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CIRCUMSTANTIAL DELIVERY

Caring Through Restraint: Violence, Intimacy and Identity in Mental Health Practice

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Abstract In this article, I discuss the meanings of "restraints," or physical intervention strategies that are used at a total institution for mentally ill adolescents in the United States. This paper argues that this particularly complex form of mental health treatment is simultaneously a violent and an intimate way in which men relate to one another and also takes on complex meanings about trust and identity in mental health recovery. Using data from 18 months of ethnographic fieldwork at one residential treatment center, this article examines what restraints reveal and embody about intimate interpersonal staff/client relationships, how Black men relate to one another in this setting and how staff members use physical interventions to link institutional mental health treatment with street violence in the outside world. I conclude that understanding these meanings of restraints provides a valuable way of understanding local knowledge in mental health practice, treatment and recovery.

Keywords Violence · Intimacy · Identity · Mental health practice

William's Restraint

William, a 300-pound, 6 foot 3 inch, 16-year-old African American male resident of a residential treatment center (diagnosed with mood disorder NOS and oppositional defiant disorder) stormed down the path from school toward Steele Cottage, where residents live at this total institution. African American line staff members Steve, Allen and James and European American line staff member Pete, who were beginning a 3–11 p.m. shift, sat in the cottage watching William. Steve, the cottage

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supervisor, quietly told the rest of his staff to "get ready." The atmosphere in the cottage transformed: a calm milieu changed into one of hypervigilance and intensity. Steve told the other 14 residents to go to the back of the cottage, out of the way, and "do what they do."

William threw open the cottage front door, yelled "Fuck you" and kicked the mop bucket located near the front door. Pete and James moved toward William and, in quiet voices and with hands up, palms forward, told William to calm down and to talk to them. William, wild eyed, looked at Steve and screamed, "Fucking touch me! I know you want to. Fucking do it!" Steve stood still, with his hands palm forward, and said nothing. William threw coats and kicked the wall. In the blink of an eye, he attempted to kick Allen in the stomach.

Allen, aware of William's split-second approach, blocked much of the kick with his right hand. Steve, Pete and James lunged at William and tried to take him down to the ground using the Therapeutic Crisis Intervention procedure[1] for two-person restraints. William struggled, moved, kicked, swung his arms, grunted, cursed and thrashed. Allen quickly recovered and helped Steve, Pete and James struggle to put William on the ground. But before they made it to the floor, the group of four men and William—over 1,100 lb of sweat, muscle, and force—bounced off walls, hit the front door with a slam, and grunted in their labor. The goal was not to beat William up: that would have been much easier and quicker and, as I point out later, less laden with care. The goal was to restrain him from hurting himself or anyone else. They did, finally, get William to the ground, but not without him losing his pants and underwear. James' shirt ripped during the restraint and his back was bruised, leaving a mark the size of a soccer ball in the days to come. Allen dripped with sweat as he tried to hold William still. He had a bleeding goose egg on his forehead from having been slammed against the wall and a fractured bone in his wrist from blocking William's kick. Pete almost lost his pants as he wrestled to keep William from getting out of his grip. William howled, wailed and panted during his remaining exhausted attempts to wrestle free from the restraint. Two grown men held William's legs so he could not kick and two grown men held his arms and chest down so he could not swing or thrash.

One of the residents ran across the gravel road to a neighboring cottage to seek additional staff help. Soon other staff members ran into the cottage. They covered William's unclothed lower body with a bed sheet, opened the confinement room[2] door and mobilized the other residents into the living room. The other residents sat in the living room quietly, wide eyed and vigilant. William had ceased wailing and now whimpered.

I heard talk I could not make out from the pile of men on the floor. Suddenly, the pile shifted and William's large, limp body was dragged to the confinement room. William struggled, and the men had to take a few breaks, even though the distance from the restraint site to the confinement room was just 20 feet.

[1] Therapeutic Crisis Intervention is a formal treatment philosophy at Havenwood focusing on manual restraint practice.

[2] Residents often recovered in confinement rooms following restraints. Confinement rooms are small, white concrete rooms with a small windowed door. The door can only be locked if it is closed and a red button is pressed and held.

William, now subdued, curled in a fetal position on the floor of the confinement room and cried. Steve pulled up a chair and waited, with the confinement room door half-open, for William to recover enough to process what had happened. Pete cleaned himself up in the back office. Allen stood in the hallway watching Steve, to be sure things were stabilized. James supervised the other residents. In the next few hours, the cottage returned to normal. William was sent to his room when he was calm enough to do so. As he did, I heard Steve tell him, "If you want a hug, ask for a hug. I'll give you a hug." The other residents watched TV or played video games. Pete, James, and Allen sat, supervised the residents, documented the incident and tried not to cringe when they moved. Steve supervised the cottage in his calm, confident way. I would catch him purse his lips and shake his head periodically. I returned to my room around 10 o'clock that night, as the residents readied themselves for bed.

Introduction

In the United States, more than 50,000 adolescents are removed each year from their homes, guardians and schools and the streets and, as a result of state-level decisions, are institutionalized at residential treatment centers (U.S. Department of Health and Human Services 2009). These young men and women pose a great threat to social order, but instead of being incarcerated in juvenile detention and labeled deviant or criminal, their behavior is identified as dysfunctional and they are sent to treatment. Residential treatment centers are total institutions where adolescents are housed, educated, and treated for behavioral, emotional and mental disorders (Aichhorn 1955; Courtney and Hughes-Heuring 2009; Goffman 1961). The goal of these total institutions is to take in problem adolescents, rehabilitate them and discharge "law-abiding and productive" subjects. However, what actually happens during the quotidian practice of institution life is much different than articulated in the official philosophies behind adolescent residential treatment.

One of the significant factors differentiating residential treatment from other foster care placements is that institutionally sanctioned physical restraints are used as part of the treatment protocol. At the center I call Havenwood, where I lived and conducted ethnographic research for 18 months beginning in 2006 and proceeding into 2007, physical restraints are defined—according to the institution's official manuals—as "a behavior management technique involving the use of physical contact or force, characterized by measures such as arm or body holds." These restraints are used to curb "dangerous" behavior. Restraints are taught to line staff members in week-long certification courses. During these trainings, line staff members are taught the techniques of restraint and practice on one another. However, they are advised by the course instructors that the restraints "we practice in here are nothing like the real restraints." Officially, restraints are simply a means to prevent out-of-control adolescents from physically hurting themselves or others.

However, I argue that restraints are more than just physical intervention strategies. As in William's case, the restraint develops into a complex situation where violence is used in a treatment situation, and through this aspect of treatment,

care is shown in the physical holding of an adolescent by multiple adults. I came to see how restraints were an important medium through which intimate bonds between residents and staff members were created or fractured, leading to various understandings of recovery facilitated by speech codes and expressed knowledge indicating commonalities of social identity between line staff and residents.

In this paper I ask: What can restraints tell us about how male staff relate to one another and build intimacy in the context of mental health treatment? How do staff members link the use of restraints with street-level violence and their own protective actions? I describe the context for these restraints at Havenwood and at one cottage in particular, which I call Steele. I argue that restraints are more than techniques of mental health treatment. They are also violent, intimate ways in which particular men relate to one another, taking on complex meanings about trust in which perceived common social identities facilitate mental health treatment and recovery.

Havenwood and Steele Cottage

Havenwood has nine cottages, housing residents of varying age, gender and mental illness status. Steele Cottage houses young teenage men, most of whom are diagnosed with conduct disorder, oppositional defiant disorder and other behavioral disorders. Over the course of my 18 months of research, 35 young men lived at Steele, 10–14 at a time. Thirty of these were African American, three were of European ancestry, and two were of Latin American ancestry. All of the young men were funded by the Department of Children and Family Services, the state's juvenile probation program or home school districts.[3] Like other residents at Havenwood and in residential treatment (Lyons 2004), most had criminal records and long histories of abuse, neglect and foster care placements.

Over the course of my research, nine full-time staff members were assigned to work the evening shift, 3–11 p.m.,[4] at Steele Cottage. These nine people were the direct care or line staff. The line staff spent 8-h shifts with 10 to 14 adolescents, teaching social skills, running anger management and goals groups and playing video and card games and sports. They monitored the residents' hygiene, dispensed medication, met family members who visited and supervised off-campus excursions.

Steele line staff members included six African American men, one African American woman and two European American (unspecified) men. Three of the African American men had college degrees and were raised in the same neighborhoods as many of the residents and so knew "the streets," but had taken a path somewhat different than those in the facility. The other staff members held

[3] If residents were sent to Havenwood by the juvenile courts, their first month was funded by "probation." The remaining months of treatment were usually funded by their public school districts.

[4] The other shifts were 11 p.m. to 7 a.m., or overnight; then the school hours, 7:30 a.m. to 3:30 p.m., were worked by Teaching Assistants who worked in the cottage from 7:30 to 9 a.m. and from 3 to 3:30 p.m. The Teaching Assistants were assigned to different classrooms during the school day.

professional certificates, had attended college or had finished their formal education with high school. The line staff members were paid by the hour.

Other employees in residential treatment included clinicians, teachers and administrative staff. The clinicians were psychologists and were overwhelmingly European American (unspecified) women; the administrative staff and teachers were somewhat more heterogeneous; however, more European American men and women made up these professional groups. All of the psychologists had master's or doctoral degrees, many of the administrative staff had 4-year college degrees and all teachers held bachelor's or master's degrees. These individuals were all salaried. One of the most salient distinctions between the various staff members was that line staff members were trained to, and actually performed, most of the restraints. Thus, the staffing of the institution showed signs of an ethnic (or "racial") hierarchy.

The Meaning of Restraint

The act(s) of restraining the residents was the job of the line staff members at Havenwood. In addition to its being a job task, the act of restraint carried significant meaning and was fundamental to the way in which residents and line staff members related to one another. Being restrained and having to perform restraints meant that individuals engaged in a very intimate physical interaction. Restraints are violent (adult teams physically hold down adolescents), but they are also acts of considerable care. It is not insignificant that in the case above, Steve likened the restraint to a hug, suggesting that William could have just asked for a hug instead of creating a situation in which he would be restrained. Because of this kind of interaction and the meaning of the care, intimate bonds of trust were fostered during restraints. I suggest that, because of these bonds, the male line staff were better able to encourage recovery from the male residents.

Violence, Intimacy and "Racialized" Mental Health Practice

It is perhaps counterintuitive that such violent interactions should build, rather than destroy, trust relationships between adults and adolescents. However, throughout my time at Havenwood, relationships between particular residents and staff members changed in a positive direction following restraints. Residents would comment to me, after displays of affection with staff members, in conversations about well-being and fist bumps, or hugs, that "[he] restrained me last week." They would reference when they had shared a restraint with a staff member, and it seems that this allowed them to relate more intimately with said staff member(s). Bonds of trust were built when staff members invoked the violence the residents experience in life outside of residential treatment to make sense of restraints. Staff members would recount to me what they would say to residents: "If you ain't hearin what I'm sayin, then I gotta restrain you. I would rather fuck you up in here than get you shot [out there]." This was to show the residents that they cannot "swing on people" (hit or attack) without consequences—at Havenwood or in the "real world." However,

this staff member articulated, "I don't want to have to do that [restrain you]. I would rather talk it out, come at you straight [honestly, without unnecessary and or irrelevant actions or speech]. But I will [restrain you]." In this vein, Gilmer (2009), in his analysis of Black football coaches, argues that sometimes aggression can lead to intimacy, thus building, rather than deconstructing, bonds.

I argue that many of the men at Steele interpret their experiences of restraining and being restrained as spaces where aggression and violence build intimate bonds. Working to "not get someone shot" was seen as trustworthy because the line staff member knew the realities of "the streets" (neighborhoods of origin). Even a violent restraint was considered caring because it taught valuable lessons without incurring the extreme level of violence adolescents had experienced in their lives outside of Havenwood. Furthermore, references to "the streets" built trust between staff and residents by drawing attention to their putatively shared experiences and realities outside of residential treatment. Although both residents and staff code switched or "style-switched" in and out of what Baugh (1983) calls Black Street Speech, on a continuous basis, talk placing restraints in the context of a greater violence outside of the institution most often occurred in Black Street Speech. In addition, this communicative code was used to link knowledge of street violence with restraints as a means of mental health recovery as well as to show the veracity of the speaker.

Physical restraints, then, are events in residential treatment where intimacy through close physical engagement with others leads to intimate bonds among the individuals involved. This trust is established either through the act of restraining or by using restraints as a protective measure against possible street violence. Once this trust is established, the residents and line staff members maintain that the "real" work of treatment can begin. Line staff members articulate that restraints show them the "real" resident, and only after a restraint happens can the staff members know "for real" "what they are workin with" in terms of the mental health needs of the residents.

Restraints were also seen by line staff members as important events that shifted knowledge of restraints for residents. Staff members articulated that once the residents experienced a restraint, they could then trust the staff members to care for them not only during restraints but also in other aspects of the mental health treatment practice, including individual, group and recreational therapy as well as everyday life in the cottages.

The meanings attached to restraints, intimacy, trust and perceived Black Street identities become a space where staff members struggle to understand their jobs, the way they relate to the young men who live at Steele Cottage and what it means to "fuck [a resident] up" in treatment so that he does not "get shot in the real world." It is significant that "getting shot" is a very real outcome for many of the young men who live at Steele. In this way, restraints and various understandings of Black Street identities are put into practice in mental health treatment at Havenwood. In other words, caring for and building trust and intimacy with the residents through restraints are used to understand not only how positive relationships among men can be established (Gilmer 2009) but also that not "getting a resident shot" through the act of restraining is understood as mental health practice.

Conclusion

In this paper, I have discussed how restraints are events where trust, intimacy, violence and what might appear to be racialized forms of mental health practice are articulated. At Havenwood, and, specifically, at Steele Cottage, restraints served as an intervention strategy in which intimate bonds of trust were established between residents and staff members in ways that went beyond other forms of mental health treatment there. Restraints were likened to other forms of physical affection, including hugs, indicating the intimacy involved in physical touch between staff members and residents. Restraints were also seen as therapeutic events when the "real" residents and staff members "come out" and key moments after which the "real" work of mental health treatment could commence. Talk about restraints and street violence occurred in Black Street Speech, indexing a relationship among social identities, local knowledge (of the neighborhoods of origin) and mental health treatment.

In various ways, restraints become particularly important therapeutic events for staff members and residents. Through intimate and violent restraints and particular ways of talking about them (which show common identity and local knowledge), therapeutic relationships of trust are built and meaningful mental health treatment takes place.

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