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Physical constraint as psychological holding: Mental-health treatment for difficult and violent adolescents in France

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ABSTRACT

The phrase "*Contraindre est thérapeutique*"—constraining is therapeutic—underpins the principle of numerous interventions within the field of mental health in France, ranging from traditional psychiatric units to the courthouse to violence management and prevention of dangerousness. The treatment of violence in "difficult and violent adolescents" provides a paradigmatic and revealing example of this tendency.

The aim of this article is to understand how the clinical category—*contenir*, or "to contain"—was formed and is used. The perspective taken is that of the political anthropology of mental health and the article combines a genealogical approach of the notion with a multisite ethnographical study (conducted between September 2008 and June 2012 in three facilities for adolescent care). This study will show how "psychological *holding*" is used to justify "physical *constraint*" in the treatment of adolescent crisis and violence. Furthermore, we will see how this "dirty work", delegated to front-line professionals (educators, social workers, nurses), is used within a moral economy of suffering that promotes care and control measures in a population largely from immigrant backgrounds, judged to be both potentially vulnerable and dangerous.

1. Introduction

1.1. Violence in psychiatry

The violence of mental-health patients is a central psychopathological issue and the violence of professionals towards patients is a highly controversial topic in regards to psychiatric practices. These two aspects of the treatment of violence are most often separated out in layman's depictions and form the basis of a very common critique of psychiatry: on the one hand, those who are mentally unstable must be stigmatised for their dangerousness and violence even if there is no proven link between violence and mental health (Elbogen and Johnson, 2009); on the other hand, the arbitrary violence of psychiatric confinement and physical containment is denounced, even though chronically ill patients exist who must be institutionally cared for and who do not fit into the ideal schemes of rehabilitation and re-integration (American Academy of Child Adolescent Psychiatry, 2002:4S). In both cases, even though violence does not affect the same population, concern stems from the same moral and legal principles: what is now intolerable is the infringement of physical integrity (Fassin and Bourdelais, 2010).

It is noteworthy that this moral tension regarding clinical practices has been the object of so little research in psychiatry or the social sciences. The link between psychiatry and social control appears to have become self-evident. Yet all depends on how "violence" is defined in this treatment: a patient's *physical agitation*, for example, may justify *physical intervention* by medical teams. The management of crises through restraint can act as a lever to encourage strong bonds between professionals and clients, as one of the rare recent studies in a residential treatment centre for adolescents shows (Hejtmanek, 2010:671).

In France, as in numerous countries, there exists consensus-based data about containment, but in a highly paradoxical and problematic form. In two successive reports (Muralidharan and Fenton, 1996; Sailas and Fenton, 2000), the Cochrane Library concluded that there was not enough empirical evidence to allow this practice to be recommended. It is generally acknowledged to be

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a last-course intervention (American Academy of Child Adolescent Psychiatry, 2002:5S; Larson et al., 2008). However, several professional bodies (medical associations) (American Academy of Child Adolescent Psychiatry, 2002) or state bodies (Haute Autorité en Santé, 2005a, 2005b) have put forward recommendations about the use of containment (i.e. guidelines). Traditional practices (such as surrounding the patient by a large number of nurses and the technique known in French as the "*technique du belier*"—or "battering-ram" technique—aimed at immobilising the patient with a mattress) have been proscribed in favour of standard methods of immobilisation (like the Canadian "*Approche Préventive et Intervention Contrôlée*"—"Preventive Approach and Controlled Intervention"). These recommendations result in a paradox: containing patients cannot be recommended, but means for containing them can. In short, containment exists and has to be used, but the conditions should be provided in which it can be avoided.

Furthermore, even within the same country and even when the need to standardise treatments has been called for (Brown and Tooke, 1992; Siponen et al., 2012), mental-health professionals put this into practice in a large number of ways. The issue of the therapeutic and ethical meaning of this act underpins all these recommendations. For example, a difficult and highly discussed question is whether the psychiatrist should physically participate (or not) (Kim et al., 2013) in the act of containment. Moreover, containment constantly stands in tension with, or even contradicts, the application of new ethical principles within the field of health such as autonomy, patient satisfaction and the contractual–care relationship. For example, how can the principle of informed consent be applied during crises? More precisely, what is a "crisis" and how can it be evaluated in practice? Once again, there exists a large variation in evaluations of the necessity to use containment, including among patients (Bowers et al., 2007).

1.2. Adolescent crisis and violence

The clinic difficulty is even greater when the patient is an adolescent, adolescence is indeed generally qualified by "crisis", to the point that it has become a new psychopathological condition to be monitored (Rechtman, 2004). This study focuses on the treatment of adolescent violence within a general environment and is not limited to the management of agitated patients in a medical arena (emergency room or psychiatric hospitalisation) (Coutant and Eideliman, 2013; Brodwin and Velpry, 2014). How is this ideal translated into practical standards? Factual elements do exist within the field of child psychiatry, such as frequency, type of containment and variation according to age and gender (Siponen et al., 2012). In diagnostic terms, the targeted population covers all possible cases of behavioural disorders. Moreover, in France, as in numerous countries, an adolescent is considered as a partial, autonomous yet dependant social subject, and is therefore a partial exception to the framework surrounding legal minority. Using the specific case of France, this study will explore the growing preoccupation in the West with adolescent mental health and its integration into extra-psychiatric outreach and medical Systems: "integrating medical health with other youth health and welfare expertise" (Patel et al., 2007).

This boundary between psychiatry and the field of pedagogy remains understudied within the social sciences. The concept of "treatment" therefore has the advantage of harbouring the necessary tension between *cure* and *care* in the medical sense of the word (and in its broader meaning within public health policies). Within this paper, this concept is understood in its wider meaning of *resolution of a political problem*, of *consensual moral attitude* towards a vulnerable population and of implementation of a local and *specific medical strategy* (Fernandez and Lézé, 2011, 2014). All treatment involves an evaluation and all evaluations are based on both professionals' expectations and moral criteria such as values, norms and affects. The issue at stake is therefore to better understand the dynamic and complex link between local clinical practice and the general political context. This link can be thought of as identifying a "moral economy" as define by Didier Fassin (2009), i.e. an unequal distribution of moral feelings in the treatment of populations identified as vulnerable.

In France, the specific response to this issue of treating adolescent violence can be summarised by the following category of clinical judgement: "constraint is therapeutic". The term *contention* (constraint) disappears in favour of the word *contenance* (holding). The ambiguity and confusion within these terms must immediately be underscored. There is a shift from *contention physique*, or "physical constraint" (physical containment and restraint then treatment with medication and/or in a seclusion room), to *contenance psychique*, or "psychological holding", which is part of a psychoanalytical theory concerning the lack of bodily limits of the baby, the autistic or psychotic patient and, by extension, the difficult and violent adolescent. It is even possible to talk about physical holding. Constraint, as a physical-intervention strategy, still exists, but no longer has the same target. It is aimed at the violence of "difficult" adolescents rather than the psychotic crisis (classically referred to as *psychomotor agitation*). Above all, it is no longer justified in the same way—constraint is no longer simply an act to prevent or defuse violence, it also has a therapeutic role to play in *pacifying* the crisis and allowing the *internalising* of the moral law. The focus of this article will be the forming of this clinical self-evidence and its everyday uses by front-line professionals: educators, social workers, nurses.

1.3. French background

At the end of the 1990s and the beginning of the 2000s, children and adolescents' violence against themselves (addiction, self-harming, suicide, binge-drinking) or others (assaults and anti-social behaviour) became a political mental-health problem. Within a few years, focusing attention on teenage suffering became a virtual cliché. This new situation was the product of the encounter between the state of the medico-social field and the political climate of the time. These two lines of power developed separately and, whilst initially incoherent, went on to become a specific political configuration highlighting the crystallisation of a contemporary *concern* with the adolescent. This tendency echoes a general regulatory mechanism of relationship to self and to others, a moral economy, generated in a specific political context where the call to "listen to suffering" became, in the 1990s, a mode of local, legitimised intervention within vulnerable populations (Fassin, 2004). In the same period, but this time under a right-wing Government, the field of mental health grew and the attention focused on "behavioural disorders" became more and more central to the implementation of new facilities and the rolling-out of new diagnoses. Following a report to the Ministère de la famille (Ministry for Family Development) (Rufo and Joyeux, 2004) regarding the health of adolescents in France, *Maisons d'adolescents* or "Adolescent Centres"—local-authority accommodation and care institutions—became responsible for identifying adolescents' "suffering" in general contexts and, from 2004, were progressively established throughout France (Coutant and Eideliman, 2013). At the current time, there are 102 (over the 119 administrative *départements*) based on the "Le Havre" model, launched in that city in 1999. In 2005, the Inserm report. On behavioural disorders caused controversy and provoked a collective of child psychiatrists ("*Pas de 0 de Conduite*"—"No Zero for Conduct") to react against the early detection of behavioural disorders in children under the age of 3

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