



11

Embodied Care Practices and the Realization of the Best Interests of the Child in Residential Institutions for Young Children

Cecilie Basberg Neumann

1 Introduction

In Norway, we have recently witnessed a shift in the public critique of the child protection services (CPS), from legal and economical shortcomings within the services, lack of professionalism, care ethics and knowledge in social work, towards an increased emphasis on the concept of love (Thrana 2016; Barnevernpanelets rapport (2011)). Here, love is used to denote what professional social work cannot promote unless the social workers invest themselves deeply in emotional involvement with the children. Although I acknowledge this shift as an attempt to meet children's need for love, and as embedded in a legitimate criticism based on client's experiences with CPS as cold and sometimes alienating bureaucracies, I worry that the privileging of deep emotions like love represents a setback for the continuous goal to professionalize social work. While the conduct of competent social work takes years to master, love invokes an image of

C. B. Neumann (✉)

Department of Social Work, Oslo Metropolitan University, Oslo, Norway
e-mail: nece@oslomet.no

© The Author(s) 2018

A. Falch-Eriksen, E. Backe-Hansen (eds.), *Human Rights in Child Protection*,
https://doi.org/10.1007/978-3-319-94800-3_11

‘natural’ and ‘innate’ abilities that all good persons potentially are in possession of, including social workers. Hence, the privileging of love may imply a de-professionalization of social work instead of furthering professional social work with a care ethics that departs from awareness of self and others, responsibility and sensitivity towards power that may be seen in connection with the securing of children’s rights. In this chapter, I make the case for social workers in residential childcare institutions and ask, What is it that social workers do when they provide care to young children in residential childcare institutions? Moreover, what are the features or specific qualities of that care, which would justify the labelling of their caring activities as good care? Finally, what do these good care practices have to do with the realization of the best interests of the child and children’s right to participate?

These questions depart from a larger research project on residential institutions for young children in Norway, where my part of the project was to explore social workers care practices through fieldwork and interviews. In addition, a particular focus was to investigate how the children’s rights to participate, figuring most notably in the United Nations Convention on the Rights of the Child (CRC) Article 12, was handled by the social workers. However, as the study evolved, I found that in order to be able to understand the realization of the children’s rights to participation, I first had to understand how the best interest of the child was secured (CRC Art. 3).

The ideal childhood proposed in the CRC’s preamble states that all children should grow up with warmth, love and security, hence, the quality of care and the caring practices the child is a part of must be pivotal to the overall realization of the rights-principle referred to as the child’s best interests (cf. CRC Art 3.1). In a residential context, one obvious approach to understanding the realization of the best interest of the child is to explore what kind of care the children receive.

Although I worry that the CRC’s idealized view of childhood would be translated into an emotional requirement of love in professional social work settings (Neumann 2016), good care should, and does, serve as a guideline for professional social work practices in residential institutions, not in the sense that social workers should love the children they look after, but that they should engage professionally with

the children in sensitive, responsible and respectful ways (see Kendrick 2013; Lorentzen 2015). This way of thinking is indebted to and departs from an ethics of proximity where the social worker is interpellated to act when he or she sees the pain in the Other's face (see Levinas 2006). As I hope to demonstrate in this chapter, this is also what good social workers in residential institutions do.

The background for the study, and for my part of the study in particular, is that there is a paucity of knowledge with regard to how (good) care is provided for young children in residential care (Backe-Hansen et al. 2017; Storø et al. 2017; Smith 2010). In addition, exploring good care practices in everyday residential contexts as realizations of children's rights is even rarer to come across, even if the law professor Kristen Sandberg has created opportunity for this connection on some occasions (see for example Sandberg 2016, p. 103).

In the following, I depart from the premise that social workers' accessibility and attentive presence towards the children is conducted within the framework of care and care practices. My aim is to specify that which may be characterized as the 'good' in the social workers' care practices with young children, seen in connection with, and as expressions of, the securing of the child's best interest in residential institutions. While the body is central to these articulations, I am not attempting to reduce good social work practices solely to a matter of the connectedness of embodied care practices and the child's best interest. Rather, I wish to investigate and articulate the meaning of the bodily aspects of the social workers' care work with young children in residential institutions, as these aspects intersect with an ethics of care that is already grounded in the social work ethos on sensitivity and responsibility towards the vulnerable Other (Lorentzen 2015).

2 Discovering the Body

Precisely because of the paucity of knowledge on how good care is practised in residential institutions for young children, the fieldwork took place in an institution that achieves good results and has a good reputation. This reputation was confirmed in my study, as the children

I followed over a period of almost one-and-a-half years appeared to heal, socially and physically.

An everyday interpretation of my observations of the children's improved social and physical health and skills, is that there was something going on in the institution that was good for the children that had to do with the particularities of the care they received and were a part of. What struck me as key to this care was how central the body was in the interactions between the children and the social workers.

Hence, my preliminary proposal for conceptualizing the relationship between good care practices and the securing of the best interests of the child is related to the social worker's bodily awareness and sensitive presence when interacting with and caring for children (see also Leseth and Engelsrud 2017, p. 2 on the relationship between teachers and pupils). Leseth and Engelsrud thus states:

Thomas Fuchs, taking a phenomenological perspective, argues that human sociality does not originate in isolated individuals, but through intercorporeality and embodied affectivity (Fuchs 2016). Applying the concept of embodied inter-affectivity Fuchs (2016) asserts that in face-to-face encounters, intertwined subject-bodies resonate with each other; this inter-affectivity creates situations in which mutual empathy and understanding can develop. (Leseth and Engelsrud 2017, p. 3)

Following Leseth and Engelsrud, I see these embodied care practices as intertwined with an ethics of proximity, or ethics of care, that is intimately connected to and serves as a prerequisite for the realization of the best interests of the child. Moreover, I understand embodied care practices as a particular form of social work professionalism, namely, that it is intertwined with how practices are conducted and the rationale behind those practices (Freidson 2001, p. 35). Still, even if the interconnectedness of care ethics, the social worker's relational responsibilities, embodied care practices and the realization of the child's best interests are clearly present as theoretical and practice-based prerequisites and possibilities in social work, this cluster, that lies at the core of social work thinking and doing, is not often clearly articulated (see Pösö, Chap. 6 in this book, and Neumann 2016).

3 Good Practice, Knowing Bad Practices Occur

Before I continue, I should address a reservation. The Scottish researchers Joan Shaw and Andrew Kendrick (2016; see also Steckley and Kendrick 2008) have studied residential institutions for children in protective care and have interviewed former social workers with experience from residential institutions. They worry that Scottish and English care practices in residential child protection institutions have lost, or are in danger of losing, the bodily aspects of the social workers' care practices (p. 13) due to recent disclosures of violence and abuse in residential institutions. For the same reasons, social workers are prohibited to physically touch or be touched by the children in some residential institutions in Scotland (Smith 2010). As history and research on institutions in a variety of settings have taught us (Goffman 1961/1990), not all touch is good touch, and there is always a potential danger of the misuse of intimacy, power and authority in the child–social worker relationship (Ulset 2010; Munro 2008). While acknowledging both the possibilities for violence and abuse, my aim here is not to focus on bad social work practices, but on the unfolding of good care practices.

In the following, I will give a brief account of my methodological entry before I introduce some central phenomenological insights on embodiment, which provide a focused entry to understand the embodied conduct of care for young children in residential institutions.

4 A Methodological Consideration of Embodiment

The findings and discussions in the present chapter are based on ethnographic data from fieldwork and interviews with social workers in one residential institution for young children, and on interviews (but not fieldwork) with social workers in another residential institution for young children. Young children in this context are from the age of six to around twelve years.

The study consists of 20 field observations in a residential institution for young children that lasted 3–4 hours each time. I observed the interactions between social workers and the children. In addition to this, I conducted qualitative interviews with five social workers in this institution as well as with four social workers in an additional institution.

It was especially one incident with a child, in which I was directly involved, that made me acutely aware of the importance of the bodily aspects of the social worker's good care practices. One afternoon I sat at the dining table in the living room and followed the interaction between the children and the social workers. One of the children asked me if I wanted to throw a ball with him. I answered yes and left the chair in which I had been sitting. While I attempted to sit down at the floor beside him I lost my balance and came to touch his arm with my left hand. He pulled his arm quickly away and looked anxiously at me.

The incident made me feel shameful, and I feared that my touch could be harmful for the boy. Later, in one of the interviews, I asked the social worker who had been present in the situation what her opinion of the situation was. She told me not to worry and offered an alternative interpretation, namely that the boy had marked a clear bodily boundary for himself.

This incident changed my analytical focus; from a generalized focus on relational care work and participation, to a more specific focus on the meaning of the bodily aspects of the social workers' care work and thus the securing of the children's best interests (see Neumann and Neumann 2018 Chap. 2 on situatedness as an entry to specific analyses).

5 The Body in Care Practices, or the Embodiment of Care

That the body is involved in human practices—in our thinking, our actions and our ways of being in the world—has been highlighted and theorized in many different contexts. To Mauss (2004), the body was the site where the mental, social and biological system met. For Bourdieu, the body, captured in his conceptual concept *habitus*, was the point of departure in his analyses of our classed and gendered ways of being in the world

(Bourdieu 1999). Foucault (1997) articulated the body as the site for power, and feminists have focused on the body in their investigations of gender and gender relations in a number of different thematic contexts (for example Butler 1999; Sedgwick 2003; Mol and Law 2004).

In a passage on the body that is always with us, but at the edge of our consciousness, Merleau-Ponty wrote,

Now the permanence of my own body is entirely of a different kind: it is not at the extremity of some indefinite exploration; it defies exploration and is always presented to me from the same angle. Its permanence is not a permanence in the world, but a permanence on my part. To say that it is always near me, that I cannot array it before my eyes, that it remains marginal to all my perceptions, that it is with me. (2002, pp. 103–104)

In other words, the body is the basis for our being in the world and for our communication with others (see also Lakoff and Johnson 1999; Leseth and Engelsrud 2017). It is precisely because of these and other phenomenological insights on our bodies and embodied being in the world that Twigg et al. (2011) calls for research that sees concrete bodies as important conditions and contexts for care work and the practising of care.

The question then is how the bodily aspects of care can be central to the conduct of good care practices, and if and in what ways these bodily aspects may be seen as normative prerequisites for good caring practices in social work with young children, as concrete realizations of the child's best interests.

6 Towards a Specific Understanding of Social Work Professionalism: Care Ethics, Good Care Practices and the Child's Best Interest

The starting point in research on the practice of care is that care means that one person cares for and looks after another person (Leira 1992; Ungerson 2005). For Levinas (2006) the essence of care was connected to the essence of being human. One becomes a moral person by recognizing

the subjectivity of the other, and feeling responsible for acting when one sees the pain in the Other's face. This is a central premise in the ethics of care (Martinsen 1993; Held 2006; Lorentzen 2015), and can also be understood as the central feature in empathy (Lakoff and Johnson 1999). Thus, care is fundamentally relational, and the sociological point of departure for analyses of professional care work in institutions is that it is one person's task to look after and care for another person, who for different reason relies on this care (Wærness 1992; Kittay Feder 2011).

In theorizations of care, and what care practice is or could be, emphasis is placed on the ways this work is performed; for example with regard to 'warm' emotions (Wærness 1992), or with regard to collaboration around practicalities (Mol 2008). Emphasis is also placed on the professional practice of care relationships with the exercise of power and control (Ericsson 1996, 2009; Hennem 1997; Skau 2013) as well as with the conditions for the exercise of (good) discretion in the conduct of care work (Freidson 2001; Skau 2013; Skivenes and Sørsdal, Chap. 4 in this book).

It is especially in discussions of the *ways* care is given, as experienced by the recipients of care, that one talks about good care and bad care. Annemarie Mol's (2008) point of departure is to reserve the term care for the conduct of a specific set of concrete actions such as washing, feeding and attending to physical wounds. The body and embodied practices are central premises for Mol's exploration of care, and her project is to identify the logic of care and to show what good care is. She disconnects her analyses of care from more traditional understandings of good care practices as something that has to do with care conducted with the right feelings of compassion and love (Noddings 1984; Wærness 1992). Instead, she locates her understanding of good care as activities and practices that are carried out in specific, flexible and mutually respectful ways (Mol 2008, p. 2).

The conduct of good care is demanding and takes as its point of departure that the patient deserves support (Mol 2008, p. 37). This, Mol emphasizes, does not imply that health personnel should always do what the patient wants, nor is it an undermining of professional knowledge and responsibility. It rather means that health personnel recognize the patient's own knowledge, include the patient as a part of the care team

and encourage the patient to take good care of herself. In good care, this is a collaborative endeavour (Mol 2008, p. 29).

Although Mol has explored good care as practices unfolding in collaboration between grown-ups with chronic diseases and health professionals, I believe she has identified some generic elements in good care that are valid when attempting to identify what good care may mean in residential child protection institutions for young children (see also Lakoff and Johnson 1999, Chap. 14).

Good care is something practical, involving collaborative actions and practices, and important values in this work are recognition, equality and sensitivity (see also Held 2006). This way of understanding good care resonates with the way Per Lorentzen (2015) views ethical action and responsibility in social work in residential institutions. Lorentzen, who grounds his thinking in the ethics of proximity, examines the ethical challenges and demands of social work, and, as for Levinas, it is a dialogical and relational approach that forms the basis of his thinking. What Lorentzen understands as ethical action in social work are actions based on a responsibility that is explicitly directed at and sensitive towards the Other. Like Martinsen (1993), Lorentzen emphasizes that it does not make sense to set out firm ethical principles in advance, but that they must be adjusted by the professional to particular, specific and flexible behaviour based on what a particular situation requires (see also Mol 2008).

The emphasis on the responsibility of the social worker means that the social worker acknowledges being part of the event (a meeting between two people) as she perceives it, and that she is doing her best with the resources, knowledge and skills at her disposal. It is the experience of responsibility, says Lorentzen, which is the reality of the social worker in her meeting with the child or client, and for this reason, professional approaches to children and clients should be based on such a condition (Lorentzen 2015, pp. 50–51).

By adding to this argument Virginia Held's emphasis that care as practice seeks good caring relations (Held 2006, p. 36; see also Mol 2008), we have a ground from where we can articulate the space where the children's best interests may be realized.

7 Connecting Embodied Care Practices with the Best Interests of the Child

During my fieldwork, I observed the social workers in the residential institution as they were acting with warmth, humour and flexibility, and at the same time, maintained routines such as serving regular meals, helping the children with their homework and following up the children's leisure activities. They also made sure that bedtime rituals were adapted to the needs and wishes of the individual child. It is here that I gradually came to understand this work as much more profound than merely securing the children's formal rights to participation, such as ensuring that house meetings are held regularly, that the child has good information about his case, receives regular health-care follow-ups and is allowed to decide what to eat for lunch. Although such activities are important elements of participation, and also in this institution's policy, it nevertheless constituted only a small part of what I eventually came to understand as the child's participation in practice; which was largely based on securing the child's best interests as integral to good embodied care practices. Here, the body itself is key to my understanding of good care, as connected to the realization of the child's rights to have her best interests tended to.

Liv Holmen (2009) has described how the body is a necessary prerequisite for pedagogical care with deafblind children:

Kasper was so fond of rolling around on the floor; so we rolled around on the floor. We were constantly bumping into one another, and finally I was allowed to hold him in my arms while we rolled around, body to body. He was very excited; he hollered and shouted for joy, but because we were physically close to each other, it was possible for me to regulate his discomfort with my body movements. (2009, p. 47, my translation)

Holmen shows in an insightful manner what it could mean to work with and through the body. The disabled child who cannot see and cannot hear communicates directly through the body, and Holmen must follow her own and the child's body to be able to do a job, and to provide care for the child. The question is whether these are valid observations only for children with severe physical impairment. I will start my exploration

of the bodily aspects of good caring practices by showing how the social workers caring practices unfolded in interaction with the children, and then go on to analyse some important reasons for their particular approaches to embodied care practices, that became evident in the interviews with the social workers.

Here is an extract from my field notes:

I am sitting at the dining table in the living room outside the kitchen. Like all the other rooms in the institution, the living room is bright and cosy. Throughout the institution, the walls are painted in bright colours, white, light grey and light yellow, and the curtains and pillows match the colours of the walls in the different rooms. There is a cosy corner with a large couch at the far end of the living room. A few metres outside the corner with the couch is the dining table where I am sitting. From here I have an open view into the kitchen, as well as to the adjacent TV-room. Today, two regular social workers are present, in addition to a social worker trainee and a visiting social worker from another residential institution.

The atmosphere among the adults is cheerful. They prepare dinner, talk, laugh and set the table. Two of the children come home from school and sit down in the adjacent living room to watch TV while waiting for dinner. The phone constantly rings, and the social workers plan the afternoon and evening for the three children living in the institution, apparently not distracted by the interruptions. They have a couple of options for each of the children and talk about what the children might want to do. The dinner is at four o'clock. Then the children have to do homework. They consult with each child, and together they decide that one child is going on a bike ride, while another child is going to the gym. The third wants to be at home.

One of the children has received a new cover for his mobile phone. He comes out of the TV-room periodically, appears to be very happy, jumps around and says that this cover must surely be the coolest in the world. Then he sits down on one of the social worker's lap and gets a hug.

When he leaves, the social workers talk about a new child that will come later that evening or the next morning. They discuss how they should arrange the day so that the child may feel welcome and secure. The social workers agree to let the child decide. They prepare for the possibility that the child might just want to greet the other children, and then go to her room and get to know the social worker who will have the main responsibility for her while she is in the institution.

It is when I am sitting at the large dining table watching the social workers and children's interaction on the couch in the corner that I can observe the bodily dimension of their caring interactions. This is one of many examples:

John has just returned from school. I hear him in the hallway. He takes off his shoes and outerwear in a hurry and comes storming into the room, crying 'Ellen!' to one of the social workers. He jumps onto her lap, and Ellen gives him a big hug, sniffs his hair and starts stroking his back. 'Well, have you had a nice day today?' she asks warmly. He looks up at her, smiles and says 'yes' while sitting on her lap. Another social worker, Karin, enters the room from her office and sits down at the edge of the big couch. John bounces out of Ellen's lap and says to Karin: 'Karin, can we play helicopter? Please, please!' Karin smiles and says 'yes, we can.' She then adds, addressed to the rest of us: 'It will be a good workout for my thighs this one.' She lays down on her back and lifts John into the air with her legs. He hangs with his belly over her feet and laughs. When she puts him down, he asks her to do it again, and they go on for a while until Karin says 'no, now I'll have to take a break.' 'Look here' she shows him her arm, 'I'm totally sweaty.' John touches her arm and goes back to sit on Ellen's lap, who resumes stroking his back. 'Ellen, can you read to me?' Ellen says yes and together they find the book he wants her to read for him.

What is so special about this example? First, it is the body's involvement in the social workers' care work that is striking. Second, it is the importance of touch, and third, it is the willingness of the social worker to enter into the bodily interaction that the child has invited to and asked for. This was what I observed, and that the social workers themselves did not articulate, until I began to ask them directly about the meaning of the body in their embodied care practices.

When I asked the social workers directly in the last four interviews about what the most important thing about the care they provide to the children was, everyone replied that it was about knowing and using their own bodies in their interactions in ways that gestalt therapists would call awareness (Neumann and Neumann 2018). They described their care practices as very physical, and gave many examples of how the job was largely about relating to and receiving the bodies of the children, with and through their own bodies and bodily consciousness and awareness (as in the example with John).

On my question about the importance of the body in their care practices with the children, a social worker responded this way:

It really starts with the social workers own body ... that we are conscious of how we appear towards the child. We need to be aware of things like: How do I move [when I'm stressed]? How do I keep my body when I talk to the child? Do I stand a bit like this [showing physically] backwards and with my arms crossed over my chest, or am I keeping my body in an open and relaxed position? You must also be aware not to use abrupt movements. There was a boy standing next to me while I was cleaning the dishwasher a few months ago. I turned a little abruptly while I held a lid in my hand and he threw himself at the floor. He waited for a blow ... If the child is sitting on a couch and we want to talk to the child about something that might be uncomfortable for the child, we place ourselves on the couch beside the child, or kneel down beside him. They are so fragile. We try to keep this consciousness with us at all times.

Here, the social worker clearly expresses her reflections on her own bodily expressions as linked to her responsibility for the child in the situation (Lorentzen 2015). She connects her awareness and knowledge of her own bodily expressions directly to the care for the boy in the example above, with a further search for knowledge of the boy's situation. The bodily aspects of the good care practices are therefore not just about the child's body, but also about the social worker's own bodily involvement and understanding thereof.

Moreover, in order for the conscious and feeling body to be integrated into the social, there must be someone who responds to and accepts our bodily expressions. Central to Kari Martinsen's descriptions of the body in care and care work is touch, and the way this touch is performed (Martinsen 1993, p. 49). Translated to the understandings of the good care I have accounted for above, the touch must be perceived as something good by the recipient, in order for it to be claimed as good care (see also McKinney and Kempson 2012). This resonates with Mol's (2008) emphasis of the collaborative, sensitive and respectful aspects of good care and the logic of care.

The social workers I encountered were willing to enter into interaction with the children that involved a high degree of bodily contact and touch.

John was hugged and lifted up in the air when he asked for it. The interaction between the social workers and John showed that they were focused and sensitive towards John's specific bodily expressions and needs.

However, embodied care practices and touching in child–social work relationships in residential child care institutions have also, as mentioned earlier, been problematized (Smith 2010) because touch is not always good touch, but may on the contrary be experienced as, or in connection with, abuse and coercion (Ulset and Tjelflaat 2012; Goffman 1990). Hence, the emphasis on the social workers' professional responsibility for the relationship with the child. Conversely, the good touch will have a lot to do with empathy and sensitivity. In a description of moral sympathy, Lakoff and Johnson say that sympathy can be understood as 'a feeling based on empathy that moves us to ensure that the other experiences well-being' (1999, p. 318). Thus, the warranting of a child's best interests while in residential care depends on the social workers' collaborative, responsible and sensitive efforts to respond to the child's presence in the world with and through their own bodies, in a fashion that responds to and respects the child's needs and boundaries. This, I think, is also the crux of social work professionalism in institutions, read through their actions as expressions of an ethics of care.

8 Conclusion

When social workers provide children with good care, I understand their care work as practices where they show the children that they see it as their responsibility to answer to the needs the children express. In doing this, they show empathy, and that they have the ability to take the child's perspective and to imagine the world as the child may see it, and to make an effort to feel what the child may feel (Lakoff and Johnson 1999, p. 309). Central to this care practice is the body; or embodied care practices. The young children invite the social workers in interactions that involves their bodies, and the social workers answer with their own bodies.

Precisely because of this, good care practices for young children depend on the social worker's own bodily awareness and knowledge, and her sensitivity towards the needs of the child at all times. When the child asks or

invites the social worker to give him a hug, he will get a hug, even if the social worker is on the phone or is preparing dinner. Interpreted with Lorentzen, this corresponds to their 'sensitivity in the situation' (Lorentzen 2015, p. 64), which is also connected with their embodied presence, and awareness of self and others (Lorentzen 2015, p. 72). Seen in relation to the child's best interest and his rights to participate, this does not mean that the child should be allowed to decide whether or not to attend school or do his homework, or to decide that he will eat chocolate all day long. The situational sensitivity, and embodied care, is linked to the position of the social worker as the responsible party in the relationship, thus warranting a secure social space in which the child's best interest and right to participate are respected and welcomed. More than securing the children's rights to be protected and provided for, these care practices potentially allow the children to experience participation similar, but not equal, to the (ideal) care received by children in secure family settings. This implies an understanding of the securing of the child's best interest as something that is located in the continuous interactions between the children and the social workers, where the bodily aspects of the social workers' care practices play a central part, as they unfold in their day-to-day interactions with the children.

References

- Backe-Hansen, E., Løvgren M., Neumann, C.B. & Storø, J. (2017). *God omsorg i barnevernsinstitusjoner*. Oslo: Nova rapport nr. 12.
- Barnevernpanelets rapport. (2011). Oslo: Barne-, likestillings og inkluderings departementet.
- Bourdieu, P. (1999). *Meditasjoner*. Oslo: Pax.
- Butler, J. (1999). *Gender trouble*. New York: Routledge.
- Ericsson, K. (1996). *Barnevern som samfunnsspeil*. Oslo: Pax.
- Ericsson, K. (2009). *Samfunnets stebarn*. Oslo: Universitetsforlaget.
- Foucault, M. (1997). *Ethics*. London: The Penguin Press.
- Freidson, E. (2001). *Professionalism, The third logic: On the practice of knowledge*. Chicago: Chicago University Press.
- Goffman, E. (1990). *Asylums*. New York: Anchor Books.

- Held, V. (2006). *The ethics of care. Personal, political, and global*. Oxford: Oxford University Press.
- Hennum, N. (1997). *Den komplekse virkelighet*. Oslo: Nova Rapport nr. 11.
- Holmen, L. (2009). *Pedagogikk og kjærlighet*. Oslo: Skådalen Publication Series No. 29.
- Kendrick, A. (2013). Relations, relationships and relatedness: Residential child care and the family metaphor. *Child & Family Social Work, 18*, 77–86.
- Kittay, E. F. (2011). The ethics of care, dependence and disability. *Ratio Juris, 24*(1), 49–58.
- Lakoff, G., & Johnson, M. (1999). *Philosophy in the flesh. The embodied mind and its challenge to western thought*. New York: Basic Books.
- Leira, A. (1992). *Welfare states and working mothers*. Cambridge: Cambridge University Press.
- Leseth, A., & Engelsrud, G. (2017). Situating cultural diversity in movement. A case study on physical education teacher education in Norway. *Sport, Education and Society, 1–12*. <https://doi.org/10.1080/13573322.2017.1414694>.
- Levinas, E. (2006). *Humanism of the other*. Chicago: University of Illinois Press.
- Lorentzen, P. (2015). *Ansvar og etikk i miljøarbeid*. Oslo: Universitetsforlaget.
- Martinsen, K. (1993). *Fra Marx til Løgstrup. Om etikk og sanselighet i sykepleien*. Oslo: Tano.
- Mauss, M. (2004). *Kropp og person. To essays*. Oslo: Cappelen Akademisk Forlag.
- Mckinney, K. G., & Kempson, D. A. (2012). Losing touch in social work practice. *Social Work, 57*(2), 189–191.
- Merleau-Ponty, M. (2002). *The phenomenology of perception*. London: Routledge.
- Mol, A. (2008). *The logic of care*. London: Routledge.
- Mol, A., & Law, J. (2004). Embodied action, enacted bodies. The example of Hypoglycaemia. *Body & Society, 10*(2–3), 43–62.
- Munro, E. (2008). *Effective child protection*. London: SAGE.
- Neumann, C. B., & Neumann, I. B. (2018). *Power, ethics and situated research methodology*. New York: Palgrave Pivot.
- Neumann, C. B. (2016). Children quest for love and professional child protection work: The case of Norway. *Scottish Journal of Residential Child Care, 15*(3), 104–123.
- Noddings, N. (1984). *Caring, a feminine approach to ethics & moral education*. Berkeley: University of California Press.
- Sandberg, K. (2016). Barnets rett til å bli hørt. In N. Høstmælingen, E. S. Kjørholt, & K. Sandberg (Eds.), *Barnekonvensjonen. Barns rettigheter i Norge*. Oslo: Universitetsforlaget.
- Sedgwick, E. K. (2003). *Touching, feeling*. Durham: Duke University Press.

- Shaw, J., & Kendrick, A. (2016). Reflecting on the past: Children's service workers' experiences of residential care in Scotland from 1960 to 1975. *British Journal of Social Work, 47*, 1–17.
- Skau, G. M. (2013). *Mellom makt og hjelp: om det flertydige forholdet mellom klient og hjelper*. Oslo: Universitetsforlaget.
- Smith, M. (2010). Victim narratives of historical abuse in residential child care. *Qualitative Social Work, 9*(3), 303–320.
- Steckley, L., & Kendrick, A. (2008). Hold on. Physical restraint in residential child care. In A. Kendrick (Ed.), *Residential child care. Prospects and challenges*. London: Jessica Kingsley Publishers.
- Storø, J., Backe-Hansen, E., & Løvgren, E. (2017). Kunnskapsoversikt til prosjektet 'Barneverninstitusjoner som arena for omsorg'. *Tidsskriftet Norges Barnevern, 94*(3), 166–184.
- Thrana, H. M. (2016). Kjærlighetens inntreden i barnevernet—en utfordring for den profesjonelle relasjon? *Tidsskriftet Norges barnevern, 93*(2), 96–109.
- Twigg, J., Wolkowitz, C., Cohen, R. J., & Nettleton, S. (2011). Conceptualising body work in health and social care. *Sociology of Health, and Illness, 32*(2), 171–188.
- Ulset, G. (2010). Tilværelse og oppvekst i ungdomsinstitusjon. *Tidsskrift for ungdomsforskning, 10*(1), 49–71.
- Ulset, G. & Tjellfaat, T. (2012). *Tvang i barnevernsinstitusjoner*. Trondheim: NTNU Rapport20/2012 Skriftserien fra Barnevernets utviklingscenter i Midt-Norge.
- Ungerson, C. (2005). Care, work and feeling. *The Sociological Review, 53*(2), 188–203.
- Wærness, K. 1992 (1987). On the rationality of caring. In Showstack Sasson, A. (ed.), *Women and the state*. London: Routledge.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.

