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Editorial	2
Compassion fatigue, compassion satisfaction and work engagement in residential child care	5
Fellowship as social-pedagogical treatment.	28
Gender and restraint training. Why are all the trainers men and why might this really matter?	49
Diary	69
The Importance of Love within the Care System: Making Love a Right.....	74
Mind the Gap: Factors that can support responses to offending in residential child care and the challenges of implementation	79
Change and Continuity: Caring for Children and Young People	92
Ambiguous Loss.....	99
Book reviews: can I share this with you?	107
Book Review.....	109

Editorial

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@DocTweets

Welcome to the September 2018 (Vol 17, No 3) issue of the Scottish Journal of Residential Child Care (SJRCC). It was in September 2002 that Professor Andy Kendrick launched SJRCC as a hard copy, bi-annual publication. Sixteen years later, we are still going, now in digital form and with four issues this year. Andy retired from the University of Strathclyde at the end of June, but will have continuing connections, one of which will be to remain a member of the editorial board with the title of Editor Emeritus. We send Andy our very best wishes for a long, happy and action-packed retirement.

This year marks another anniversary: 50 years since the enactment of the [Social Work Scotland Act 1968](#). This Act was significant, in the sense that its very title acknowledged social work's development as a profession, one practical manifestation of which was the statutory requirement to appoint a director of social work (later to be amended to chief social work officer) in each local authority area. The Act included provisions for the general social welfare services of local authorities, and for a system of children's hearings, that is still the fundamental basis of child and youth justice and welfare in Scotland. One interesting provision in the Act, particularly in these more austere times, is the inclusion of a section giving the state and local authorities legal authority (and therefore encouragement) to conduct research. Given that provision, it is highly appropriate that [Social Work Scotland](#), the organisation representing social work leaders in Scotland, should have commissioned a research project led by Professor Brigid Daniel of Queen Margaret University to mark the anniversary. Professor Daniel's research will be published in due course and will be featured in a future issue of SJRCC. Meanwhile our readers can listen to her [address](#) at a recent Social Work Scotland conference on the Vimeo Channel.

Turning now to the present issue, we present our usual mix of peer-reviewed papers, commentaries and a book review. In the first of three full-length original

research articles, Kerry Audin, Jolanta Burke and Itai Ivztan report on compassion fatigue, compassion satisfaction and work engagement in residential child care. Their study surveyed 100 residential workers and managers in independent sectors organisations in England, Scotland and Wales. They conclude that burnout and secondary traumatic stress constitute a significant concern for residential child care staff. Mogens Jensen's article, written from a Danish context, argues for 'a need for a concept of social pedagogical treatment as part of the professional terminology of social pedagogy'. Brodie Paterson, Bryan Shewry, Patrick Bradley and Vaughan Bowie reports a small-scale study of women's experience of participation in training in restraint in the residential context, concluding that 'a "male" model of aggression may permeate some training programmes and negatively influence women's experience'.

Olivia Khan, a student and herself care-experienced, has contributed the first of five shorter commentaries. In a very powerful account of her experience of foster care, Olivia writes about how a private diary she was encouraged to keep as a personal therapeutic tool became the reason for the placement breaking down, precipitating another move. Helen Johnson, care experienced and a social work student, tweeted with a view to opening up a conversation about the impact of love within the care system. Such a conversation, which we hope that readers of the SJRCC will engage in, has global relevance; in Scotland it has particular significance because of the current Independent Care Review. Deborah Nolan and Joe Gibb have contributed a paper framing learning from their 2016 research on responses to offending in residential child care. Among the points made is that organisational culture and ethos are important: 'children should be provided with a caring, safe, calm, nurturing, loving and therapeutic environment to achieve their potential, where police contact is the option of last resort and corporate parenting duties fulfilled'. Carole Wilkinson's article, appropriately given our earlier reference to the anniversary of the Social Work (Scotland) Act 1968, is a reflection on her 20 years working in social care in Scotland, most recently as chair of the Scottish Children's Reporter Administration. Our final commentary is unusual because it began life as a Twitter feed. Nina Vaswani discusses the importance of ambiguous loss and disenfranchised grief in residential child care and the implications for practice.

She concludes that the focus should be on 'building tolerance and resilience to the ambiguity'.

In this issue, we introduce our new Book Review Editor, Dr Leanne McIver. Leanne has written a call for readers to suggest books for review in future issues. Meanwhile, in this issue Linda Brewster reviews 'That's So Gay: Challenging Homophobic Bullying'.

SJRCC will be back in December, with a special issue on disability.

Compassion fatigue, compassion satisfaction and work engagement in residential child care

Dr Kerry Audin, Dr Jolanta Burke, Dr Itai Ivtzan

Abstract

Due to the challenging nature of the setting, residential childcare staff are at risk of developing compassion fatigue, including burnout and secondary traumatic stress. There is also opportunity to experience compassion satisfaction from supporting young people in need. These concepts are under-researched in residential childcare, as is work engagement; a sense of vigour, dedication and absorption at work which is beneficial for employees and organisations. This quantitative study investigated the relationship between compassion fatigue, compassion satisfaction and work engagement in staff working in independent residential childcare organisations in England, Scotland and Wales. The study used a within-participants design using correlational analyses, with a sample of 100 participants who completed a self-report questionnaire. Work engagement was positively correlated with compassion satisfaction and negatively correlated with the burnout aspect of compassion fatigue but not secondary traumatic stress. However, the absorption component of work engagement was positively associated with secondary traumatic stress, reflecting that burnout and secondary trauma are distinct aspects of compassion fatigue that relate differently with work engagement. It is recommended that residential childcare organisations be aware of, and implement support structures to prevent or minimise, both burnout and secondary traumatic stress in their employees.

Keywords

Residential childcare, compassion fatigue, compassion satisfaction, work engagement

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Introduction

Residential childcare is a challenging profession requiring employees to be resilient in caring for vulnerable children and young people; it is also a potentially rewarding setting with opportunities to help those in need (Barton, Gonzalez & Tomlinson, 2012). Young people in residential care have often suffered chronic neglect and abuse in their early lives, experiencing further losses, disruption and instability in care (Barton et al., 2012). Such early adversity affects children's development, compromising ability to cope effectively, and resulting in social, emotional and behavioural problems including aggression, self-harm, absconding, substance misuse, sexualised behaviour, social withdrawal, and non-compliance (Whittaker, del Valle & Holmes, 2015). Residential childcare staff are therefore exposed to, and required to deal effectively with, high levels of negative emotion and behaviours (Colton & Roberts, 2007), yet must help young people feel heard, understood, validated and cared for (Clough, 2006). Furthermore, staff are exposed to distressing information about childhood trauma, neglect and abuse, and disclosures from children (Zerach, 2013).

Working in residential childcare presents a risk of developing compassion fatigue (Eastwood & Ecklund, 2008), a negative psychological state resulting from helping people who have experienced trauma or are distressed (Figley, 1995). Compassion itself is a complex concept necessitating connection with, and motivation to reduce, the distress of others (Ivtzan, Lomas, Hefferon & Worth, 2016). Compassion fatigue is conceptualised in terms of two distinct factors; burnout and secondary traumatic stress, which both impact on ability to maintain compassion for others (Stamm, 2010) and which are pertinent for the residential childcare role.

Burnout is a general feeling of emotional exhaustion caused by frequent exposure to emotionally challenging situations and leading to becoming detached from those in need and frustrated with the helping role (Maslach & Jackson, 1981). Secondary trauma is more specific, occurring when helpers experience symptoms of traumatic stress through being indirectly exposed to

other people's experiences of actual or threatened injury, harm or death (Figley, 1995). Symptoms of secondary traumatic stress reflect the symptoms experienced by individuals who were directly exposed to traumatic events, and include sleeping problems, anxiety, irritability, hyper-arousal, intrusive thoughts, emotional numbing, and preoccupation with (or avoidance of) the trauma source (Figley, 2002). Secondary traumatic stress typically has a more rapid onset than burnout, which emerges gradually in response to a build-up of emotional exhaustion (Pearlman & Saakvitne, 1995), though both are problematic for staff. Compassion fatigue impacts negatively on staff well-being (Figley, 1995), and there are consequences for employers, as compassion fatigue is associated with staff turnover and absenteeism, low motivation and morale, and employee performance, including poor judgement, decision-making and quality of care (Bride, Radley & Figley, 2007; Salloum, Kondrat, Johnco & Olson, 2015; Seti, 2008; Yassen, 1995). Ultimately, compassion fatigue in staff impacts on the relationship with those requiring help (Seti, 2008; Valent, 2002), which is concerning when considering the significant needs of children and young people in residential childcare.

Indeed, compassion fatigue presents a challenge for residential care staff due to the interpersonal impact on how helpers feel and behave towards those they care for. As staff become emotionally detached and disengaged, they can be perceived as uncaring by those requiring help (Maslach & Jackson, 1981; Valent, 2002). To be effective, residential childcare staff need to provide consistent and empathic care for young people (Cameron & Maginn, 2008) and build secure attachment relationships as a foundation for children's social, emotional and moral development (Barton et al., 2012). Compassion fatigue reduces ability to provide sensitive, responsive care, which then negatively affects the attachment relationship (Seti, 2008; Zerach, 2013). This can intensify distress and aggression in young people who can experience the detachment of staff as rejection or abandonment, creating a negative spiral of disrupted attachment relationships for young people, and increasing compassion fatigue in staff (Winstanley & Hales, 2014).

In contrast to compassion fatigue, helping professionals can also experience a feeling of pleasure and success from helping others, known as compassion satisfaction (Figley, 1995; Stamm, 2010). Compassion satisfaction is thought to buffer the impact of compassion fatigue in terms of the emotional exhaustion of burnout, and the symptoms of secondary traumatic stress (Conrad & Kellar-Guenther, 2006; Ray, Wong, White & Heaslip, 2013; Samios, Abel & Rodzik, 2013).

Another positive psychological state that can be experienced by employees is work engagement, defined as 'a positive, fulfilling, work-related state of mind that is characterised by vigour, dedication, and absorption' (Schaufeli, Salanova, Gonzalez-Roma & Bakker, 2002, p. 74). Work engagement is a broad concept, incorporating positive attitudes and feelings about a work role, such as enthusiasm, resilience, pride and commitment, which help maintain effort and motivation (Stairs & Galpin, 2013). Work engagement has been found to be positively associated with staff well-being, attendance, creativity, effort, and performance, plus staff retention and desirable business outcomes for organisations (Bakker et al., 2014; Stairs & Galpin, 2013). Both compassion satisfaction and work engagement involve experiencing positive emotions (Stairs & Galpin, 2013; Stamm, 2010) which are important in building personal coping resources, according to the broaden-and-build theory of positive emotions (Fredrickson, 2001). Therefore, compassion satisfaction and work engagement are important factors when considering the resilience and well-being of staff working with traumatised and distressed young people. In addition, emotions within teams can be seen as contagious in that they spread between team members (Kelly & Barsade, 2001), making it even more important that the emotional climate of a team is positive rather than negative.

On top of the challenges inherent in the task of caring, there are often additional issues for staff working in residential childcare that affect engagement and persistence in the role, including limited training opportunities, lack of support and supervision, insufficient pay, and inadequate recognition (Colton & Roberts, 2007; Decker, Bailey & Westergaard, 2002; Seti, 2008). Inadequate training, supervision, support, and leadership have been found to be among the factors

associated with increased compassion fatigue in residential childcare staff (Decker et al., 2002; Lakin, Leon & Miller, 2008; Pinchover, Attar-Schwartz & Matattov-Sekeles, 2015), particularly the emotional exhaustion and reduced morale which typifies burnout. These organisational factors, along with compassion fatigue itself, contribute to high levels of staff turnover in the residential childcare profession, which has negative consequences for staff, organisations, and ultimately children and young people who experience unstable and inconsistent care (Colton & Roberts, 2007; Seti, 2008; Salloum et al., 2015; Showalter, 2010).

Compassion fatigue, compassion satisfaction and work engagement are therefore relevant to residential childcare staff and organisations. Whilst compassion fatigue and satisfaction have been studied in many health and social care professions there are few studies within residential childcare (Pinchover et al., 2015; Seti, 2008; Zerach, 2013), and the relatively new concept of work engagement has not been studied in residential childcare. This study aims to address the gap by measuring compassion fatigue, compassion satisfaction and work engagement in residential childcare staff, examining the relationship between these variables in line with the following hypotheses:

- Hypothesis 1: Work engagement is negatively correlated with compassion fatigue (burnout and secondary traumatic stress), such that higher levels of work engagement are associated with lower levels of both burnout and secondary traumatic stress.
- Hypothesis 2: Work engagement is positively correlated with compassion satisfaction such that higher levels of work engagement are associated with greater compassion satisfaction.

In addition, a third area is explored; length of time working in a residential childcare role. There are inconsistent findings in the literature regarding the association between years of experience in a helping role and compassion fatigue (Seti, 2008). The present study hypothesised that length of time in a residential childcare role and compassion fatigue (both burnout and secondary trauma) are related, but did not specify the direction of this relationship.

Burnout, for example, may be greater with longer exposure to the challenges of working in residential childcare (Salloum et al., 2015), or may be greater in employees with less experience (del Valle, Lopez & Bravo, 2007), as employees with more experience may become resilient, enabling them to continue working (Seti, 2008).

Method

Design

This was a quantitative study, using a self-report survey method, adopting a correlational, within-subjects design to examine relationships between the variables stated in the hypotheses.

Participants

The sample was 100 employees of independent residential childcare organisations in England, Scotland and Wales. The sample comprised residential childcare workers, therapeutic care practitioners and senior care practitioners (n = 51), team leaders, and registered managers (n = 31), and directors and senior managers (n = 18). There were 57 females and the average age was 39.9 (SD = 11.4). The average length of time working in residential childcare was 10.7 years (SD = 9.8).

A sample of convenience was used, recruiting participants from members of the Independent Children's Homes Association (ICHA), and/or The Consortium of Therapeutic Communities (TCTC) via an online survey. Employees working in organisations known to the first author were also recruited, via the online survey or paper questionnaire. Independent rather than local authority children's homes were used, as this was considered a more direct and accessible route to participants.

The initial sample comprised 70 online participants and 56 completing a paper questionnaire. Nineteen respondents were excluded for submitting incomplete surveys and seven were excluded because they were administrative, teaching or clinical staff and not representative of the target population, giving a final sample of 100 participants.

Procedure

The study received ethical approval from the University of East London. An online survey was created using Qualtrics Survey Software and circulated via email by the ICHA Chief Executive and TCTC Chair to their respective members. Participants were recruited at children's homes known to the first author during delivery of clinical psychology services.

Participants were invited to take part if they were directly involved in the care of children and young people. Informed consent was obtained before participants completed a brief questionnaire. For on-site recruitment, participants returned their questionnaires in blank envelopes and consent forms were collected separately to maintain anonymity. Debrief information was provided. The survey was also emailed to organisations known to, but not receiving services from the first author. As the potential reach of such correspondence is not known, it was not possible to determine the response rate.

Measures

Work engagement and burnout are considered to be opposing but separate concepts that should be studied independently (Demerouti, Mostert & Bakker, 2010) as they have different outcomes; burnout impacting more on health, and engagement impacting more on motivation at work (Bakker, Demerouti & Sanz-Vergel, 2014). Therefore, two standardised measures were used. The Utrecht Work Engagement Scale-9 (UWES-9; Schaufeli, Bakker & Salanova, 2006) was used to measure work engagement. The nine-item version of the original UWES (Schaufeli et al., 2002) was used for brevity. A seven-point Likert scale captures how frequently employees have felt the way each item describes, ranging from 0 (never) to 6 (always/every day). The UWES-9 full scale is considered a reliable measure of work engagement, with good internal consistency (Cronbach's $\alpha = .92$) (Schaufeli et al., 2006). It has three 3-item subscales measuring vigour, dedication and absorption, with Cronbach's $\alpha = .84$, $.89$ and $.79$ respectively (Schaufeli & Bakker, 2004). The current sample had alpha coefficients of $.89$ for the full scale, and $.81$, $.79$ and $.68$ for the vigour, dedication and absorption

subscales. The UWES-9 has been used within many professions (Schaufeli & Bakker, 2004), but not residential childcare.

The Professional Quality of Life (ProQOL-5, Stamm, 2010) was used to measure compassion fatigue and compassion satisfaction. The ProQOL-5 is a 30-item questionnaire comprising three 10-item scales; compassion satisfaction, burnout and secondary traumatic stress, the latter two being components of compassion fatigue. The ProQOL-5 uses a five-point Likert scale ranging from 1 (never) to 5 (very often), capturing the extent that participants have experienced the feelings, thoughts or situations identified in each statement. The ProQOL-5 has been used widely in health and social care research (Stamm, 2010) including some studies within child welfare and residential childcare settings (Eastwood & Ecklund, 2008; Salloum et al., 2015; Zerach, 2013). The ProQOL-5's subscales have good internal consistency reliability, with Cronbach's $\alpha = .88, .75$ and $.81$ for compassion satisfaction, burnout and secondary traumatic stress and good construct, convergent and discriminant validity (Stamm, 2010). In the current sample, alpha coefficients were $.86, .65$ and $.82$ for compassion satisfaction, burnout and secondary traumatic stress.

Demographic information, including age, gender, and length of time working in residential childcare was also collected.

Data Analysis

The criteria of including scale data with less than 10% missing items was adopted (Bryman & Cramer, 1997). After reverse scoring relevant items, the ProQOL-5 data were converted to T-scores as recommended by Stamm (2010). Cut-off scores derived from normative data were used to categorise ProQOL-5 data into low, average and high levels of compassion satisfaction, burnout and secondary traumatic stress (Stamm, 2010). The UWES-9 full scale and subscale data were categorised as very low, low, average, high and very high levels using cut-off scores derived from normative data (Schaufeli & Bakker, 2004).

As the sample was relatively small (Field, 2013), normality tests were used to assess the data spread on each scale, revealing that all except burnout were non-normally distributed. Non-parametric tests were therefore used for subsequent analyses. Spearman's rho correlation coefficient was used to examine relationships between variables; one-tailed for the directional hypotheses (1 and 2), and two-tailed for the non-directional third hypothesis.

Results

Compassion Satisfaction and Compassion Fatigue

ProQOL-5 results are presented in Table 1, including the median (Mdn), range, and percentages of low, average and high compassion satisfaction, burnout and secondary traumatic stress. One-quarter of participants scored low on compassion satisfaction. Almost one-third (32%) scored high for burnout and just over one-quarter (26%) scored high for secondary traumatic stress. These categories are not diagnostic but reflect a method for categorising data based on results from normative data (Stamm, 2010).

Table 1 ProQOL-5 Results (N = 100)

	Compassion Satisfaction	Burnout	Secondary Traumatic Stress
Mdn	51.30	48.35	48.83
Range	19.96-66.97	30.08-76.78	33.30-81.64
%			
Low	25	24	32
Average	52	44	42
High	23	32	26

Work Engagement

Results for the vigour, dedication and absorption subscales and the UWES-9 full scale are shown in Table 2, including median (Mdn), range, and percentages for categories representing very low to very high scores. Vigour had the lowest median, with almost one-fifth of participants (19%) scoring low or very low, compared to only 4% and 2% for dedication and absorption. The dedication subscale had the highest median, with just over one-half of participants (51%) scoring high or very high, though 61% scored high or very high for absorption. On the full UWES-9 scale, only 3% scored low or very low.

Table 2 UWES-9 Results (N = 100)

	Vigour	Dedication	Absorption	UWES-9 Full Scale
Mdn	4.00	5.00	4.33	4.44
Range	0.67-5.67	2.00-6.00	1.33-6.00	1.56-5.89
%				
Very Low	2	0	0	1
Low	17	4	2	2
Average	51	45	37	54
High	27	38	51	37
Very High	3	13	10	6

Correlational Analyses

Work engagement (UWES-9 full scale) and compassion satisfaction were strongly positively correlated ($r_s = .69, p < .001$) meaning that higher levels of work engagement were associated with greater compassion satisfaction. The positive correlation with compassion satisfaction held for all three UWES-9 subscales; $r_s = .52, p < .001$; $r_s = .68, p < .001$ and $r_s = .64, p < .001$ for vigour, dedication and absorption respectively.

Work engagement (UWES-9 full scale) and burnout were negatively correlated ($r_s = -.44, p < .001$) such that as work engagement increased, burnout decreased and as burnout increased, work engagement decreased. The negative correlation with burnout held for all three UWES-9 subscales; $r_s = -.48, p < .001$; $r_s = -.45, p < .001$ and $r_s = -.20, p = .02$ for vigour, dedication and absorption.

There was no significant correlation between work engagement (UWES-9 full scale) and secondary traumatic stress ($r_s = .02; p = .44$) and this held for the

correlation between secondary traumatic stress and the UWES-9 subscales of vigour and dedication ($r_s = -.13, p = .10$ and $r_s = .00, p = .50$). However, absorption and secondary traumatic stress were mildly positively correlated ($r_s = .18, p = .04$) such that higher levels of absorption were associated with increased secondary traumatic stress.

There were no significant correlations between years working in residential childcare and burnout, secondary traumatic stress, compassion satisfaction, or the work engagement full scale and subscales (all $p > .05$).

The results provide partial support for hypothesis 1; work engagement was negatively correlated with burnout but not with secondary traumatic stress. Hypothesis 2 was confirmed; work engagement was positively correlated with compassion satisfaction. The third hypothesis was not supported; length of time working in a residential childcare role was not correlated with burnout or secondary traumatic stress.

Additional Analyses

To investigate demographic variables and work engagement, burnout, compassion satisfaction and secondary traumatic stress, further analyses were conducted. Mann-Whitney U tests revealed no significant differences between males and females on the above variables (all $p > .05$). Spearman's rho (two-tailed) analyses identified no correlations between age and the above variables (all $p > .05$) except for absorption, which was mildly positively correlated ($r_s = .24, p = .02$) such that as age increased so did absorption. Role was analysed by categorising job titles into management (directors, senior managers, registered managers, assistant/deputy managers, and team leaders, $n = 49$), and non-management (residential childcare workers and senior residential childcare workers, $n = 51$). Mann-Whitney U tests revealed that management had higher levels of work engagement (UWES-9 full scale) (Mdn = 4.78) than non-management (Mdn = 4.33), $U = 826.00, z = -2.92, p = .003, r = -.29$, with management having higher vigour (Mdn = 4.33) than non-management (Mdn = 3.67), $U = 903.00, z = -2.41, p = .01, r = -.24$, and management having higher absorption (Mdn = 4.67) than non-management (Mdn = 4.00), $U = 740.50, z =$

-3.54, $p < .001$, $r = -.35$. On compassion satisfaction, management also scored higher (Mdn = 53.04) than non-management (Mdn = 47.82), $U = 910.50$, $z = -2.34$, $p = .02$, $r = -.23$. There were no differences on dedication, burnout or secondary traumatic stress between management and non-management (all $p > .05$).

Discussion

This study measured compassion fatigue (burnout and secondary traumatic stress), compassion satisfaction and work engagement in residential childcare employees, and assessed the relationship between work engagement and compassion fatigue. Whilst the tests for burnout and secondary traumatic stress are not diagnostic, it is concerning that one-third of participants were experiencing high levels of burnout and that just over one-quarter were experiencing high levels of secondary traumatic stress. The results are consistent with previous research indicating that compassion fatigue is a concern in residential childcare (Zerach, 2013). Results for work engagement were more encouraging, with only a small percentage categorised as below average, and one-half scoring high or very high on dedication, reflecting the degree of commitment that is often present in residential childcare workers (Seti, 2008). Similarly, high levels of absorption were found, but given the challenging nature of the residential childcare task it can be questioned whether high absorption is desirable, as discussed below. That almost one-fifth of participants had low or very low levels of vigour reflects depleted energy levels for a significant number of employees, highlighting the demanding nature of residential childcare work (Barton et al., 2012).

The positive correlation between work engagement and compassion satisfaction fits with research in other helping professions (Ray et al., 2013), and makes sense considering both involve experiencing work as rewarding, meaningful, and a source of positive emotion (Bakker et al., 2014). Similarly, the negative correlation between work engagement and burnout is consistent with existing research (Schaufeli & Bakker, 2004) and their position as opposing constructs (Demerouti et al., 2010). Burnout may lead to disengagement from work as a

coping mechanism by detaching from the role; conversely staff who are highly engaged in their work might obtain the associated psychological benefits, protecting them from burnout (Bakker et al., 2014). It makes sense that staff who are not experiencing the emotional exhaustion and dissatisfaction of burnout are able to be more engaged in their work.

The association between absorption and secondary traumatic stress can be understood in that residential childcare work exposes staff to significant levels of trauma and distress. Given that absorption includes difficulties detaching from work (Schaufeli & Bakker, 2004), it could be that high levels of absorption, with heightened exposure to young peoples' distress, causes greater secondary traumatic stress. Conversely, it could be that as secondary traumatic stress increases, absorption increases, given that preoccupation with the trauma source is a symptom of secondary traumatic stress (Figley, 2002). Managers scored higher on absorption than non-managers, but there was no difference on secondary traumatic stress. Managers had higher levels of vigour and compassion satisfaction which may buffer against secondary traumatic stress (Conrad & Kellar-Guenther, 2006; Ray et al., 2013; Samios et al., 2013). Also, managers may be less exposed to young people's distress than direct care staff (Pinchover et al., 2015), which may protect against secondary traumatic stress despite higher levels of absorption at work.

The results for length of time working in residential childcare matched existing research, showing no clear relationship between years of experience and compassion fatigue, indicating that further research is needed to understand which staff are vulnerable to experiencing compassion fatigue (Seti, 2008).

Practical Implications

Given that work engagement and burnout are strongly related, residential childcare organisations should implement interventions to promote work engagement and minimise burnout in employees. To facilitate work engagement, several factors are recommended; providing access to support, creating opportunities to use skills, instilling a sense of control, setting clear goals and expectations, introducing variety and diversity to work roles, providing sufficient

pay, maintaining physical safety, and helping staff feel valued (Ling, Hunter & Maple, 2014; Stairs & Galpin, 2013). However, as highly absorbed employees reported greater secondary traumatic stress, a balance is needed so that staff are supported to maintain professional boundaries and protect their well-being; regular supervision is an important vehicle for such discussions (Salloum et al., 2015; Seti, 2008). Organisations should encourage staff to maintain a good work-life balance and to detach and re-charge between shifts (del Valle et al., 2007; Figley, 2002). Training is vital for residential childcare staff to feel knowledgeable and skilled in performing their duties, and 'system-wide championing of residential care' is needed to help staff feel valued (Clough, 2006, p.3).

Interventions that promote compassion satisfaction are important, given its association with work engagement, and its buffering action against compassion fatigue (Conrad & Kellar-Guenther, 2006). Staff who find meaning in their work are more likely to experience compassion satisfaction (Stamm, 2010) and therefore residential childcare organisations should encourage reflective practice in staff teams (North, 2014) to develop deeper understanding of young people in their care, and awareness of the significance and value of their work. Being able to identify the progress made by young people is important for feeling that the work is meaningful and satisfying (del Valle et al., 2007), therefore outcomes monitoring is recommended for tracking children's progress (Barton et al., 2012).

Protective factors such as adequate organisational support, regular supervision, and relevant training are important for preventing or minimising burnout in residential childcare employees (Decker et al., 2002; del Valle et al., 2007; Seti, 2008). Reducing stress by providing manageable tasks and workloads is also recommended for burnout prevention (Figley, 2002; Seti, 2008). Managers need to recognise compassion fatigue in their employees, so they can tailor support accordingly; again regular supervision is vital, and incorporating information about compassion fatigue into supervisors' training is recommended (Lakin et al., 2008; Pinchover et al., 2015).

Staff need to recognise the indicators of compassion fatigue in themselves, so they can adopt good self-care and coping strategies, including social, physical, emotional and spiritual self-care (Eastwood & Ecklund, 2008; Seti, 2008; Zerach, 2013). Self-monitoring of compassion fatigue has been advocated (Stamm, 2010), but given the high dedication of professional helpers, staff can fail to recognise compassion fatigue in themselves (Scanlon, 2013; Seti, 2008), and should also be encouraged to recognise when colleagues are struggling and support one another accordingly (del Valle et al., 2007; Figley, 2002). Providing opportunities for teams to engage in group supervision, debriefings and professional development can help sustain employees in their challenging roles (Eastwood & Ecklund, 2008).

Regarding leadership, creating a positive, collaborative working environment and building trust within the organisation are considered protective factors against burnout (Figley, 2002; Pinchover et al., 2015; Seti, 2008) and an open, non-judgemental culture is necessary to enable staff to request help when needed (Sheppard, 2015).

The support for employees with secondary traumatic stress may need to be more intense, specialist and targeted than that required for burnout, including trauma training, clinical supervision and self-care practices that focus on trauma symptoms (Ling et al., 2014; Salloum et al., 2015; Scanlon, 2013). Given the link between compassion fatigue and staff turnover (Salloum et al., 2015), national policy-makers and regulators should ensure that organisations have adequate, effective systems for minimising compassion fatigue and helping retain staff, thereby protecting attachment relationships with young people.

Limitations

The study was correlational, meaning that causal inferences could not be made. The recruitment method meant the response rate could not be determined and gave limited control over the survey reach, though exclusion criteria were applied to restrict analyses to the target population. The amount of direct contact with children and young people was not measured, and it is possible that some managers will have had more contact than others. More engaged workers

may have been more motivated to participate in the study, and those experiencing severe compassion fatigue may have been unable or unavailable to participate.

Given the topic and self-report method, there was potential for social desirability bias (Richman, Kiesler, Weisband & Fritz, 1999), particularly from participants known to the first author who completed paper questionnaires, with less scope for such bias from the online participants who had total anonymity. Attempts were made to manage this using blank envelopes for questionnaires left in a designated place, with consent forms collected separately.

Participants were only recruited from independent rather than local authority homes, which limits the generalisability of the results. Different types of provision face different pressures depending on remit, statutory requirements and available resources, leading to different staff experiences. Therefore, the above practical implications need to be considered by individual provisions in terms of applicability and feasibility.

Future Research

This study contributes to the literature on compassion fatigue in residential childcare and introduces the concept of work engagement. Further research in this setting is recommended to explore risk and protective factors for compassion satisfaction and compassion fatigue and to identify drivers and barriers of work engagement. The Job Demand-Resources (JD-R) model of organisational well-being (Bakker et al., 2014) may be a useful framework for structuring further research, to highlight demands of the residential childcare role that increase burnout and secondary traumatic stress, and work-related resources that promote work engagement and buffer compassion fatigue.

The literature remains inconsistent regarding the impact of demographic variables and years of experience on compassion fatigue (Salloum et al., 2015; Seti, 2008) and there may be unexplored variables mediating the relationship between compassion fatigue and work engagement. Research exploring differences between roles may highlight specific risk and protective factors and measuring the degree of involvement in direct care of young people is

recommended. Incorporating personal factors such as personality, previous trauma and attachment style (Zerach, 2013), and work-related factors such as autonomy, pay and leadership style (Seti, 2008) may help identify variables that impact on compassion fatigue so that staff support can be tailored accordingly. The different relationship of burnout and secondary traumatic stress with work engagement indicates that these elements of compassion fatigue should be measured separately (Stamm, 2010; Zerach, 2013). Longitudinal research is needed to assess the relationship between work engagement and compassion fatigue, and with larger samples to improve generalisability of results (Schonbrodt & Perugini, 2013).

Conclusion

Burnout and secondary traumatic stress which make up compassion fatigue, are a significant concern for residential childcare staff and organisations. Residential childcare staff are typically engaged and highly dedicated to the task of looking after vulnerable children and young people, though greater absorption in the work was correlated with (but not necessarily causal of) greater secondary traumatic stress. Staff need to recognise the signs of burnout and secondary traumatic stress so they can adopt good self-care, and organisations should provide adequate support to sustain their employees, enabling them to provide consistent, compassionate care to children and young people in need.

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Fellowship as social-pedagogical treatment.

Mogens Jensen

Abstract

There is a need for a concept of social-pedagogical treatment as part of the professional terminology of social pedagogy in order to characterise and qualify the professional work going on besides therapeutic or educational sessions. A social-pedagogical concept of treatment is based on communities and their formation, and it is distinct from both the psychological and the medical concept of treatment. The article discusses a residential centre for young people as a social-pedagogical community for its residents and personnel due to their contracts, recognition, and competencies, and maintains that social-pedagogical treatment is a specific and relevant professional term in social work.

Keywords

Social pedagogical treatment, social pedagogical fellowship, recognition, planned spontaneity

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Introduction

When young people are placed in residential care you can arrange for different kinds of therapy, education on different topics, training sessions etc. but the majority of time at the residence is social interaction as always when people live at the same place. In this article I want to develop a concept of social-pedagogical treatment in order to characterise and qualify this part of the professional intervention.

About 15 years ago I was contacted by a newly established residential facility in Denmark. They had four boys between the ages of 12 and 16 living there and wanted external supervision on their work. I paid them a visit and met with all of the social pedagogues (in Denmark we have a degree at bachelor-level specialised in pedagogical work qualifying candidates as "pedagogues") to hear more about their work and educational approach. They told me that most of their work consisted of reminding the boys of the consequences of their actions so that they could learn from this and change them in the future. For example if they sat with their shoes up on the couch even though they were not allowed to, it was the social pedagogue's task to make sure that they had a clear understanding of the connection between their behaviour and the consequence: that they would be sent to their room. Therefore they were quite intent on setting clear rules for how one should behave at the residence and that it was very important to follow these rules.

I thought to myself that this sounded like an abnormally rigid pedagogical understanding, but when I asked them to tell me about specific episodes, it immediately became clear to me that they were much more nuanced in their practice than they had let on in their initial explanations. They did not just enforce consequences, but also helped the boys get back on the right track by speaking with them about what had happened, and what was bothering them at the time since they had done things they knew they were supposed not to and so forth. In other words, there was much more empathy for the boys' comprehension of the situation and of their lives in general than I had initially

thought. This account touches upon the classic problem: the difference between what one says one does and what really takes place. It is an old and banal point that could lead some to focus solely on actions and not the words and concepts that we use to describe them. That would underestimate the importance of the words. If the staff at this place discussed the rules of their residence, they could disagree over their enforcement – for example some do not ‘uphold’ the rules (too much consideration for a boy who currently has a lot to deal with in his life) or undermine them by lessening the consequences. In such a discussion a lack of a nuanced vocabulary can lead to a rigid practice of rule-following. The words we use are not innocent, but they lead us to think in certain directions and therefore it is important to be aware of them. It also applies to a concept of social-pedagogical treatment and the aim of this article is to develop several concepts to understand and discuss social-pedagogical treatment. This is done in the context of, and in contrast to, a medical and a psychological concept of treatment which are highly influential in discussions about residential care.

This article is written from a Danish context and ideas have been developed in research on places for residential care for young people with personal and social problems such as crime, abuse, anger problems, anxiety, self-harm and so on. The residential care homes are mainly small with five to 15 youths and characterised by intentions of building a homely atmosphere.

The concept of treatment

For some time it has been criticised to speak of ‘treatment’ in social-pedagogical work (Madsen 2005). In the eyes of many social pedagogues, the concept of treatment was regarded as signifying a constellation where the social pedagogue stood on the side-lines and changed the young person from a distance instead of standing together in solidarity with the young person against the marginalising processes in society. The same debate was raised about concepts such as therapy and resocialisation. Seen from another perspective, however, society has assigned social pedagogues the task of changing the young person’s behaviour or the way he/she copes with problems. It is therefore useful to

develop a concept of treatment to address this change in accordance with a social-pedagogical tradition. I choose 'treatment' as a slightly more neutral term, to be defined in light of collaboration rather than control.

The traditional notion of treatment is taken from medical practice, where an expert intervenes. A typical example might be the surgeon who operates on an appendix. Here we are speaking of an expert, who treats a patient, and this treatment does not require that the patient and surgeon be involved in each other's lives or form a relationship. The task for the surgeon is to correct a defect in the patient's body and from the surgeon's perspective, the treatment can be limited to the operation.

The surgeon can be seen as a 'side-line expert' – he/she stands on the side-line of the patient's life and intervenes in it. The goal of the surgeon's interaction with the patient is primarily inform his/her work and his/her decision. Setting goals, ongoing assessment, decision making and management as well as evaluations are all performed by the side-line expert. It could very well be that the patient has some requests for the surgery, e.g. concerning the scar's appearance, but it is the surgeon alone, who decides whether this could be pursued in the treatment.

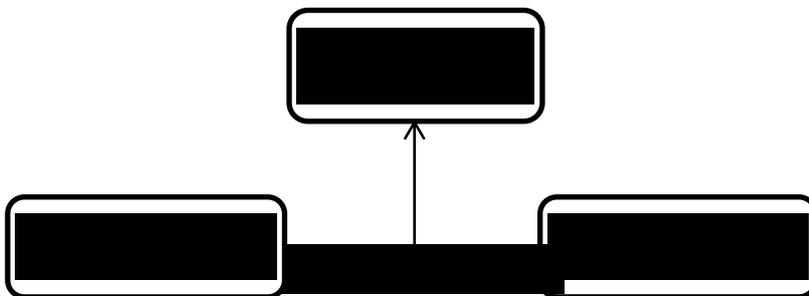
A social-pedagogical understanding of human development

In social-pedagogical thinking, as it is formulated in extension of the philosophical roots of the 19th century – P. Natorp, W. Dilthey, et al. (e.g. Mathiesen, 1999), it is a characteristic of human beings that development takes place in social communities. An individual cannot develop optimally if isolated from human contact, and the community facilitates both the expression of certain possibilities and affects the development of the individual in specific ways. It is therefore central to all pedagogy that the young person has the opportunity to engage in a community of practice (Lave & Wenger, 1991) with other people. In this community there are both obligations to adhere to such

group's norms (to a certain extent) and opportunities to participate in the formation of these norms by way of further development of the community.

A similar understanding of a person's requirements for development is seen in contemporary cultural psychological theory (e.g. Hundel, 2004, 2006; Bruner, 1990). From this perspective, a newly-born human being can be described as more incomplete than new-borns of any other species and therefore completes development after birth. Consequently, humans are dependent upon the care of others to a greater degree and for a longer period of time than most animals, and a biologically founded inclination towards other humans and an attachment behaviour that helps secure the necessary care has evolved. These developmental requirements have the advantage that a person matures in and in relation to the environment in which they will live and hence they develop an understanding and a behavioural repertoire that fits this particular environment. According to Bruner (1990), a person's development does not consist of a cultural construction fabricated on top of a biological foundation, but rather that a human is constituted by biological potentials interacting with the environment in which he/she grows up.

Figure 1: The relationship of biological and culture to the developing person.



Children who have developed to function in a specific environment can experience problems when they shift to live in an environment that is very different from the one where they were raised. This can be observed with children growing up in one subculture as for example a family dominated by lack of education, unemployment, alcohol-abuse, and then moving to an environment where education and a steady job are expected. In such cases, there can be a

need for changes in the way that the person functions psychologically in relation to his/her surroundings. Such a modification proceeds by their entrance into a new social community or sub-culture where, through learning and participation, they move from being peripheral participants to a full-fledged member (Lave & Wenger, 1991) – a description in line with social-pedagogical tradition.

A social-pedagogic understanding of the human being and its ways of development are therefore in accordance with contemporary understandings of human development within parts of psychological and philosophical theories and research. We then need to conceptualise treatment not as correcting defects but as (further) learning and development to qualify for this new or changed community.

A social-pedagogic concept of treatment

Every community implies something to be united for – a communal project – and certain norms for how one operates in relation to the other members of the community as well as in relation to the communal project. Communities can function in various ways. Where some communities may have an equal distribution of responsibility for maintenance and development of the community, other communities have a more noticeable distribution of work in that some people direct and have responsibility for the community, while others 'merely' do what they are told. Most communities change over time and the different roles participants occupy within these change as well. It is by the actions of participants that the community is maintained and gradually changed with time.

If one examines a traditional family as an example of such a community, the parent(s) initially have the responsibility for establishing the communal project and the norms of the community. They make the daily routine function, they establish and maintain the traditions the family has, they care for their children's health, well-being and development, and so on. Over time this distribution of responsibility gradually changes, in that the children, as they become able to, take on increasing responsibility for both their own world and eventually also the

family's functioning. Part of the difficulty of being good parents is certainly to achieve the gradual change of responsibility and tasks in step with the development of the children's abilities. At a certain point in time the family matures and the children leave home and establish their own families, which then provide new roles for the parents, e.g. as grandparents. Later in life the roles can be reversed even further and the children become the ones who now have to take care of the parents.

When a young person moves into a residential facility, there are no bonds comparative to when a child is born into a family. The challenge for the social pedagogue is to establish collaboration (Jensen, 2018) which is often described in terms of a 'relation' – a term I find unsuitable (see later). Instead, I suggest talking about establishing a social-pedagogical fellowship. There can be many communal projects for the social pedagogue and the young person, but if one is to collect all these under one title, the communal project can be characterised as the young person's life. In contrast to the family this is professional work from the social pedagogue's perspective, and the social pedagogue's own lifeworld is not a constituent part of the communal project, although a pedagogue can be strongly influenced by it. Society has decided the young person's development did not progress suitably, so the task is to establish an appropriate lifeworld for the young person in accordance with societal norms. This encompasses, however, a multitude of decisions that are dependent upon values, attitudes and interests, which the social pedagogue cannot decide by him-/herself. From the perspective of society and the social pedagogue it can be decided that certain behaviours are unwanted, but not what should replace these because there are many ways of living which are acceptable within society. Furthermore, the organisation of young people's lifeworlds runs easier and they develop quicker if they experience collaboration rather than combativeness between the young people and the social pedagogue. From a learning theoretical perspective it is easier and more effective to work towards a common goal, rather than having to navigate with the rear-view mirror away from the unwanted behaviour without any goal to focus on. During the social-pedagogical treatment there will be an

ongoing negotiation as conceptualised in this schema that was established after an observational study with a girl, Maria, who was 15 years old and brought to a residential home facility (Jensen, 2010, p.56; Figure 2 below):

The young person			
		In Focus	Out of focus
Social pedagogue	In focus	Joint perspective	Professional perspective
	Out of focus	Young person's perspective	External perspective

There can be issues in the young person's lifeworld that both the young person and the social pedagogue focus on in order to find appropriate ways to handle these — they have a joint perspective.

Likewise there can be issues that the young person is much occupied with, but that the social pedagogue does not estimate to be significant — these are alone the young person's perspective. This could be, for example, because the social pedagogue with his/her broader experience can see that the issue will go away or become irrelevant within a short period of time.

On the other hand, the social pedagogue, because of their greater life experience, can see issues that they think the young person should deal with, but which the young person is not currently engaged with — a professional perspective. It is then a challenge to the social pedagogue as a professional to get these issues transferred to be part of the joint perspective during their collaboration.

Last of all, there can be issues that none of them are focused on, but which could, for example, be apparent to someone coming from the outside — this is

called an external perspective. By working every day together, routines and norms are established that we are not always conscious of, but which are only discovered and brought into the discussion when someone comes from the outside and can see the daily routine from a different perspective.

Returning to the social-pedagogical fellowship, such a dynamic fellowship will be under constant development. In every interaction the collaborating unit will be confirmed or adjusted and developed, and a part of this ongoing 'negotiation' includes the determination of a common perspective through the communal project: the young person's lifeworld.

In a similar manner every interaction also encompasses a negotiation of the norms of the fellowship — how to treat one another, what is allowed when speaking with one another, how important it is to uphold agreements, when it is allowed to prioritise something else or others as more important than the community, etc.

Relations and contracts

Above I voiced my scepticism towards the concept of 'relation' and now I will consider alternatives. Hundeide (2004) discusses 'contracts' for being together: two people establish a contract in their relationship with each other. This contract is negotiated in every interaction, where it is adjusted or confirmed. There is a point in talking about a contract instead of a relationship, which is more often the case when discussing pedagogical work (e.g. Ritchie, 2004; Lihme, 2004). For most people a relationship has a positive ring to it, so a relationship between two people who agree to fight and wage war upon each other as soon as the opportunity presents itself will hardly be considered a relationship, but it could very well be covered by a contract. On the other hand, a contract sounds a bit formal, so some clarification could be beneficial.

Honneth's (2003) work on social groups' attitudes towards each other develop three different forms of recognition between groups:

- Legal- or rule-recognition: rules are shared and apply to both parties. Breaking of a rule/agreement can and should be discussed — not to treat others in accordance with a rule that applies to oneself, or not to point out a breach of the rules is the same as ignoring the others — a demarcation that the other group is so unimportant to those in our group that we do not even bother.
- Social recognition: the others perform something important for the community. An observation that the others contribute to society/the social community with something positive that we in our group value and would only reluctantly do without.
- Emotional recognition: how they are doing in the other group affects how we do in our group. It makes us sad, if the others are sad.

Applying these forms of recognition to social-pedagogical treatment gives us nuances in the relations between social pedagogue and young person. We often talk about the relation between social pedagogue and young person as an emotional bond and there is no doubt that if the young person and social pedagogue are emotionally bonded, there is a greater chance that the social pedagogue can influence the young person's choice in handling their life, but this line of thought produces problems in some circumstances.

There are young people who have a very difficult time forming attachment with others emotionally, and if one views an emotional relation as the prerequisite for social-pedagogical treatment then it becomes either very difficult or impossible. In this case, other forms of contracts (Hundeide 2004) can introduce some approaches to the work. If one works pedagogically with a young person who is so disturbed in his/her personal development that he/she cannot form emotional bonds with others, one can still use a contract according to legal or rule-recognition. Clear agreements can be made on what the communal project entails with open and honest negotiations of the joint perspective. For example the young person will often agree to a project that will help keep him/her from spending his/her life in jail or to be able to afford a motorcycle. This then

becomes the joint perspective of the project in the first instance through the establishment of a social-pedagogical fellowship. The re-socialisation task can work in a social-pedagogical fellowship even though a common project and norms have to be negotiated as we have a starting point from which the fellowship can develop.

When the young person moves into the residence, one cannot already have an emotional bond with them (Jensen, 2018) – to feign this would be false and most likely be perceived as such. It takes time and a common history to foster an emotionally based relationship. On the other hand one can recognise from the start the influence that the young person may have at the facility and in their daily routines – a social recognition – and one can state common rules applying to everybody at the place – rule recognition.

For many young people the contract will change over the course of their stay at the residence. They can start by entering into a fellowship based upon a rule-recognition of one another and experience being socially recognised in their daily life for their contribution to communal life. Over time some may develop more emotionally based contracts in relation to some of the social pedagogues. How these contracts are formed can certainly influence how the social-pedagogical treatment evidences progress (e.g. how simple it may be to move issues from the professional perspective to a joint perspective).

Until now I have spoken of the community in an ideal type form as a fellowship between a young person and a social pedagogue. This is an oversimplification undertaken to analytically underscore certain points. Stockholm (2005) relates in her research that at a children's home the children take part in several arenas that might require different management from the children (e.g. the community with the social pedagogues, the community between children at the residence, the biological family, their friends at home by their family, and so forth). In this context the children are challenged to manoeuvre between these potentially contradictory demands. This conception does not oppose that of the social-pedagogical fellowship, rather, it deals with the dilemmas as part of the

communal project. This demands precisely that social pedagogues see themselves as sharing the responsibility for the child's lifeworld which encompasses other arenas and that the child needs support in order to learn to handle these different obligations. Here it might not be the social pedagogues' opinions and norms that are the most appropriate norms (Jensen, 2011, Jensen, S.Q., 2011).

Social-pedagogic competences in everyday treatment

When the social-pedagogical fellowship is thought of dynamically alongside of Hundeide's concept of contracts, under continuous negotiation at every interaction, greater demands are placed on the social pedagogue. An element of this daily treatment can be characterised as follows:

In the daily contact with the young person the social pedagogue continuously adjusts their part of the interaction to fit the situation so that the young person is provided the optimal opportunity to develop the competences they need to handle their lifeworld (Jensen 2010).

How much a young person can handle varies. Some days they could be highly capable and take their share of responsibility for the social-pedagogical fellowship by adapting to the social pedagogue and the environment, while at the same time having enough energy to handle the day-to-day routines. Other days they can, however, be less capable – because their family is in disarray, they just broke up with someone, they received a bad grade in school, they slept poorly etc. On these days the social pedagogue takes a greater share of the responsibility both for the daily routines and for the maintenance of the social-pedagogical fellowship fulfilling its goal: managing the young person's lifeworld. There might also be the need for extra support, fewer demands and more care. The social pedagogue's work consists of a continual evaluation from day to day or even situation to situation of how to act in order to support the young people optimally in their development. At the same time the individual situation can often be used to develop different sides of the young person's life competencies,

and here the social pedagogue may judge which challenges in the current situation should be used as a learning opportunity.

This also clarifies part of social pedagogues' competencies: they are often good at making an interaction and collaboration function regardless of how competent the partner carries out his/her share of the interaction. This can be due to poorly developed social competencies, psychological problems, physical or mental disabilities, etc. It is not enough that the interaction can function regardless, but it should also be used to give the other party developmental opportunities according to their needs. Concurrently, situational opportunities often demand fast decision making, and if the interaction should retain a stamp of authenticity, action needs to be spontaneous. These well reflected, spontaneous actions I have elsewhere termed 'planned spontaneity' (Jensen, 2010).

Competence is developed to a large extent by interacting with others, but this can be supported by theoretical knowledge about a person's way of functioning (Eriksson & Markström, 2003) and by the ability to reflect and link this knowledge with practical experience. The shared reflections with colleagues after the actual situation with the young person and concerning the treatment are very important. Otherwise the social-pedagogical work can turn into each social pedagogue acting spontaneously without reflection and justification, and this paves the way for all kinds of self-deception. There should be a shared professionalism concerning the analysis and discussion of daily incidents and a mutual obligation to engage in this – even if this means that one's own understanding and conduct comes into question – and these collective reflections should be organised as part of the treatment.

A psychological concept of treatment

In social-pedagogical treatment an understanding of treatment has traditionally been taken from psychological approaches, so to clarify, we now characterise a psychological concept of treatment. This is often perceived in its ideal type as psychotherapy which proceeds as a meeting between therapist and client in a therapy room that is limited in both time and space – a set amount of time is

agreed upon and meetings are held at a clinic. In this way therapy is moved away from everyday life, which provides both advantages and raises problems. When the therapy room is separated from everyday life, it can contribute to a sense of security that allows the client to take up issues that would be too difficult and burdensome to relate to in their everyday context. It also creates problems since the demarcation leaves clients alone in transferring insights from what is learned in the therapy room to their daily lives.

In the context of theories on learning, one discussion focuses on the difficulties of transference of what is learned from one (learning) context to another (practical) context, which in the past years has given rise to new critical approaches to learning (e.g. Lave, 1988; Lave & Wenger, 1991).

In this article I am arguing for a more precise differentiation between a psychological and a social-pedagogical concept of treatment. In psychological treatment the client is protected from the outside world during the therapy sessions, which provides the opportunity for them to work with issues that cannot be handled in daily life. The price is that the client is then alone in transferring what they learned to their everyday life. In comparison, social-pedagogical treatment takes place during the client's daily routines, so the social pedagogue and the client collaborate on the challenges in the life of the youth while this is taking place. This also implies that the treatment can only concern the issues that the young person is able to take up in the everyday context and handle in collaboration with the social pedagogue. The two kinds of treatment make different demands of the young person and can be used for different purposes.

Manualised treatment

For the last two or three decades manualised and evidence-based programmes for treatment have been very much debated in Denmark (Krogstrup, 2011; Jensen, 2014; Juul Jensen, 2004; Ekedal, 2002). In this context they can be described as in line with the psychological concept of treatment. They describe certain interventions, exercises and lectures which are arranged on the side-line

of the life of the young person. Often they include role-plays to simulate the everyday life and reflections on experiences since the last session but they are limited in time and only cover a small part of the young people's lives. The idea of manualising is in essence contradicting an understanding where the social pedagogue takes part in the shifting and unforeseeable situations in the young person's everyday life. Like psychotherapy, it is limited to operating on the side-line, arranging training sessions for specific skills, exercising reflections on daily experiences, and so forth. In contrast this paper proposes an understanding of social-pedagogical treatment where social pedagogue and young person in fellowship handle the daily life as and when this is actually going on – not in an artificially organised setting.

Some characteristics of social-pedagogical treatment

Social-pedagogical treatment proceeds in the context in which the objectives to be learned should be applied which is the young person's lifeworld. Therefore it can definitely be good social-pedagogical treatment to attend a football match with the young person, go to a store and look at clothing or discuss makeup. All the time the social pedagogue considers how the situations can be used for the young person to learn to handle such situations independently (Fog, 2003). This implies that social-pedagogical treatment can look like a normal everyday routine and be misinterpreted as leisure (Perch, 1983; Rothuizen, 2001). But there is a crucial difference: the social pedagogue is continuously evaluating and adapting their part in the interaction, and the young person is characterised as not being able consistently to handle their lifeworld themselves, including the interactions in these types of situations. There is a constant threat to social-pedagogical treatment of deteriorating into complacency and letting the relationship slip into a normal, pleasant social familiarity. This threat emphasises the necessity of an organisational system to continuously reflect on whether one could have used the situations more productively. These considerations are strengthened by a professional and collegial collaboration in communities of practice that support participants against complacency.

Differences in concepts of treatment

The outline of social-pedagogical treatment which I have discussed is summarised in Table 1.

Table 1.

	Surgical Treatment	Social-Pedagogic Treatment	Psychological Treatment
Understanding of the problem	Apparatus failure Defects	Inappropriate or insufficient handling of life	Inappropriate or insufficient handling of life
Nature of the problem	Limited, well-defined, fixed possible outcomes	Contextual, multi-factored, open sample set	Limited to the client's handling life
Possible solutions	Set beforehand in relation to the apparatus failure	Multiple possibilities which are set during the collaboration with the youth	Several possibilities is set on the way – sometimes in collaboration
Professional competences	To be able to uncover problem and resolve it	Life experience, judgment in situations and for the future, creating new ways of handling life, planning of activities, competencies of social interaction	Relational competence Theoretical knowledge to understand the client
Young person's competences	Deliver information to the professional in response to their questioning Comply with the expert	Deliver information to use in the pedagogical treatment, try out new ways of coping Participate in the setting of goals and paths in the treatment	Deliver information to sue for the therapeutic work Should be able to enter into the therapist's treatment

	Surgical Treatment	Social-Pedagogic Treatment	Psychological Treatment
Distribution of Responsibility	The youth is responsible for the delivery of information The professional is responsible for identifying the problem and realizing the solution.	Joint responsibility for the course of actions and results No one can veto (maybe the young person)	Joint responsibility (often the biggest responsibility is upon the therapist) The client has responsibility to transfer what is learned to their everyday life.
Topography	The professional on the side-line	The professional and the young person in a fellowship in the life of the youth	The therapist and client in a communal space on the side-line

The table pinpoints differences between the different concepts of treatment contrasted with different dimensions. In practice there can be different hybrids and overlapping interventions. The aim of this article is to develop a concept of social-pedagogical treatment that enables a distinct kind of intervention which is less dominated by medical and psychological traditions.

When one works with tasks of various types, different kinds of treatment need to be different too. The interaction one should engage in within the pedagogical field is different from that of the surgeon, but has some commonality with psychological therapeutic work and still differs. Social-pedagogical approaches handle challenges that are characterised as follows:

- The goal is not set at the outset, but develops along the way;
- The young person takes part in setting the goal so it is not the professional who decides or controls this by him-/herself;

- There are many paths of equal value to reach a goal, but with different challenges and implications for the result;
- The treatment process and the results are dependent upon teamwork between the practitioner and the young person in a way where their perception of each other is central.

It is necessary for those of us working with social-pedagogical treatment to operate differently from in surgery or psychotherapy, and so we need a different concept of treatment. While there is overlap with psychological treatment as described here, each still has its own characteristics, strengths, weaknesses and prerequisites. There are consequently problems, which are treated better under social-pedagogical direction, while other issues will certainly benefit from psychological treatment with the specific opportunities and prerequisites that go along with it.

Conclusion

This article was instigated by an experience at a residential home that used certain words and concepts when pedagogues were asked to describe their own social-pedagogical work, but these words and concepts did not encompass the nuances that their practice demonstrated – they did more qualified work than they could express in their own description. I believed that the lack of a professional language with which to articulate concepts that matched their praxis could be contributing to poor professional practice. Consequently, I have attempted to formulate certain words and concepts that are both close to the daily work and simultaneously descriptive of several of its nuances.

I define social-pedagogical treatment as a process where the social pedagogue forms a fellowship with the young person and their mutual project is to handle the life of the young person by joining in this on an everyday basis. During this phase of the young person's life the social pedagogue should constantly engage in a way that creates optimal opportunities for the youth

to learn how to handle life by him- or herself. One part of this is to develop competencies in creating and maintaining social relations with others.

This definition and the concepts I have articulated in this article can support the development of social-pedagogical treatment at places for residential care. The intention is to support this in a way stressing collaboration and the need to include the way the young people at the place experience their own lives. As an example, I see a need for more nuanced concepts than 'relation' and this is why I suggest a social-pedagogical fellowship and try to find concepts, which allow for more detailed discussion of a specific case among the many variations which appear. This way of viewing social-pedagogical treatment makes some demands of social pedagogues who want to work like this. They have to develop a systematic approach and a continual professionalisation through continual discussions of their daily experiences. I believe that it will improve the treatment if we shift our understanding from both the surgeon's concept of treatment and the psychotherapeutic approach and instead develop an explanation of strengths and weaknesses in social-pedagogical treatment as different.

About the author

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Gender and restraint training. Why are all the trainers men and why might this really matter?

Brodie Paterson, Bryan Shewry, Patrick Bradley and Vaughan Bowie

Abstract

Staff working in the residential child care sector will typically continue to receive some training in how to accomplish restraint where it represents the last resort. However, it appears a disproportionate number of males appear to be involved in the delivery of such training. Why this situation may have come about and the potential implications are examined in this paper. A non-systematic thematic review of the literature investigates the potential implications of the current situation and a qualitative thematic analysis of interview data from a small group (n = 4) of women explores women's experience of participation in training in restraint. Sample numbers were restricted by ethical restrictions imposed on data collection. Findings suggest that a 'male' model of aggression may permeate some training programmes and negatively influence women's experience.

Keywords

Keywords. Gender, restraint, training, trauma, child care

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Introduction

Physical restraint remains a not uncommon practice in residential child care (Steckley, 2005). Census data indicates 84% of residential child care workers are female (Skills for Care, 2016). We might expect therefore that these proportions would be reflected in those whose role involves the delivery of training encompassing restraint. This is not the case with males seemingly still over-represented despite calls for changes in the gender makeup of the training workforce more than a decade ago (Zarola & Leather, 2006).

Gruber (1998, p.302) describes a process termed 'normative dominance' whereby one particular gender comes to exert greater control and influence in a given area such that roles become gendered. The process may affect a whole occupation or a subset of roles within a profession and arises from an interaction between gender stereotypes, divisions of labour and power (Acker, 1990). Why this may have happened to the role of trainers whose remit includes restraint and in particular what the implications may be for the experience of women participating in training have to date been underexplored; a deficit this research addresses.

Background

Over time a number of programmes combining suggested approaches to engaging therapeutically with children and de-escalation strategies and also offering linked training in restraint have been developed. Current guidance in residential childcare effectively mandates such training where the use of restraint is a foreseeable eventuality (Davidson, McCullough, Steckley & Warren, 2005). The premise that physical skills and modes of training, which are mainly derived from martial arts training, can successfully be adapted for teaching and use in care settings has been questioned, though (Hollins & Paterson, 2009).

Significant variations in reported injury rates to children during restraint between different approaches warrants serious concern (Hart & Howell, 2004) but there are also significant differences in reported injury rates to participants during training (Hollins & Paterson, 2009). Such statistics may reflect significant differences in technique but they may also reflect differences in the cultural messages and ultimately in the model of aggression underlying the programme and the subtle or not so subtle influence of gender.

Whilst the majority of staff in frontline posts in care positions are women, men still dominate many senior positions in social care. The under-representation of women in management and in high status professional groups may mean that women may be routinely excluded from the discussions that inform decisions and policy formation, including those around training that incorporates restraint (Robb, 2004).

Why might this gender exclusion matter? Campbell, Muncer and Odber (1987) found that men in general were more likely than women to describe their aggression as a legitimate means of control over others and to ascribe a social utility to this control mechanism. Women in contrast were more likely to see aggression as representing a loss of self-control (in the aggressor) and to view it as being morally wrong. Men reported significantly less guilt than women in relation to their use of violence (Campbell, Muncer & Odber, 1987).

Consequently, and if only as a generalisation, it appears that there may be a distinctly male versus a distinctly female view of aggression. If this contention is accepted, then the overrepresentation of men, whether in training roles that incorporate restraint or in commissioning training, may be significant. Such 'male' attitudes towards aggression may for example be associated with a decreased tendency to question the use of physical interventions or failure to emphasise the need for training to stress alternative non-physical approaches including de-escalation.

Campbell (1999) has argued that we need to understand that the fundamental source of gender differences in attitudes towards aggression is fear. From an

evolutionary viewpoint, in the human species where women are committed to a long period of gestation, lactation and child rearing, an injury or death to the mother as opposed to the father will have more serious consequences for reproductive success. Consequently, it is suggested women have evolved to react with greater fear than men to activities that may cause them physical injury (Campbell, 2002). Women's evolutionary fear response remains functional. In 2015-16 there were 58,104 incidents of domestic abuse recorded by police in Scotland, with 79% involving a female victim and a male accused (Scottish Government, 2016). Research consistently suggests that women are much more likely than men to be badly injured in such scenarios (Tjaden & Thoene, 2000).

Are women expected to comply with a male model of violence management during training? Scourfield and Coffey (2002) suggest that the social work workplace, often operates in accordance with and accedes to societal gender stereotypes rather than challenging them. Subsequently males in some circumstances are automatically taken to pose more significant risks of violence than women, with 'male' violence seen as being problematic. When it comes to training in restraint it appears this framing may be reversed and instead 'the absence of aggression in women is identified as the problem to be explained' (Gilligan, 1982, p.43). If this premise has validity the 'male model' of aggression management may be, if only implicitly, seen as the norm. What then are the potential consequences for women being trained how to restrain by men using an approach designed, albeit perhaps unconsciously, to meet the needs of men? Gilligan (1982, p.14) suggests that 'when women do not conform to the standards of psychological expectation, the conclusion has generally been that something is wrong with the women'. At the very least such a suggestion raises the possibility that an incongruence between the design and nature of training and the psychology and physiology of women may result in women being injured or psychologically traumatised more frequently and for their performance to be judged as inadequate because they do not conform to a 'male' model.

Common working practices in some residential child care settings require that an agreed proportion of men are on any shift at any given time because of the possibility of the need to use restraint. Such practices are perhaps pragmatic but they may also serve to frame the task of restraint as being predominantly male and lead to males being exposed disproportionately to the risks involved in attempting to restrain that are not insignificant (Watson, 2005).

The increased risk of exposure to assault that may be experienced by men is not reflected in studies of perceived vulnerability to assault in care settings when women consistently report themselves as feeling more at risk (Hatch-Maillette, Scalora, Bader & Bornstein, 2007). This perception may reflect a lack of confidence in their ability to protect themselves from any assault, particularly if the assailant is male. The origins of such differences in perception may reflect a physiological reality where women typically have 30-50% of the upper body strength and 70% of the lower body strength of a male of similar size (Wilmore, 1979).

Such a difference has significant implications for the nature of training. Adopting a gender-neutral approach to training that expects all participants, irrespective of gender, to perform to the same competency standards over the same timescale has been associated with a significantly increased risk of injury to women during training in a number of military studies (Bergman & Miller, 2001). The implications are clear in suggesting women are at increased likelihood of risk of experiencing an injury when being trained in restraint a finding confirmed by the limited research in the area (Moyo & Robinson, 2012).

Research Questions

Such concerns gave rise to the following research questions.

- What are the characteristics of women participating in restraint training and what are the implications?
- What is women's experience of training in restraint?

This study therefore sought to explore the experiences of women involved in the care sector who have been trained in, or had experience of, using restrictive physical intervention. The main findings of the quantitative elements are reported elsewhere but key demographics and relevant findings are given here to provide context for the qualitative element.

Recruitment and Results

The quantitative element comprised two surveys. Survey A was a national online survey of restraint Respondents (n=51). Seventy one per cent of respondents were male and 27% were female (Two percent chose not to disclose their gender). 80.4% were training in the health sector, 19.6% in adult social care, 17.6% in children's social care, 19.6% in education and 5.9% worked across sectors.

Subjects were recruited via e-mails to trainers and training organisations, invitations via an online professional forum and an online link distributed via the British Institute of Learning Disabilities (BILD) to organisations accredited by them to deliver physical interventions training. Because of this recruitment method a response rate for this element of the study cannot be established.

Survey B comprised a survey of local authority staff working in both social care and education settings (adults and young people) post training in CALM (crisis and aggression limitation management). Thirty one restraint course participants responded, with a response rate of 38%. Respondents were female, n=18 (58.1%) and male, n=12 (38.7%). Unidentified gender, n=1 (3.2%).

The qualitative element reported here comprised semi-structured interviews with four women who had experience of physical intervention training and its use. These women were recruited via their expression of willingness to participate in further research in either the online or paper questionnaire. The interviewees had experience working with both adults and children. Their age range varied from 20+ to 50+ and they had worked from five to 20+ years in their respective professions.

Two of the four women in the qualitative sample interviewed disclosed that they had previously experienced violence and aggression from males in a domestic context and one woman disclosed she had experienced sexual abuse as a child.

Only four interviews were conducted because a) the frequency of distress encountered in participants during interviews was extremely high, with 75% becoming distressed during the interview at some point, and b) no significant new issues or potential themes were identified as a result of interviews, with four suggesting that further interviews might not yield further insights and the potential for causing distress to further participants could not therefore be justified.

A male researcher undertook the interviews. The potential advantages of using a female interviewer were considered at the planning stage to be outweighed by the advantages of the researcher who was an experienced trainer in restraint, collecting the data and thus having the knowledge and experience to introduce follow up questions. Some of the questions asked did trigger strong emotional reactions relating to previous traumatic experiences and the interview process was managed carefully in order to minimise the potential for further harm to interviewees. A pre-arranged option of access to independent counselling was available as an option to research participants, subsequent to their interview.

Where specific reference was made to a physical intervention system this was rendered anonymous in order that participants could speak freely about their experience including models their organisation might still be using. The women interviewed had experience of the use of restraint from several standpoints including as senior trainers / training commissioners, trainers and as course participants. Three participants had experience of being trained in more than one system of violence prevention/ physical intervention.

Data Analysis

The approach used in data analysis was theoretical rather than inductive as it was informed by the research questions. The six-phase process identified by

Braun and Clarke (2006) was followed with both the coding and the thematic analysis of data which undertaken manually.

Results

The women interviewed perceived their response to aggression and violence as being qualitatively different from their male colleagues. A respondent drawing the distinction between them suggested:

They framed it different in their heads. I saw it as we were almost taking on the role as assailant; they (Male trainers) saw it as we're actually making a bad situation better by controlling in a different way and reducing the risk of harm.

The notion of a 'male response' was directly contrasted with that of the female.

what you need to understand is that the children here, if they're properly communicated with in a positive way, if they're given respect, all the things a human being with a positive value base you should do, you're actually not going to be that much at risk.

This whole idea that if you're going into the caring profession, these are all the things you should have anyway. And it's almost like a challenge to say, well, are you? Because you empathise, it's your job.

Does the dominance of men in the development of restraint training have a negative or positive impact for those women who receive training?

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Some training programmes were seen as promoting a 'macho culture' in which restraint was framed as a means of intimidating children with the implicit, and sometimes explicit, aim of both punishing a child for their behaviour and dissuading them from future violence. This raises serious questions about the

potential for a disconnect between the messages being conveyed in those elements of the training focusing on prevention and those focused on restraint. Participant's experience of macho cultures was not positive.

It was frightening. I felt frightened for myself, for others and the child

I know how intimidated I was when I went into the early stages of it. I felt inadequate

...surrounded by big burly guys who looked like fire fighters, you know. And the token woman was in there, trainer, because there was only one of her. They were the A-Team, the elitists.

You've got to be a hard-edged, hard-nosed person, you know. That's what it felt like.

I don't know if I can do that because other people that do it are martial artists'. You need to be able to do Judo, Karate, Jujitsu, something like that. And I must admit that I myself fell into that trap a few years ago, because I thought in order to be credible, I need to know these things.

Where the training was inappropriate it was evident that some participants actively resisted using it.

...the whole [System Y] package did not sit well with my value base or why I went into the profession

...when I did the very first course I did, I did not like, the model we use now. I came out of it feeling really uncomfortable. ... it just didn't sit right with me I don't want to and I can't do this to children. It didn't seem right

...having been trained in a form of restraint, which I now look back on as being abusive' 'we were trained in [System X] but en masse we refused to use it

The first one we had (restrictive physical intervention training) we thought none of those would be any good for our kids they were too severe, too aggressive they would further aggravate the situation.

...using [System X] I look back now and it scares the bejesus out of me. Two possibly three fully grown adults with quite a small child routinely taken down to the floor, you look at it, quite scary and potentially damaging.

The women were not universally negative about their experiences of training in restraint acknowledging that we need secure minor interventions but their experience was strongly mediated by the nature of the programme.

I love the fact that [System Z] is the way it is, is completely non-pain compliant - I love the fact that it does not routinely have kids on the floor.

Regular theory training - one day refresher training every other year ... Most of our decisions are made through thought and risk assessment

I liked the philosophy. It was all about minimising the risk to the member of staff and the child equally. The idea that kept being repeated was that no-one gets hurt, so that was I must admit really reassuring when that happened

I don't want to restrain anyone but I do feel more confident that if there is no alternative but to hold a child I am more likely to be

able to do it without hurting the child than I would have been before the training.

Discussion

Because of the extremely small sample in the qualitative element of this study the high level of physical and sexual abuse reported cannot be interpreted as representative of the sector and may be an artefact of the recruitment method or simply an unrepresentative cluster. However, Bussey (2008) reported high levels of assault, abuse and PTSD in human services students and graduates (22%) and Sellers and Hunter (2005) found 35% of a sample of US social work students reported a 'family history' of violence. Esaki and Larkin (2013) found an increased prevalence of Adverse Childhood Experiences in a US sample of residential child service workers, indicating that the possibility of a significantly increased prevalence of trauma in the workforce must be acknowledged and should inform every aspect of service planning and delivery, including training.

Trauma may clearly mediate women's experience of training/learning and influence their ability to gain positive outcomes. If unacknowledged the impact of trauma on training in physical interventions may mean that many women get only a chance to fail, to falsely confirm to themselves that they really cannot learn (Horsman, 2006, p.178). One implication of this research is that much greater consideration must be given to the potential for trauma histories in all staff irrespective of gender, for whom training in restraint is being considered. We know that restraint may re-traumatise those with a history of abuse (Gallop, McCay, Guha & Khan, 1999; Wynn, 2004). The possibility that training in physical interventions may re-traumatise staff who themselves have been abused is less recognised but the emerging evidence suggests that explicit attention in the design and delivery of training and in the preparation of restraint trainers is needed (Virrki, 2007).

Course guidance and instructions from trainers may ask participants to discuss any concerns over their participation in training. Expecting such disclosure to a stranger in a context in which both time and privacy may be compromised, such

as at the commencement of a training programme, imposes an unrealistic expectation. 'Assault survivors often feel silenced when violence against women is discussed. I'm afraid to talk ... I'm sure they [other students] will think badly of me' (Konradi, 1993, p.17).

If the culture of the training programme demands that 'you are able to handle yourself' (Hollins & Paterson, 2009, p.379) and the reporting of abuse is framed as conveying vulnerability, then the default scenario in many cases may be that women are implicitly required to suppress their experiences of trauma and violence. This may result in scenarios in which 'Women are expected to learn as though they are not victims of violence, and to erase the experience of violence, in spite of the ongoing profound effect it has on shaping identity and meaning', including their experiences of training in restraint (Lewis, 1999, p.182).

The limitations of the practice of seeking disclosure immediately before training can and should be addressed at a strategic level. The routine provision of opportunities for individuals to seek support in a confidential setting with staff trained in dealing with the issues of violence, aggression and trauma should be seen as an integral element of the broader strategic response needed to address gender based violence. All organisations, irrespective of whether they provide training in restraint, should already have this process in place (NHS Scotland, 2011).

To assume, however, that even if such opportunities are provided, that all potential training participants who have experienced trauma related to violence will recognise the need and choose to disclose in advance of participation in training is naïve. Trainers must therefore be aware of the potential signs of trauma including disassociation that may present during training.

For the women involved in the case studies training in and the use of restrictive physical intervention was not always a positive experience and at times their experience of training appears to have been traumatic and disempowering. Such results do not mean that men should not be involved in training female staff in

restraint but that the role played by gender both physiologically and in the sense of the meanings attributed to sexual difference must be explored (Virkki, 2007). Recognising the role played by gender has, however, implications for men, too. An interesting dichotomous process may be observed in male child care workers in their attempts to positively identify with a profession seen as essentially female (Christie, 2006). One strategy was that of the 'heroic man of action' whose violence is framed as 'protective'. This 'embodies the currently most honored way of being a man' defined by hegemonic masculinity (Connell & Messerschmidt, 2005, p.832) and the role of restraint trainer may facilitate this strategy only too well. The suggested alternative is that of the 'gentle-man' (Christie, 2006, p.399), abiding by a different and higher moral standard than those of other men in which they seek to be both caring and masculine. The negative consequences of an inappropriate style and approach by a trainer may of course have detrimental consequence for any course participant no matter their gender. Hollins and Paterson (2000, p.378) report individuals who have attended courses where instructors have presided over robust simulated restraint scenarios where staff struggled to restrain colleagues role playing children in crisis and directed participants by bellowing 'Harder, come on, you've got to show them who's boss'. The gender of individual trainers may therefore be mediated by the culture underpinning the training regime and the cultural messages implicit to a specific training programme.

However, the role of trainers remains highly significant, 'praise by instructors, even though often tendered informally, will have a powerful conditioning effect because the instructor after all is there as the embodiment of wisdom and authority' (Hollins & Paterson, 2009, p.377). If the majority of trainers involved in teaching restraint are men, then the possibility exists that 'male' attitudes towards the use of force, acknowledging that these will themselves vary, may unduly and potentially negatively influence the experience of course participants and ultimately perhaps the experience of vulnerable children.

When asked about the experience of being trained in restraint skills a number of respondents reported incongruence between their value base and their experience. Such incongruence may of course be an issue irrespective of gender but a number of the issues reported were specific to women's experience. Such responses appear to validate Gilligan's position, which is that male and female perceptions of danger are different, 'women's construction of the moral problem as a problem of care and responsibility in relationships rather than as one of rights and rules' (Gilligan, 1982, p.73).

The physiological aspects of differences in gender remain significant. We know that there are significant differences in muscle physiology, bone architecture and body make-up between genders and that there appears to be a significantly increased risk of injury for women undertaking gender neutral physical exercise programmes (Gemmel, 2002, p.26). Adopting different standards of competence for women may, however, be difficult if operational policy requires all staff to practise to the same standard irrespective of gender and could pose difficulties in terms of equal opportunity legislation (Gemmel, 2002). Ignoring the physiological differences that exist between men and women and the implications for developing safe systems of working may though be equally questionable.

Further research is required to identify whether female participants in restraint training and those in instructor roles are at increased risk of injury. We already know that the risk to all staff irrespective of gender of being injured during restraint may be very high, with a recent study in a learning disability setting reporting that nearly 50% of staff were injured when attempting restraint (Johnson, 2012). What we presently do not know is whether there is an interaction between a specific training model, gender and the likelihood of physical injury or trauma to staff or children during either restraint training or practice and this requires further investigation.

Residential child care providers whose trainers are male predominately should reflect carefully on the desirability of this and perhaps seek to positively

discriminate in terms of female prospective trainers. However, further research is needed to develop, identify and test strategies which could increase the involvement of female staff and service users in the commissioning, design and delivery of training incorporating restraint (Gemmel, 2002). Addressing the gender bias amongst the restraint training workforce will also require addressing more generic problems affecting the ability of women to participate in many types of training, such as enabling access to training for those women with children or other caring responsibilities (Green, 1991, Walsh, 2006). These continue to be challenges in residential childcare.

Gender related models of violence may mediate not only the practice of restraint but also attempts to engage therapeutically with young people in crisis more generally. There is no universally accepted conceptual framework underpinning training which seeks to enhance staff ability to de-escalate crisis and the research evaluating the impact of such training has been described as so poor it cannot support the premise that de-escalation training actually works (Price & Baker, 2012; Price, Baker, Bee & Lovell, 2015). Further research into de-escalation is therefore needed and given the potential significance of gender an exploration of its impact on the conceptualisation and practice of de-escalation should form part of any programme.

Conclusion

The primary focus across childcare services is on promoting alternatives to physically intervening that enhance recovery and promote healing. The use of restraint is, however, likely to remain necessary in some settings and may sometimes represent the least worst alternative. Given this, greater consideration must be given to the implications of gender. There are significant ethical issues involved, not least equity. The majority of the workforce in most residential child care setting is female. This reality must be reflected in the design, delivery and evaluation of training programmes in the prevention and safer management of acute crisis, which in some services may incorporate training in restraint. The act of holding a child against resistance should always

be abhorrent to the practitioner but the containment of an expression of distress that cannot be managed otherwise must ultimately be an act of compassion.

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Diary

Olivia Khan

Abstract

I discuss the excessive toys and presents that were expected to make up for the lack of affection in my first foster home. I compare life at home to life in care using money and love as a theme. My foster parents at the time spend a year continuously reading my diary and sharing its contents around their family. I share my feelings of alienation into the diary as the family continues to pull away from me. I am then asked to leave with two days' notice.

Keywords

Foster care, trust, love, affection

When I first went into care, I had arrived with nothing. I didn't even have a change of clothes. The house I arrived in was clean and stylish. The colour of the wallpaper matched the candles, which matched the rug and the cushions. There were things in excess. Decorations and designs, and things, all for the sake of aesthetics. It fascinated me but it all felt short term. The things were plastic and seemed unsustainable. Not like the royal stone fireplace in our old house that would be around forever and ever. These things looked as though they could all be removed and replaced and that they would expire one day. I was right and the house had a new style and colour scheme every six months or so.

When I woke up my first morning as a foster child, I got breakfast straight away. I was allowed to choose what cereal to eat and what piece of fruit I would like. The other kids were nice to me and knew what kind of questions I had and what I needed to know to feel better. I was taken shopping at a nearby kids clothing shop. My foster mum asked me my opinion on the t-shirts she bought me and even the colour of pants I'd like. She got me matching top and bottom pyjamas and I was even allowed a magazine, sweet and bottle of juice for when we got home. It seemed too good to be true. It was like on the rare occasion I'd get to

stay with my friend or with my grandmother but this would be my life now. Once my foster mum came in from buying food shopping and she had bought my foster sister and me matching pink personal CD players and a CD each. My birthday was magical too. We went for dinner, then to a science centre — I got perfectly wrapped presents and a cake. Everyone's attention was on me all day. It was surreal. I don't remember feeling much of anything around this time though and the adults noticed this. I was put on the waiting list for cognitive behavioural therapy but in the meantime, my social worker gifted me a diary. I guess she hoped I could trust it and vent some of my worries in it. It took me a while, but I did eventually. I wrote about the boys I liked at school. I wrote about not understanding how sex works. I wrote about falling out with friends and missing mum and wondering when she would come and get me.

My older foster sister had been staying in the house for six years when I was living there. So she was kind of the favourite. The family would talk with her about old times a lot and I'd listen and wonder if I'd be doing the same one day to another young girl. I thought that maybe you can't have things and have love. We had nothing when I was with mum but when she kissed me or hugged me or tickled me I felt full up with love. When I slept beside my sister, I felt safe and when we wrestled and played, I felt like we were made for each other. I belonged to her and she to me. I didn't feel that here. There was obviously very little touching allowed. No one needed to say it for me to notice. You could ask for a cuddle or just take one but it felt forced and one sided. I wasn't allowed to be naked and suddenly my body became something I should hide. People didn't act ashamed or embarrassed around nudity, they would act scared. My body wasn't simply something to be ashamed of, it was something to fear. I had things though. I had dinner every single night, and sometimes we'd even go to restaurants and get take away food. They bought me clothes and let me choose my own stuff. I thought this was just how the world worked. You either had things or you felt loved, but you couldn't have both.

One night my older foster sister came in past her curfew in a bad mood, a fight erupted and the police were called. That girl never came back. My foster mum

packed her bag the next morning and I never saw her again. A relationship of six years was gone because of one fight. Another girl had been removed before then but she was violent and I assumed there was a zero tolerance policy for foster care just like there was for people who worked in shops or post offices. But my older sister was just shouting, just an angry teenager, and she was punished so severely. I was the only young person in the house after this and things started to feel odd. My best friend was my foster mum's granddaughter, but suddenly she didn't want to talk to me anymore. We used to walk to the subway to go to school together but she started to leave early so she'd miss me. Then I stopped being invited to families' houses. I would stay inside and someone would pull the short straw and stay in with me while the rest of the aunts, uncles and grandkids had lunch somewhere else. I started eating dinner alone, too. My foster mum and dad would have their dinner later when I was in my room. By that time, I had a TV, DVD player, portable DVD player, stereo, a CD player and a keyboard. So I had no excuse to want to sit downstairs. I came downstairs on New Year's Eve once just before midnight, assuming I could at least watch the celebration with my foster parents. They told me to go back upstairs and I did.

One Monday in January, I sat on my bed with my laptop open on my knee. It was just after the winter holiday season and I had received a bright pink laptop for Christmas. School wasn't back yet so the days were long. I must have been writing or drawing because I wasn't allowed to be connected to the internet. I started to have my usual fantasy of mum pulling up outside in a red convertible with the top down. In the driver seat was a man that looked like Prince because I knew mum liked having a man around so had imagined her with a boyfriend. She would get out the car, call up to me and I'd escape out of the window and be with her forever. I remember stopping and tears started flowing down my face as I realised that she was never coming back. All of the excuses I had made for her over the past year and a half that I had been in care fell away and I realised that she didn't want me. I think I even said the words out aloud.

'Mum doesn't want me anymore, she's not coming back'.

I picked myself up after a long and therapeutic cry and told myself I was going to make the most of my new life. I knew that this new house and these new people might not love me like mum and my sister do but I'd stay here and get by until I'd be old enough to move out. I was 11 years old so it was only five more years until I could get my own flat. I'd just be here. This would be fine. I'd be fine. I felt pretty okay after that and I returned to playing on my offline laptop. Soon after my foster mum knocked lightly on my door and came into my room. She was making herself look very small and she practically tiptoed over to me, head tilted to one side apologetically. I wondered if she had heard me crying, I wondered if she'd finally hug me and this would be the start of our new life together now that I had accepted my fate.

She sat beside me and carefully explained how someone had come across my diary. She went on to say that what was in the diary was unacceptable and that on Wednesday, in two days, I'd have to leave. I nodded, she hugged me with a foot between both our bodies and left my room. I was numb. I didn't eat for the rest of my time there, I barely remember thinking. I wasn't sad or relieved or angry. I was just so full of nothing. She left me crisps and sweets, and juice at my door but I touched none of it. It felt tainted. These empty gestures. I couldn't bear to read over what I had written in the diary. I looked at the first page and I was filled with shame as I remembered questioning a sex scene I'd seen in a film. I disposed of the diary in an outdoor, public bin near the house. I squeezed a cartridge of pen ink on the pages and threw it away.

I remember thinking back to all of the treatment I had received over the previous months. I remembered my foster mum's granddaughter avoiding me. I remembered the family not wanting me at celebrations and events. I had vague memories of writing about her granddaughter when we had fallen out. I didn't hold back because I didn't think I needed to. I thought diaries were places you could be completely honest and not have to worry about judgement. I wondered if they all read the diary and discussed it like at a book club. I imagined that what I must have written must have been so important or interesting that it would have been a waste not to share. I started to remember coming home on a

few occasions and thinking that the diary wasn't in the place I had left it. I realised that that was so long ago and they must have been checking it every day or so to catch up. I felt violated.

My social worker, 'Elizabeth' (name changed), picked me up on Wednesday and I could see how angry she was. We loaded up the car with all my clothes but I left the TV, the stereos and the DVD players. My foster mum hugged me once and told me to keep in touch. She looked sad to see me go. She put on a whole show of standing at the door with her arms wrapped around herself, consoling herself as we drove away. Why would she even pretend to be sad? She was literally the one who decided that I was to go. I sat in the car and rested my head on the window, empty and lost.

'Elizabeth' had been my social worker for just over a year now. She supported my two sisters, too. We all had contact together every month or so. Mum hated 'Elizabeth', so I did, too. She was the one who split us up. I thought about how I imagined I'd leave this place. In mum's red convertible, but now here I was with 'Elizabeth' in her car, going in the opposite direction, going deeper into the care system. I looked at 'Elizabeth' and saw her for the first time. I saw how she tried to control her anger for me. I saw how hard it was for her to see me like this, I saw worry in her that I never saw in mum. It made me feel like I could relax and let her think about everything for me for a while.

About the author

Olivia is a Rural Business student in her final year of study. She works as a freelance consultant for a number of organisations focused around care and for events throughout Europe and Asia. Following this series of events Olivia spent 9 years living with her wonderful new foster parents in the countryside. She has been living independently for 4 years now and is still very close with her foster family.

The Importance of Love within the Care System: Love should be a Right

Helen Johnston

Abstract

I wrote this piece in the hopes to open a conversation about the impact of love within the care system. As a care experienced person, it often baffles me that we still cannot openly speak about love within the care system. It is the one thing that all children need to thrive yet when they are placed within care, the system is not required to love them, it is not a right and therefore many go without feeling loved when they are in the system. In this piece I have written about my experience of growing up for half my life within the care system and the isolating effect it had on me when I never felt loved, nor was given the chance to feel and understand what real, unconditional love was. I have also highlighted the impact love had on me when aged 17 I felt loved by an adult for the first time in my life in the hopes to highlight the importance love has on ensuring Scotland's care experienced young people are given the best chance at life.

Keywords

Love, meaningful relationships

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Growing up in a system for over half my life now has taught me many lessons. Lessons no child should ever have to learn. Lessons no person should ever have to learn.

When I was taken from my parents I was promised protection, I was promised care and I was promised security.

And in a roundabout way this is exactly what I got. I never went hungry, I always had a roof over my head and I was safe from the harms in which I'd previously lived.

The system offered me these things:

- care
- protection
- security

In a practical sense, or in other words a material way, I was provided for.

But the one thing they failed to offer me was the emotional side, emotional security, emotional protection, emotional care — and as such, it's something that I, like all people, have craved in my life.

I quickly learned that I was the only person I could trust or turn to, who would make sure I'm okay.

I quickly learned not to trust relationships, especially not adults, and I quickly learned that no matter how good something appears, it never lasted for very long.

As such, I became a very skeptical child, a child who was untrusting and weary of everything, because I had learned that no matter what, I'd get hurt in some form or another.

I was moved in and out of foster placements without anyone ever asking me what I wanted or needed. I felt isolated and alone, and never got the chance to deal with any of the trauma I had experienced before and during my time in the system.

In my first foster placement it was made clear to me that I wasn't liked, I was bullied by the other young people and my carer took great pleasure in telling me things that no child should ever hear.

Within months I was in pieces to my social worker, begging him to find me somewhere I'd be wanted.

And he tried.

Soon I was moving again. I felt like I'd been given a second chance.

My second placement was one that I loved and my foster carer tried her best for me, but sadly she wasn't equipped with the skills she needed to care for me, and although I became very attached to her, her family and the life I was building, it became clear to social work that things weren't working.

I still remember the feeling of heartbreak I felt the evening my social worker told me I would be moving.

I was too young to understand the reasons I was being moved and no one ever tried to explain it to me.

It was at this point I learnt the lesson that I should never trust. Not even when things appeared to be really good.

So, I moved on to my third placement, where despite my own best advice I let down my guard, placed trust in the people around me and formed really close relationships with my foster sisters and brothers.

However, this trust was abused, and my placement broke down after five and a half years.

I was forced to leave behind my foster brothers and sisters whom I had watched grow and who equally had grown with me and truthfully, it destroyed me because they very much were my siblings regardless of the fact we didn't share DNA.

I wasn't allowed to see them or remain in contact with them and still to this day it's something that destroys me. I miss them more than anything and there isn't a day that goes by where I don't think about them.

So again, my things were packed into black bags and plastic carrier bags and I was moved to a temporary foster placement, a week before Christmas.

Those feelings of isolation and mistrust came back with strength and I was left again feeling like I was all alone. A couple of months later I was moved again during my higher exams and placed with my last foster family.

It took well over a year for me to feel comfortable within the house and two and a half years later I was still struggling to feel like I was part of the family.

No matter how hard I tried, I couldn't relax and I couldn't trust. My carer found this difficult to deal with as she wasn't able to understand why I was guarded. As such her actions only added to my doubts.

Sadly, not too long ago that placement, too, came to an end and now aged 19 I made the decision to leave care because I honestly cannot face anymore distrust and isolation.

But yet again I've had to leave behind my foster siblings whom I absolutely adored and again I'm missing them more than anything.

In this whole time my foster siblings in each placement were the only people who I was able to let love me. They were my rocks and it's destroying me knowing they're not going to be a part of my life. #standupforsiblings

But on reflection, I realise that that four letter word could have changed everything. If the system had offered me love instead of material things it could have been so different for me.

I was 17 before an adult told me they loved me without expectation or condition.
17!

The point I'm making? It's simple: love may be just a four letter word to many, but to us? To children and young people growing up in care, it's everything. It's the one thing that can and does alter a young person's life.

It took 17 years for me to experience unconditional love from a person (they weren't even my foster carer).

And so many other young people face similar situations and often go longer without knowing and believing they are loved and valued.

Knowing I was loved saved my life and gave me strength to fight the trauma I had experienced. Those words offer me comfort and still to this day give me strength in my toughest moments.

It's time we made love a right for all care experienced people.

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About the author

I am 19 and I am a care experienced campaigner and Care Experienced student officer studying social work at Glasgow Caledonian University. I am also an MSYP for Who Cares? Scotland. I spend a huge amount of my time around Who Cares? Scotland attending participation groups, campaigns, gatherings and have helped deliver corporate parenting training to Scotland's corporate Parents.

Mind the Gap: Factors that can support responses to offending in residential child care and the challenges of implementation

Deborah Nolan and Joe Gibb

Abstract

Responding to offending in residential child care is inherently complex (Moodie & Nolan, 2016). There has been longstanding concern about the overrepresentation of care leavers in the criminal justice system and the fact that the behaviours of care experienced children are more likely to come to the attention of the police and to attract a criminalising response (Scottish Government, 2018; Scottish Care Leavers Covenant, 2015). Work completed by the Centre for Youth and Criminal Justice (CYCJ) and Staf (Scottish Throughcare and Aftercare Forum) over the past two years has highlighted a range of factors which can support good quality, consistent and confident decision making, towards the aim of ensuring that police contact is avoided unless absolutely necessary. These factors include relationships, multi-agency working, the adoption of a joined-up approach, agreed principles to inform practice, a positive organisational culture and ethos, caring for the carers, and data. While these findings present a range of opportunities, the challenges to implementation are clear. Acknowledgement of these challenges, as well as a plan of action on how to overcome them, is necessary if children are to benefit from a more positive care experience. We also need to address the systemic issues that contribute to police contact in the first place.

Keywords

Residential child care, responses to offending, complexity, support

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Introduction

Building on research undertaken in 2016, as detailed in 'Between a Rock and a Hard Place': Responses to Offending in Residential Child Care (Moodie & Nolan, 2016) and The Duality of the Corporate Parenting Role: A Delicate Balancing Act (Moodie & Nolan, 2017), for the last year the Centre for Youth and Criminal Justice (CYCJ) has partnered with Staf (Scottish Throughcare and Aftercare Forum) on the Responding to Offending in Residential Childcare - Next Steps project (Nolan & Moodie, 2018). This project has focused on supporting the implementation of the findings of the above research in practice, and on embedding this learning at local and national levels towards the ultimate aim of improving outcomes for looked after children (Nolan & Moodie, 2018). The project has involved influencing and developing an understanding of local practice, through adopting an improvement methodology with four children's houses from two local authorities and one third sector organisation in Scotland (Nolan & Moodie, 2018). This has been supplemented with individual and collective discussions and reflection with national organisations such as Police Scotland, the Care Inspectorate, Community Justice Scotland, COSLA (Convention of Scottish Local Authorities) and Social Work Scotland (Nolan & Moodie, 2018). In addition to the learning gained from this project, there has been significant interest in this topic since 2016 and we have engaged with several hundred workers, including residential child care workers, police officers, social workers, third sector workers, managers, advocates, education staff and care experienced young people.

This paper will synthesise the learning gained from the above work by highlighting what supports good quality decision making in responding to offending behaviour in residential child care. This will be followed by the response to the findings of this work by Joe Gibb, an experienced residential

child care worker, who will highlight how this learning could be utilised in practice and some of the challenges to implementation.

Still between a rock and a hard place

The majority of looked after children do not come to the attention of the police, and when they do this can be for a range of reasons including missing persons reports, victimisation, and offending (Moodie & Nolan, 2016). Nonetheless, there has been longstanding concern regarding the criminalisation of looked after children, particularly those in residential child care (Moodie & Nolan, 2016; The Howard League, 2016). Research consistently highlights that care leavers are more likely to be involved with the criminal justice system (Scottish Care Leavers Covenant, 2015) and the behaviours of children with care experience (especially those looked after away from home) 'are more likely to have been reported to police – and therefore to attract a criminalising state response – than Scotland's child population in general' (Scottish Government, 2018, p.10).

As detailed in our previous work, responding to offending behaviour is inherently complex, influenced by a multitude of factors and involving the reconciling of a range of dilemmas and tensions, necessitating professional judgment to provide individualised responses (Moodie & Nolan, 2016; 2017). However, various factors have been highlighted which can support good quality, robust, consistent, considered and confident decision making in responding to offending behaviour, towards the aim of ensuring that police contact is avoided unless absolutely necessary. This aim is driven by the recognised significant impacts that responses to offending can have on children's future outcomes, including the detrimental impact of premature involvement with formal systems and the justice system on offending behaviour, as found in the Edinburgh Study of Youth Transitions and Crime (McAra & McVie, 2010), and on life chances and opportunities resulting from the need to disclose childhood criminal records (Nolan, 2018a; Moodie & Nolan, 2016).

Factors that support better responses to offending in residential child care

In navigating the range of tensions and dilemmas involved in responding to offending in residential child care, and in promoting robust, considered and confident decision making, a range of factors have been highlighted, each of which will now be explored.

Relationships

Relationships are the golden thread of good practice, and significant attention has been devoted to relationship-based practice (The Care Inquiry, 2013). Our work has again echoed this, with the importance of relationships in responding to offending in residential child care clear. This includes relationships with residential staff, the children in care and their families, police, social work, health, and education, as well as between practitioners and their managers (Moodie & Nolan, 2016; Nolan & Moodie, 2018). Moreover, we would echo the conclusion of The Howard League (2017, p.1) that 'multi-agency working is essential to put in place the structures and support needed to address factors leading to the criminalisation of children in residential care', which must involve all corporate parents.

Utmost importance has been accredited to the relationships between residential workers and the children in their care. These relationships are regarded as critical in preventing and defusing situations, and require that staff know the child in question, know their history and their behaviours and what works for them individually, and also know when it would be better for another staff member to intervene (Moodie & Nolan, 2016). The police have also been recognised as a key partner, with residential staff citing positive relationships as critical in sharing information, preventing crises and gaining advice, guidance and support. Having a single point of contact within local police for children's houses is useful, although the availability of this provision has often varied in the face of competing demands and resource constraints (Moodie & Nolan, 2016; Nolan & Moodie, 2018). It is important that such support continues, but as discussed below, this should not result in unnecessary interactions between the police and children within the house (The Howard League, 2017).

In terms of relationships between young people and the police, the difficulties which are often apparent in these relationships have been highlighted in both our own research and in that of others (for example Who Cares? Scotland, 2018). This has often resulted in efforts to encourage greater contact between the police and looked after children, including through informal visits to children's houses. While such strategies have often been positively commented upon, including in our own research, there is increasing debate in the literature about the potential risks associated with children having unnecessary contact with the police, including drawing young people into further contact with the justice system, labelling and stigmatising (thereby creating a self-fulfilling prophecy), and normalising police interactions that would not occur in non-care settings (McAra & McVie, 2010; The Howard League, 2017). It is acknowledged that there is a complex balance between avoiding these risks and improving relationships between the police and children, with the Howard League (2017) concluding that the best outcome for a child living in a children's home is to not have any contact with the police at all. As with all matters, it is critically important that we hear young people's views on such police contact.

The relationship with social work, who usually retain the role of lead professional for children in residential child care, is also important, given their responsibilities for planning, decision making, encouraging partnership working, and sharing and receiving information (CYCJ, 2017). Residential workers have reported that it is important to be and to feel included and listened to as part of the team around the child (Nolan & Moodie, 2018). This does not always appear to be the case, resulting in feelings of hopelessness that there is little staff can do to influence decisions and anxieties about what could happen to the young person (Nolan & Moodie, 2018). Our work would also suggest that there may be some partners with whom further efforts are needed to secure their full engagement in working with looked after children involved in offending, namely education and health, and in particular mental health services. As a result, we conclude that formal and informal methods of building and sustaining relationships, bringing partners together and enabling communication, as well as relationship-based practice, should be given priority (Moodie & Nolan, 2016).

A joined-up approach

A joined-up approach has been identified as important in supporting relationships and partnership working. A key aspect of a joined-up approach is each agency having a clear and agreed understanding of their own role and responsibilities in responding to offending behaviour, which can be shared with other agencies (Nolan & Moodie, 2018). This is critical in order to develop a consistent and mutual understanding of what each agency can do, the limitations of their role, how these differ across agencies and what they can expect from each other (Nolan & Moodie, 2018). Other important components of a joined-up approach include: shared understanding across agencies about the needs and experiences of looked after children; the impact of these experiences on young people; the impact of responses; the purpose of residential child care and what individual houses and placements are trying to achieve; and the impact of criminalisation (Nolan & Moodie, 2018).

A range of strategies have been highlighted as useful in achieving this and in addressing some of the tensions which appear to arise when the above components are missing. These strategies include joint training; sharing of information and knowledge from each other's areas of expertise; ongoing communication; and developing opportunities to bring agencies together in a safe and enabling space to discuss in practice what is working well, what could be improved and how this could be achieved (Nolan & Moodie, 2018).

Policies, protocols and principles

Debate has arisen in our work regarding the place of policies and protocols to guide and inform staff practice in responding to offending behaviour. Our initial study found a lack of clarity from practitioners regarding the existence of such internal policies, but more fundamentally there was consensus that policies could only go so far in influencing practitioner responses. There was also agreement that, whether in existence or not, decision making should be individualised, depending on the circumstances of the incident, and should be a matter of professional judgement (Moodie & Nolan, 2016).

In our later work, interest has been expressed in developing procedural guidance in respect of police contact to promote consistency of approaches and to support the use of discretion, for example in respect of the safe disposal of drugs (Nolan & Moodie, 2018). Other research has found that multi-agency protocols can be useful, with a National Protocol on Reducing Criminalisation of Looked after Children currently being developed by the Department for Education (The Howard League, 2017). Our work would suggest that rather than having a protocol, it may be more useful to have an agreed multi-agency set of goals and agreed principles to inform practice. Drawing on the work of the Howard League (2017) such principles may include that police contact is the option of last resort; that no child is unnecessarily criminalised; that any decision to contact the police is made in a thoughtful and considered manner; that efforts are made to understand behaviour; that diversionary and de-escalation measures and restorative approaches are used where possible; and that those children who are criminalised are supported through the justice process.

Organisational culture and ethos

Organisational culture and ethos has been highlighted as being of critical importance in effecting day-to-day decision making. It has been suggested that the culture and ethos of organisations should be positive, shared, well understood, supportive, respectful and child-centred (Moodie & Nolan, 2016). Moreover, children should be provided with a caring, safe, calm, nurturing, loving and therapeutic environment to achieve their potential, where police contact is the option of last resort and corporate parenting duties fulfilled (Moodie & Nolan, 2016).

Coupled with this, residential staff should be supported and empowered by their managers and organisations to make decisions, whilst being able to draw on a wide range of formal and informal managerial and peer supports (Moodie & Nolan, 2016). In achieving this, important factors include: clear, consistent and streamlined communication; modelling by managers; and having a good team, with clear boundaries, structures and routines, including clear expectations of responses to certain offences (Nolan & Moodie, 2018). Moreover, the ability to access external support as needed, such as on call services, team meetings,

debriefing, incident monitoring and supervision were additional identified factors (Nolan & Moodie, 2018). We have, however, found that the presence of such supports, and how they are experienced, varies. This includes supports in respect of very serious and/or violent offences, which can leave staff with a level of unresolved trauma, affecting not just staff members' practice but also their overall welfare and wellbeing (Nolan & Moodie, 2018). It is important that staff feel listened to regarding the impact of organisational issues such as staffing (Nolan & Moodie, 2018). We must ensure that our carers are cared for, that their needs are met, and their rights are prioritised if they are to be able to effectively care for the children they are looking after on our behalf. A further means of demonstrating such care and worth is through the investment in, and the prioritisation of, staff training, professional development, and high quality induction to equip staff with the knowledge, understanding, tools and skills required to understand and meet the needs of all the children in their care (Moodie & Nolan, 2016).

Data

While our 2016 study went some way towards filling the gap in data on offending by looked after children in Scotland, through raising concerns about the prevalence of police contact, the types of offences resulting in such contact, and the challenges of data collection, we still lack single and multi-agency, locally and nationally collected consistent data (Nolan & Moodie, 2018). In the absence of such information, we often rely on anecdotal evidence or retrospective studies, for example, although 0.5% of the general population have been in care (Who Cares? Scotland, 2018), of those who responded to the 2015 Scottish Prison Service Prisoner Survey, 33% of the young offender institution population and 31% of the adult prison population reported having been in care as a child (Broderick & Cairney, 2015). As a result of this lack of data, we do not have access to accurate information regarding the extent to which looked after children are criminalised, how this may vary, for example by gender or placement type, offending prior to entering residential care, trends and patterns, outcomes, and areas of good practice or practice issues (Moodie &

Nolan, 2016; Nolan, 2018b). In the absence of such data, the issues detailed above will be inherently difficult to tackle.

Practice implications and the challenges to implementation

It is recognised that understanding the practice implications of research and improvement projects, such as those which have been outlined in this piece, can be difficult. There can be various challenges to implementation, which are often most apparent to children and workers, those who are closest to direct practice. As a result, in this piece the decision was made to partner with an experienced residential child care worker to capture these unique insights and understanding in this paper. The following section captures his voice.

There will never be a silver bullet that can remove complexity from residential child care practice, including in responding to offending behaviour. However, the above areas have been highlighted as potentially being supportive, and indeed echo many of the recognised key components of good practice and quality residential child care – caring for the carer, good recruitment and induction processes, highly trained practitioners, learning and reflection embedded at all levels, well planned placements, partnership working, and well-resourced services (see for example Skinner, 1992; Maier, 2006; Horwath, 2000; Smith, 2009; Bayes, 2009).

Moreover, the above findings could be used within the residential setting to help frame and shape practice. The findings could be particularly useful if utilised to encourage individual and organisational discussion and critical reflection, for example during individual practitioner study, formal supervision, and team meetings. Additionally, there is scope for the findings to be used during multi-agency learning events in the hope of improving the whole system responses to children involved in offending behaviour.

However, we cannot ignore the challenges to the implementation of these findings in practice, including the role of wider systemic factors. We still have a care system within which young people often arrive in crisis through admissions on an unplanned basis, where the perception of residential child care as an option of 'last resort' remains, and with instability and impermanence arguably

inbuilt within the system (Nolan, 2018b). Moreover, there remains a continuing fight between the different professions within the human services who are jostling for position, with historical challenges associated with status, oppression and stifled creativity of the residential child care workforce that have yet to be addressed (Archer, 2002; Bayes, 2009). Furthermore, the system and the staff within it continue to function within a blame culture, where justifying and defending practice as opposed to learning is often prioritised. It could be argued that until the workforce begins to feel cared for via proper resourcing and support, police involvement within the residential setting will happen more frequently than it should (Moodie & Nolan, 2018).

It is critical that collectively we take an uncomfortable look at the barriers preventing young people from experiencing a more positive care experience, and the system's issues that lead to police involvement in the first place. It is also essential that we examine the barriers stifling the implementation of what we know works, and ensure the implementation of recommendations from previous reviews (for example from National Residential Child Care Initiative) are not lost. The Independent Care review may provide the opportunity to do so and continues to gather pace with an enthusiastic sense of optimism that change will happen for the better. This review, together with the Scottish Government's National Abuse Inquiry, will have implications for practice.

CYCJ and Staf continue to work on the above issues, supporting local practice and exploring how the implementation of these findings can be supported at a national level. We will continue to promote the factors which can support good quality, consistent and confident decision making and better responses to offending, including: relationships; multi-agency working; the adoption of a joined-up approach; agreed principles to inform practice; a positive organisational culture and ethos; caring for the carers; and data. If you would like more information or to stay updated on this work, please contact the corresponding author.

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Change and Continuity: Caring for Children and Young People

Carole Wilkinson

Abstract

The article is the author's reflections on a working life in social care that has spanned over 20 years in Scotland, starting with the most recent as Chair of Scottish Children's Reporter Administration. It examines changes since the Killbrandon report, arguing that change has not fundamentally altered the original philosophy and has helped bring the Hearing System into the 21st century. Some of the changes have been about ensuring children, young people and their families can participate more fully in their Panel Hearings. It then goes on to highlight some of the work now in progress to further the aim of better hearings for all those involved. The article then looks back at the establishment of the Scottish Social Services Council and the registration and regulation of the social services workforce, covering some of the debates and arguments. It examines issues around the status of the workforce particularly residential child care staff, and what still needs to be done to achieve proper recognition for such a demanding and important role.

Keywords

Children and young people, residential child care, workforce, participation, status and value

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The Hearing System

An invitation to contribute to the journal provided an opportunity to reflect on a career working in the public sector for over 30 years which has included periods as a social work practitioner, as a senior manager of social work services, and the opportunity to set up the Scottish Social Services Council (SSSC). This was followed by positions as a non-executive on Boards covering health, education and child care, the particular highlights of which include setting up the Social Work Department in Falkirk, establishing the Scottish Social Services Council and my eight years as chair of The Scottish Children's Reporter Administration (SCRA). Those of us who work in public service do so because we want to make a difference, in my case to be part of improving the lives of children and families and those who are disadvantaged, and supporting and developing the workforce. In this article I intend to firstly say something about the Hearing System, its purpose, current focus and future plans. I will then reflect on the work to establish the registration and regulation of the workforce with particular reference to social workers and residential child care staff and finally I will reflect on where we are now as public sector workers.

It is remarkable to consider the longevity of the Children's Hearing System. Designed to serve society in the 1960s, it has survived amendments in the 1990s, tinkering in 2004, and legislative reform in 2011. For the most part these changes, apart from those in 2004, have continued to support the philosophy of the hearing system as set down by Lord Kilbrandon (Scottish Home and Health Department, Scottish Education Department, 1964). In acknowledging the soundness of the original report and legislation, it is important to acknowledge the changes to the system, to see them as supporting it and not as attacks. Resisting change, I would argue, undermines progress towards an appropriate approach to helping children and young people.

Society in 1960s Scotland was a very different society to today and it makes sense to have a system for the 21st century that reflects the current needs of children, young people and their families. It is particularly interesting to note that a system designed primarily to deal with children who offend now receives more referrals for children in need of care and protection. The vast majority of

children and young people referred to the Reporter are for concerns about their welfare. In 2016/17 a total of 15,118 children were referred to the Reporter, 13,254 on non-offence grounds, and 2,995 on offence grounds, representing 1.7% of all children and young people. There has been an increase in the number of referrals of children aged two years and younger, suggesting perhaps a greater focus on early intervention and GIRFEC, the Scottish Government policy, Getting It Right for Every Child, having an impact? The overall number of referrals has been falling, through a combination of better early identification and assessment through pre-referral screening, allowing some families who need help to be given it without recourse to a hearing. This allows for greater attention to be given to those most in need of compulsory measures and at greater risk. The cases coming to the attention of the reporter are increasingly complex and challenging, recent research by SCRA sought to explore what this means in more depth (Woods, Henderson, Kurlus, Proudfoot, Hobbs & Lamb, 2018).

What makes this approach to children and young people so unique? It is the focus on welfare, the unitary nature of the system (dealing with those who offend and those offended against as children in need), the forum that hears cases and the informality. The role of the Hearing is to balance the rights of adults and children with the clear focus on the welfare and best interests of the child being paramount. Our system in Scotland recognises the impact of family background, poverty, social exclusion, poor school attainment, not as excuses, but as factors in the child's experience. When it works well it allows for discussion, identifies the important issues, facilitates participation, and comes to good decisions about the best ways of helping children and young people.

I want now to look at some of the changes that have taken place or are planned as part of ensuring the System remains relevant and fit for purpose. I begin with three legal challenges McMichael versus UK 1995, S versus Miller 2001 and PR versus K and others 2010, all challenged the welfare versus rights debate and their outcomes and what constituted a fair hearing. The judgements led to the provision of panel papers and reports for parents, for children and young people, the provision of Legal Aid and broadened the scope of 'relevant person' to

include an unmarried father and grandparents. The definition of a relevant person was a key debate in the drafting 2011 legislation (Children's Hearing (Scotland) Act 2011). Looking back it seems odd that it took so long to make what seem sensible and proper changes, ones that recognised the importance of the participation of children, young people and their families, and that this needed to be meaningful. This does, I maintain, chime with Kilbrandon. This only goes so far and there is still work to do to make reports and papers more accessible; they need to be shorter, written in plain English and in appropriate formats. Young people often complain that Panels rehearse their pasts, focus on the negatives rather than on progress, on their good points and what needs to happen, so why keep producing reports, often lengthy ones, with lots of historical detail?

As I leave SCRA, work continues to develop information in formats that are meaningful, to encourage pre-hearing visits, to extend the programme of modernising hearing rooms across all localities, work with partners to create better hearings for all participants and the creation of a Young Peoples' Board now known as Our Hearings Our Voice. This programme of work is all designed to ensure the Hearing System helps children and young people to really feel part of their hearings ([Children's Hearings Improvement Partnership](#)).

One piece of work undertaken during my period as Chair of SCRA took me back to my work with the Scottish Social Services Council (SSSC), this was the creation of a Diploma and a specific training and qualification programme for Reporters, a recognition that the role of the Reporter is an important one and needs to be carried out by an appropriately qualified professional.

Scotland took a very bold step in the mid 1990s when it embarked upon the registration and regulation of the care workforce. Following consultation, it was agreed to extend the workers to be registered beyond social workers to include, amongst others, those in residential care, day care, early years workers, housing support and to encompass those in managerial and supervisory roles. It is important to note that residential child care workers were initially included as their roles were considered as important as fieldwork staff. Registration required workers to hold a qualification or to be working towards gaining one, a

significant step towards having a fully qualified social services workforce and to recognising that the work they do is skilled and of value.

When the Register opened in 2003, other than social workers, only a small number of social services staff held a qualification and one of the early tasks of the SSSC, in consultation with stakeholders, was to set a timetable for groups of staff to be registered and then to agree the relevant qualification requirements. Residential child care workers were the second group to be registered following social workers. By 2016 there were 90,000 registered social services workers.

Early investigation into the educational background and qualifications of residential child care staff indicated a mixed picture of staff with few school-based or professional qualifications. This reflected their status despite the difficult and demanding job they do, and is very different when compared to similar workers in parts of Europe, such as, Scandinavia where they are seen, much like teachers, as respected professionals and paid accordingly. One of the challenges of registration and regulation is to raise the profile and standing of those who work in care services, many of whom are women on low pay.

In those early years of registration there were lots of debates about what Scottish Vocational Qualification level should be set for key staff, with arguments that the bar was being set too high, or too low, that SSSC was not sufficiently rigorous or aspirational. All of this was set against a backdrop of fears that staff would not be able to achieve the necessary qualification, that they would leave, placing pressure on service delivery and stability, that resources were limited, that qualified staff would demand more pay and there were even those who questioned why certain staff needed a qualification. Whilst the path to a fully qualified workforce, one that is recognised and valued, remains aspirational, many of the fears have not been realised. Staff have worked hard to achieve their qualifications and over time the bar has been raised, for example, in the early years sector. There has not been a mass exodus of staff but resources remain stretched and recruitment and retention a source of concern. The latter, I would argue, as much to do with the nature of the work, how well staff are supported and the levels of pay and less to do with needing to register, and being subject to regulation.

Alongside the work to register and regulate workers, the SSSC has done extensive work to develop training and education materials, to promote professional development and to embed learning in the workplace. There is still much to do in this area and there remains the task of raising the profile of the workforce, gaining proper recognition for an important and difficult job.

The profession is helped by the voices of those who receive services and their many campaigns. One example is Who Cares? Scotland and the work they have done to highlight the experiences of being looked after, of frequent changes of school and what this means for children's education, what it's like attending a Hearing, and their expectations of residential care. Speaking out is having an impact and has influenced the setting up of a review of the child care system particularly looking at how we might deliver better residential care services to children and young people. Any recommendations will need to consider those who work in the service and how things can be made better for them. I strongly believe the route to quality services is by having a well qualified workforce, with opportunities for continuous professional development, one that is properly supported and valued and appropriately remunerated.

About the author

Carole Wilkinson has spent over 30 years working in the public sector in England and in Scotland. She came to Scotland in 1995 to take up the post as Director of Social Work in Falkirk then moved in 2001 to become the first Chief Executive of the Scottish social Services Council, the body set up to register and regulate the social services workforce. Since her retirement in 2009 she has served as a Non-Executive on public boards, this has included chairing the Board of Children's Reporter Administration and positions on NHS Education and the Scottish Qualifications Authority.

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Ambiguous Loss

Nina Vaswani

Abstract

Loss is an inescapable part of human existence, but we know that vulnerable or marginalised groups of children experience higher rates of loss and bereavement than the general population. Children who are cared for in placements outside of the family home are also more likely to experience ambiguous loss, which is when a loss remains unclear and without closure. Ambiguous losses can be 'physical' e.g. an absent parent, or 'psychological' e.g. a parent who is emotionally unavailable due to substance misuse. Ambiguous loss is less often recognised than bereavement and often goes unsupported, thereby leading to an increased risk of prolonged distress, poor outcomes and disenfranchised grief. It is therefore important that childcare workers are aware of the presence and impact of ambiguous loss in the lives of children that they work with. This paper will describe these concepts and consider the implications for residential childcare practice.

Keywords

Loss, ambiguous loss, grief, disenfranchised grief, residential care

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Loss

Any life change or transition will be accompanied by loss in one form or another, and thus loss is an inescapable part of human existence. Indeed, Bowlby, in his seminal work on attachment and separation, observed that 'a majority of losses that occur in society are due to causes other than death' (Bowlby, 1998, p.75). Yet when we talk about loss, we often tend to think about the finality of loss through death. In this paper I will consider a fuller range of losses that children might experience, with a particular focus on losses that can be beset by ambiguity, and I will also reflect on the implications for residential childcare practice.

The extent of loss in childhood

Childhood is a time of great developmental change and transition. Children will change friendship groups, move house, bury a much-loved pet, transition between schools and wave older siblings off when they leave home. As a result, no child is immune to the anxiety, pain or sorrow of loss, despite our desire to protect them from it. Significant proportions of children will also experience loss of a parent or loved-one. Around one-in-four children in Scotland have a non-resident parent following parental separation (Marryat, Reid & Wasoff, 2009) and between 43% (Hight & Jamieson, 2007) and 78% (Harrison & Harrington, 2001) of schoolchildren have experienced the death of a relative or friend. In relation to vulnerable or marginalised groups of children we know that they experience higher rates of loss and bereavement than the general adolescent population. For example, my research found that almost all young people in custody had experienced one significant bereavement, two-thirds had experienced four or more, and more than three-quarters had experienced at least one traumatic bereavement (caused by murder or suicide, for example), and often multiple traumatic bereavements (Vaswani, 2014).

From my time spent training with residential childcare workers on the subject of loss, it has also become clear that the breadth of loss experienced by children in care far exceeds these 'typical' childhood losses. From tangible losses, such as removal from the family home, separation from brothers and sisters, or the loss

of personal possessions; to the less tangible, such as loss of identity, loss of status, or the loss of family roles (for example 'carer'), loss among children cared for away from home is pervasive and impinges upon every aspect of children's lives.

Ambiguous Loss

What is important to note is that some of these losses are more 'ambiguous' than others. Ambiguous loss was a term first coined by Pauline Boss in the 1970s when she was researching the families of soldiers missing in action in Vietnam. Boss (2009) distinguishes between two types of ambiguous loss: where the person is psychologically present but physically absent, most clearly exemplified by missing persons; and where the person is physically present, but psychologically absent such as with people suffering from dementia. More commonplace examples that are of relevance to children in care include: psychologically absent parents, such as those who are emotionally unavailable due to substance misuse or mental ill-health, or physically absent parents with whom they have no direct contact.

According to Boss, any loss that is temporary, potentially reversible or confused in some way can be perceived as ambiguous. Does a child removed from the family home know when they will return or whether to even begin mourning their loss? If a child is misinformed about an imprisoned parent's whereabouts do they perceive the lack of attendance at their birthday party as rejection and abandonment? Even parental separation can be ambiguous, especially if the child continues to harbour hopes of a reunion. Boss (2006, p.4) argues that it is precisely this confusion that is problematic about ambiguous loss, as 'the inability to resolve the situation causes pain, shock, distress, and often immobilisation. Without closure, the trauma of this unique kind of loss becomes chronic'.

Bereavement may be, by virtue of its permanence, the ultimate loss. Yet bereavement is conceptualised as a normative experience, and is accompanied by societal understanding, social support and rituals to help mark or process the loss. Ambiguous loss rarely receives the same attention as bereavement and, it

has been argued, can be harder to process or accept as it is less often recognised or acknowledged and is therefore more likely to go unsupported (Boss, 2009). To give an example, while bereaved individuals can attend funerals, wakes, gravesides or memorials, there are rarely such markers for adoption (Courtney, 2000).

When losses are not openly acknowledged, publicly mourned or socially supported then this can lead to 'disenfranchised grief' (Doka, 1999). Doka describes a number of scenarios where grief is more likely to be disenfranchised, including where the loss is not recognised (e.g. miscarriage or pet loss); where the relationship is not recognised (e.g. ex-spouses or friends); where the griever is not recognised (e.g. young children or people with learning disabilities); in certain disenfranchising deaths (e.g. suicide or overdose) and where the griever does not conform to societal norms and expectations about grieving.

The importance of ambiguous loss and disenfranchised grief in residential childcare

Simply by being removed from the family home, loss, and frequently ambiguous loss, colours the lives of every child that is in care (Mitchell, 2016). How long will they be in care? When will they see their brothers and sisters again? Will anyone care for their beloved pet? The potential mix of emotions, including relief, shock, uncertainty and sadness can be conflicting and ambiguous. And while every child's journey to care will follow a different path we know that their backgrounds are too often characterised by loss, disruption and disconnection (Bocknek, Sanderson & Britner, 2009; Samuels & Pryce, 2008). Furthermore, we also know that vulnerable, at risk, and 'risky' children have been exposed to an extensive array of Adverse Childhood Experiences (Vaswani, 2018), included within which are many events that raise the prospect of ambiguous loss, such as: parental separation; parental substance misuse; parental mental illness; emotional neglect and the incarceration of a family member. Once caught up in the care system placement instability can cause uncertainty, confusion and ambiguity (Samuels, 2009). And to layer stress upon all of that, the shame and stigma associated with these types of losses, or with being in care, only serves to disenfranchise grief further (Bocknek et al., 2009; Samuels, 2009).

A further consequence of the experience of loss is that many young people have, often proudly, learnt to rely solely on themselves (Samuels & Pryce, 2008). While this can be seen positively as independence, maturity and personal growth, this view of independence as a key marker of success and survival tends to encourage the rejection of help and support. Furthermore, young people experiencing ambiguous loss describe themselves as disconnected, different, and with coping strategies that have been disrupted by the ambiguity (Bocknek et al., 2009). Lastly, children report internalising their feelings due to the lack of social support for their grief (Bocknek et al., 2009).

The upshot of ambiguous loss and disenfranchised grief is that children can be isolated and at risk of prolonged distress and poor outcomes. Indeed, Samuels (2009, p.1230) describes foster care as 'a unique trauma embedded in myriad losses that remain ambiguous and unresolved' and Courtney (2000) concludes that adjusting to life as an adopted child is often more complicated than a bereaved child's task. It is therefore imperative that childcare workers are aware of and sensitive to loss, ambiguous loss and disenfranchised grief in the children they support.

Implications for practice?

Families and workers should aim to prevent ambiguity wherever possible by ensuring that children are given as much information as is developmentally appropriate, whether this is about birth parents, terminally ill relatives or the whereabouts of incarcerated parents (Mooney, Oliver & Smith, 2009). The system should also aim to prevent or minimise secondary losses, such as the separation of siblings (Brodzinsky, 2009).

Once loss has occurred it is important to acknowledge and label the loss. Simply being given the chance to tell one's story can sometimes be sufficient (Mitchell, 2016), as it validates the loss and 'enfranchises' rather than disenfranchises the grief. After all, Doka prompts us to remember that disenfranchised grief is just grief. In acknowledging the loss, it is also important to accept what cannot be changed and to remember both what has been lost but also, importantly, what

has not been lost. In this way Boss and Yeats (2014) suggest that attachments can be revised and reformed, and individuals can rediscover hope again.

There are unique opportunities within residential childcare (and in other placements away from home) that come from the domesticity of the care setting, which helps build the intimacy and relationships that are needed to support children through their losses. Boss (2006) stresses the importance of family and community responses to ambiguous loss, and although this approach has stemmed from responses to large-scale trauma such as school bereavements or natural disasters, it can equally apply to individual loss. Children in care may be disconnected from their families or communities, but the pervasiveness of ambiguous loss, while on one hand posing a challenge because of the sheer scale of need, also provides a shared experience, empathy and understanding among children in care. In this way the residential home or foster home can be the basis for a family or community response.

When supporting children through ambiguous loss it is important to recognise that it often cannot be resolved (Boss, 2009). The focus therefore is on building tolerance and resilience to the ambiguity. As ambiguity causes stress, then teaching skills to manage stress will be important. Some people will also require traditional therapies and interventions, such as those used with Post Traumatic Stress Disorder, however, individual interventions should also consider family and community too (Boss, 2006).

About the author

Nina Vaswani is Research Fellow, and the Research Lead at the Centre for Youth and Criminal Justice (CYCJ), hosted by the University of Strathclyde. Nina oversees the varied research programme at CYCJ, which aims to conduct primary research or synthesise existing research to help support policy and practice in youth justice and related fields. Nina's main research interest is in the experiences of loss, bereavement and adversity in children and young people, especially those who are marginalised or who come into contact with the justice system.

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Book reviews: can I share this with you?

Dr Leanne McIver

Dear Reader

Recently, while reading another journal, I spotted a book review editor taking the opportunity to write directly to readers, and acknowledging how unusual that is compared to their traditional 'in-the-shadows' role. When I took up the role of book review editor for SJRCC, I decided to take a leaf out of their book, to introduce myself and outline my hopes for the future of book reviews in SJRCC.

I've taken up the role of Book Reviews Editor with great excitement, because books are one of my first loves, and I'm always keen to share the joy of them, as well as to look with a more critical eye at what works well and less well for all of us as individual readers. That to me is the purpose of this book reviews section, which should (in keeping with the academic nature of a peer reviewed journal) include text books and academic writing, but should also include reviews of other writing on the topic closest to our hearts – residential child care.

It is with that in mind that I invite you to consider whether there are books which have particularly struck you. Have you read anything recently which has really made you think, or which you've been keen to discuss with colleagues and friends? Are you a student of social work or residential child care who's been asked to read something as part of your course, and would like to share your thoughts on it?

If you have an idea for a book review, or would be interested in being contacted to review new books in the future, please do let me know – you can contact me at sjrcc@strath.ac.uk. Similarly, if you have colleagues, friends, or young people in your life who might like to share their thoughts on relevant books, I'd love to hear from them – please spread the word!

I look forward to learning from you about the books I should read (or avoid), and to sharing that learning with the community of SJRCC readers!

About the author

Leanne is a Research Associate in the Improving Care Experiences hub at CELCIS. She works mainly on evaluation, research, and research support in relation to children and young people who are looked after away from home. Leanne comes from a background in education and health services research and evaluation, and joined CELCIS in 2015.

Book Review

Book Title

Charlesworth, J. (2015). *That's So Gay: Challenging Homophobic Bullying*, Jessica Kingsley Publishers, ISBN 978-1-84905

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With the number of homophobic prejudice based crimes (hate crimes) recorded by police in Britain increasing each year, Jonathan Charlesworth's book, *That's So Gay: Challenging Homophobic Bullying*, provides anyone involved in education or children's services with a practical, and thought provoking guide to challenge homophobic bullying. Charlesworth indicates that 'gay', as used in the context of the book, emerged as an acronym for 'Good As You' in the human rights movement of the 60's and 70's. He goes on to propose that homophobia will only end if society catches up with established legislation, through the normalisation of gay relationships. His work shows us how to educate pupils from a young age to understand the impact of their behaviour on individuals, but also in terms of rights, respect, equality and justice.

Charlesworth's work as Executive Director of Educational Action Challenging Homophobia (EACH), and his decades of experience in teaching, training and consultancy work with a vast range of local and national organisations including: Education, Ofsted, Police, Prison Services and the National Health Service, is evident in the depth and breadth of relevant information and guidance provided in this book.

Charlesworth's use of the atypical title, *That's So Gay*, creatively highlights how homophobic language is habitually used by children and young people today. The need to challenge this negative language that stereotypes gay as undesirable is the thread that runs through this work. The author proposes that homophobic bullying is not characterised by specific acts but by the negative attitudes and beliefs that ground them. Throughout the book Charlesworth's strong use of a rights based approach to challenge homophobic bullying, targets

its root causes, prejudice and discrimination. The comprehensive details describing what homophobic bullying is, and who experiences and perpetrates this distinct type of bullying, provide a clear understanding of homophobic bullying and to what extent it impacts on individuals and society. Moreover, Charlesworth's illustration of why implicit language depicting gay as inferior needs to be consistently challenged, even when it does not directly constitute homophobic bullying, may make you reflect on your value base and question your practice. Consequentially, this book provides examples of didactic responses and concise guidelines to help teachers and practitioners respond to verbal incidents in an age appropriate manner. Focusing on how children's values are formed at a very young age, regarding what is and what is not acceptable in reference to gender and sexual orientation, Charlesworth evidences the particular need for all primary schools to challenge pupils who use 'gay' in negative ways. Offering activities that help pupils of all ages to understand how their common language can attack people's characteristics and identity, this book may help you to explore, and challenge, children and young people's stereotypical images of gay people, and how these are influenced by media depictions.

By dedicating a chapter to Sensitive Handling of Disclosures, Charlesworth stresses the importance of practitioners being confident when supporting a young person who discloses their experience of homophobic bullying, or that they are gay. The guidance detailed in the book on the appropriate sharing of information and advice on handling disclosures should help practitioners to be sensitive to the context and needs of children and young people, especially if they are feeling isolated because they have been unable to tell their family or friends. Charlesworth hopes his practical guide will steer practitioners away from directly referring gay pupils to counselling, emphasising that this implies that gay people need therapy and treatment.

Charlesworth advocates a positive school ethos, with an anti-bullying policy as its foundation to be the essence that prevents homophobic bullying. However, this book does not offer a copy and paste anti-bullying policy, but a range of straight forward activities and flow charts, which can be used to promote and

evaluate the inclusive environment in your school. By promoting the co-production of a robust anti-bullying policy that specifically references homophobic bullying, the writer helps schools to realise opportunities to engage the whole school, including pupils and parents, in conversations, training and learning that encourages ownership of their anti-bullying policy and the establishment of an inclusive culture.

This book successfully achieves Charlesworth's aims to clarify what constitutes homophobic bullying and the production of a practical guide to challenge homophobic language and bullying. However, the occasional reference to American research and statistics and the inclusion of Scotland when referring to some legislation, appears incongruent to the book's focus on English school policy.

Although this does not distract from the book's worth to schools and practitioners its relevance in Scotland may have been enriched if the author had also referenced Scottish policy. If an appendix detailing the list of activities in the book had been included, it may have further improved its practical use. Furthermore, the reference to EACH, of which the charity Jonathan Charlesworth is Executive Director, is made in the book over 40 times, and may be considered excessive by some or perceived as a marketing opportunity for the consultancy and training offered by the charity.

As a children's services worker located in schools, this book has painfully reminded me of the times I have not fully utilised the opportunities available when addressing homophobic bullying. It has made me question my practice and given me the practical skills to change and improve how I challenge oppression and promote equality for all pupils in relation to rights, not just gender prejudice. The book also reinforces how management, staff, pupils and families need to promote a consistent rights based approach to challenging prejudice based bullying, relating to the protected characteristics of the UK Equality Act 2010: race, religion, sexual orientation, transgender identity and disability. The insights and learning exhibited by pupils participating in groups I have delivered, using activities detailed in the book, has motivated me to continue to use

Charlesworth's other ideas further in learning and change programmes that I am developing.

Conclusively, this book is a recommended read for anyone involved in working in, or delivering education as well as children's services as it provides insightful and practical advice to effectively prevent and challenge homophobic bullying, particularly through the challenging of homophobic language. As Charlesworth suggests in his book 'if we change the way we speak we change the way we think'.

About the author

Linda Brewster (brewsterlj@gmail.com) is a children's services worker, she is employed by a local authority and works in both primary and secondary schools helping to protect vulnerable children and to support families in need. Her work empowers pupils and families to engage fully in education and learning, to give every child the opportunity to succeed. She has previously worked and managed children's services in both social work and education, including alternative educational provision, residential care, and Throughcare and Aftercare services. Having a MSc in Young People, Social Inclusion and Change her focus has always been about promoting equality and social justice, particularly for children, young people and families that are vulnerable and socially excluded.

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