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

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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

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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.

Whist 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 & Thoenne, 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 disproportionally 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

Theme 1: 'Men and women think about violence differently'.

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?

Theme 2: 'Macho and non-Macho Training Programme'

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.

Theme 3 'Active and Passive Resistance'

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.

Theme 4: 'Training as a positive experience'

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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