Touch, Sexuality and Power in Residential Settings

LEONARD F. DAVIS

Leonard F. Davis is a Lecturer in Social Work at Brunel University. He started his career as a teacher in the Channel Islands and in France, and was principal teacher at Liverpool Remand Home from 1962 to 1964 before taking the Advanced Course in Residential Care and Education at Newcastle University. After a further period in residential work he obtained the M.Ed. of Newcastle University and the M.A. in Applied Social Studies of Brunel University, and has recently completed the Course in Educational Studies at the National Institute for Social Work.

SUMMARY

This paper examines areas of concern surrounding touch, sexuality and associated power in residential establishments. The place of touch and the expression of sexuality are considered in relation to residents and staff. It is suggested that these are important factors in framing a concept of residential care based on rights and duties, and that current practice often takes a limited perspective of some of the fundamental needs of residents.

In Hannah Green's book *I never promised you a rose garden* we read about Deborah's parents: 'When he and Esther quarrelled, the crucial thing remained unspoken, leaving an atmosphere of wordless rancour and accusation.'[1] The guarded reference to the issues which are discussed in this paper results in a similar atmosphere in many residential establishments. Touch, sexuality and associated power—the genesis of common problems, uncommonly discussed—remain subtle, interacting forces which determine a great deal of what happens in any institution and bite deeply into the life patterns of those concerned. Yet comment about them is often oblique, self-conscious, excessively ribald or accusatory, denying the core content. Frequently the underlying meaning is harsh, wounding to the recipient or defamatory about the third person. Somehow we all feel uncomfortable dealing with these subjects in a close-living environment. If we can distance ourselves from them and clutch at 'public opinion', the good of the greatest number or the security of referral to those more elevated in the hierarchy, the personal involvement lessens and we can hurriedly pass on to the next matter.

This appears strange in a world wherein all owe their existence to touch in reproduction and in mothering, all have sexuality from birth and all have power, if only in bringing about their own premature deaths as a means of stirring the public conscience. Perhaps it is this very baseness which is so disturbing. However, if we are to make more than semantic progress in

the movement towards the provision of a therapeutic community—in its broadest sense—it is as well to appreciate the impact, both direct and indirect, of these elements on the life of a residential group.

In any discussion of power in a residential setting we cannot avoid eventual reference to the other factors. Similarly, focused attention on touch and sexuality soon embraces the subject of power. Although for the purpose of analysis, touch and sexuality will be given separate consideration in this text the following illustrates how such divisions are not always possible. Some years ago a former colleague had responsibility for the primary care of a group of adolescent boys. X will suffice for his name. It could have been argued that because of the extent and nature of the boys' deprivation (or even because they were growing adolescents) that touch would play a part in the developmental and treatment processes which were taking place. X believed and practised this, providing colleague-approved standards of care which involved varying degrees of physical contact with his charges. Extended comment about the sexuality of X is unnecessary. Sufficient is it to say that he was male, alert and in his late twenties. However, the swift outcome of an 'allegation'—perhaps in retrospect no more than strong rumours among the sexually loaded banter of the boys (it was always difficult to pinpoint the source of the comments)—was suspension from duty, police investigation and the suicide of X. Enquiries were never 'satisfactorily' completed and X's 'guilt' or otherwise never established. Indications are that any findings would have hinged on slender interpretations, the accusation originating from a stimulated, physically affectionate and purposeful group containing all the minor jealousies and developmental anxieties of any such closely knit unit.

Touch was there, used and approved at colleague level, although only 'distanced' and accepted by the head of the establishment. Sexuality was everywhere—within X, within the boys, within his colleagues—but, perhaps most pertinent of all, not really recognized or discussed by the officer-in-charge. This might say something about his own fears and reflects the shallowness of communication within the establishment, but in power he was supreme and could take the 'objective' decision to suspend X from duty, ignorant of the later unexpected turn of events. Or was it 'unexpected'? The point to grasp perhaps is that power—or lack of it—became a central issue in this establishment. All of a sudden the power of the boys—wittingly or unwittingly—erupted and with dire consequences. Or was it the use of power by the officer-in-charge in deciding upon suspension that was destructive? Or was the climate of the institution reasonable by most standards and the power of X in hastening his own death of comparatively minor and passing importance, an intra-personal conflict which he chose to resolve in this way? There are no answers to these questions. Nevertheless, neither the boys nor the officer-in-charge will

easily forget the manner in which they used their power, and the way in which X used his and consequently negated their own. Undoubtedly, as in every other residential establishment, the issues of touch, sexuality and power were vitally present in this inter-personal, intra-personal and organizational complex but the custom and environment neither allowed for the degree of progressive understanding calculated to avoid such (exceptional) tragedy nor for the use of the incident as a learning situation.

It is hoped that we are approaching an era in which such subjects will be more freely discussed by both residents and staff at all levels. Sensitivity and understanding appear to be gaining slightly stronger footholds. Outside of these, however, there often remains a frightening rigidity which cannot admit lateral thinking. This in an area where an extension of thought and feeling is most urgent in residential work. The first necessity seems to be universal, open recognition of the need for touch, of the presence of sexuality and of the effect of power and powerlessness, followed by the development of attitudes which move away from suspicion, carping, accusation or rejection immediately an individual gets caught up in them. There are bare wires running through every residential establishment along which pulsating currents travel. Anyone, resident or staff member, who makes contact or dares to approach too near may become a victim of the implicit or explicit labelling which arises, even to the extent of a 'criminal' tag being attached.

I do not deny the complexities involved, nor the value of legal protection and proceedings on occasion. However, there is need to ask searching questions about the roots of certain 'problems' surrounding touch and sexuality, and to examine the nature of our response. It is important to query whether sometimes there is a problem. Do we create difficulties and then reject the most heavily involved party because the residential establishment is not in essence a caring community, no more being offered than benevolence and tolerance in return for major conformity?

If touch is acknowledged as a need, if sexuality is viewed as a human attribute requiring expression, their place in residential care demands greater attention. In creating establishments which surround with suspicion so much that is comforting and acceptable to those 'outside' and which then take retributory action for 'rule-breaking', the level of understanding displayed is incompatible with the philosophy of the caring profession to which residential staff are aligned. We need to make a stand for channels of communication wherein the relative comforts, dangers, and dysfunctions of touch, sexuality and associated power can be safely acknowledged and evaluated. Unless we are able to broaden our approaches, we cannot be seen as very far along the therapeutic road. How would you approach the following?:

A slightly crippled, mildly epileptic girl, Maria, who is seventeen years of age

and of limited intelligence makes a seemingly positive friendship with Bill, a single man in his early twenties, who is employed as an assistant gardener in the establishment. Maria lives and works in this 'closed' institution, has been 'protected' for several years and has no emotional links with the outside world. The relationship between Maria and Bill is tolerated for six months whilst it apparently remains at a superficial level, but one day she tells a favoured member of staff that she is having intercourse with Bill.

There is no easy solution. Many opinions could be sought and each would provide a different focus: the officer-in-charge, the homes supervisor, the committee members, the staff, even the other residents could bring influence to bear. Some organizations would require Bill's resignation (and later supply a reference which would make no comment about the reason for his departure), others would aid the couple in arranging a solution to what could be their chosen future. The foremost considerations must surely be the feelings of Maria and Bill and how they will be affected by any decisions which are made.

THE PLACE OF TOUCH

I take as my starting point on touch some of the dangers made explicit by Suttie in his observations on the 'taboo' on tenderness. His thesis that modern science has a positive aversion of anything savouring of sentimentality[2] has double implications for residents in institutions. Not only are they subject to the pressures of 'modern science' but often receive additional insulation from the staff who care for them, accentuating the taboo.

In deprecating the current approaches which fail to allow children time to outgrow their childishness, Suttie considers the defences which are hastily built as a bulwark against painful loss:

> As I see it, this protective indifference is essentially a 'sour grapes' kind of self-comfort—a self-insulation from love hunger by the 'cultivation' of a 'loveshyness'—but it *demands a psychic blindness to pathos of any kind*—a refusal to participate in emotion. It can be carried to such a point that the individual is not only 'steeled against' the appeal and suffering of others, but he actually dreads appealing to their sympathy, and may, for example, conceal illness for fear of making a 'fuss' or 'scene'. One can only suppose that the privation of love is here recognized as so inevitable, yet the longing remains so painful, that the whole conflict is forced out of mind. Anything that tends to arouse it (pathos and sentiment) is therefore resented exactly as the prude resents an erotic suggestion and for the same reason. The taboo upon regressive longings extends to all manifestations of affection until we can neither offer nor tolerate overt affection.[3]

Suttie draws attention to unconscious love hunger as a motive for the 'flight into illness', to the widespread incidence of 'disease' of this origin and to the later substitution of sex for love. He further comments that 'The

undefended, unreserved character makes a far better parent.'[4] How many such characters emerge from residential care?

There are many contacts involving touch which are acceptable in residential work: bathing children, tending the sick and injured of all ages, comforting in distress, restraining in anger and responding to some of the demands for affection. In most of these the initiative stems from the worker and only in the latter instance, when responding to the demands of a child, does it usually originate from the resident. For some, of course, what constitutes 'response' and what is meant by 'children' are delicate questions. The onlooker, whether resident or staff member, may well interpret 'response' as 'initiation' and in some institutions physical contact is limited to the very young. In others, however, the climate allows for touch between staff and even older adolescents as part of their developmental and compensatory needs.

Can we divorce touch from sexuality? Sometimes what is sexually significant for the resident holds no such meaning for the worker. Alternatively, a sexually significant act for the latter may be unregistered by the resident. Rarely, I would maintain, is the exchange without sexual meaning for either party, but this does not of necessity make it 'dangerous' or immediate grounds for 'suspicion'.

In an important section on physical communication with children Trieschman and his colleagues consider particularly: (i) physical contact and peer group rivalry, (ii) physical contact and sexual stimulation, (iii) sexual contact as an anxiety-producing stimulus and (iv) physical contact and aggression.[5] Jealousy and competition among children for physical contact often result in strong feelings being displayed. The origins of some allegations made against adults have as their roots uncontrollable upsurges of rivalry resulting from seeming rejection or lack of attention from a favoured member of staff. Many children are sexually stimulated by physical contact. The dividing line is thin between those children for whom the 'holding situation' in a temper tantrum is comforting and secure and those for whom it is sexually arousing. Staff needs at this time must not be forgotten and events can swiftly slide into a mutually seductive process. On the other hand, as Trieschman points out, some children will misinterpret even the most innocuous physical contact as a sexual advance, basing their fears on earlier experiences of assault or brutality. The introduction of tenderness to the lives of such children is highly charged but remains a primary task in working towards the development of their ability to relate. As regards aggression, it is often possible to observe over-reaction in the everyday staff/child rough-and-tumble. Again, in restraining a child in a temper tantrum prolonged holding by a member of staff can produce unnecessary mutual aggression, not only during the particular incident, but later continued as part of the longer term struggle for dominance.

It helps, I think, to be clear that these are not unnatural or necessarily unhealthy responses. They are normal and human but are intensified by the close-living situation and the intimate interaction of those concerned. They become unhealthy when the climate of the institution is such that the feelings which are aroused can only be diverted underground and act as a springboard for later violent eruption. Without an atmosphere in which such feelings can be expressed and explored, both in group and individual supervisory sessions, there are few residential establishments which exist long without hurt to a resident or a staff member following some issue of overwhelming emotions. The taboo on touch in residential work acts strongly on what is regarded by some as developmental need. As Pease says: 'The story of the loss of this important channel of communication as a child gets older is one of the great untold stories of child psychology.'[6] In much the same way as sex itself, touch has untapped potential as a comforting agent and communication process. Its denial must impoverish further the life of many people in residential institutions.

THE EXPRESSION OF SEXUALITY

Deviants are treated according to the formal and informal laws of the moment. In matters of sexuality these have shown considerable variation over the years. Who can tell what will be acceptable or unacceptable by the turn of the century or even at the end of the decade? I would agree that the protective functions of the law play an essential role in sexual relationships which result from unequal power bases. This is well argued, for example, by Storr in his consideration of incestuous relationships[7] and few would dispute the need for the support of a legal framework. Nevertheless, there are many incidents in residential work which are questionable regarding their classification as 'offences'. In too many instances we pounce, punish and convey 'guilt' with alacrity, barely pausing to examine the often infinite implications of our actions.

Residential workers, as indeed most social workers, have tended to avoid discussion of sexuality, unable or unwilling to recognize its key function in human affairs. In an article on 'Sexual Problems in Social Work Practice' Gochros suggests that:

> The goal of social work activities in the area of human sexuality—as in other areas of practice—should be to maximize the choices of the profession's constituency and minimize those limitations of sexual expression that result from dysfunctional taboos, ignorance, or irrationality. No one, including a social worker, can specify what will make another person happy. The sexual rights of individuals and groups must be preserved, regardless of their income or circumstances, as long as these rights do not impinge on the rights of others . . . as preoccupations with right and wrong and normalcy of sexual behavior diminish, social work can

join the search for a new meaning to sexuality. . . . Sexuality is one of the most powerful experiences of man. It can be spiritually and emotionally fulfilling and pleasurable or it can lead to loneliness, fear or misery. Social workers could do more to enhance the former and minimize the latter.[8]

I take as my starting point on sexuality, therefore, the belief that the rights of the physically handicapped, the mentally retarded, the elderly and the adolescent together with members of staff should be no less—by virtue of their residential situation (and/or handicap)—than those of their peers who are not similarly situated. Let us consider these five groups in order.

THE PHYSICALLY HANDICAPPED

Often the idea of copulation between those with severe (or even less severe) physical handicap, or of assistance by a third party in the act, is regarded with abhorrence or coarse humour. Are we being humane in such an approach? In a recent article on sex counselling for those with spinal cord injuries,[9] Isaacson and Delgado draw attention to evidence accumulated since 1950 which indicates that the loss of sexual function is far less prevalent than had been believed by many professionals and laymen. The authors quote studies which demonstrate the injustice of imputing universal impotence to male patients and confirm that intercourse and conception are usually possible for disabled women. In condemning social work practice which fails to give sufficient acknowledgement to the fact that sexuality is a central factor in human affairs it is suggested that:

> Owing to their physical limitations, persons with spinal cord injuries have been seen as passive, dependent individuals who could not perform sexually. Because of this feeling, health professionals have believed that repressive and suppressive psychological processes should be encouraged as a means of limiting patients' thoughts about an active sex life. This approach to the subject is understandable in light of the fact that, in the past, repression of sexuality was a part of the prevailing mores. It does not, however, serve the current generation, which has been raised with fewer inhibitions and less emphasis on repression of sexual thoughts and feelings.[10]

The same theme is taken up in this country by Miller and Gwynne in their study of institutions for the physically handicapped. They report commonly held attitudes against the development of heterosexual pair relationships between residents; which rule out marriage between residents as a matter of policy; and which uphold active measures to segregate the men from the women. In this way an atmosphere is built up within an establishment wherein residents tend:

> . . . to take on the value system that suggests that marriage, or a mature heterosexual relationship without the legal tie, is the preserve of the able-bodied.[11]

Such attitudes militate against the broad caring function which residential staff set out to provide, denying to the physically handicapped—perhaps for no other reason than the fact that they are in residential care—basic choices in human functioning. Isaacson and Delgado call for a comprehensive sex education and counselling programme for the physically handicapped given by those with a mature sexual adjustment themselves and able to deal frankly with the subject in a relaxed manner. The importance of including the spouse, the partner or fiancé is underlined together with the need to examine the place of physical satisfaction *vis-à-vis* that of emotional and psychological satisfaction. In practical terms, Isaacson and Delgado draw attention to two categories of the physically handicapped. The first includes those who no longer have the capacity or ability to manage intercourse and need help in working out alternative methods of satisfying partner and self. The second group consists of those for whom intercourse is possible but who need help with positioning and other adaptive measures.[12]

How far do these ideas fit in with current approaches in residential work? The following illustrates how one member of staff came to his own decisions about the needs of someone for whom he cared:

> John, twenty-three years of age, had worked for two years as an assistant in a home for the severely physically handicapped, and had recently married. He enjoyed an easy relationship with Ted, an intelligent seventeen-year-old resident who at times became overwhelmingly frustrated and depressed because of the serious nature of his handicap and partial paralysis. In the course of the intimate care which John had to give Ted as part of his duties, the latter prevailed upon John to masturbate him from time to time. The fact became known within the institution.

The reactions of the officer-in-charge, the homes supervisor, the social worker, other members of staff, committee members and other residents in the home produced forceful comments varying from uncompromising condemnation to sympathetic approval. Only the residents and a limited number of staff seemed able to appreciate the anxieties sustained by John and Ted both before and after the facts became known. Sincerely held opinions of the other 'onlookers' had to be respected and evaluated, but whose lives were affected? What was 'deviant' in this instance? Certainly, if we believe in basic rights for human beings, there is no justification for withholding them in the residential setting. Indeed, to do so must be viewed as malpractice. This has implications for the training of staff, for the support of staff and for the sex education programmes of the physically handicapped adolescent. Do we pay lip service to sex education as the latter moves from childhood to adult status—talking in biological or intellectual terms—then deny to him for ever the physical sensations? Because nature has determined that we have physical care—and apparent

custody—of the physically handicapped, does this give us licence to control the sexual satisfactions which they may enjoy? This is not a demand for unfettered freedom, but it is a plea for an examination of the rights which we (as individuals or in groups) assume we acquire over others merely because they are forced to live in buildings and situations for which we have responsibility.

THE MENTALLY RETARDED

In moving to a consideration of the mentally handicapped one notes the same broad organizational and individual attitudes considered earlier. These can again be matched with counter-attitudes although the standpoint is slightly different and the weight of public prejudice even heavier. Many are repulsed by the idea that various categories of the retarded have a right to a sexual life. It seems important to explode a number of myths: (i) there is no evidence to suggest that the sexual development of many retarded children, adolescents and adults varies a great deal from parallel growth in the rest of the population, (ii) very many of those regarded as subnormal do not in any way give cause for complaints about their sexual behaviour and (iii) the retarded are no more prone to sexual violence than other people.

The case is clearly stated in a publication of the National Society for Mentally Handicapped Children entitled *Sexuality and Subnormality*.[13] In adopting a view on sexuality in which the sexual relationship 'can be regarded as something which is valuable, good and satisfying in itself'[14] the Swedish authors argue in favour of allowing sexual activity its appropriate place in the lives of the mentally subnormal. This would therefore apply no less to those who reside in institutions. With safeguards to protect the retarded from those in a more powerful situation to initiate a sexual relationship and with current contraceptive techniques, there is no reason to become apprehensive at the development of heterosexual relationships among the mentally retarded. Not all will have a physical base but, if this arises: 'Today one cannot any longer disregard the mentally handicapped person's right to the rewards and satisfactions of a sex life.'[15] There will remain problems as in any other expressive and developmental phase. However, in terms of counteracting the loneliness so acutely felt by the mentally retarded and in the total life enrichment process of their charges to which residential workers must be committed, the question of rights and duties must be squarely faced. The blanket approach in the past has been one of denial. The views expressed here in no way envisage unlimited freedom and accessibility. At least we must ensure that the rights of the retarded in institutions are no less than those of the similarly handicapped 'outside'. Thinking of our earlier example, I draw back from the thought

of any decision which would fail to allow for the personal fulfilment of Maria and Bill in whatever relationship they could be helped to attain.

THE NEEDS OF THE ELDERLY

For the most part, we choose to ignore the sexual interests and needs of the elderly in residential care. Of course, many will have experienced a decline in activity long before admission to an institution but this is by no means universal and McCary concludes that physiologically:

> . . . there is little reason—short of actual disease—for an older man or woman not to enjoy an active sex life, even if it must be a relatively modified one.[16]

He suggests that marital coitus among older men and their wives occurs considerably more frequently than is commonly realized and quotes a figure of 48% for men between the ages of seventy-five and ninety-two who are capable of satisfactory sexual experience. McCary also points to the lack of evidence that ageing produces 'any decline in the sexual capacity of women until, possibly, quite late in life'.[17]

Dyadic relationships do develop in institutions, the continuation of marriage relationships is encouraged (with certain organizational and accommodation limitations) and marriages are not unknown. However, in general, the mode of living is so contrary to previous existence (with the demands for adjustment to new routines, the requirements of group functioning and undoubted depersonalization) that the individual space and time constraints combine with a dissuading atmosphere to produce premature death of tactile and sexual experience. But:

> . . . older people *do* have sexual yearnings, and these desires are perfectly normal. Is it any wonder, though, that the older person is frequently bewildered by his sexual drive and is ashamed of it? The Victorian ethic pervading American sexual mores says that he should live in a sexless vacuum. His children very likely say, voicelessly, 'Sex is for the young. Act your age.' And it is entirely possible that the physician compounds his elderly patient's confusion and bewilderment by answering any questions having to do with sex by saying, 'Well, what do you expect at your age?' Unless a physician is convinced of the psychological importance of sexual expression in the later years of life, he can do irreparable damage to his geriatric patient's sexuality, to say nothing of his general mental and physical health. . . . Since there is so much to be gained from continued sexual activity, and since intercourse is certainly physically possible in the later years of life, why, then, do so many older people shrink from it? For many of them, the popular attitude that the older person is sexless becomes a self-fulfilling prophecy.[18]

Residential living reinforces this idea. With only a marginal difference of approach from that made to the physically and mentally handicapped, we

frequently take it upon ourselves to assume the rights of sexual control of the elderly. If a primary task with this resident group is also one of life enrichment, we must, as a minimum duty, create a climate for discussion in which changes of attitude are seen as possible and acceptable.

ADOLESCENTS IN CARE

It would appear that adolescents often have less in the way of rights than their peers who are not in residential care. This is certainly the case in the realm of sexuality where the interpretation of what is permissible varies so much from one locality to another. For example, in one area a fourteen- or fifteen-year-old girl may be prescribed the pill after referral to an advisory clinic whilst elsewhere an older girl may have it withheld pending consideration by 'higher authority', even awaiting a committee decision. But, given the opportunity for open counselling, this is a personal matter and not one to be controlled by the demands of residential living alone.

I see the sexual education and almost inevitable experimentation of adolescents in care as a time for learning how to handle feelings, how to make appropriate responses and how to prepare for a world of sexuality which they otherwise meet abruptly, secretively and without protection. Too many establishments regard themselves as the last bastions of moral concern where adolescent sexuality is suppressed in a way no longer prevalent in the world outside. This is especially damaging amongst adolescents who have a heightened awareness but who lack accurate knowledge and the ability to control feelings.

This expression of sexuality is all the more likely with adolescents in residential care in the face of the distress and uncertainty brought about by the abnormality of their situation. The nature of the close-living environment created by the caring agents engenders many of the conditions from which the problems emerge. Unfortunately, too few institutions are prepared (in either sense) to discuss healthily the sex-related difficulties. Subsequent condemnation and overlading with guilt only serve as a reflection of staff fears and inadequacies.

There seems no reason for the semi-public haranguing (at breakfast time) as 'dirty little beasts' of two thirteen-year-old boys found together in bed in a remand home. The incident was recently brought to my notice and, as residential staff will know, is a common occurrence. Apart from all that has been said previously in this paper about touch and sexuality, basic texts on human growth and behaviour regard this as a natural part of development. What do we achieve by making the boys experience guilt and temporary if not lasting ostracism?

I am not suggesting unrestricted licence for homosexual practices among

adolescents in residential establishments (in fact, a concept of homosexuality at this age is in itself difficult to crystallize). I am, however, making a strong argument for the defence of residents against those whose own anxieties, irregularly constructed moral codes or panic at the strength of their own feelings bring about a climate of suspicion and guilt. This does nothing to help adolescents on their path towards relationship-building and sexual maturation. We somehow reverence the former but shudder at and reject its sex-linked experimentation, thus seeking to make of man an inhuman being.

Most adolescents I have known have inbuilt discriminatory powers about sex and their sexual partners. The 'power' of the institution will rarely make them lessen their sexuality or change its direction. Heavy-handedness will drive it underground, may increase its 'perversion' and add one more weight to the odds against successful functioning later in life.

In a different context the following example presents a not uncommon challenge to many residential staff:

> One of the girls in an adolescent hostel, Jane, is found to be pregnant. She has recently had her fifteenth birthday. Since admission eighteen months previously Jane has maintained a balanced and affectionate relationship with Michael, another resident who is a year older than Jane. She acknowledges that Michael is the father of her unborn child.

Which establishment would now be able to contain both the boy and the girl? Which would be forced to recommend transfer, then dampen the conversations of those remaining, many of whom would have been 'in the know'? Can we *really* legislate for the expression of sexuality in the case of these two young people? It is interesting to note that few unmarried adolescent mothers feel 'sinful' and different[19] until made to experience this —directly or indirectly—by the comments and attitudes of those who surround them. The primary question must be: how can we best help Jane and Michael? All else is secondary. The apparently 'neatest' solution of the moment—whether this means abortion, transfer of the offenders or 'punishment'—has ultimately proved, time and time again, to be the most damaging. As professional caring agents, is the task presented by Jane and Michael beyond our skill? In south London there is day nursery accommodation for unmarried schoolgirl mothers who live with their parents, friends or relatives, and continue their education. In every way the differences of their situation are thus minimized and supportive fieldwork is concentrated on the preservation of large areas of normal, everyday functioning. Should we provide less, should we stigmatize more, merely on the grounds that a girl is living in a residential situation? Because he fathered a child in his fourteen-year-old girlfriend would Michael have been sent away from home if he had been living with his parents?

RESIDENTIAL STAFF

The close-living atmosphere is no less sexually powerful for the staff and many people coming straight into the work from some comparatively normal type of family living are unprepared for the impact of their own or the sexuality of others. For most there is adequate adjustment to the intimate relationships which often develop between members of staff. Indeed, many relationships are strengthened by the unnatural testing to which they are subjected as a result of staff and resident comment and innuendo. Pressures, however, can be far greater than is realized in the presence of strong feelings and an important management task must be to ensure that staff rights and freedom of movement are not less than those of colleagues in a non-residential setting. Whilst acknowledging the additional responsibility of the staff members (towards the residents) in the conduct of their private lives, the officer-in-charge and the homes supervisor must make a sympathetic approach to the handling of staff problems. Consider the following:

> Miss J, a twenty-year-old resident staff member, has her bed-sitting-room on a corridor of a girls' wing of a reception centre. The girls are eleven to seventeen years and their bedrooms are both adjacent and opposite. It becomes common knowledge—and a talking point—that Miss J's boyfriend, who is in charge of a group of boys in another part of the building, regularly stays in Miss J's room overnight.

I know of similar incidents in two local authorities. In the first the matter was blown up into a 'scandal' so that the couple left the establishment, the girl taking a non-resident post in another children's home and the man leaving the work altogether. In the other authority a rearrangement of accommodation and talking-through appropriately at staff and resident levels enabled a natural relationship to develop and flourish to the benefit of the community.

VICTIMS AND OFFENDERS

Undoubtedly the most tragic and action-producing incidents concern any hint of a sexual exchange between a resident and a member of staff. We behave as if all members of staff—trained or untrained, experienced or inexperienced, and perhaps not far removed from adolescence—should be able to insulate themselves instantly against sexual forces in residential settings. We have already seen how X fared and the reader was able to consider how Maria and Bill should be treated. Apart from a number of clear-cut assaults, there seem to be vast grey areas where the damaging experience to those concerned is not always the alleged happening but its aftermath. This applies equally to staff–resident involvement and to contacts between the residents themselves.

Gauche handling following the first reports of *any* 'incident' in a residential establishment leads to strong ripples of anger, guilt, rejection and indefensible hurt, as if the whole weight of society's vengeance is temporarily concentrated on wrecking the lives of those concerned. But what amount of 'harm' has been done? Are we, the caring agents, doing more? Does the action stem from an uneven power base? What is gained from the identification of a 'victim' and an 'offender' other than the rationalization of punishment?

In most reports of sexual 'deviance' in residential institutions we still look for a victim and an offender, seeking to protect the former (although frequently alienating or punishing him in the process) and punish the latter. Sometimes it is easier to treat both parties as offenders, and to dismiss them from our midst. I become apprehensive at the swiftness of some decision-taking. How often does the offender of the moment become society's long-term victim, receiving retributory action out of all proportion to the 'harm' done to the originally identified victim, whether this be the image of an institution or a named individual? Perhaps in this area there are stronger deterrent elements operating than we choose to acknowledge. Could this again be an expression of fear about very powerful forces within ourselves? Maybe it is the final point on a continuum which places a taboo on tenderness, touch and sexuality in residential institutions.

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