Coercive Restraint Therapies: A Dangerous Alternative Mental Health Intervention

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Abstract

Physicians caring for adopted or foster children should be aware of the use of coercive restraint therapy (CRT) practices by parents and mental health practitioners. CRT is defined as a mental health intervention involving physical restraint and is used in adoptive or foster families with the intention of increasing emotional attachment to parents. Coercive restraint therapy parenting (CRTP) is a set of child care practices adjuvant to CRT. CRT and CRTP have been associated with child deaths and poor growth. Examination of the CRT literature shows a conflict with accepted practice, an unusual theoretic basis, and an absence of empirical support. Nevertheless, CRT appears to be increasing in popularity. This article discusses possible reasons for the increase, and offers suggestions for professional responses to the CRT problem.

Introduction

The term coercive restraint therapy (CRT) describes a category of alternative mental health interventions that are generally directed at adopted or foster children, that are claimed to cause alterations in emotional attachment, and that employ physically intrusive techniques. Other names for such treatments are attachment therapy, corrective attachment therapy, dyadic synchronous bonding, holding therapy, rage reduction therapy, and Z-therapy. CRT may be carried out by practitioners trained in extracurricular workshops, or such practitioners may instruct parents who perform all or part of the treatment.

CRT practices involve the use of restraint as a tool of treatment rather than simply as a safety device. While restraining the child, CRT practitioners may also exert physical pressure in the form of tickling or intense prodding of the torso, grab the child's face, and command the child to kick the legs rhythmically. Some CRT practitioners lie prone with their body weight on the child, a practice they call compression therapy. Most practitioners restrain the child in a supine position, but some place the child in prone when using restraint for calming purposes.[1,2] Although it is less common than it once was, CRT practitioners may employ a rebirthing technique, in which the child is wrapped in fabric and required to emerge in a simulacrum of birth.

CRT practices are generally accompanied by adjuvant child care practices that may be carried out by a therapeutic foster parent or by the child's adoptive or foster parent. These practices, which we may call coercive restraint therapy parenting (CRTP), stress the adult's absolute authority.[3] For example, a child receiving CRTP is not to be told when or if he/she will see his/her parents again. The child may not have access to food without the parent's involvement and may not use the bathroom without permission. Food may be withheld, or an unpalatable and inadequate diet may be provided. A child who asks for a hug or kiss may not have one, but the child is required to respond to the adult's offers of affection and to participate in developmentally inappropriate rocking and bottle-feeding.

CRT is employed primarily in the treatment of adopted and foster children whose parents believe that they are lacking in affection, emotional engagement, and obedience -- a group of factors that CRT advocates consider to show attachment. CRT practices may also be applied preemptively to asymptomatic adopted children, on the principle that these children are concealing their pathology, which will emerge later in serious forms, such as lying and cruelty. Practitioners of CRT and CRTP use the conventional diagnosis of reactive attachment disorder, although they claim to be able to detect a more serious disturbance, which they term attachment disorder. Attachment disorder is diagnosed by a questionnaire instrument, the Randolph Attachment Disorder Questionnaire (RADQ), which obtains parent answers about issues, such as the frequency with which the child makes eye contact.[4]

Concerns

There is obvious potential danger in the use of physical restraint and the withholding of food characteristic of CRT and CRTP. The impact of these practices began to be apparent with the death of 10-year-old Candace Newmaker in Evergreen, Colorado, in April 2000. Candace's asphyxiation in the course of a rebirthing procedure at first appeared to be a freak event due to the mishandling of 2 CRT practitioners, but further investigation revealed a number of other child deaths caused by parents following the instructions of CRT advocates. It appears to be the CRT belief system, rather than specific techniques, that causes adults to make dangerous decisions.[5]

In response to Candace's death, some professional organizations, such as the American Psychiatric Association,[6] issued resolutions condemning CRT practices. Two issues of the APSAC Advisor rejected the beliefs and practices of CRT. The journal Attachment and Human Development dedicated an issue to articles on this topic, most of them strongly condemning the use of restraint as a therapeutic measure. Two activist Web sites, Advocates for Children in Therapy and KidsComeFirst.info, were created for public education purposes. Medicaid has declined to pay for CRT. A Congressional resolution condemned the use of rebirthing, although without mentioning other CRT practices.[7]

These points suggest a successful anti-CRT movement. On the contrary, however, CRT advocacy and practice appear to have increased despite all efforts against them. Over 100 commercial Internet sites offer or advocate CRT and CRTP. State government Web sites list CRT publications as appropriate reading for professionals and adoptive parents (for example, NJ ARCH), and describe CRT beliefs in the guise of educational material (for example, "Child and Adolescent Mental Health Problems"). Services of CRT practitioners (for example, Post Institute for Family-Centered Therapy) have been used for military dependents, a group that is particularly vulnerable to concerns about attachment and that may be seen as suitable adoptive parents for children with attachment problems (National Adoption Information Clearinghouse).

Purpose

The purpose of this study is to analyze the theoretic background of CRT and to compare it with evidence-supported information about human development, to critique the research offered by CRT advocates in support of their views and practices, and to evaluate CRT and CRTP practices, concluding with a statement about the importance of this issue. This material will enable readers to recognize the vocabulary and assumptions associated with CRT and to consider how to respond to patients who broach this subject.

Method

It has not been possible to observe CRT directly or to hold serious discussions with practitioners or advocates. However, there is a great deal of related material available commercially or via the Internet.

An important source was a series of audiotapes of conference papers, published by the Association for Treatment and Training in the Attachment of Children (ATTACh). A related organization, the Association for Prenatal and Perinatal Psychology and Health (APPPAH), also makes conference tapes commercially available.

CRT advocates have produced their own training tapes that can be obtained commercially. CRT practitioners, such as Neil Feinberg and Martha Welch, and the CRTP advocate Nancy Thomas have shown their philosophy and practices on videotape.

CRT advocates have published statements of their opinions, a few of these through standard publishers and professional journals,[8,9] but most through self-published print materials and through Internet sites. Commercial organizations offering CRT and CRTP services, nonprofit advocacy organizations, and parent support groups provide descriptions of the CRT belief system on the Internet. Most of these do not provide details about CRT practice as it is to be found in other sources.

Courtroom and professional licensing board material was a useful source of information. Several prominent CRT advocates have surrendered their licenses following disciplinary action connected with injury to a patient or other misconduct. Some courtroom materials (for example, Advocates for Children in Therapy) have discussed the actions of parents or practitioners who employed CRT. The most detailed discussion of CRT methods occurred in the trial of Connell Watkins and Julie Ponder for the death of Candace Newmaker; the author attended the trial and has examined the transcript of Watkins' testimony. Of particular value in the Watkins-Ponder trial was the fact that the practitioners videotaped their proceedings with Candace, and this 11-hour videotape was shown in its entirety in the courtroom, although the judge did not permit it to be released to the public.

The author, as an expert witness, also had access to the discovery in a related licensing matter involving CRT practices. Confidentiality does not permit specific reference to this material, but it is appropriate to say that statements in the discovery were congruent with all other evidence about CRT.

Although, as a general rule, newspaper articles may be an inadequate source of information about mental health interventions, newspaper accounts of 2 cases were of help. One of these involved the trial of the adoptive parents of Viktor Matthey, who died of hypothermia and malnutrition; he had been fed on uncooked oatmeal for some time.[10] Adoption services had been provided by Bethany Christian Services, an organization whose Internet site links with CRT organizations. The other case involved the long-term starvation of 4 adopted boys by a New Jersey family.[11] The New York Times account of this revealed a number of CRTP practices at work.

Results

Investigation of the sources described above revealed sharp contrasts between evidence-based treatment and CRT practices. There is a systematic theoretical background for CRT and CRTP, but it is severely at odds with either accepted theory or research evidence about the nature of child development. The research evidence offered by CRT advocates in support of their practices is so flawed in design as to be useless.

Practice Issues

The use of physical restraint and other coercive practices by CRT advocates stands in the sharpest possible contrast to conventional mental health practices. However, other contrasts also exist and have been noted by CRT proponents (Attachment Disorder Site). Generally, CRT views emphasize the authority of the adult and reject any active decision-making role to be played by the child. For example, parents are to establish behavioral goals and the child is not to participate in this process. Children are to be told the words to say that are thought to express their emotions; adults do not wait or follow the child's lead in this matter. All information is to be shared with the family; the child does not talk privately with a therapist. Finally, wraparound services are rejected on a number of grounds, including the idea that children may be given rewards that the parents do not approve of.

Theoretic Background

CRT advocates claim that their belief system is derived from the theory of attachment developed by Bowlby and Ainsworth,[12] but examination of CRT materials shows little relevance except for the use of the term "attachment." In fact, CRT beliefs appear to derive from a combination of fringe systems, including the work of Wilhelm Reich,[13] Arthur Janov,[14] Milton Erickson,[15] and the various body therapy proponents (for example, Soul Song).

Many CRT and CRTP advocates assume that each cell of the body can carry out mental functions, such as memory and the experience of emotion (for example, Official Site of Dr. Bruce Lipton). This belief implies that physical treatment, such as restraint or compression, can alter thinking and attitudes. In addition, body cells may contain memories that interfere with processes, such as emotional attachment, and physical treatment can erase those memories so that the individual is free to develop loving

relationships. Another implication is that a sperm or ovum, as a cell, is able to store memories and emotional responses.

Many CRT and CRTP advocates assume that personality functions and attitudes date back to the time of conception or before (Emerson Training Seminars). According to this view, a fetus, or even an embryo, stores memories of events, including the mother's emotional response to the pregnancy. If her feelings are positive, the unborn child begins to develop an emotional attachment to the mother; if she is distressed by the pregnancy or considers abortion, the unborn child responds with rage and grief over this rejection and cannot form a normal attachment.

CRT and CRTP advocates assume that all adopted children, even those adopted on the day of birth, experience a profound sense of loss, grief, rage, and desire for the vanished birth mother. This emotional pattern interferes with attachment to an adoptive mother.

CRT and CRTP advocates assume that anger and grief must be removed through a process of catharsis. The child must experience and express these negative feelings in an intense manner. He or she can be helped to do this by a therapist or parent who initiates restraint and physical and emotional discomfort in order to stimulate expression of feeling.

Unlike conventional child development researchers, CRT and CRTP advocates believe that normal attachment follows an attachment cycle[1] consisting of experiences of frustration and rage, alternating with relief provided by the parents. On the basis of this assumption, they posit that emotional attachment in the adopted child can be achieved through the alternation of distress and gratification of infantile needs, such as sucking and the consumption of sweets. Some CRT proponents warn that conventional therapy, with its emphasis on following the child's communicative lead, will in fact worsen an adopted child's emotional status.

CRT and CRTP advocates believe that cheerful and grateful obedience to parents is the behavioral correlate of emotional attachment, and that this is true for children of all ages. A parent's sense that the child is aloof and unaffectionate is the best indication of disordered attachment.

A comparison of these CRT points to conventional theory and evidence-based views of early development shows little or no overlap beyond the idea that emotional attachment occurs in infancy and has some impact on behavior. Cells outside the nervous system are not conventionally believed to be capable of memory or experience, nor are memories considered to go back to preconception or even to the embryonic or early fetal stage. Although a mother's emotional state and stressful experiences during pregnancy do appear to have some effects on development, these effects have never been specifically related to her attitude toward the pregnancy, nor is that attitude easily isolated from postnatal events. Emotional attachment is generally considered to be a process beginning after the fifth or sixth month after birth and resulting from pleasurable, predictable social interactions with a small number of interested caregivers. Attachment behaviors vary with age and developmental status and at some stages include negative actions, such as tantrums or arguing. Attachment disorders are not easy to define or to diagnose, but, like most early emotional problems, they are best treated through techniques that facilitate the child's enjoyment of social play and mutual social interaction, as well as by treatment of factors, such as maternal depression.

Research Evidence

The difficulties of clinical outcome research are obvious, but professionals working with outcome issues have set out criteria for effective work of this type.[16] One useful approach has involved the concept of levels of evidence, which can be used to define the conclusions that can legitimately be drawn from different research designs.

CRT advocates in the 1970s showed little concern for research evidence,[17] but in more recent years have become aware of the commercial value of claiming an evidence basis. Internet sites offering CRT frequently include claims that a favored treatment "works" and that conventional treatments not only fail to

"work," but cause exacerbation of problems. A small number of empirical studies of CRT have been published or posted on the Internet; these are critiqued below. Surprisingly, there are no CRT studies at the lowest level of evidence, the case study level, although there are scattered anecdotes about cases. Of no surprise, there are also no randomized, controlled trials, and, considering the deaths and other problems associated with CRT, it seems unlikely that an institutional review board will ever permit such research. Available research reports are at the second level of evidence, with quasi-experimental designs, and can thus not be used to support conclusions about causality. It should be noted that there are a number of confounded variables in all of these studies; children who receive CRT usually are separated from their parents for a period of time, and they experience CRTP carried out either by foster parents or by the adoptive parents.

The use of a paper-and-pencil instrument, the RADQ, is frequent in research reported by CRT proponents.[4] An understanding of the development and nature of this instrument is a necessary beginning for a survey of CRT research.

The RADQ is a questionnaire that is to be answered by a parent or another adult who has spent a great deal of time with the child. Diagnosis of an attachment disorder (reactive attachment disorder, or the CRT-posited attachment disorder, depending on the investigator) is based on the adult's responses to statements about the child. These statements uniformly refer to undesirable behaviors or attitudes; there is no check for response bias, so an adult who agrees with every statement creates the highest possible attachment disorder score. The items on the RADQ were not derived from empirical work. A number of them actually come from a questionnaire that has been in existence for decades, at one time being used as a measure of child sexual abuse, but originally coming from a survey meant to detect masturbation.[18,19]

A major problem of the RADQ is that it has not been validated against any established objective measure of emotional disturbance. Validation was against a Rorschach test administered and scored by the creator of the RADQ, who also administered and scored the RADQ.[4] A degree of spurious respectability has been given to the RADQ in the last few years as a result of psychometric studies concentrating on the internal reliability of the test, but this does not, of course, speak to validity issues.

The RADQ and other ad hoc questionnaire measures used in studies of CRT outcomes are thus inadequate evaluative devices. Similarly, there is no evidence to support claims that a child's movement patterns can be interpreted to yield an attachment disorder score.[20] There is 1 empirical study of CRT published in a peer-reviewed journal.[9] This report, based on a doctoral dissertation at a distance-learning institution with problematic accreditation, has a controlled clinical trial design with serious flaws in the comparison group. The investigation studied children whose families had contacted the Attachment Center at Evergreen and expressed their wish to bring the children for treatment because of behaviors categorized as disorders of attachment. All the parents were asked to respond to a questionnaire about the children soon after their initial contact. One group brought the children for a 2-week intensive treatment, during which time the children had little contact with the parents and stayed in therapeutic foster homes for CRTP, while the parents themselves often vacationed. The comparison group in this study was comprised of families who had made the initial contact with the Attachment Center, but for reasons of their own had not brought the child for treatment. Both groups were asked to respond to a second identical questionnaire about a year after the initial contact had been made. The investigators concluded that the treatment group improved more than the comparison group in the course of that year.

This study has been used by CRT advocates as evidence supporting the efficacy of their practices. However, one would expect some degree of improvement in the course of a year, both because of maturation and regression to the mean. The difference in amounts of improvement could result from the many variables confounded with the treatment variable: the reason for the comparison group's failure to attend treatment (marital disagreement over the decision, financial concerns, physical or mental health needs of other family members, or employment problems); the effect of separation from the parents on the children in the treatment group; the effect of separation from the children on the parents in the treatment group; the parents' vacations and travel experiences; and cognitive dissonance factors encouraging the parents to believe that there must have been a positive outcome resulting from this

expensive and disturbing experience, or a negative effect if they were unable to come for treatment. Design problems thus make it impossible to accept this study as evidence supporting CRT.

Two simple before-and-after studies claiming to support CRT have been posted on the Internet (Adopting.org and Attachment Treatment & Training Institute). The first, by Becker-Weidman, administered the RADQ and a behavior checklist to parents of 34 children before and after CRT. Becker-Weidman concluded that CRT had caused changes in the children, basing this statement on significant differences between test scores. However, the treatment variable in this study was confounded with simultaneous maturational change. In addition, natural variations in behavior and attitudes may be involved, because parents are most likely to bring children for mental health treatment when their behavior is at its worst, so that spontaneous improvement occurs during the time of treatment but not because of treatment.

The second, similarly designed study by Levy and Orlans is difficult to follow because of the lack of detail in the Internet posting, but its conclusion that CRT is effective appears to be subject to the same criticisms as the Becker-Weidman work.

Discussion

CRT lacks an evidentiary basis, is derived from an unconventional theoretic background, and is at odds with practices accepted by the helping professions. There is clear evidence of serious harm done to children by adults influenced by the CRT view. Professional organizations and academic publications have rejected CRT practices and beliefs. Nonetheless, Internet sites offering CRT flourish, and state agencies promulgate the CRT philosophy. Why is this happening, and what can be done?
First Amendment Issues

The apparent public regard for CRT may be related to advertisement and advocacy that are protected as free speech under the First Amendment.[21] Advocacy of CRT cannot be prevented even when CRT practices cause injury. The media, the Internet, and practitioners themselves are all free to claim safety and efficacy for CRT.

The mass media have made a practice of presenting CRT as exciting and acceptable. From the depiction of CRT years ago in the Elvis Presley movie Change of Habit to a Dateline program in 2004,[22] CRT has been shown as strange and frightening but effective. The media have never presented clear arguments against the use of CRT.

The rise of the Internet was a gift to CRT advertisers, who can now contact and be contacted by families in every part of the country. Internet parent support groups have allowed families involved with CRT to develop cultlike support systems that counter criticisms of CRT practices. A recent survey reported in The Wall Street Journal showed that in 2004, 23% of Internet users searched for experimental treatments,[23] providing a large audience for CRT-related material.

Although practitioners who cause harm directly are legally liable, it would appear that many CRT practitioners are moving from practices of which they themselves restrain children to an approach of which they teach parents to do this. Any injury to the child is then caused by the parent. The practitioner's speech to the parent is protected, as are workshops and courses that claim efficacy for CRT.

Professional and Institutional Responsibility

As was noted earlier, some professional organizations have adopted resolutions rejecting CRT. However, other organizations have acted in ways that support CRT practices. These actions include publication of a book by the Child Welfare League of America[24] and approval of continuing education credit for CRT workshops by the American Psychological Association and the National Association of Social Workers.

One accredited educational institution, Texas Christian University, Fort Worth, Texas, now offers credit-bearing courses involving the CRT belief system. A number of unaccredited institutions, such as the Santa Barbara Graduate Institute, Santa Barbara, California, also do so.

What Is to Be Done?

Given that curtailment of freedom of speech is neither possible nor generally desirable, it cannot be expected that advertisement of CRT will stop. Professionals who are concerned about CRT have the responsibility of employing their own freedom of speech to present the facts to other professionals and to parents who consult them, bearing in mind that the concepts and empirical evidence are not easy to summarize. An important start would be for all relevant professional organizations to adopt resolutions rejecting CRT and to communicate those resolutions to the media. In the meantime, physicians should be prepared to respond to parents' references to CRT and should realize that poor growth in adopted and foster children may result from CRTP practices.

References

1. Cline F. Hope for High Risk and Rage Filled Children. Evergreen, Colo: EC Publications; 1992.
2. Federici R. Help for the Hopeless Child. Alexandria, Va: Dr. Ronald S. Federici and Associates; 1998.
3. Thomas N. Parenting children with attachment disorders. In: Levy T, ed. Handbook of Attachment Interventions. San Diego, Calif: Academic Press; 2000.
4. Randolph E. Manual for the Randolph Attachment Disorder Questionnaire. Evergreen, Colo: The Attachment Center Press; 2000.
5. Shermer M. Death by theory. Sci Am. 2004;June:48.
6. American Psychiatric Association. Position Statement: Reactive Attachment Disorder. Washington, DC: American Psychiatric Association; 2002.
7. Myrick SH. Congessional resolution 435. In: Congressional Record. 107th Congress, 2nd Session, 17 September 2002. H6268. Introduced July 8, 2002.
8. Levy T. Handbook of Attachment Interventions. San Diego, Calif: Academic Press; 2000.
9. Myeroff R, Mertlich G, Gross G. Comparative effectiveness of holding therapy with aggressive children. Child Psychiatry Hum Dev. 1999;29:303-313.
10. Dowling M. Mattheys convicted of abusing Viktor. Newark Star-Ledger. May 20, 2004.
11. Kaufman L, Jones RL. Child agency tries to grasp how one case got away. New York Times. October 28, 2003:B8.
12. Bowlby J. Attachment and Loss. New York: Basic Books; 1982.
13. Sharaf M. Fury on Earth: A Biography of Wilhelm Reich. New York: St. Martin's Press; 1983.
14. Janov A. The Primal Scream. New York: Putnam; 1970.
15. Erickson M. The identification of a secure reality. Family Process. 1962;1:294-303.
16. Chambless D, Hollon S. Defining empirically supported therapies. J Consult Clin Psychol. 1998;66:7-18.
17. Zaslow R, Menta M. The Psychology of the Z-Process: Attachment and Activity. San Jose, Calif: San Jose State University Press; 1975.
18. Dawes R. House of Cards: Psychology and Psychotherapy Built Upon Myth. New York: Free Press; 1994.
19. Underwager R, Wakefield H. The Real World of Child Interrogations. Springfield, Ill: C.C. Thomas; 1990.
20. Randolph E. Broken Hearts, Wounded Minds. Evergreen, Colo: RFR Publications; 2001.
21. Kennedy SS, Mercer J, Mohr W, Huffine C. Snake oil, ethics, and the First Amendment. Am J Orthopsychiatry. 2002;72:40-49.
22. Mercer J. Media watch: radio and television programs approve of coercive restraint therapies. Sci Rev Mental Health Pract. 2003;2:154-156.
23. Landro L. Web grows as health research tool. Wall Street Journal. May 18, 2005; D7.
24. Levy T, Orlans M. Attachment, Trauma, and Healing: Understanding and Treating Attachment Disorder in Children and Families. Washington, DC: Child Welfare League of America; 1998.