be insights that are more widely transferable. These will be used in a focus group with residential workers from another organization to test whether they resonate with them and identify any differences.

Although we will be exploring difficult issues that may be distressing for you or others, it is unlikely that this will be any greater than that incurred in your normal work experience. I will, however, be available on the day following each group for individual support if required. This research has the support of the managers, and the usual supervisory and reflective opportunities will be available to all participants. In addition, the consultant psychotherapist can be available for additional support where needed.

Confidentiality of the Data

Consent forms will be kept in a securely locked filing cabinet. All other data will be kept on a password protected laptop and backed up to a university server. All interviews and groups will be audio recorded using a digital recorder. These recordings will be uploaded to a password protected laptop as soon as possible. All audio files will be transcribed and individual and organizational names de-identified at this point. Any creative productions will be preserved through photography and stored in the same way. Data will be kept securely for ten years and then destroyed.

Within your organization there will be limits to the confidentiality and anonymity of the data. Your participation in the project will be known to all your immediate colleagues and the design of the research requires some of the content of the sessions to be fed back to the wider staff team. The detailed content of the sessions will remain confidential, and any direct quotations or creative products will be de-identified. Nevertheless, it is possible that your contributions may be identifiable by your close colleagues. The organization and individual participants will be de-identified in any wider dissemination of the findings. There is still, however, a very small possibility that the organization may be recognisable within the residential child care sector because of the specialised nature of your work.

Any information that raises issues of safeguarding cannot remain confidential and appropriate sharing of information will be negotiated. All research also has legal limits on confidentiality that may mean that information has to be shared if there is a clear legal basis for this such as a subpoena.

Location

The group discussions will take place at your normal place of work. The individual interviews will be online at a time that suits you.

Dissemination

Initially this research will be published through a doctoral thesis which will be held in the Tavistock and Portman Library and may also be published online. There may also be additional publications in both academic and professional journals. Insights may also be shared at conferences, workshops, seminars and other professional groupings. Any of these may include direct written quotations from both interviews and group sessions as well as illustrations of the creative work you produce.

Disclaimer

You are not obliged to take part in this study, and you are free to withdraw from the process up to one month after the final group. Should you choose to withdraw from participation you may do so without disadvantage to yourself and without any obligation to give a reason. This will not affect your employment or your support in any way. If you wish, all unprocessed individual data will be removed as far as possible and destroyed. It will not be possible to do

this with the group sessions although it will be possible to ensure that your contributions are not directly referenced.

Tavistock and Portman Trust Research Ethics Committee

If you have any concerns regarding the conduct of the researcher or any other aspect of this research project in which you are being asked to participate, please contact:

Beverly Roberts, Interim Head of Academic Governance, academicquality@tavi-port.nhs.uk

Participant Information 2

The Tavistock and Portman 
NHS Foundation Trust

Information Sheet

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

Research Project: *Restraining self and others or holding and being held? An in- depth exploration of restraint and holding in residential child care.*

Researcher Details: Judith Furnivall, Part-time Professional Doctorate student at the Tavistock and Portman Trust

Address: Flat 2, 56 Bentinck St, Glasgow, G3 7TT

Email and phone number: info@judyfurnivall.co.uk 07843017945

Supervisor Details: Dr Simon Tucker

Address: Directorate of Education & Training, Tavistock Centre, 120 Belsize Lane, NW3 5AB

Email: drsimontucker@icloud.com

This project has been approved by the Tavistock Research Ethics Committee

Project Description

Physical restraint in residential child care is a distressing event for all concerned. It can involve injury to children and adults and can cause lasting psychological harm. Many children, in residential settings, however, are severely dysregulated and emotionally reactive which can lead to outbursts of physical aggression and destructiveness where adults have to intervene physically for their own and others safety. This research is seeking to explore the various factors, conscious and unconscious, that affect how physical restraint occurs in residential care settings for children as well as examining the impact of a focused opportunity for reflection on the issue.

I have undertaken the first stage of this research in a small therapeutic home in England. This involved individual interviews and five group experiences where we explored the experience of physical restraint through reflection and creative methods to try and identify and understand the various processes happening in and between people (adults and children) before during and after incidents of restraint.

If you agree to participate you will take part in a single two-hour focus group where the insights from the first stage of the research that appear to be transferrable across contexts will be shared. The purpose of the group is to check whether these insights resonate with staff in a different type of organization and in a different regulatory context. Where appropriate, participants may wish to share their own experiences of physical restraint to compare and contrast with the insights being offered.

Although we will be exploring difficult issues that may be distressing for you or others, it is unlikely that this will be any greater than that incurred in your normal work experience. I will,

however, be available on the day following the group for individual support if required. This research has the support of your managers and the normal supervisory, reflection and external counselling opportunities will also be available for participants

Confidentiality of the Data

Consent forms will be kept in a securely locked filing cabinet. All other data will be kept on a password protected laptop and backed up to a university server. The group will be audio recorded using a digital recorder. This recording will be uploaded to a password protected laptop as soon as possible. The audio file will be transcribed and individual and organizational names de-identified at this point

Within your organisation there may be limits to the confidentiality of the data. Your participation in the project may be known to some of your immediate colleagues and it is possible that your contributions may be identifiable by them. The organization and individual participants will, however, be de-identified in any wider dissemination of the findings. There is still, however, a very small possibility that the organisation may be recognisable within the residential child care sector because of the specialised nature of your work.

Any information that raises issues of safeguarding cannot remain confidential and appropriate sharing of information will be negotiated. All research also has legal limits on confidentiality that may mean that information has to be shared if there is a clear legal basis for this such as a subpoena.

Dissemination

Initially this research will be published through a doctoral thesis which will be held in the Tavistock and Portman Library and may also be published online. There may also be additional publications in both academic and professional journals. Insights may also be shared at conferences, workshops, seminars and other professional groupings both in person and on digital media. Any of these may include direct written quotations from the focus group.

Disclaimer

You are not obliged to take part in this study, and you are free to withdraw from the process at any time up to one month after the group. Should you choose to withdraw from participation you may do so without disadvantage to yourself and without any obligation to give a reason. This will not affect your employment or your support in any way. It will not be possible to completely remove your data from the focus group though it will be possible to ensure that your contributions are not directly referenced.

Tavistock and Portman Trust Research Ethics Committee

If you have any concerns regarding the conduct of the researcher or any other aspect of this research project in which you are being asked to participate, please contact:

Beverly Roberts, Interim Head of Academic Governance, academicquality@tavi-port.nhs.uk

Consent Form

The Tavistock and Portman 
NHS Foundation Trust

Consent to Participate in a Research Study

Restraining self and others or holding and being held? An in- depth exploration of restraint and holding in residential child care.

If you consent to take part please tick and initial each box and sign

I have read the information leaflet relating to the above research study in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what it being proposed and the processes in which I will be involved have been explained to me.

I understand that my involvement in this study, and identifying data from this research, will remain strictly confidential outside my organization within the limits outlined in the participant information sheet. Only the researcher will have access to this data. It has been explained to me what will happen once the study has been completed. I agree to the publication of my data in de-identified form in this doctoral thesis and any future academic and practice format as well as in conference presentations.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent, I understand that I have the right to withdraw from the research at any time without disadvantage to myself and without being obliged to give any reason. I understand that my individual data can be withdrawn up to one month after my last involvement in the data collection process.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name JUDITH FURNIVALL

Researcher's Signature

.....

Date:

Organisation Agreement 1

This letter is to confirm that I am happy for staff from my organization to take part in the proposed research that Judith Furnivall is undertaking for her professional doctorate at the Tavistock and Portman Trust. I have discussed this fully with her and understand the requirements of the research. I understand that the focus of the research is on physical intervention in residential child care and will involve a maximum of five participants across the organisation. I recognize that each participant will have two individual interviews and attend 5 monthly group sessions. I also understand that the anonymity of both the organisation and individual participants will be protected.

Registered Manager

Organisation Agreement 2

To whom it may concern

This is to confirm that I have discussed the proposed research project , *“Restraining self and others or holding and being held? An in- depth exploration of restraint and holding in residential child care”*, which Judith Furnivall is undertaking for her professional doctorate. I understand that this will involve a single focus group with a maximum of six participants and will last two hours. I have been informed that this will be audio recorded and transcribed but that all participants will be anonymised, and the organization will not be named in the thesis or in any other publications or dissemination events. On this basis, I am happy for staff from this organization to take part.

Head of Care

Interview questions

Restraining self and others or holding and being held? An in- depth exploration of restraint and holding in residential child care.

Interview topic guides

Interview 1:

- Having read the participant information sheet are there any questions, concerns, reflections you wish to share before the groups start?
- What did you know or understand about physical restraint before you joined this organization?
- Are there aspects of your own personal or professional history that affect your perspective on and experience of physical restraint?

Interview 2:

- Looking back on the group experiences as a whole are there any reflections you wish to share?
- Is there anything you would like to discuss or comment on that you felt unable to bring up in the group setting?
- Has your perspective or practice around physical restraint changed at all in the last six months?
- Exploring these issues was a challenging task – how have you been left feeling? Do you require any further support?
- What was the impact on you and the research process of my existing role as a consultant?

Appendix 3 Letter to Directors

The Tavistock and Portman 
NHS Foundation Trust

Dear Directors,

I would like to formally record my thanks for allowing your staff to participate in the research for my doctoral thesis examining the psychological and social dynamics involved in physical restraint. I believe this took considerable organisational courage and I am pleased to say that the findings of the research will be important not only for your organisation but also for the wider residential child care sector.

This was an action research project that was always intended to influence practice directly within your organisation as well as informing the wider debate around physical restraint and other restrictive practices. The group has already shared some of their reflections in the staff meeting but I felt it was important that I also wrote to you all formally to identify the key themes and possible practice developments that might be helpful for you to consider. I would first like to acknowledge the honesty and courage of those who participated in the group and I believe this was made possible by the quality of support and containment provided for all your staff. As you know I have worked all over the UK and beyond and this level of support is unusual but has clear benefits as was demonstrated in this project.

Key Findings

- Although this was a very experienced group of staff, some of whom had senior roles, the physical, psychological and moral costs of physically restraining severely distressed children were very apparent. All of them agreed on the importance of intervening physically to provide safety and at times emotional containment for children as well as at times ensuring the stability of placements, but the potential risk of physical injury and concerns about longer term psychological damage both for children and adults were also recognised. Physical restraint was justified as a lesser harm, but staff still described wrestling with the ethical dilemmas this practice posed for them. Having clear criteria for initiating a restraint was felt to be very important but they still felt ethically compromised. Staff also identified the importance of having trusting relationships with each other in situations where at times they felt that they were dealing with life and death levels of risk. You have created a culture in which such relationships can thrive but this requires constant monitoring and support to ensure its continuity.
- Staff were clear that any incident of physical restraint could not be properly understood without taking into account multiple contextual factors including:

- The individual child's history and current experiences in their family, school and community as well as within the home itself.
- The past and current experiences and emotional/physical state of the adults within the home.
- Where and when the incident took place
- External pressures from social workers, inspection and regulatory processes and the perceptions of the wider public.

The depth of knowledge your staff have about the children and each other seems to contribute to their capacity to understand the factors that may lead to a restraint and also how to de-escalate wherever possible. It also enables them to support the child and each other when restraints do occur. The multiple organisational support mechanisms in place also provide opportunities for the safe expression of difficult feelings and the space to reflect on and make sense of these incidents. Some of the regulatory requirements for the recording of incidents, however, caused concern that some of this understanding could not be reflected in the lasting record of the event.

- The contributions from participants highlighted the complexity of working effectively with dysregulated young children with such distressing histories. They described often having to navigate a tightrope between potentially opposing negative outcomes. This included, for example, taking the risk of a child being unable to manage a particular situation which might end in a restraint versus preventing a child having the opportunity to learn how to self-regulate and thus develop the resilience to manage future challenges. The research group was helpful in clarifying some of these issues which are not only relevant for you but across the sector.
- A key finding of the research was the recognition that the other children in the home are often invisible victims of a restraint. Not only do they experience the immediate loss of attention and time from adults who are important to them they also witness (or hear) frightening interactions that may reactivate their own traumatic histories. Moreover, they may be supported through these situations by some of the less experienced staff members who may be struggling to contain their own emotional reactions. You have an excellent system for identifying in a participative way the most effective responses to help de-escalate difficult situations for individual children. It would be worth instituting a similar process for discovering the most effective ways to support individual child witnesses of restraints during and after such an event. It would also be helpful to provide space in the children's meeting to allow children to reflect on the impact of restraint in a non-shaming way.
- Although participants were unanimous in recognising the level of support provided for regular debriefing and reflection, they felt that the research group

was the first opportunity they had had to examine and reflect on their experiences of restraint in general rather than about a particular incident. They felt that this was an opportunity that should be afforded to all staff. It would be helpful if the weekly reflective sessions could on occasion be devoted specifically to physical restraint and its impact on staff and children.

I am sure you will be glad to know that the findings from the research resonated with very experienced managers from the other organisation involved in the research. This work has relevance across the entire residential child care sector and beyond into other organisations such as adult care, health services and criminal justice settings. I hope to submit the final thesis by September this year.

Thank you again for your support and the time and expertise of your staff.

Yours sincerely

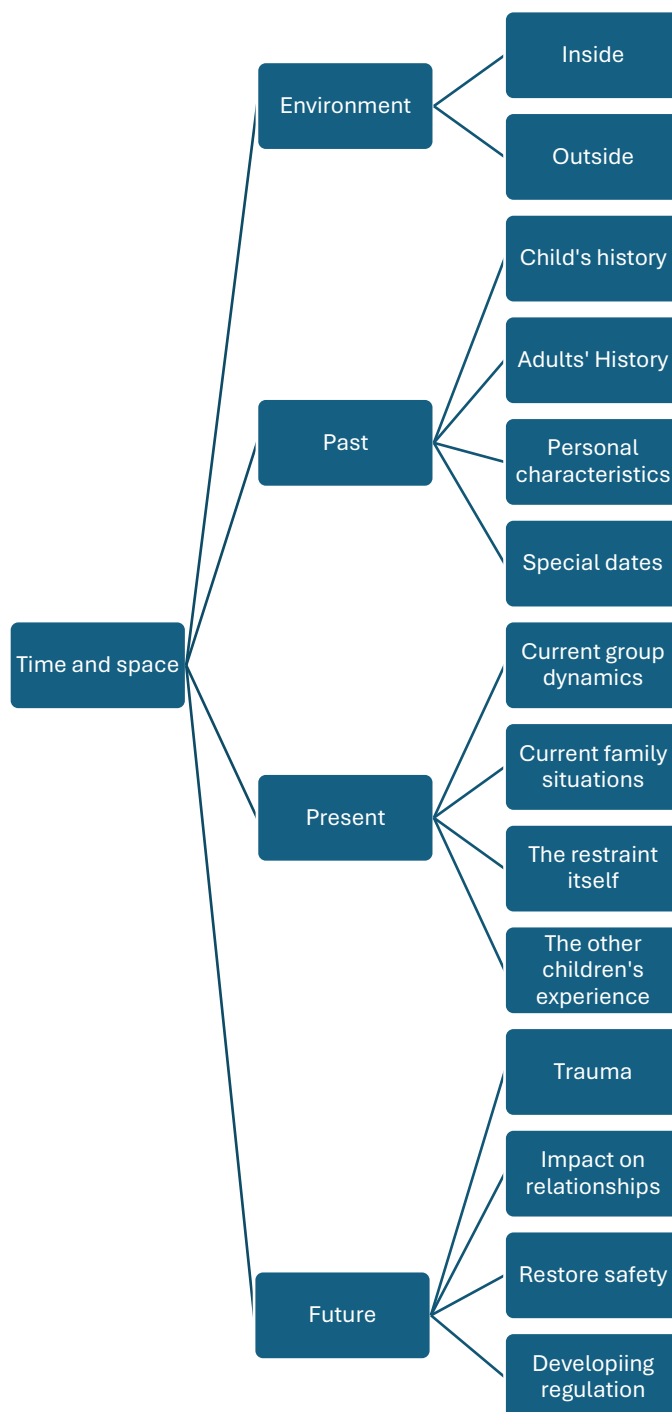
A handwritten signature in black ink that reads "J.M.R. Furnivall". The signature is written in a cursive style with a clear, legible font.

Judy Furnivall

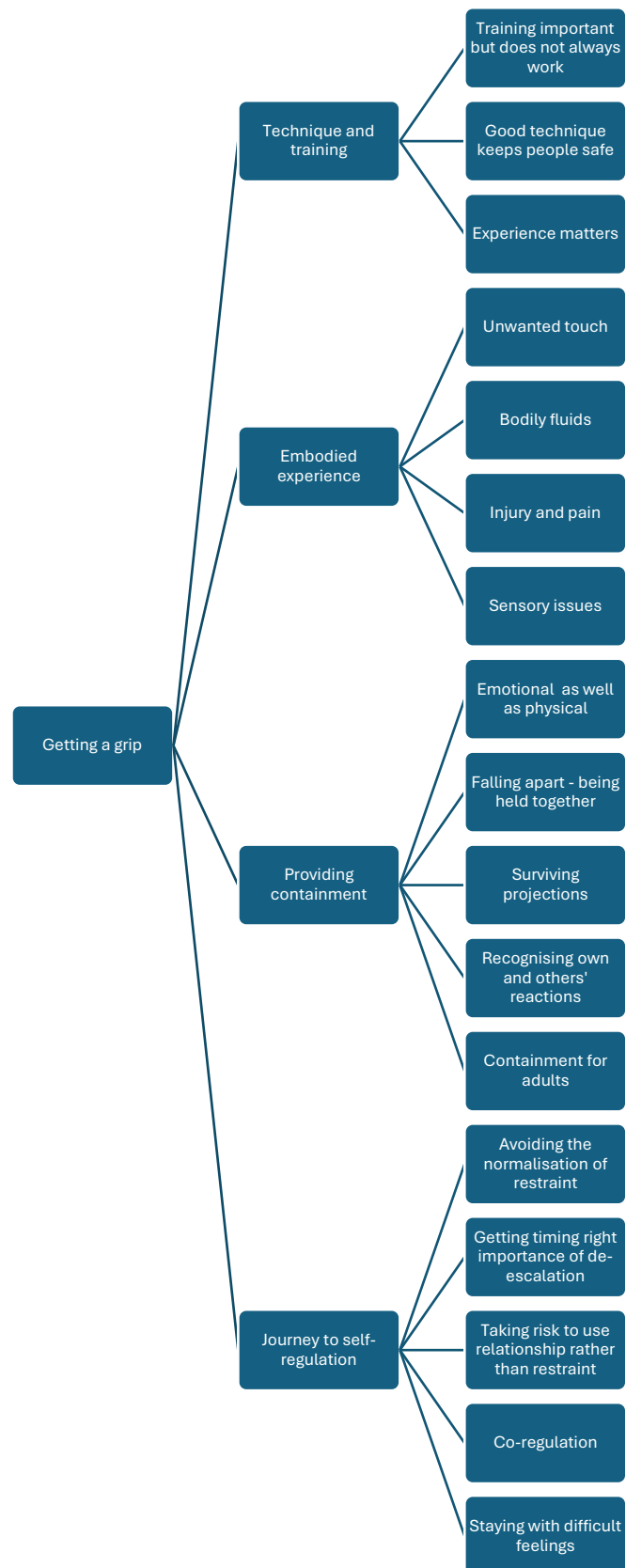
(Independent Consultant and Doctoral Researcher)

Appendix 4 Themes and subthemes

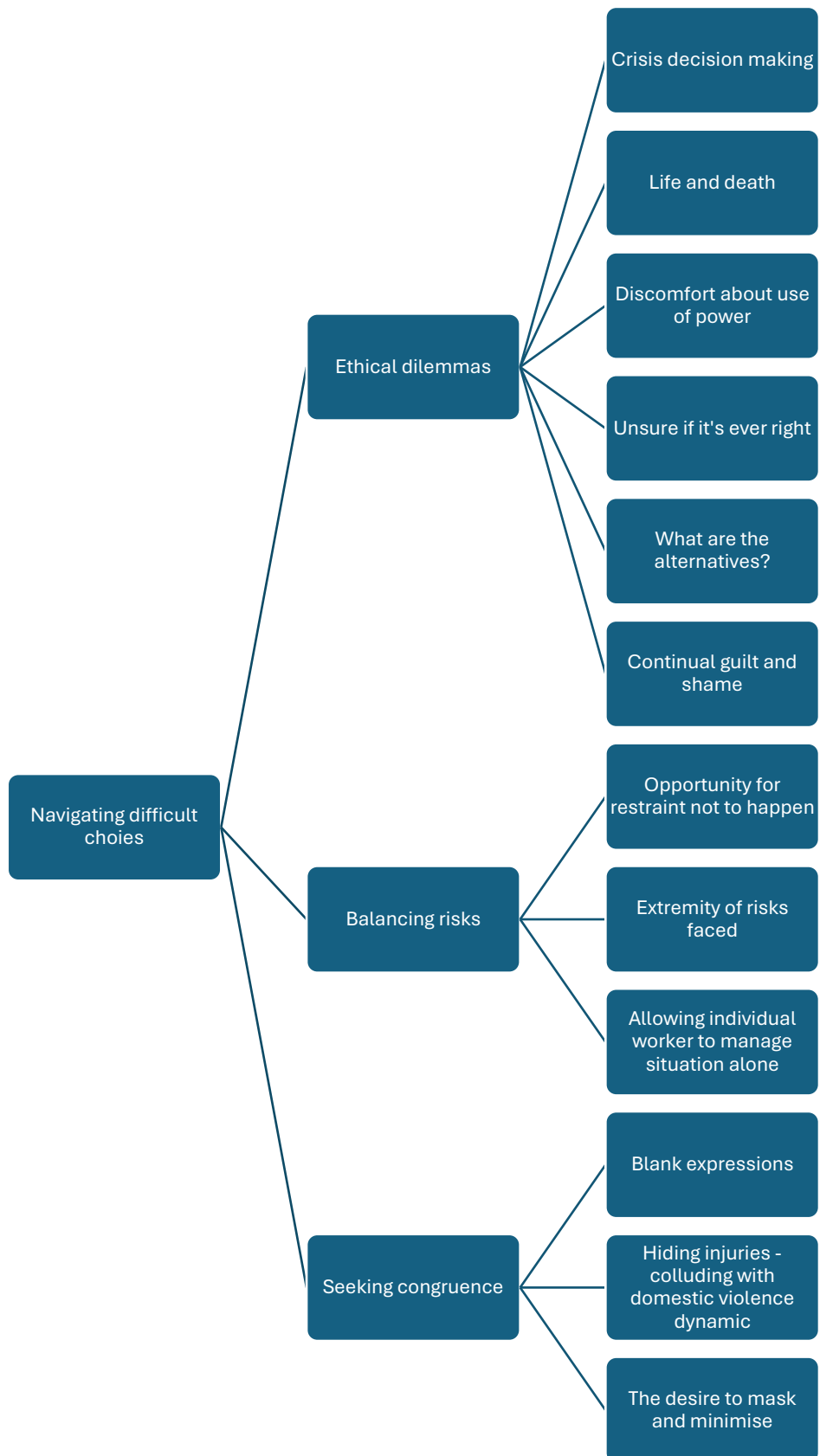
Time and space



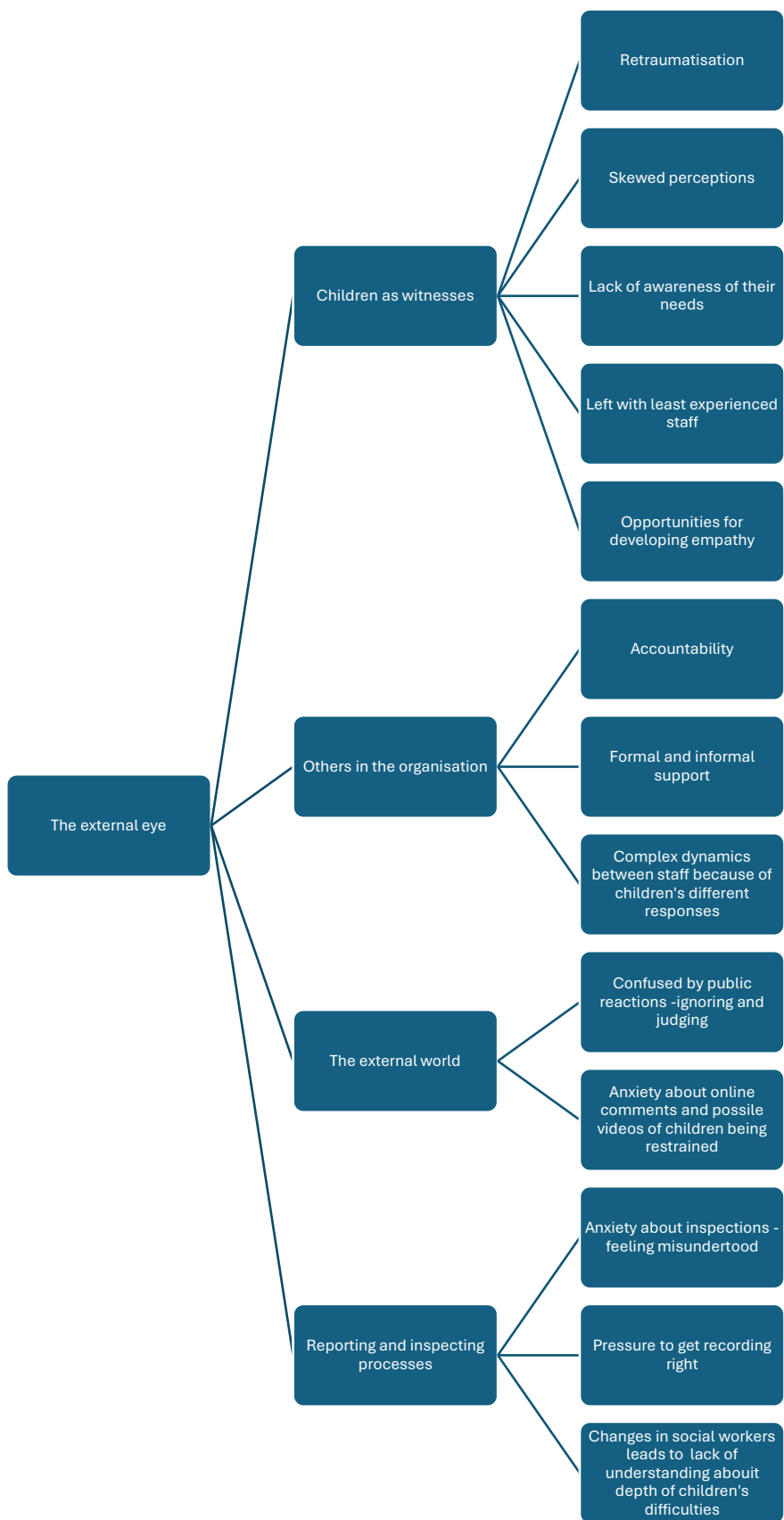
Getting a grip



Navigating difficult choices



The External Eye



Appendix 5 Timeline data

Potential antecedents of restraint

| Distal Factors | Evidence |
|-----------------------------------|--|
| Social attributes | <i>At times with Jamie and Liam they'd start running around and it felt really uncomfortable and very sexualized but not named at the time. And it was better, it was definitely better that they were separate, else it was going to be we're sharpening sticks and we're coming, and it would be they were going to come and get the adults. So, it was intervene early and keep them apart. And it might have been me and Kenny or there was definitely a gender... it felt like an all-boys kind of situation. So, it was probably rarer, but there was something like happening between all four of us, and I think it was, it was like - not testosterone- but it was something of that kind of ilk of that, you know, it was literally they wanted to sharpen sticks and go hunting (Antony, Group 3)</i> |
| Changing personal characteristics | <i>[increased strength/size], one of our children now, he is getting to the point where he's like needing five people to hold him...Because like the restraint the other day with five, it was like our manager, Steve, our other manager Sarah and it was three other like well experienced members of staff. And it like took all five of them to hold him. (Sally Interview 1)</i> |
| Children's histories | <i>you know their background and how restrictive certain things have been and how things have been out with their control and how like adults have abused like, their control with them and in your head and your heart like you know, like you're doing this like to protect them or keep them safe, or others safe but it's like when you get called like a child abuser, child beater or a paedophile or a nonce - they're not words that you take lightly even though you know that they're getting said because of the situation, getting like them names and that is like it's awful to think that you might be putting the same fear and feelings into them as what it has been in the past and that has been an adult abusing the control and they taking what they want and having no regard for the child (Sally Group 4)</i> |
| Personal anniversaries | <i>we do see like a higher number around like contact, birthdays or memorials – like one of our children lost their grandda at the beginning of January, and, although we knew what it was round about that time, she couldn't bring herself to say until it was the day that she'd been told that he passed away,((Sally Interview 1)</i> |
| Shared key events/rituals | <i>then I looked completely different that night, because it was Halloween. So, I had put like a day of the dead sticker thing on me face. So, like, everything about me was kinda - my voice hadn't changed or anything, but my face was and my hair. And that was massive for her. Like, because once she started picking everything off my face, and she was rough, but not rough enough for me to be like stop. Once though it was like the more of my face she started seeing and the more she started seeing me smiling and laughing the more she recognised me and being able to tolerate us (Sally Group 5)</i> |

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|-------------------|---|
| Adult's histories | <i>well with me having ADHD as I was growing up, obviously, my dad he used to like he was very like firm and kind of punishment kind of thing. It was never really like restraint or anything, but I have discussed like there was once like he tied me up to the bed and they left me and stuff like that. So, like, that type of restraint. Like I now know was wrong, but at the time, although I was like, you don't enjoy it. You don't know that's wrong kind of thing. Where now working here, obviously seeing how we restrain the children and what criteria needs to be met and everything like that. It changes it changed my perspective of like, what was acceptable for my childhood. (Sally Interview 1)</i> |
|-------------------|---|

| Current personal/family factors outside the home | Evidence |
|--|---|
| Children's current family, school and community experience | <i>Hang on, you said that word at school. And I know what this is about. Now I've got it, I've got a navigation point". But because I was so pleased at having a thought that linked. I did smirk. And then so then having to explain what it was saying "I think, you know, this is how you seem to be feeling. And I think this has something to do with school" and instead of the "GET AWAY!" it was a "Right". They let you in. And sometimes you navigate that kind of the say "Don't talk about my contact" and you think "Right, okay, I know the lie of the land here. I'll just, I'll just stay" and like, that's where Hermione is with me now. She doesn't want me to talk about any of those issues, she'll throw the picture of Keith {her brother} at me normally and then I'll just know that it's family and I just stay with her. And we don't talk. And if she wants something she'll ask me. (Antony Group 3)</i> |
| Adults' current home, family, community and personal experiences | <i>- particularly the early days would be coming was bites and marks of kind of injury. And being told, not always tongue in cheek, why don't you just deck them and there was there was always that barrier even it's the closest people around of the difference between what are your what we actually do what would be good because I'm not suggesting they would be really meaning that but it was that kind of the people closest could not understand (Antony Interview 1)</i> |

| Current emotional and social factors within the home | Evidence |
|---|--|
| Children's group dynamics | <i>when Sam first moved in, she could not bring up anything that Max made her feel, she was just petrified of him, unless she was actually angry at the point when she'd throw a shoe at him back or something like that. But now she does it a lot (Faye Group2)</i> |
| Children's and adults' relationships with each other | <i>his other key worker, he had an accident, so he was off for quite a bit. So, at that time, he only had like one key worker. But she only does one shift a week on the floor. So, there was a lot of like restraints over how he felt alone, and that he had no one and that he'd gone from having all these people to now like having no one. (Sally Interview 1)</i> |
| Adult group dynamics | <i>And you know, as well when you're on, when you're on a team that's got the experience, you know, as well that they're gonna be thinking probably the same as you they know that it's gonna go okay, you're at this point now, it's only gonna go this way. (Kitty Group 3)</i> |
| Management support/ expectations | <i>after that experience, {in a different setting} when I had to speak to my managers, I was very upset about this. So, my thought of physical intervention was not that it wasn't a great thing to use, but it was what is the backlash gonna be for me personally in using it. Thankfully, when I came here and I was taught CALM, which is very different, and knowing that the supports were in place for me, I then felt more confident in using it and knowing that I was I was going to be using it in the right situation, I would have that support from the staff and the managers around me. But at first physical intervention was something that I wasn't...I was dubious about (Kitty Interview 1)</i> |
| Impact of external pressures or scrutiny | <i>from the comments of having too, too high holds, and not enough de-escalation. And we're not doing this. And we're not doing that where, from a from someone walking in and looking at paperwork that might be the case but when you're in a real life experience of a child who can quite easily break your nose, and has attempted to and has cut people's faces open with spoons and with Lego, then you say, that's great but in that situation, I'm going to hold that child because he is causing physical harm. (Kitty Interview 1)</i> |

| Immediate Triggers | Evidence |
|--------------------------------------|--|
| Sensory or environmental triggers | <i>No one goes to White Rose Park ...it's always, "Oh, you're definitely part of the team if you've been in a PI, in White Rose Park". So if we've got that, concept, these kids must, as well with regard to White Rose Park... You go there to prove it wrong. We have done and now we we do go through the park and, there isn't any restraints. But when I first started, that's what it was. I've sat down in planning and got told "If we go through White Rose Park." and someone else went "Oh the curse of White Rose" (Faye, Group 5)</i> |
| Child's extreme response to distress | <i>I want to add the cars rushing past - the literal feeling of this is, this is a life or death literally, if he gets out of this car, he's running on the dual carriagewaynd that's kind of why I put his feelings or what he was saying in red, because it was just anger it was just all his emotions (Faye Group 4 Picture 3)</i> |
| Adult's anxiety/ fear | <i>I've said about the anxiousness, the anticipation, the stress. If you've come in, in if there's been a restraint the night before, you think hope there's not another one tonight and it's what you would just say just like, has it been resolved? Was that restraint enough to resolve what was going on for them? Or is it still going on for them? So tonight, it's going to happen again and then we're going to have another replay if at all (Kitty, Group 5)</i> |
| Adult insensitivity | <i>A young person was showing that they're in an agitated state, was doing gestures that I later would know would be part of their repertoire of saying that they were starting to escalate. But even to someone that didn't know them very well, she was punching her fist into her other hand to make a kind of punching sound and saying, "do you want some of this?" So, they, the signs were fairly obvious that it was a more threatening gesture. And maybe me who'd never been in a fight and never had to deal with the situation where someone was deliberately offering violence. I suppose she said she was gonna punch me, and I said, "you're not going to punch me". And then I remember getting up off the floor. (Antony Interview 1)</i> |
| Communication breakdown | <i>It was in the playroom, and I was holding him but using a lot of force to keep him still. And it was, he was wanting a cuddle off Sarah, and I think it ended with saying, "I'm gonna let go." And he's still, to me all that, you know, this is my justification, I need to hold him. And it was one of those where, you know, it was a nod and "are you okay? I'm about to let go now" And he did just you know melt into Sarah, and he had bruises on his arms from like how hard ... and it was, you know, the kind of locked arms and it's, it's that's what as soon as power was mentioned. And that's what stuck out to me because it {Very long pause} I don't know. Everything, like the rationale in my head was I'm closest, I'm going to initiate the PR, and this is the reason why. But it's recognising though, you know, where - like at that point it was Sarah, at another time that somebody else would be better. And you know, we have this whole thing of, "I'm not going to let you have this person because you're not going to control and dictate" and like there's that other level of sometimes they know exactly who can soothe or what's going to help. And we keep that away and say "no, this is my restraint. This is my issue that I'm now going to help you with" (Antony Group 4)</i> |

Different processes that may be involved in an incident of restraint

| De-escalation | Evidence |
|---|---|
| No attempt to de-escalate - restraint as first option | <i>And it's once you're trained in PI, that's their 'go to'. It's not de-escalation, it's not trying to understand and make things safe, it's a 'well just restrain them'. And it's simply, purely, because they have the power that they can do it. (Faye, Group1)</i> |
| Leaving it too long | <i>And last resort doesn't mean that you've went through all the de-escalation techniques before. Do you know? So on one hand, you're trying to say, let's reduce this. Let's not do it as much as we can. But the other hand, you're going uh huh, because that child was really not feeling very safe. (Kristy) I think before, we were too quick to intervene, yeah, whereas now, I think some people are going "No, no", and I think sometimes you really need to get in there. (Moyra, Sanctuary Group)</i> |
| Child seems to be asking for restraint | <i>like when they feel like they're literally going to fall apart. And the only way they can get it is through restraint and even you can feel like those ones where you think 'I'm trying everything' you know, like I think we would again, to summarise, go, 'it was as if they wanted to be held'. And you can see some sometimes, like they're not goading you into it. But just like saying, 'I need this'. And you can offer everything else in between (Antony Group1)</i> |
| Understanding children's individual emotional and sensory needs | <i>in the last year, we've really focused on like, yeah, their strategies to help bring them down. And like, yeah, and like that are all specific to the kids. And I think like, we're all more attuned to like what child needs what to like to bring them down (Sally Group 2)</i> |
| Attunement through relationship | <i>there are the times when someone else will say -and that's when you got the level of trust is different- where you go in and you say, I'm ready for restraint, the criteria has been met and someone else will say, "No, I've got this" and they will go into that room alone, or they'll, and I think that happens far more often, where someone will say "I'm connected with something - you're seeing a risk of me getting hurt and the risk is still there. It's very real. But I think I can do this" (Antony Group3)</i> |
| Co-regulation | <i>because in the past people who've been angry with him have hit him strangled him, and he can feel that same feeling. And it was like play acting because, because I wasn't calm, I wasn't regulated, I was just putting on this, you know, mask. Whereas the difference now is the, you know, sitting and being calm. And you know, showing things like regulating the heartbeat and having that skin, we're not skin on skin, but that kind of direct touch so that they can hug and feel the difference in what it's doing and talk about adrenaline states and like it's, it's the time with my key child now it's the tiniest little things. So it's the, the look, whether it's a smile or a smirk and not fitting what the situation would be the angry face, the heartbeat, the quivering voice, it's those little kind of micro indications that someone is becoming dysregulated and I think that they, particularly recently, that's been my kind of the experience of coregulation and you know like being them being so aware and saying like 'you need to calm down' or 'you need this' or like it'd be in a kind of reciprocal and both ways interaction. (Antony Interview 1)</i> |

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| Physical and psychological preparation | <i>We tried to give him space, we tried humour, we tried all the de-escalation, and he started throwing things. Okay, right. We came out and Bethany just went "We need to be ready" sort of thing. So literally, you saw me, Keira and Bethany go in, watch off, rings off, necklace off. Alright, you go in that toilet, I'll go in this one and you two there. And we're literally taking turns to go in the toilet. (Faye Group 3)</i> |
|--|--|

| Beginnings | Evidence |
|---|--|
| Signalling to colleagues to initiate | <i>is I say all the time when I'm training and I'm like, "This is what you saw in training -you say like on 3 ...1, 2, 3. And" but I was like "in real life it'll literally just be a glance, and everyone has their own little thing". So, I say to them "if I feel like it's, it's building up to a restraint. You'll see me take the watch off." (Kitty Group 3)</i> |
| Losing a sense of child and self as whole individuals | <i>... But that's also my emotional protection in that first moment of, it's no longer me and this individual (Antony Group 1)</i> |
| Sometimes feels like a fight | <i>that was like the first my experience of that, and it being, it feeling like a tussle and a fight. You know, trying to stop Soraya getting, breaking into the office, which she had already done, to get to a dog, and then to get the adult who that dog belonged to, and I moved her and between where we ended up, you know, it was holding whatever could be held away from joints and like, you know, what, what CALM would teach us would have been described on the form, and then into a room, but feeling like, that was not CALM, that was not the same. (Antony Group1)</i> |
| Difficulty getting into and maintaining a hold | <i>like Sam once saw a PI with Max. And it was like, really, like, it was really not a good one. And we're ended up like, basically Sam described it as we pinned him to the floor, which I think is probably quite an accurate depiction of what it was. And it was just kind of like, oh,' yeah, like, that's what you do.' It's like, 'Yeah, but that wasn't like, how we should do it. That was us getting safe so we can hold him properly and stuff.' (Sarah Group 2)</i> |
| Impact of environment | <i>when you try to explain how that you've got potentially got into that situation because I've been in one where I've been under a cricket cover. And I haven't been able to do a calm hold because I'm under a cricket cover. But I needed to get out, I needed to restrain the child so I could then get out safely, and I had to try and explain what on earth I was doing at that point. But making it justifiable.... if you're not in like an ideal space, that in here [the lounge] is an ideal space in the sense -you've got your chairs, you've got the floor, you've got the space. When you're in a shopping centre, caravan, as you say, ... that isn't an an ideal space (Faye Group 1)</i> |
| Good technique and experience make a difference | <i>because we just knew, and we knew how it worked. We knew what was probably better for someone, like for her than it was for me and best places to hold him and the best hold for him. And you know, as well when you're on, when you're on a team that's got the experience, you know, as well that they're gonna be thinking probably the same as you they know that it's gonna go okay, you're at this point now, it's only gonna go this way. (Kitty Group 3)</i> |

| Middles | Evidence |
|---|--|
| Pain, distress, discomfort, physiological arousal for children and adults | <i>I put his feelings or what he was saying in red, because it was just anger it was just all his emotions and then the blue trying to be calming and the green was trying to recognise the feelings but the feelings at the top were not only his, but it was ours at the time. The glasses on the side as you say taking away all the sight the arms were jolty because that's where I'd just been bit. And my arms are absolutely killing. And we do that all the time. Where we end up getting injured. So difficult to hold. You're hurt but then they're hurting everywhere else which is why he's then all jolty because he's hurting everywhere. And as I said, that's why the car goes round like that, because I can exactly fit all the sort of chaos in it was all just enclosed in one place. (Faye group 4, Picture 3)</i> |
| Child's terror may be expressed through screaming and violent struggle | <i>she was head buttingas part of one of the techniques that we use, the head is free. So, they're able to do that.... and she was screaming rape because that gets people's attention. And so, it always screams (Antony Group 1)</i> |
| Individual adults appear to be violently targeted | <i>I've had a lot of like very targeted violence and stuff like that. So, for me, it's like it can feel very different as well because sometimes it can feel like personal where a lot of the times when it is one of the kid's distress, it's like, it's anyone who gets in their way. But it does feel very different when it's like it's "I'm gonna get you specifically" (Sarah Interview 1)</i> |
| Adults may have range of internal responses: concern, care dissociation, anxiety, anger, but likely to display 'blank face' | <i>I think you're right. Like, we must just look like robots, to the kids in it or to if any children are walking past us, because what fears do you have on your face? In that situation? You don't want to look angry, you don't want to be sad, you don't look happy. So yeah, we just must look potentially even like emotionless? Because what, what emotion? (Kitty Group 4)</i> |
| Verbal accusations and threats from child | <i>when the kids are shouting like, ' You're abusing me you're a paedo, you're hurting me.' (Sally Group 2)</i> |
| 'Change of face' - adults swap to attempt to reduce tension | <i>I'd been trying to support Max and he'd been really targeting me, and we'd done a change of face, and I'd come away and then I'd gone out and sat downstairs (Sarah Group 2)</i> |
| Adults use repetitive mantras – 'this will end' 'you will be ok' to calm themselves and child | <p><i>I always think about that "this will end" like you say that you're fully saying that for yourself aren't you because honestly, it feels like it's never gonna stop (Sarah Group 4 Picture 3)</i></p> <p><i>through the trauma and through those events having that phrase or that mantra really helps because you do get some that are like the rite of passage or feels like it's never gonna come to an end because there's just so much... (Antony Group 4 Picture 3)</i></p> |

| Endings | Evidence |
|--|---|
| Violence escalates – police called | <i>She had broken through a window, used glass to stab at people, had ended up spending a night in the cells. And there was an interim kind of emergency restraint. But she then had been held by the police and incarcerated afterwards. (Antony Group 1)</i> |
| Bodily changes. Child begins to relax | <i>We feel it in the feel in every part of the child, or everywhere that you're connected, that that stiffness, that resistance. It's like every bit of them's uncomfortable, not just like, not getting enough blood through but it's there's just a tension. And then some point, there's a relaxation, whether it comes with laughter or the time of where it leaves it floats away (Antony Group 5)</i> |
| Sounds change -screaming turns to sobbing | <i>and this sounds awful but their screams, there are screams from it from the beginning, but there's just something about them changes whether it's the tone, whether it but you can hear that it's no longer it's no longer a fight, a fight scream, it's more a wail it's more of a an emotional... obviously there's wails all the way through, but there's just something about it that you just feel is now so different and it's more like that breakdown cry than the fight cry (Kitty Interview 1)</i> |
| Child may seek hug/cuddle | <i>at the end of it, they want you to hug them and like they want you to like, spend time with them.... and they want like cuddles, and you're they want you to care for them (Sarah Group 1)</i> |
| Occasionally child may be able to express and explore their feelings | <i>I feel like sometimes it actually helps get out what they need to get out, because a lot of them really struggle with their feelings about what goes on in their life, having someone, not force it out in a way but assist the child in getting it out verbally instead of physically (Faye Interview 1)</i> |

| Overall Feeling | Evidence |
|--|--|
| Primitive terror. Life, death and survival | <i>It's horrible.. it's life or death for residential workers, and you can't control the conditions (Donald, Sanctuary)</i> |
| Control / compliance achieved through coercive power | <i>I've been in a situation where there wasn't, it wasn't even necessarily a violent incident. And yet they still restrained a child. And that's a massive issue I find around physical interventions is the sense of power that some people get - not here. I'd say I've never experienced it here. (Faye Group 1)</i> |
| Unsatisfying – underlying distress remains hidden | <i>So that this morning coming in, trying to do handover actually there was no resolution of Max being heightened and heightening himself up sobut when we had our PI we got yes, we got stuff. "I wish I was in juvie. I'm a bad person". But we never really got - we got a bit about "I'm worried about school" but we never really got a resolution as such.</i> |
| Part of a repetitive cycle | <i>I wanted to do something that was like the cycle. And, you know, wasn't supposed to be conclusive. But there's a difference in emotions and the chaos. And, although I tried to generalise, it was based on, it was Liam and being stuck in that cycle with Liam. And so, the poster we used to have individual photos. And during one of the events, and it was a time when you pretty much knew there was going to be a PI, and it changed how you thought because it wasn't a "what can do to avoid it? it was "at what time of night is it going to be?" And it would be the whole room, and you'd end up stepping into the chaos. And there was a point where my photo would be in there. And it was a lovely one of us together on holiday dancing, and he took it off and he ripped it in front of me. And that got through more than anything else. And he stood in that chaos. And when, when he was ready, put it back together. But there was nothing there was like literally nothing left. So if I kept on going in the cycle, it would have been like drawing the room and then it didn't have a bed and it didn't have sockets and it didn't have walls and didn't have skirting boards ...Different children at different times I feel like you get into that this is how this is, this is what we need to survive, this is what will end - but how it will end, what the end will look like? And when it happens you won't even know it'll just be a point that you refer back to once it has ended but just when you're in it it's just round and round. (Antony Group 4 Picture 5)</i> |
| Milestone experience linked to change /cathartic | <i>there's been there's probably like PIs in my head that like, pinpoint moments. But I don't think initially, I would have been like, that was like, that was good. Like I think I can pinpoint like, right, there was something happened in that restraint. We talked about this, and that's changed something. (Sarah Group1)</i> |

Aftermath

| Perceived impact on child | Evidence |
|---|--|
| Re-traumatisation /re-enactment of trauma | <i>because I think like you know, like their background and like how restrictive certain things have been and how things have been outwith their control and how like adults have abused like, their control with them ... like it's awful to think that like you might be putting the same fear and feelings into them like as what it has been in the past and that has been like an adult like abusing the control and they taking what they want and having no disregard for like the child (Sally Group 4)</i> |
| Eroded trust | <i>The same kid I was talking about was in a really difficult restraint the two years previous, and actually it came up during this really difficult period of change in Arran Place and he was then shouting at the top of his lungs that I had strangled him... that was two years - although the repair, the repair had been done..., I suppose what I'm saying is, for me, the biggest part of that learning is just because it looks repaired - because I had went back, right? We're okay. We've done this, we've done some nice things together, so we're okay, we're cool- But actually, two years later, that had triggered in his mind, and I was devastated, and I shared that with him. I was devastated for him holding that for that length of time, and his opinion of me, that I had intentionally tried to hurt him, (Fiona, Sanctuary Group)</i> |
| Injury | <i>it's not intentional to hurt, but like, part of the knowing, when you're using it is it's uncomfortable. And I think we'll, you know, say none of us are comfortable. But the person who's least comfortable is generally the person being held. And when you see like the fingerprints, it literally is the, the points of your fingers, pushing it in and in that technique, you can get, you know, you can break bones, and, you know, it's these are things that CALM kind of talked about, these are the risks that are there, but even just applying it correctly, it's gonna hurt, and bones that are growing and the age of the children, and it's uncomfortable, and it's uncomfortable then, and then it's uncomfortable after (Antony Group 3)</i> |
| Guilt/shame | <i>I think they learn from being, being able to go like in children's meetings at times where you can tell when someone's furious that someone's mentioned something in particular, like Max will, you know, show it, but in the really successful ones he's not acting on it, but he's experiencing the, "I want to punch you and make you shut up. Because you're reminding me" and the shame and guilt part, you know, we can never do something that will make him feel any worse. But there are times when it can be like, "I feel bad, or I don't like feeling how I feel now about what's happened. I want to move past", but he'll stay with it. (Antony Group 3)</i> |
| Normalisation of restraint | <i>we were seeing a pattern of, we could be holding on to him every day, and we were going, we need to break this pattern, because the only way that he's regulating is by us physically intervening (Moyra Sanctuary)</i> |
| Release/ catharsis | <i>And it was like you had to get him past that stage, to break down so you can actually get the feelings out. He thought if he intimidated, he shouted, he banged about enough, he'd keep you at the distance. do you know that way and it. But</i> |

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| | <i>he had to get past that to actually get to him and allow him to be vulnerable. But it took quite a while, and only once or twice, I think it really, really happened (Jeanie, Sanctuary group)</i> |
| Feeling safe and contained | <i>I had, like, Jonny say to me, it was one time “ Catriona, I just don't know why nobody stopped me before. Why did nobody stop me hurting myself? ...Why did people just let me, you know, punch my walls” and he's like, “they would just let me be unsafe because they weren't stepping in” (Catriona, Sanctuary Group)</i> |
| Helped to regulate | <i>you've then got to understand that you can, once you get into it, it is a form of containment, it's something that is regulating and helping to deescalate them. And from that, you can have times where they'll communicate what's going on and what's happening for them. So it can be something really negative, but to understand that you can contain them, then they then have that feeling of safety in that, which then allows them to speak about what's on their mind, you'd obviously hope that you didn't need go through that process, but there is some positive, positivity can come at the end of it. (Kitty Group 5)</i> |
| Knowing their destructiveness can be managed | <i>And a week later, she tried to enact the same thing, and I held her in the garden with neighbours watching, with broken glass around us for several hours ... she was head buttingas part of one of the techniques that we use, the head is free. So, they're able to do that. And she was. And that took a long time. But the incident came to an end. But that was something about our relationship about keeping her safe and held. And it was like the test of 'in these moments, I'm so traumatised, I can't stop myself'. (Antony, Group 1)</i> |

| Potential impact on other children | Evidence |
|---|---|
| Re-traumatisation | <p><i>I think you can focus on the support for the child that was held, but not maybe as much for the one that witnessed it, or two of them in a different room, and they didn't even witness it, but they heard it. That must be quite ... I don't know how that feels.</i></p> <p><i>Sometimes... it can sound worse than it is as well...for us as well</i></p> <p><i>then it must be even worse. If you were the child, yeah, not knowing, (Donald and Kristy Sanctuary)</i></p> |
| Rupturing relationships with adults and interruption of their day/routine | <p><i>more recently in the formal meetings or the, you know, the regular meetings it, it becomes 'They took away my adult' or it, it becomes a much more kind of simplistic thing, and that can hide a whole depth of I didn't get the warmth and the love and it's just kind of verbalises that I've missed this adult time. (Antony Group 2)</i></p> |
| Anger with child involved in restraint | <p><i>Alex said Max hurts the adults. And he like, does this to us or whatever. And it's trying to explain to him that, yes, he hurts adults, but it's not like it's not because he's hurting the adults, which is why we're holding him. And there's a lot. There's so much more going on that. We can't explain it. We can't explain it to you. We can but we can't go into the depths of it. Because it's Max's information. It's like, it's trying to get him to understand, yes, he's hurting the adults, but he's hurting the adults, because he can't show x y z. And this is how he's showing us and it's trying not to make perceive him as the naughty child because that's how they're going to look at him in the house as he's the naughty one because he's always getting held and he's always hurting the adults and he's always screaming at us and if he wasn't here that was it would all be fixed (Kitty, Group 5)</i></p> |
| Normalisation of restraint | <p><i>I'll close this door -we can still hear someone shouting, 'You're killing me'. or you're doing this, and, having worked with like children where you do some level of follow up and like respect confidentiality, but they've heard they've seen, they've seen the build up to the thing, where children would say 'It's alright, I know what was happening'. And they would literally describe it, you know, 'He was being strangled, I know what was happening' and it's like, 'No, that's not okay. (Antony Group 2)</i></p> |
| Awakening the capacity for concern/empathy | <p><i>where, Sam slammed my hand in the door. And Hermione could tell, like I was in so much pain, and she was amazing. She got me ice; she'd seen to me. And she really calmed me down because like, I was like, I was up there and like she was like 'Do you want to talk about something? What do you want to do? Do you want to come and have a cuddle?' like, she was amazing. (Sally Group 2)</i></p> |

| Impact on adults | Evidence |
|--|--|
| Traumatisation | <i>it's traumatising to hear people screaming, and to also know that violence might be happening, to people you care about but also violence might be happening to one of their peers. And you can't do anything. Or seeing people being pinned down. (Kitty Group 2)</i> |
| Resigning | <i>then it doesn't help that the outcome was that the adult left straight after that PI...did I cause that? I know it wouldn't have been me. And it wouldn't be Max. But it's the, if that hadn't happened, that particular situation hadn't happened. Would they be okay? Would they still be with us? I still, I still communicate a little bit with her. Not a lot. The very, very occasional but my mind still goes to. Would you have been here longer and had bigger relationships with everyone had that not incident happened? And am I responsible? (Faye Group 1)</i> |
| Injury | <i>I've had, like chunks taken out of my arm. I've had chunks taken out of my boobs. I've had my face scratched. I've had my ankle... I've had my foot broke, I've had my fingers broke. Like, the level of like, violence that comes from them children, like the children is really high and like, after, you've kind of got to deal with how you're feeling about the restraints whilst being able to check on that child and make sure they're okay - but have pain running through your body from whatever injury you've got. (Sally Interview 1)</i> |
| Feeling like an abuser | <i>you just feel like an abuser that type thing. Like, if anything happens, and say like, when the kids end up with a bruise or anything like that, and then, like, you kind of know that's from when you were in the PI with them. And you're like aw that's from me. And that feels that feels absolutely terrible. I'll never, I'll never ever get over that whenever I see a bruise. And I think that was from when I was in a PI. (Sarah Interview 1)</i> |
| Guilt/shame | <i>I don't think there's been a hold I've been involved in where I've not felt some element of guilt or shame - could I have done something different at any point to avoid this? Or could someone else have been who would have avoided it ... you feel shame and guilt and, and you jumped to that if somebody else had been here the situation could have been resolved ... but actually, if someone else had been here it could have been a lot worse (Donald, Sanctuary Group)</i> |
| Anxiety about other people's perceptions | <i>I feel really anxious on what people are thinking in the sense of do they think I'm actually hurting this child? (Faye Group 2)</i> |
| Erosion of hope | <i>it takes something out of you each time that resonates, because I feel it does just a wee bit of you sometimes. (Donald, Sanctuary)</i> |
| Seeking absolution | <i>and I think sometimes again, speaking personally, you can be in a PI and you're telling people almost in an apologetic way, 'I'm really sorry we tried everything we did this, we did that.' And you want them to say it's okay. You know like, like forgiveness. You know, 'if you'd have been there, they would have been okay, but they only have me and I can only do the best I can'. You've done all the rest. Everything was covered, but it's like an apology for something (Antony Group 1)</i> |

| | |
|--|---|
| Belief that restraint can be therapeutic | <p><i>I think at first it was always, like I would always feel like, oh my God, I'm terrible. What am I doing to this kid. After a while my perception of it changed but it was more like you could see the work that was being done with them through the relationships and stuff as well and the rupture and repair. And then there's been there's been some kids like some times that I have been involved in physical interventions that have been like, to the extreme level and for a very, very long time and that's the one where you kind of mainly see how much that's the child in complete fight and flight and you're dealing with the trauma right there. And I always, I always have a little bit of it's like a little jigsaw piece of every single time it's gonna help them at some point. That's my kind of thinking of it now.</i></p> <p><i>(Sarah, Interview 1)</i></p> |
|--|---|

| Impact on relationships | Evidence |
|--|--|
| Can permanently shape the relationship problematically | <i>For me personally, with particular children, I've held them before I've ever cuddled them. And what that means when you get to know somebody, and they're setting their boundaries, and we talk about your body as private to you, except if, if something you're doing is, you know, serious damage to property, is going to injure you or another person.. (Antony Group 1)</i> |
| Can help build relationship/strengthen bond with child | <i>The one I can think of it, the reason it feels like it strengthened my bond with the child was because they felt like I'd could provide that safety for them. And then they started to open up to me a lot more. Beforehand, they basically pushed me aside in the sense of meh, you're not a real adult sort of thing. And then after it they realised, I could do that, and I could provide that sort of containment in a way during the physical intervention. They then started to accept me more, started to tell me more about their personal, like their home life before here, and started wanting to do activities with me. So that felt like it did strengthen our bond. (Faye Group 1)</i> |
| Can strengthen bonds with other adults | <i>it wasn't very, like it wasn't like super dangerous, like Max would be now, but was a "we need to stop you from hitting us. And the only way we can do that is by sitting here all day". But I think you build relationships with other people through that</i> |
| Can reduce the likelihood of future incidents | <i>But the incident came to an end. But that was something about our relationship about keeping her safe and held. And it was like the test of 'In these moments, I'm so traumatised, I can't stop myself'. But after that, there were no other incidents that went to a level where the police would be involved. It was a, we can do this, and we can be safe together. (Antony Group 1)</i> |

| Creating the narrative | Evidence |
|--|---|
| Adults' perspective becomes the accepted reality | <i>we can't, there's not enough time to always be explaining everything that was going on for each individual. And so, it gets lost in these little islands or, and it's all adult-led and we can decide what, what it was.... what's happened. And, you know, the child might talk to their social worker, or they might report, the kind of feedback, but it doesn't carry the same sense of identity or claiming that this is what the event was. (Antony Group 1)</i> |
| Difference between how an event feels and the written record | <i>what stuck with me about the write up, and you can create a reality. That's neat. And kind of that is it. That is the, the lasting truth of the event, but it's different for each person how it feels, and it doesn't cover, yeah, it doesn't, it doesn't do justice to the emotional impact, let alone the relationship side (Antony Interview 2)</i> |
| Difficulty in ensuring children's voices are heard | <p><i>and the kids don't really say much like, in their post restraint, like, not like where they have like a chance to say like, like, I think like, they didn't hold me right or they hurt me or they used too much force or whatever, whatever. Like, their time is to like, have their views and that. There's not very many times I look at a PI form, where there's actually been something written, other than 'no comment' or 'declined'. And I just think like, do these kids really have nothing to say about these restraints? (Sally Group 1)</i></p> <p><i>I think they're worried that they need to protect the relationship as well. So, they need to not say anything to anyone because if they do... when things have happened bad in the past, had an injury, they've moved. They need to protect, like, 'yeah, yeah, you're here, you've held me, I'm not too happy about it. You tell me that's what's supposed to happen. But I don't know.' (Sarah Group 1)</i></p> |

| Impact on organisation | Evidence |
|--|--|
| Can lead to downgrading or requirements from regulatory body and reputational damage | <p><i>So, the message came from Ofsted and them questioning the the, the amount of holds that we, we had had. For us we were very shocked because we've had previous years where it was over 200 And this time it was in the hundreds, but they were questioning it. So, they thought it wasn't OK ... and I think I believe it came from obviously, us always doing figure fours. And I think maybe that was questioned, as well about the level of fours that we were using. So, we were told that we needed to try lower-level holds before we went into higher-level be like we need to do lower-level holds and they want to see more lower-level holds. So, that the high-level holds could be more justified, in a sense. So that just made everyone immediately go, "Whoa, I'm not doing a secure comfort on Max", which is a lower-level hold for someone who can, who can be violent, but they're not. They're not at the stage of that tipping point where they've heightened and there's no calming down from it. (Kitty, Interview 1)</i></p> |
| Staff leaving or off sick | <p><i>then it doesn't help that the outcome was that the adult left straight after that PI...did I cause that? I know it wouldn't have been me. And it wouldn't be Max. But it's the, if that hadn't happened, that particular situation hadn't happened. Would they be okay? Would they still be with us? I still, I still communicate a little bit with her. Not a lot. The very, very occasional but my mind still goes to. Would you have been here longer and had bigger relationships with everyone had that not incident happened? And am I responsible? (Faye Group 1)</i></p> |
| Bureaucratic requirements | <p><i>Yeah, I do think about OFSTED I think I definitely didn't when I first started. But it's the, it would I think when we changed the way that we wrote the paperwork, because I was happier when. when it was more of a story. So, when there was more, there was a lot more words, but there was more of a context and this, is this situation. And there certainly wasn't the clarity of the holds and kind of the being able to take this as a template and then adapting it to how, how it was. And I found those easier to tell apart from the events now. So, I think about Ofsted of like what if they come in and they say you were wrong, or this was wrong? (Antony)</i></p> |
| Improves possibility of containing traumatised children and maintain placements | <p><i>I don't know how we could have managed Davy, for as long as we did at the beginning, if there wasn't some kind of physical containment, he was off the wall...It's about safety. Smashing windows. He swallowed things. He threw things. He covered himself things. He hurt himself. He hurt like he'd hide things. Yeah, the smallest wee things he would put in his mouth (Jeanie, Sanctuary)</i></p> |

Appendix 6 Supplementary Quotes

This Appendix provides additional quotes from participants to underpin the themes and the argument of this thesis. This also includes some excerpts of conversations which are presented in text boxes.

Power

There was a man talking about being used as the muscle and being called into, 'You wait till he gets here'. And being forced into this role of being like the enforcer, and coming into PI - being very good, technically sound, all safe.... And that just made me think around kind of because ...there are less men around ...and how you kind of where you fit into stereotypes.... (Antony Group 1)

There's been times where I've been able to get him in his room with a secure comfort on my own - because he was kicking out or something -he kept going for me. I was like he's going for me because I've been able to do that. But then I need to do it again to keep him safe. I don't want to do it again, because I don't need to exert my power. But then he's gonna keep coming for me because I've been able to (Faye, Group 3)

We were in a power situation where he was trying to come out of his room. So, he had the space in his bedroom that he could use, he was given a little bit of landing, the bit outside of his room. But I'd made the decision to not let him out on the landing, not out of his room. And again, that's a restriction, you're restricting his movement. So that then became a power thing, with me blocking that entrance. And yes, I did it for the right reasons because of the time and the other children and what it might cause for them, and he had that space if he wanted to use it, but you're then "I am right. I'm not letting you move. No, you're not getting out, no". And that then becomes a power thing. And it's how you then again, it's a fine line of how I justify why I've restricted that movement to why I didn't just let him roam free down downstairs. (Kitty, Group 3)

Technique and training

So we put every safety, health and safety concept that we can but in real life, you kind of know that you might get hit in the face or when you sit down it might end up in a heap, but your technique will be dealt with, you know your technique well enough.(Kitty, Group 2)

*when you do the training, and then it's like, this is the way it is blah blah blah and you think I know you're saying this, but **have you actually met the children?** like have you actually I know you said, that you know lots and lots about PIs, you've been in PIs. But have you with **our** kids? (Sarah, Group 1).*

Triggers

Seeming different

I looked completely different that night, because it was Halloween. So, I had put like a day of the dead sticker thing on my face. Everything about me was - my voice hadn't changed or anything, but my face was and my hair. And that was massive for her... once she started picking everything off my face, ...it was like the more of my face she started seeing and the more she started seeing me smiling and laughing the more she recognised me in being able to tolerate us... I'd have looked completely, completely different. Like I recognised the fact that I had my face stickers on, but like, like, my hair was darker. Like it was a really dark deep red. And like it had been cut. And it was styled different and everything like... (Sally Group 5)

There must be a change to your smell and your appearance, mustn't there? that they, that they then see or feel because Max is obviously always aware of smell, isn't he? So, can he pick up that slight change of adrenaline? (Kitty Group 3)

Loss

When he lost his father his behaviour started, obviously from the trauma, to become disruptive and physical with other children (Kitty Interview 1)

as staff started to come and go, again, we've kind of noticed like the PIs are getting more, but also like round contact and stuff like that with certain key members of staff not being in (Sally Interview 1)

Non- verbal communication

when you've got that relationship with the other adults, you just know, you can look at each other you just know. But I might take my watch off, might tie my hair up, might go to the toilet. (Kitty Interview 2)

all the time when I'm training and I'm like, "This is what you saw in training -you say like on 3 ...1, 2, 3. And" but I was like "in real life it'll literally just be a glance, and everyone has their own little thing". So, I say to them "if I feel like it's, it's building up to a restraint. You'll see me take the watch off." (Kitty Group 3)

...like the trauma pathways in the brain. Like for the kids. We know a lot about that. But I think for the adults, you've got restraint pathways. Yeah, they're like pathways in our brain. And they're linked up with each other. (Sarah, Group 3)

Child just seems to need it

He couldn't accept like any kind of like hugs or someone to sit near him or hold his hand or anything at that time... the only way he could feel close to someone was to trigger restraint. And he even said like that what made him feel comfortable was when he was being restrained (Sally Int 1)

being stopped and being held and literally held together at a time when you've fallen apart. And I think there's times when the child just needs you close, they can't accept

hugs, but they know they will, you will be close and you will hold them and you will, like when they feel like they're literally going to fall apart. And the only way they can get it is through restraint. and you will hold them ... (Antony Group 1)

You can feel like those ones where you think "I'm trying everything" ... to summarise, "it was as if they wanted to be held". And you can see some sometimes, like they're not goading you into it but just like saying, "I need this". And you can offer everything else in between. But there's something fulfilling in that. "I'm, I'm just safe and I'm here, I can't hurt anybody, and you're with me" (Antony Group1)

And I think there is that emotional containment time where sometimes the children say, "Just hold me". And the thing, I don't want this, I want what comes afterwards, when I feel like you ... I have fallen apart, and you've put me back together. And I think they're generally the quiet, I don't mean -they're physically very difficult - but they're often the quieter restraints where you think there's a crisis here. And sometimes, cos I'm thinking of Lucy, and like Lucy is so warm and thoughtful and motherly when she's around. But that's the duality of the job, that you're providing all those things all the time, but then you're prepared, if, if everything else from the toolkit doesn't work, this is what we're gonna do. And I think you do have to have them both in your head. (Antony Group 3)

Sensory needs

Max you could be gripping on for dear life and to one child that's the extreme amount of like pain they could feel. But for Max it was like, "Oh, actually, this is what's gonna bring me down"... on Sunday night, Max was climbing to try to get out of his room, but he was pulling and pushing against us. So, it was like, we're gonna do something different. I asked him "Do you want us to lie on you and do your pressure?" and he just stopped dead and was like, "Yeah", and that's what we did...would he have got the same thing he was seeking if he'd continued then hit one of us? Because we would have held him, but it never got to that point. And that's like hard as well. Because like even with us three laying on him then we are restraining him because he couldn't move but it's not like we were restraining him completely against his will. (Sally, Group 5)

Taylor asked me to lie on her, but she was able, I was able to talk to her, ...And I said, "Why don't we stand up and we'll tight hug each other, like the two of us, really tight, hug each other." But she's fourteen, she's quite articulate, yeah, able to have that conversation, yeah, do you know? But like, she's actually asked me, could you lie on me? (Kristy, Sanctuary)

We had a couple of boys who would actually lie on the floor, so they went through the process of, like, recognizing that actually that was something they needed. But it almost like they went through a process of, rather than having that sort of pain-based outburst that they just lay on the floor to let you go...So, you were trying to then get them to, like, learn. "Well, you don't need to do that. You could get that touch and comfort another way" (Kristy, Sanctuary)

Initial interactions

It's that instinctive almost, not instinctive, but you're thinking about how you're going to stop them hurting you and it's not until you have that, and you're back down and you catch breath, that you can start to maybe connect again. (Jeanie Sanctuary)

Leaving it too long

My first physical touch with Matt was restraint because the inspector was in. He was running amok he was going "Fuck you, fuck you", but nobody wanted, in my opinion, to intervene, because I think they were going, "Oh, my God, the inspector's here. Like, what am I going to do?" ... it was Stevie (Assistant Manager) and I and, I mean, that was the day I met him, but he needed somebody, and I had to say, "No, no". because he was just so all over the place - don't get me wrong, I was like "I'm sorry, we're having to do this, but you can't keep running about, we need to be safe'. (Kristy Sanctuary)

I think a lot of us - we can meet the criteria quite quick, like the PI criteria will be met. And I think a lot of us will continue to try and de-escalate until it got to a point where it really was what we have to do.(Faye, Group 1)

Chaotic/Like a fight

I've been in situations with Max where, where it's literally felt like a fight. Like I'm literally tackling him to the ground. And thinking that was not any sort of anything that you would want someone to do. But that was proportionate, because if not, I was gonna get me head kicked in. (Sarah Group 3)

the drawing like is chaotic and I think that's how sometimes a PI can feel like you're you're literally scrambling to try and get a hand get a leg without you trying to be hit with a hand and a leg and preventing someone else from being hit with a hand and a leg I feel you go into a PI and everything and as we always say you teach them in the training room where we all just stand still and they come in when realistically your arms and legs are going all over like you're not just going to sail into a, into a nice PI and there not be some chaos surrounding it (Faye, Group 4)

Embodied experiences

Bodily responses

and I'd come away and then I'd gone out and sat downstairs with Isobel - and she made me a drink and she passed me the drink and I was like that, shaking, and and she was like are you alright and I was like 'Oh it's the adrenaline because I've been in like a dangerous situation and stuff' (Sally Group 2)

Injuries

But I think we've always been bad at acknowledging when we need - this is talking about first aid, like cold compresses, and, you know, kind of the basic first aid we're

trained in, not the emotional support that we give. But I think the actual physical things we minimise or trying to hide or just don't realise the importance of... (Antony, Group 1)

Bodily changes during restraint

And the claw hand is around, it was something that was mentioned around adults and how you get tense. We feel it in the feel in every part of the child or everywhere that you connected that that stiffness, that resistance. It's like every bit of them's uncomfortable, not just like, not getting enough blood through but it's there's just a tension. (Kitty Group 5)

you're there protecting Sam from all the things that come at night, to have you pulled away and then come back and smell different, and be different, and all you know, the tiny bits it's it's re-traumatising. The smell like, like she turned around to me after one that I had and told me I need to, I think you should shower before you go to bed.(Faye Group 2)

Emotional impact on adults

Feeling like an abuser

It feels massively invasive on every level. And that's where you feel closest to being an abuser, regardless of what they're actually saying, it's just - how it feels is really uncomfortable. And you, you're forcing your will upon somebody else. And that's when you really need to think, you know, is this a situation that I've assessed and thought ... and have you tried absolutely everything else? (Antony, Group 1)

my experience of having my first key child and that mixture of being their safe space, and really what's secure base would mean, and safe touch particularly when knowing through their background, what they told you what they showed, and what you learned from kind of contact and their experience of safe touch or touch that would just be harmful and just really not okay. But then also being the pair of hands that would hold them and be there through that kind of trauma. And that brought up lots of different feelings of feeling like an abuser. (Antony, Group1)

You just feel like an abuser...Like, if anything happens, and say the kids end up with a bruise or anything like that, and you know that's from when you were in the PI with them... that feels absolutely terrible. I'll never ever get over that whenever I see a bruise. And I think that was from when I was in a PI. (Sarah Interview 1)

But the lingering impact would be that I feel unclean...I would literally - the drive home was my safe space, then having a shower, when I got in and washing away something, whether it be kind of guilt or shame. (Antony Interview 1)

Adults' difficult emotions

It's guilt, isn't it ...especially when you see a mark on a child and then you just sit there and feel absolute guilt (Faye, Group 3)

it's always last resort, because it doesn't make you feel good -it doesn't make them feel good. And sometimes even though you've held them, it still doesn't get to what

was actually going on. And they're left with marks that linger for days, or you're left with marks that linger for days, and you're left with them shitty feelings, I'd just rather like have spent like two hours de-escalating than half an hour in a PI (Sally Group 1)

I don't think there's been a hold I've been involved in where I've not felt some element of guilt or shame. Could I have done something different at any point to avoid this? Or could someone else have avoided it ... you feel shame and guilt and, and you jump to if somebody else had been here the situation could have been resolved but actually if someone else had been here it could have been a lot worse (Donald Sanctuary)

logically I know this will be what happens because of the relationship but then I'm like - I do so much for you how can you do this to me? So there's, like the logical part of my brain and the feeling part of my brain are always fighting each other. (Sarah, Interview 1)

That was a very personal thing about because there's the technical side, that in that, in that moment, it's the teeth that bite, the hands that hit, there is no individual there, there is my half of you know, what the puzzle is to get this back to being safe. And then it opens up again. But it's, it would be so much easier just to not think about them as a whole person or, like, a lot of their thoughts and things about their behaviours are indicating, if they if they could they would, they would have just said this is on my mind, or you know what's happened in that situation. But it's that next bit of the whole person could do you know, will be that child who then you might be spending hours with who's bitten and punched and called you all these horrible names and then you're still there. And because of what we do you're a carer you're a symbolic vessel, you're all these things at all these different times. And it's so many different hats to wear, I think was where I was kind of coming out with the thoughts about us as individuals and be alert to the person and like, it doesn't go away when you think it someone said, you've hurt me and it's on purpose. (Antony Group 5)

Dissociation

It sounds awful, but I think you have to kind of block it out in a sense. So, you can't let it affect you. In some ways, you'll either break down, or you have to, you have to hold it together because obviously PIs where you are being accused of, of abusing them. ... I think I've generally felt that I have to block myself off to it... I know you can be trying to be open; you need to try and be open to it but I I just find it too difficult sometimes in a lot of PIs in the midst of it (Kitty Interview 1)

Sometimes, particularly when someone gets everything, you can come out and think like, I think that I was just dissociated, I was, I just wasn't connected to something. And there's a numbness to that when you come out and someone else will be describing how attuned they were to it. You think I was, I was just, I was just there. (Antony Group1)

Psychological processes

Splitting

he also has a way of making you feel, like the person holding, feel bad about holding, but also about who you are in the hold with. So, when he said "Oh, she's already here", my mind went "But no, I can hold you". And it makes you feel like you need to show that power (Faye Group 3)

You get like those people where they've got a relationship with that kid that and, to be fair, that could be me at some point, where you know, you've had the worst day with them and the second they come in then they're going to be good as gold. (Sarah, Group 5)

Counter transference

The first proper restraint I was in, that was like, it was really quite traumatic for me. Like seeing them crying, and begging to be let go of and, like saying that they want their mom and, obviously, you know, the relationship between them and their mum wasn't good, and, that they would want someone that was like, like a hurtful person, like, when they had like, adults who they knew was safe, but at that time, we weren't safe to them, even though we were trying to keep them safe. And I think like, feeding off their feelings that's what made me kind of like, look back on my my times of being like restrained and I could acknowledge, like what that felt like at that time. (Sally, Interview 1)

I think, where I've thought back to an incident that I can see my own responses haven't been the best if I've felt a lot of anger or anything like that, and I've not responded in the best way, to like the kids and stuff. And afterwards, like, I reflect on that. And, like, that was my own feelings (Sarah Interview 1)

Lack of attunement

I have this image in my head of a PI where me and Sarah were involved. And I was closer to Max. And at that time, Sarah got a toddler who was all limbs that could be contained in a hug. And I got Max, who, it would be an armchair descent without armchair... It was in the playroom, and I was holding him but using a lot of force to keep him still. ...he was wanting a cuddle off Sarah, and I think it ended with saying, "I'm gonna let go." ...And he did just you know melt into Sarah, and he had bruises on his arms from like how hard ... and it was, you know, the kind of locked arms and it's, it's that's what as soon as power was mentioned. And that's what stuck out to me because it {Very long pause} I don't know...the rationale in my head was I'm closest, I'm going to initiate the PI, and this is the reason why. But it's recognising though, you know, where - ...somebody else would be better...., we have this whole thing of, "I'm not going to let you have this person because you're not going to control and dictate" but...sometimes they know exactly who can soothe or what's going to help. And we keep that away and say "No, this is my restraint. This is my issue that I'm now going to help you with" (Antony Group 3)

Regulating processes

Containment

... it can very much feel like a fight... but you've then got to understand, once you get into it, it is a form of containment, it's something that is regulating and helping to deescalate them. And from that, you can have times where they'll communicate what's going on and what's happening for them. So it can be something really negative, but to understand that you can contain them, then they then have that feeling of safety in that, which then allows them to speak about what's on their mind, you'd obviously hope that you didn't need go through that process, but there is some positive, positivity can come at the end of it. (Kitty Group 5)

there was a time when I think emotional containment was when we talked about the boundaries and being stopped and being held and literally held together at a time when you've fallen apart. And I think there's times when, you know, not just thinking pressure, but like the times when the child just needs you close, they can't accept hugs, but they know they will, you will be close and you will hold them and you will, like when they feel like they're literally going to fall apart. (Antony Group1)

It's not the only frontier, I think there was a point when, even describing holding the emotions, it was still the physical part that was vital. Whereas now I think the holding in mind, it happens at a much different level, collectively, cos like you can be in a room and someone can be really upset. And we can stay in that space. It's uncomfortable (Antony Group 3)

Self-regulation

If you are able to let it divert to something else, I think that's where there starts to be a change. Like it's not inevitable. It's like because the emotional containment we used to talk about - it's predictable, I do this and then I get that and then afterwards we feel better. And there's a catharsis there, but you don't have to go through restraint to get to that but that takes a leap of faith to think I can, I can be in that place. (Antony Group 5)

We've not had a restraint for nearly two weeks But even if there was one yesterday, she would say, "I've not been held onto for ages", absolutely, and that's how I actually think we managed to avoid it last night, because I was saying to her, I've really, honestly said, "If we continue with this, this is where we're gonna have to go. And I don't want to do that", you know, and praising her afterwards, and "Look what we did, and you managed to use your words" (Moyra, Sanctuary)

Not intervening

Someone else will say, "No, I've got this" and they will go into that room alone, or they'll, and I think that happens far more often, where someone will say "I'm connected with something - you're seeing a risk of me getting hurt and the risk is still there. It's very real. But I think I can do this Can I do this?" (Antony Group 3)

Kitty: you're like literally stood...you literally have your ears on the door ... you have to be like "Can you hear anything", right? He's not... there's no shout. There's no, there's no "Help!" There's no..... But yeah, you're literally like as close to the door as you possibly could be. And your heart, your heart's racing. And you're just thinking, you're thinking "I know they've done the right thing. And I know they've got it. But I hope they've done the right thing". Like how, how, how, how because the last thing you want to hear is like "Help!"

Sarah: In my head, like, because I'm often the one in the room with Max it's "Please don't check on us. Because if you open this door right now, all of this work, I've done is going to go tits up!"

Antony: You've built the bubble. Yeah, we're in this fragile space where this is working. It's so close. But if you, if you come in, yeah, you'll ruin the rhythm

Faye: But you've, just got to have that trust in who's there and their relationship with the child. But also, as the person when you're in there de-escalating, you've got to have that trust that that person is there (Group 3)

Holding on to thinking

I think that the thoughts are the bits that you use to bolster your strength through the use of words- to survive. They're a bit of a mantra that build up the defence to get through it, and then to provide the emotional containment. (Antony Group 5)

Impact on children

Re-traumatisation

We get kids in from like trauma backgrounds, and restraining them like, is a traumatic experience. And like, the last thing we want to be doing is adding more trauma to someone who's already had trauma (Sally Int 1)

You think about the restrictions that's already on them in their life, and then they come for us to keep them safe and look after them and provide these nice memories and we put restrictions... (Fiona, Sanctuary)

Positive impact

there's probably PIs in my head that are pinpoint moments. But I don't think initially, I would have been like, that was good. I think I can pinpoint there was something happened in that restraint. We talked about this, and that's changed something. But I think it's harder to... like, just following it (Sarah Group 1)

Now we know those revelations or breakthroughs don't come as part of it. But the feeling is, is it is literally the orgasmic kind of - at the end there will be, this will all be worthwhile because they'll tell you exactly, specifically and exactly what the feeling was and what it was. And then you'll have an idea of how to fix it. And we normally like when you're handing over, you get the joining the dots of the, this is what's going on. And then there's just a something and then you know, comes in the quiet times, or comes somewhere else, or it doesn't come at all - sometimes they and we just continue. (Antony Group 3)

Normalisation of restraint

It's just like, it's very accepted that's what happens, and for the kids who go to a school where it happens as well. And I obviously think Max has lived here for years. That's life. That's what happens for kids. That's what happens for the kids at school. That's what happens for the kids here (Sarah Group 2)

Impact on other children

It wasn't on my radar. So, like in my reality of writing event, and the paperwork is about the individual. I wouldn't talk about in the past have thought about children How do you know they're okay, cuz you haven't knocked on the door to check. They're just quiet in their bedroom, but they must have heard everything. But I hadn't thought about that in a wider context of each episode and how it like it can feel chaotic in the house. Absorb all this stress and cortisol, and then you just expect you're not expected to get on as normal. As soon as you know. Whoever was having the issue is sorted and the house is put back together, then we all just carry on regardless. (Antony Interview 2)

Re-traumatisation

"What are they doing in there?" Like that kind of when you're listening and build it in your head? "Why did this happen to me?" So, like, hearing it happen to someone else, and then, whether it's thinking about restraints or other things, it's touch that you didn't want. It's, it's in whatever form it's that kind of thing where it triggers. And when you're not sure about where you end and the world begins, having it forced upon you -even the sounds and the thoughts of it, it's, it's invasive. (Antony Group 5)

it was years and years ago, and it sticks with us, from, from a different setting, where it was being passed over and lots of information to cover, and who was where, and what the adults were... where the kids were, and a child was mentioned really briefly, just the, and 'they were fine'. And they and 'they were fine' came from that they didn't come out of their room. And no one went in to see whether they were awake and terrorised or anything..... they were, they weren't part of the situation because nobody went to check, and they didn't then impact on it. And it's and there were some, you know, the door was here, the PI was outside the door. Even if they were asleep, it's all going in and informing a nightmare or something. And it kind of stuck with me...the that's why you check or like you like, if you're there protecting Sam from all the things that come at night, to have you pulled away and then come back and smell different, and be different, and all the you know, the tiny bits it's, it's re-traumatising (Antony Group 2)

Perception that child is being abused

something that's crossed my mind before, when we get new kids in - do they think that we just abuse kids and it's just okay? Sam once saw a PI with Max and it was really not a good one... Sam described it as we pinned him to the floor, which I think is probably quite an accurate depiction. And it was just, "Oh, that's what you do". It's like, "Yeah, but that wasn't how we should do it. That was us getting safe so we can hold him properly." But it's just accepted that's what happens, and for the kids who go to a school where it happens as well... That's life. That's what happens for kids. That's what happens for the kids at school. That's what happens for the kids here (Sarah Group 2)

Isobel used to do the "You're strangling someone". And until we started to unpick it's literally that's what she thought we did, because that's what she could hear - "You hurt my arms" and she was like "You hurt his arms first and then you start to strangle him, then he banged about for a bit, then he broke some of his toys because they came out". And that's what she lived with here - and then she had to accept care from us because we're the only people around, (Antony, Group 5)

Modelling denial and repression

The way that we mask or minimise, I don't think it's going to be the easy solution but being aware about the viewpoint around what others must think. And being transparent, along with when it's all chaos in the house and we pretend like it's all fine. Because one of the themes and the dangers that we were kind of looking at was around not just recreating the abuse cycle and minimising bruises and injuries, and just, "Now this is normal". I think what, what we expect from the person who's not involved and what the group do, and how we support each other. The doors closed, so we're no longer experiencing it, but we are we're all soaking it up and, you know, we're all, we're all stressed. So, trying not to role model repression I suppose. And just how much how much exploration we do because I think we hide it behind, you know, "It's confidential", or "You're not part of this". So, you can make it easier by ignoring it, or by being where you're at where you've been asked to be. But that only scratches the surface of like, what's actually going on. (Antony Interview 2)

When you hear them, but you don't see them, that's when they feel the worst, because the kids are in so much distress. And if you're going around trying to help the other children out and keep them regulated and calm. But you can hear like screaming or whatever from the other room, but you're not at the point where you can go in and help anything like that. That's one of the worst bits where you hear it cos it's just all the distress comes out and that feels horrible. (Sarah, Interview 1)

I don't think we give enough guidance, I think there's a practical task of simplifying the equation and getting people out of the way. Or, like, effectively, what if we're talking about people not intervening, we'd be role modelling, when you're hearing something's going on, you sit here and watch telly, or you do, you play the tablet. Or you'd like sometimes you will say, 'Can you just be in your room'. And I think.... cos I've been the other side of that when you're the person who's kind of you know, containing the trauma, and the chaos, and stuff that comes out, and sometimes have, in a simplistic way, named what, what has happened. So, you know... 'they were saying they were

going to break the window, this had already been broken, so this is why and the adults are keeping them safe,' but I think it would be hiding, like, behind the backdrop that 'this wasn't okay. And this is to keep it safe'. And then there wouldn't be kind of any more explanation unless a special meeting called or something (Antony Group 2)

he's hurting the adults, which is why we're holding him but there's so much more going on that we can't explain. We can't explain it to you. We can but we can't go into the depths of it. Because it's his information. (Kitty Group 5)

Yeah, I think it was Alex, he'd hurt his knee at school, and we'd seen like, we'd noticed the bruise and a few days later he said my leg's really hurting and I was like "Why haven't you said that it's really hurting" and he was like, "Well", he was like, "because I know you were hurt the other night after Max hit you but you didn't say you were hurting" (Sally, Interview 2)

Supporting children to understand and regulate

I think that links up with what we were just saying about how it impacts children. So yes, him being on the landing was potentially impacting someone else in their room, but it's how you look at then supporting that child. Rather than putting in that level of power to just try and move, move Max to another space, it's how we talk about it and how they witness it and how, because we understand the impacts, so it kind of has a link to what we were talking about. (Kitty Group 2)

So, we don't we don't like we don't celebrate the really good things that people do to help, you know, settle and regulate so that we kind of have a common ground. But if someone becomes really distressed then with that we probably would, but not kind of not routinely, to kind of build up like, this is what, you know, this is what you do. And these are some of the things that worked in the past. (Antony Group 2)

I think that would be a kind of cultural shift and part of basic training around you know, this is this is what we're able to say that these would be ways that would support this child because we're all gonna be different as to like and I know with some of them they can't accept hugs when they're in that kind of state because you know, the fight or flight kicked in whether it's obvious on the outside, so like things you would think Oh, that would be reassuring might just be intolerable. Yeah. So, like on an individual basis would need to 'when when things are happening in the house and what helps you or in the kind of regulation strategies', (Antony Interview 2)

it feels better when everyone's involved in and we've called an extra meeting and it's "Let's pick this apart, with no blame, but let's pick this apart and understand what's gone on". (Antony Group 2)

I think the thing that got me more was like, the other children, how they're kinda like not an afterthought. But at that time. They could be completely like, in some cases, completely alone with each other. Because depending on the staff you've got on depends on like, what availability, you've got to be able to hold and I think like the children not really knowing what's going on and having that anxiety of like, being left, like, Are they going to come back, are they going to be hurt when they come back?

Like, we need to find like a better way to be able to support not only the child we're holding, but the other three children as well (Sally Interview 2)

Developmental opportunities for other children

there is those situations as well, where the kids really like, go above and beyond, like, the situation when we had the PI at Seaham ...Lee was brand new, and Isobel took charge and was like, 'Right, what you need to do, Lee, and are you OK and who needs ringing?' and things like that. And then there was another time where I had to get Isobel to ring someone to get someone to come back because there was a PI happening. And then Hermione, at times, like when we're on holiday when Max was really struggling, she's like, 'right, I've got these two - you sort him' like 'we're OK' (Sarah Group 2)

Recording

Impact on adults

I understand that the, the intervention forms need to be done quickly, so you don't forget anything but sometimes my brain's not ... like after an intervention... my brain is not ready to write it all up, because it's still processing everything that was said, was done and the feelings behind it. (Faye, Group 1)

The debrief is the first time we really talk around and explore but you're sometimes not ready, or like I don't think I'm ready by then. And chances are, you know, I can't write and think at the same time. And I'm going to be the person who's recording it. So, you get, you gather what everyone else is feeling and put yours away for another day.

Power to create truth

where it stuck out for me was, we get to define what it was. So, the child has the space for the post restraint interview. As a level three, I'm often the first person who's describing it to the next level three. So, I'm defining you know, the, the pace of it, the thoughtfulness, the, the trigger, the things that we're exploring, the possible. And that's probably the most it gets talked about one person to another, other than to describe the event to the authorised person, which is the mechanics of what's going on the form. By day two, not necessarily, I don't think it's one we use frequently, but the type of phrase that sticks in my head is 'someone kicked off the other night', which tells you nothing...I think the communication is like, we can't, there's not enough time to always be explaining everything that was going on for each individual. And so, it gets lost in these little islands or, and it's all adult led and we can decide what, what it was.... what's happened (Antony Group 1)

I think about the child reading these in the future and trying to make it sound factual and non-blaming for the child. I want everything that I write I want the kids to be able to read it and be like, "Okay, yeah, maybe I shouldn't have done that. Okay, I understand why they had to do what they had to do." (Sarah Group 5)

Children's voices missing

it's in the child's PR [Post Restraint] bit when we say to them "What happened, do you think it was right?" How does the child then feel? Has there ever been a child that's

been like, "No I don't think that was okay. I want to speak to this person." ... Or by that point, they're just like, "Yeah, I don't want to think about that. Don't talk about it. Yeah, it was perfectly fine. Don't ask...I don't want to go back there." Is it a leading question for them just to go "Yeah, everything's fine"? Because we're not using terminology that - or how they might look at it from their perspective. Are we leading them to be like "Yes, everything's okay"? Or is it just because they're just used to the restraints? Or they know what it feels like, it felt like it felt like it did the past four times. "Yeah, I don't think it helped me, but I don't think you'd hurt me as an adult so yeah". (Kitty, Group 5)

and the kids don't really say much in their post restraint where they have a chance to say "I think they didn't hold me right" or "They hurt me" or "They used too much force" or whatever, whatever. Like, their time is to like, have their views and that. There's not very many times I look at a PI form, where there's actually been something written, other than 'no comment' or declined, or, or yet, like now like. And I just think like, do these kids really have nothing to say about these restraints? Like, because when we're in them, it's like, 'you're hurting me, you've hurt my foot, you've done this. You're too tight. Like, you're holding me wrong. I feel uncomfortable.' And like, I think well, - going from extremes of being restrained against my will, myself- like if someone had said to me after that, like, how did you feel? I'd have told them. I'd have been like 'that hurt'. Like 'it was uncomfortable. Didn't like it'. Like, and I just I don't know what it is why the kids don't say, like if there is anything? Or if there isn't, (Sally Group 2)

I think they're worried that they need to protect the relationship as well. So, they need to not say anything to anyone because if they do, when things have happened bad in the past, had an injury, they've moved. They need to protect, like, "Yeah, yeah, you're here, you've held me, I'm not too happy about it. You tell me that's what's supposed to happen. But I don't know". (Sarah Group 1)

The importance of the team

Antony: You have to trust. Because if someone comes free on one arm, chances are it's not going to be them that gets hit - it comes across. So when, when you're going in, and all of that practice that we do and communication it's the - you have to have faith that whoever you're in the hold with knows what they're doing and is responding.

Sarah: It's like the trauma pathways in the brain. Like for the kids. We know a lot about that. But I think for the adults, like you've got restraint pathways. Yeah, they're like pathways in our brain. And they're linked up with each other. I think like it's like the same rhythm. So, I think if, me and Antony are probably never in a PI ever, but we've got the same rhythm because it's like, the Cedars rhythm.

Antony: In that way, we're like Universal Soldiers, aren't we? Because we've had the same rhythm, that pace... (Group 3)

I think it's hard. I think probably the team thing, like, there has to be trust with each other as well, because you need to know that you can say to someone what you're thinking and be "Do you know what I don't think that was right". You know. "Where

was that going there?" It's not easy conversations to have, but you also, on the other side, need to be open to people feeding that back to you. And I think that's not easy. That's difficult to have to build that with people, and it does take time. I think (Catriona Sanctuary)

I want to say like twins have this connection that like no one else knows about, they have these senses, and they know how the other one's feeling...In that moment, you can just look. And because we've all worked together so long, just know - like, there's just something underlying in that you just... (Kitty, Group 3)

No restraint policy

I left that situation because I just I couldn't do it. It was like so I'm just here to record what they do wrong and it's their fault. And so, like having an organisation that buys into wholesale and respects CALM and the use of physical intervention - I couldn't do this job without it (Group 5)

Need to justify

I don't want to hurt people but the things that I do to keep them safe, I know it hurts. And there's that kind of- I think with Max I've definitely argued, at the point of, what I'm arguing the rationale of why I'm in a restraint with him and that's the point I think I need to be quiet. Of the "I wouldn't be doing this unless you, you've done this. You've" and it would generally be "I'm doing this because you've punched someone, or you've bitten someone". (Antony Group 3)

It's like two realities clashing. The child's view is you did that because you're a bully...and part of me wants to tell them 'No, I'm, I'm a nice person. And I would only have done this because you did that.' ...but what is discussed amongst the adults is my reality and my understanding of what's happened. (Antony Group 1)

So, though you can justify in your head or talk yourself into the reasons why - I do think you still think "Was it right? Was it needed? Could I have done something else" (Kristy, Sanctuary)

Culture and practice change

I would say when you first started. It was just "You all right, you all right?", "Yep". And we'd just move on, whereas now you get that time - we process it and go, "That was horrible. That was really hard" (Catriona Sanctuary)

Years ago, it would be jumping from one to another to another and by the end of a night it was just we'll start again tomorrow.... especially if you're doing night shift, you're just jumping from one incident to another (Jeannie, Sanctuary)

there was an aspect of templating... it's the word that springs to mind. So, I think it was my kind of term for being involved in the early times of physical intervention with

the children to show them the beginning, middle and end, you know, we can get through this and, and seeking to be part of those first experiences. So that sort of becomes this is the pattern, this is survivable, this is okay. But it then kind of it forces the issue that kind of makes it you know, I will do this and this is the way it should be done (Antony, Interview 2)

We were doing it in the PI. In the very beginning, you were trying to talk someone down and say, 'Well, you did this and so that's led me to do this' And you know, the, the understanding wasn't there about adrenaline states or that they can't hear it was, you know, it might have regulated the adults a bit but it had no other function. And by the end, if the child repeated a few bits of what you said, and that's our job ...they've understood because they've repeated what I've said with enough certainty, so therefore - rubber stamp... (Antony, Group 2)

Reflective spaces

We have like a debrief at the end of the day...we'll sit and we'll talk about the shift. We'll talk about any restraints or any de-escalations or anything. And basically, you can be as open and honest as you want and like there's been times where I've just cried through the full debrief because there's been a restraint and it's been traumatic (Sally Interview 1)

A lot of the reflection that we have planned in is individual. So, it's, you know, my chance to talk with a manager or someone around the PI, or to discuss the work that I would do with the behaviour support plan around feedback with the child, but it's all smaller group, as opposed to a more collective experience (Antony Interview 2)

What really helped that was having the prompts - being able to ask a specific question of, "Did your response increase or decrease level of stress?" ...You have to answer that question. (Kristy, Sanctuary)

Ethical dilemmas

I think it's got worse, for me, it's not clear anymore. I go back to the Promise, about Scotland's aspiration to be a place where we don't physically restrain... but when I talk to other respected people and colleagues. It's like, "Oh, I don't think we'll ever get to that point". ...What at times is difficult to think about or accept, is that, and maybe this won't be the case, but in ten years' time, there'll be a decision made. Wait no restraint, right? Let's say that was made, and all the same people who tell you about they would be like," Oh, can't believe we ever did that." (Donald, Sanctuary)

Is it restraint that contributes to progress in that young person, or is it strength of relationships? Relationships. So, like I'm the one in the minority. Probably I think everyone wants to reduce restraint, absolutely. If it was me making the decision, I'd get rid of them all together, and I'm in minority... I've signed up to the way that we model and work - like that's probably a personal opinion, and my professional responsibility is to follow my training, the organisational model. (Donald, Sanctuary)

there is probably one major one that's stuck with me. And and that was that was due to me having to hold on so hard that I actually left a mark and after speaking the child, obviously he said that I understand why that happened. And he understands that he left several marks on me and other members of staff before the intervention happened. To me that still didn't justify it in my head like I was beating myself up a lot from that. And especially with the idea that children at the Cedars obviously have been through a lot start off with so it's then feel like I sort of contributed to that - took me quite a while to get through my head. (Faye Interview 1)

I do worry sometimes when the children can't talk about it even once they deescalate, they can't talk about what elevated them so much. That does happen. Does restraint actually help in any way? I understand they're calmer, they're not hurting themselves they're not destroying property anymore. But does this actually do anything for them emotionally if they can't express how they feel? (Faye, Interview 1)

Like, there's been times where I've been in like, in a restraint and my nails been too long. And I've accidentally scratched them or accidentally stood on their foot trying to get in like a safe position in although like, you don't mean to hurt them -you have actually hurt them by trying to help them and it's a very conflicting feeling to how I like to how like you feel whether you've actually helped in that scenario. (Sally, Interview 1)

you do feel and you know you're not you know, you're not harming them. But you do feel like you are and especially when you hear them shouting and screaming and you do think those like that's me causing that. (Kitty, Interview 1)

External world

Restraining outside the home

That was my experience with Max down at the park. He played and he played, and it was fine just to leave him and like eventually you'll get tired or hungry. And the tiredness set in but he went to kick at a much smaller child when they weren't playing the game his way. So that's what then triggered the PI. It was inside the pirate ship down there, so I barely fit. And kids came and went and played. And adults were around supervising and there was some level of you know, they could tell what setting we were from and kind of trying to respect confidentiality. So then different adults then came when we'd phoned for help. But what people, I think they saw, was us bundling a child into our car and driving off (Antony Group 2)

I worry for other children, so I worry for hypothetical situations where there's a kid that's been kidnapped and everyone just assumes it's fine. Like ...because the other day they saw this kid's getting walked out the shopping centre and not looking very comfortable. So, that's okay -it happens. And, what if someone then does it and they're like kidnapping someone or whatever. Like, I just, it would be nice if they'd just check that I'm not kidnapping them. (Sarah, Group 2)

I've had someone phone the police on me and a colleague because they thought we were kidnapping a young person when she was lying in the middle of the road, and we bundled her in the car, to stop her trying to kill herself. And I've never been so delighted to see the police in my life, because that's the thoughts and emotions that went through my mind. Someone just phone the police. Yeah, I hope someone thinks I'm kidnapping her. (Donald, Sanctuary)

I know there's been an incident before where one of the children was held. And the police pretty much stepped over the child and the two members of staff and just carried on walking down the street. And you think – “They're police?” They should be saying “Is everything okay?” And another member of staff involved was wanting them to say something to think, “Yes, he's the police. This is going to help the situation, this might de-escalate this”. (Kitty Group 2)

also think as well, in, in nowadays times, are people wary? ... And sometimes if something's going on, you think, well, if I say something, what's going to be the repercussion back on me? People might just think it's better, “I'm just not going to get myself involved” It's better to play like, “I have no clue what's going on”, than get involved, and then something might be brought to my door then the police come around and speak to me about what was happening what I've saw... so do you know, actually, I'm just gonna play blind to it all and I don't know, I'm not involved (Kitty Group 2).

They're making judgments...everyone outside of here just watches and doesn't ask questions ...they don't say anything that's helpful. Like these all have words... she's not put words here so it's as if they're making comments or they're doing things or they're saying things, but actually what they're doing and saying isn't, isn't helping with anything of what's going on in in the picture. (Kitty Group 4)

Negative perceptions of physical restraint

People who, who don't know restraints and have only seen restraints being used when it's brought up on the news where people have been using it for control and power. The thoughts of restraint is, it is being used for control and power and it's not to support and it's not to prevent someone else being hit. Because that's how it's been perceived by media...the only time it's ever spoken about is in a negative (Kitty Group 2)

Social media

So, I was on Tik Tok the other day and there was this girl, and she lives in a children's home. And on one of her TikToks she was really upset, and she was crying about bruises from restraints, and every comment was, “shouldn't be bruises if they're doing it, right. They're abusing you” (Sarah Group 5)

...it's interesting that that is everyone's first thought on that forum. But yet, they can see a kid being held, screaming, “You're a paedophile, you're a child abuser, you're hurting me, get off me”., it's like entertainment. They just blatantly don't care. Yeah, but put it on a TikTok forum and it's like ... (Sally, Group 5)

External professionals

What if OFSTED come in and they say you were wrong or this was wrong? Or you need to stop this now and like the you know, speaking from my perspective on what happened with Max - he'd always had hundreds of restraints but then suddenly, this is a massive issue. And it wasn't like we were belittling it before - we were living through it. And sort of with like OFSTED as the other person, who doesn't understand, coming in and saying you need to fix this, or you need to change this, or you're not doing something right. (Antony, Group 5)

How many restraints would they think is acceptable for him to have? Like, what is what is their - if they had number to give him? Like, what would they like him to have? They know his history They know everything. So, what do they then go? This is a reasonable number of restraints to have. (Kitty Group 5)

Reflections on the research

I think the overriding thing was just that something that we've done for so long and has been one of the core pillars of a career in child care, it was a first chance to really stop and look at as a group. (Antony, Interview 2)

it brought out more things than what I originally thought of. I think on the areas that we spoke about, we could have, we could have spoke forever about those areas, and maybe time or the ones would have come out. But for me, those are what I felt. We needed to we needed to look at how, from what we'd expressed (Kitty Interview 2)

was kind of like the awakening of just all the different aspects that feed into what what can often just be behind closed doors, you know, it's simplify things. So you know, keep the other children away, keep the other adults where let's pretend everything's fine. And just, you know, compress the chaos and into a little ball and bury it inside. To explore, like, what does it mean to us, to the child, to the, to the wider society and kind of the judgments, and then how we, how we explain that to ourselves (Antony, Interview 2)

it made me feel more comfortable. In, like you said, in the fact that I know you in, every possible way you know me in every possible way. We've had open and very honest conversations about personal things. So, I've felt that I could carry on that open and honest conversation with you in that space. Where I think if it was someone that I didn't know, I'd be a bit like, oh, how am I gonna take this answer? What might, what might they judge on this? (Kitty, Interview 2)

I think it was positive in the sense that the trust was already there. So in referring to you knew that you could talk about something and use specific names and circumstances, or you could generalise and talk about kind of previously, like our own experience. Because people's relationship to violence their relationship to gender stereotypes, it was very quickly kind of to the level of being able to share and feel comfortable in the space. But I don't think speaking personally, I don't think I would have felt comfortable. If it was just someone who didn't have a previous relationship. (Antony Interview 2)

it was good to find out like, you're not the only one that feels the way you do like when you're in a PI or after a PI because I think sometimes you think like, more experienced staff kinda like, take it more in their stride, and it doesn't kind of impact them as much. Where it was nice to like, know that like, even like, Antony, like, it still has the same impact on him that it has on us like, That horrible feeling like feelings of guilt. And, like, you know, you're doing it for a safe reason, but it doesn't feel very nice. (Sally, Interview 2)

I think it was easier, because we didn't have to explain so much. Because you had the knowledge of what we meant when we were saying things, where if it was someone completely outside, I think we would have had to, or even felt we had to, explain because I feel like even when, like with the eyes and things like that, even like when the CALM instructors talk about it, I always have this yeah , but our kids like yeah but we're different. So I would always feel like I need to over explain about the exact needs of our kids. But we didn't have to do that. (Sarah, Interview 2)