

## White Paper on Coercion in Treatment

**The purpose of this document is to set guidelines and standards for ethically and clinically appropriate treatment for children with attachment problems. This document is intended to provide guidance to parents and therapists so that they avoid the use of coercive techniques. ATTACH believes a central focus of treatment<sup>1</sup> for children with attachment problems is to create an environment in which the individual can safely work to integrate previously unmanageable information and emotions related to early traumatic experiences with caregivers. Those post-traumatic emotional reactions interfere with the development of healthy relationships and may have serious negative effects on a child's overall development.**

All forms of attachment therapy have been construed by some as using coercive techniques. *Merriam-Webster's Dictionary* defines coercion as “the use of express or implied threats of violence or reprisal...or other intimidating behavior that puts a person in immediate fear of the consequences in order to compel that person to act against his or her will” (coercion, n.d.). ATTACH believes an approach that relies on a base of coercion (as so defined) is contraindicated in working to create a secure parent-child relationship characterized by safety, reciprocal love, trust, and perceived security.

However, we recognize that children who have had early experiences of trauma may be predisposed to misperceive threat in benign and even positive interactions. Consequently, their real experiences of trauma, coupled with often distorted perceptions of threat, call for a treatment approach that is sensitive to the critical need for safety, and provides real assistance with emotional regulation, making meaning of experiences, and enhanced social connections (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). The problems of these children may interfere with their relationships, particularly with parents or other primary caregivers. The need for treatment and the challenges in providing it are very real.

It is important at the outset to clarify that a coercive treatment approach is separate and distinct from the occasional and judicious use of strategies such as logical and reasonable consequences, safety interventions, enforcement of limits and other legitimate interventions in the socialization of and provision of safety for children. Though these can be defined as “coercive,” they are not typically accompanied by fear and are a legitimate part of a parenting toolbox for parents of all children. When used in the context of a loving parent child relationship, the occasional and judicious use of such techniques is a constructive intervention of parenting.

Harmful and threatening forms of coercion have previously been used in treatment with children. Some of these practices were done in the name of attachment therapy. Examples include wrapping children in blankets and not allowing them to leave; poking children during therapy and strongly encouraging (even demanding) them to express anger at previous abusers; adults lying on children; and therapists forcing a child to carry out explicit instructions for behavior (e.g., sitting in a specific manner) as dictated by the therapist or risk serious consequences. These practices, and similar ones, fall in an area that is clearly coercive. We believe that the use of this type of coercion is not appropriate in treatment for children.

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<sup>1</sup> In this document, the term “treatment” refers to both psychotherapy and parenting.

In recent years, several organizations have issued statements regarding treatment for children with attachment disorders. ATTACH concurs with the American Psychiatric Association's 2002 Position Statement on Reactive Attachment Disorder that "there is a strong clinical consensus that coercive therapies are contraindicated in this disorder" (American Psychiatric Association, 2002). ATTACH also concurs with the American Academy of Child and Adolescent Psychiatry, "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Reactive Attachment Disorder of Infancy and Early Childhood," (American Academy of Child and Adolescent Psychiatry, 2003). In addition, ATTACH supports recommendations in the 2006 Report of the APSAC Task Force on Attachment Therapy, Reactive Attachment Disorder, and Attachment Problems. (Chaffin et al., 2006) Specifically, we agree with following recommendation:

...techniques involving physical coercion, psychologically or physically enforced holding, physical restraint, physical domination, provoked catharsis, ventilation of rage, age regression, humiliation, withholding or forcing food or water intake, prolonged social isolation, or assuming exaggerated levels of control and domination over a child are contraindicated...." (Chaffin et al., 2006, p. 86)

Each of these statements condemns the use of coercion in treatment. However, none gives guidance about what distinguishes coercive interventions from acceptable authoritative practices. It is easy to distinguish between the extremes. However, a wide continuum exists between the endpoints. This is the area in which parents and therapists have struggled to find interventions that effectively address the population of children who have experienced early life maltreatment and their current challenging behaviors. ATTACH believes it is important to give usable guidance to those courageous enough to work with these children, even if giving such guidance is fraught with difficulties.

The therapeutic use of confrontation and directive therapeutic techniques is widely viewed as appropriate and beneficial when appropriately applied (Hammond, Hepworth, & Smith, 2002). The phrase "confrontation" is used in therapeutic literature as a technique to help the clients resolve maladaptive defenses. **ATTACH believes the proper use of therapeutic confrontation and other directive techniques may be beneficial but must be done in a manner that promotes attunement, sensitivity, and developmental appropriateness.** A primary purpose of this paper is to describe critical issues related to providing treatment to children with early life maltreatment or adverse childhood experiences and to give guidance about appropriate therapeutic confrontation versus inappropriate coercion when working with this population.

### ***Background***

ATTACH's historical roots contribute to the continued perception that the organization supports coercive interventions. ATTACH founders organized around therapeutic work with a group of children with histories of maltreatment and loss who had been found to be highly resistant to treatment. These practitioners primarily practiced a form of treatment that included catharsis, provocation of rage, and intense confrontation, among other overtly coercive techniques. Such treatment was originally called Rage Reduction Therapy (Zaslow & Menta, 1975). To the credit of these practitioners, they were among the few who sought to develop outpatient treatments for this underserved population (O'Connor & Zeanah, 2003). Current

attachment therapy as supported by ATTACH has evolved significantly away from these early roots. The fundamental shift has been away from viewing these children as driven by a conscious need for control toward an understanding that their often controlling and aggressive behaviors are automatic, learned defensive responses to profoundly overwhelming experiences of fear and terror. **Due to ATTACH's earlier association with Rage Reduction Therapy, we believe it is important that we now unequivocally state our opposition to the use of coercive practices in therapy and parenting.**

Just as medicine has moved from highly intrusive interventions to less intrusive yet more effective ones, so has the field of attachment therapy evolved. Over time, findings in the fields of trauma, neuroscience and attachment discredited the more coercive approaches (Kelly, 2003). In recent years, the use of coercive techniques among ATTACH's membership has declined for two primary reasons. First, a number of practitioners who worked with the same population of children but employing other techniques joined ATTACH after its formation. These clinicians practiced therapy with a primary emphasis on sensitivity and attunement. Their techniques included narrative therapy, some types of play therapies, corrective emotional experiences, and other methodologies focused on increased emotional regulation and trauma processing. Second, many of the practitioners who employed the more coercive techniques began to move away from these approaches in response to research findings in many fields including trauma, attachment, and neuroscience. Movement away from the use of coercive techniques was also partially in response to adverse events involving such techniques, including the tragedy of one child's death.

As the organization's leadership and membership moved away from coercive therapies, ATTACH adopted its first position paper, *ATTACH Position Statement on Coercive Therapy*, in 2003 (Association for Treatment and Training in the Attachment of Children, 2003). This position paper was intended to be a strong statement in opposition to the use of coercion in treatment. ATTACH hoped that this statement would serve a two-fold purpose of 1) signaling to those outside ATTACH that the organization was separating from its historical roots and 2) signaling to those who still practiced coercive therapy and parenting that they would no longer have the support of the organization in such practices. ATTACH updated this statement in 2006 to reflect continued advances in neurology, trauma treatment, and related fields (Association for Treatment and Training in the Attachment of Children, 2006).

ATTACH remains committed to educating the professional and general public about state-of-the-art treatment in work with children who have experienced attachment disruptions and trauma. Moreover, we believe the field of child therapy needs an organization focused on serving this important population. These children present with emotional, behavioral, and developmental difficulties that can be very challenging to any who would attempt to help them. Too often in the past they were simply deemed untreatable or in need of institutional care. Today we know that there is reason for hope given promising approaches that help resolve traumatic reactions, promote greater security in attachment, and facilitate more appropriate development. However, this hope is tempered with very real challenges.

These children do not seek nor easily accept treatment. Indeed, their fundamental difficulties in establishing a trusting, reciprocal relationship often cause them to actively push away offers of assistance. For some, a child's failure to consent to treatment implies that the child is being coerced into treatment. Many children with histories of maltreatment who are brought by parents or professionals for treatment exhibit oppositional behavior and have high control needs (van der Kolk, 2005). If given complete choice, a large number would refuse to participate in therapy. Some would argue that no child should be made to participate in therapy if

he or she does not want to do so. We disagree. Experienced, well trained therapists and attuned, sensitive parents can better make the decision regarding a child's need for therapy than can the child. Even if the child does agree to participate, he or she may wish not to face difficult issues. Children may not be able to see the link between early maltreatment experiences and current life problems (Perry, 1995). However, their caregivers and/or professionals do see these links and see the need for appropriate treatment when their functioning and development have been adversely affected by trauma or loss. In the most extreme cases, the severity of these children's emotional and behavioral difficulties compromises their functioning and development across domains. They are often at risk of more restrictive placements (e.g., hospitalization, residential treatment, placement disruption) or increased chemical restraint through medication. The severity of this risk may indicate a more directive approach, but one that is still grounded in an understanding of the need for sensitivity and regulation.

A child with a serious infection may need an injection to promote healing. Young children react to shots with predictable resistance and/or emotional distress. Nonetheless, parents persist due to the overriding concern for the child's long term health. Nurturing parents use this as an opportunity to provide comfort and to make meaning of the experience.

### **Decision making process: Is it coercive?**

Where does appropriate therapeutic confrontation end and coercion begin? In beginning to answer this question, we believe that lists of do's and don'ts, while useful, are inadequate. Too many unique situations are encountered in a therapeutic setting, and no list can ever be complete. Rather, we think it useful to provide therapists and caretakers with principles and guidelines to employ.

ATTACH believes that the field of child therapy in general, and practitioners of attachment therapy specifically, would benefit from a greater understanding of what interventions and techniques constitute coercion and how this differs from the use of appropriate therapeutic confrontation. It is one thing to oppose the

use of coercion in treatment; it is quite another to more specifically articulate a definition of what constitutes coercion in treatment.

In many situations (such as the examples of coercion cited previously in this document), the line between appropriate therapeutic confrontation and coercion is clear. One can also draw clear guidance from legal standards that define child abuse and neglect or ethical standards that seek to insure the safety of the client.

Where such "bright line distinctions" end, one enters the gray area of potential harm where there are no clear guides for actions. In these cases, a framework for ethical decision making should be the guide. Without clear standards of appropriate behavior or intervention, one must look to how research or other accepted standards can be applied to the situation. There are three important guidelines to consider:

1. Is the approach principled; is it grounded in ethical values?
2. Is the approach reasoned; is it based on valid rationales?
3. Is the approach generalizable; can it be applied to other situations (instead of being immediately expedient for this individual circumstance)?

These principles need to guide the consideration of what is and is not coercion in any situation that falls into a gray area. Ethical decision making in gray areas is an ongoing process

of thoughtful consideration, development of a plan, and continuing review and modification of the plan as needed.

For example, some have suggested that touch has no place in therapy, but we believe that affectionate, voluntary touch can offer support, encouragement and safety for a child. To determine the appropriate parameters for the use of touch we would consider whether:

1. It is grounded in ethical values and carried out in a way that is respectful of the child's development and history.
2. It is grounded in valid rationales in that there is significant research indicating the value of nurturing touch in physiological regulation and neurological development (Hofer, 1984; Field, Healy, & Goldstein, 1990; Schore, 2001).
3. It is a practice widely used by adults with children.

In contrast, we do not feel it is appropriate for parents or therapists to hold a child forcibly, while insisting on emotional engagement on the adult's terms. For example, forcibly holding the child and demanding eye contact or emotional sharing is premised on the adult's expectations and is not responsive to the child's state (e.g., shame, terror, etc.). This technique is not supported as:

1. It is a violation of the child's dignity and autonomy.
2. It is not supported by current research as it intentionally causes dysregulation and may re-traumatize the child.
3. It is not a practice generally used with children.

In such complex situations it is helpful to consider the interaction of other principles that may guide decision making. These would include the consideration of the interplay among the parent's or therapist's behavior and intentions; the child's perceptions and experience; power differentials in the relationship; and the nature and quality of the relationship between the persons involved. This approach leads to a focus on the *effects* of the parent's or therapist's actions on the child.

## **Critical Concepts**

Decision making in complex treatment situations with the population of children damaged by early life maltreatment involves the consideration of a number of critical concepts and how the concepts apply to specific individuals and situations. Practitioners and parents would do well to have a working knowledge of these critical concepts. These concepts are described in this section.

### ***Regulation and dysregulation***

One such critically important concept in this process is regulation versus dysregulation of emotions, impulses, and physical states. Security provides children with opportunities to develop the capacity for regulation. Lack of sustained regulation puts the child at risk of inadequate development of the capacity to regulate physical and emotional states (Cook, Blaustein, Spinazzola, & van der Kolk, 2003). Research has shown that children learn best during times they are regulated (e.g., when the child is in a calm, receptive state) (Schore, 2001) It is important to support and promote children's regulation during interventions. If a child becomes dysregulated, attempts should be made to restore regulation as soon as possible (e.g., a parent

might actively assist the child in regaining a calm, receptive state by soothing the child and making sense of the experience).

Dysregulation occurs when the developing child's capacities for managing physiological, emotional, behavioral and/or interpersonal functioning are overwhelmed by distress to the extent that the child is unable to regain equilibrium independently. Dysregulation should never be a goal of an intervention; indeed, it may undermine other progress by unintentionally reinforcing the child's distorted beliefs that others are hurtful, untrustworthy, and neglectful. Sometimes children with attachment disorders who become dysregulated respond with angry or aggressive behaviors that require safety interventions that are perceived as more forceful than empathic. In situations where safety is threatened and less intrusive interventions have been tried and failed, it may become necessary to use restraint including physical holding to maintain safety. In these special situations, the use of force should be terminated as soon as possible, and efforts made to repair the break in relationship that results from its use. Restraint in these situations is not seen as part of treatment but solely as a necessary intervention to maintain safety. Given that children with histories of trauma may misperceive the actions of others as intentionally hurtful, it is critically important that the adults help the child make meaning of such experiences (e.g., "We are keeping you safe when you feel out of control" to counter the child's likely perception of "They will hurt me and/or I am bad").

When dysregulation does occur during treatment, interventions must be incorporated that will assist the child in regaining regulation and managing the distress. This concept is also called "interactive repair" (Tronick & Gianino, 1986). When the child responds with discomfort and distress, the therapist or parent uses empathy and emotional support to help regulate the child's affect so that the child does not move into dysregulation. While experiencing discomfort and distress, the child maintains regulation of affect, cognition, and behavior. However, when a child shows terror, rage, or dissociative features, indicating movement into dysregulation, the child requires help to regain a calm receptive state. So, for example, in a therapeutic situation a child may willingly discuss an event that is upsetting and increases the child's discomfort and distress. However, if the child then indicates a desire to stop, yet this signal is ignored by the therapist or parent, so that the child is forced to continue, this is coercive. This does not mean that the therapist and/or parent join with the child in avoidance of this painful material. Instead it means that they stay attuned to the child's needs and work to "dose" the exposure to this material in a way that supports the child's ability to process and integrate the information. This gradual consolidation of the material within the context of a helpful, sensitive relationship promotes a greater sense of security in the child which in turn facilitates greater security in attachment. This is very different from earlier approaches in which continued confrontation and exposure to painful material was maintained or increased until the child was exhausted or had a "break through". Such an approach is coercive and indeed counter-therapeutic due to the risk of re-traumatizing the child. For children with histories of attachment-related traumas this may unintentionally reinforce negative beliefs about others as harmful, coercive, and controlling, which may impede, if not prevent, the formation of truly secure attachment. In addition, it is coercive treatment if a child becomes dysregulated, even through an unintended triggered reaction, and the therapist or parent does not act to attempt to decrease the child's dysregulation and repair the relationship break. Power struggles and control battles may only serve to increase the dysregulation and are not recommended unless there is a clear and imminent need to establish safety.

Helping the client to explore traumatic memories or conditioned emotional reactions in order to promote integration is an appropriate goal of treatment. It is the process of exploration and how it must be handled that is the focus of this paper. Some degree of dysregulation may occur along with the processing.

Research on maltreated children has shown that a significant percentage experience chronic dysregulation (Teicher, 2002). Extreme cases may result in chronic defensive manifestations (e.g., hypervigilance, compulsive self-reliance, dissociation). These children may be highly reactive and very difficult to assist in re-regulation. Their defensive reactions are rooted in anxiety and profound fear from their traumatic experiences. It is important to recognize that even gentle and sensitive interventions may be perceived by these children in a threatening way, and may push them into a dysregulated state. The therapist or parent may still provide such interventions even knowing that the child may be triggered into a dysregulated state, but must take care to appropriately “dose” the intervention so that the child is not overwhelmed and is still able to perceive the adult as actively working to assist the child in handling any difficult emotions that arise. The intention is to provide the corrective emotional experiences of attunement that help the child resolve these maladaptive reactions with the assistance of an empathically connected adult.

### ***Therapeutic Window***

The concept of a “therapeutic window” is related to the concept of dysregulation and is vital to understanding effective treatment for victims of childhood maltreatment (Briere, 2002). A therapeutic window is the psychological space in which a client is able to learn and change because it is neither overwhelming to the individual’s defenses nor does it allow the client to move to the relatively easy (and often preferred) avoidance of the traumatic material. The challenge is to activate conditioned emotional reactions (i.e., triggers) to access avoided emotional content, but to do so **ONLY** in a way that does not overwhelm the individual’s coping resources. If such coping resources are overwhelmed, then the individual may be flooded by intrusive stimuli and re-traumatized.<sup>2</sup>

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<sup>2</sup> Briere’s Self-Trauma Model suggests that early and severe child maltreatment is associated with significant deficits in what he calls self-capacities (most importantly, affect regulation). The deficits in affect regulation place the individual at risk of becoming overwhelmed by the emotional distress associated with reminders/triggers of earlier trauma. Due to limited affect regulation skills, the traumatized individual resorts in greater and greater degrees to avoidance strategies as a form of self-protection against such overwhelming experiences. Therapy that fails to provide adequate safety may result in an unintended reinforcement of avoidant strategies and maneuvers by the client. For therapy to be effective, it must take place in what Briere calls the “therapeutic window”. This is the psychological location between overwhelming exposure on one hand and excessive avoidance on the other. If the therapist pushes the client to move outside that window the result is that the client may use heightened strategies of avoidance to manage the overwhelming affect. This may be seen as “resistance” by the therapist, but may more accurately reflect limited, but appropriate protective responses by the client. Effective trauma therapy therefore seeks to provide sufficient safety and containment, recognizing the likely deficits in the client’s affect regulation capacity. The therapist seeks to carefully measure therapeutic exposure so that such activation does not exceed the internal coping resources of the client. This allows the client to begin to explore difficult content without the risk of being re-traumatized.

In *The Developing Mind*, Dan Siegel (1999) describes dysregulation. "Each of us has a "window of tolerance" in which various intensities of emotional arousal can be processed without disrupting the functioning of the system....One's thinking or behavior can become disrupted as arousal moves beyond the boundaries of the window of tolerance...The width of the window of tolerance within a given individual may vary, depending upon the state of mind at a given time, the particular emotional valence, and the social context in which the emotion is being generated. For example, we may be more able to tolerate stressful situations when surrounded by loved ones with whom we feel secure and understood. Within the boundaries of the window, the mind continues to function well. Outside these boundaries, function becomes impaired...under these conditions, the "higher" cognitive functions of abstract thinking and self-reflection are shut down...The mind has entered a suboptimal organizational flow that may reinforce its own maladaptive pattern. This is now a state of emotion dysregulation" (pp. 253-255).

### ***Informed consent***

Another issue is the child's informed consent. Psychotherapy with children involves special considerations. Children generally do not present themselves for therapy; their parent, or caretaker, does. Children cannot fully comprehend and assent to treatment in the way an adult can. Children's reactions range from cooperation to acquiescence to resistance. One important instance that highlights issues regarding coercion is when the child's reactions move toward resistance. A potential danger occurs when parents and/or therapists perceive the child's severely disruptive behaviors as requiring an escalating response to confront and control the behavior without a simultaneous focus on the distorted perceptions and beliefs that may be driving these behaviors. One technique would be to avoid control battles in which the child is given only one option of responding. Choices that are within the adult's accepted limits of safety and appropriateness may help the child feel less controlled and therefore less threatened. Assuredly, many children who come for therapy have high control needs. However, **ATTACH believes that addressing the internal beliefs that drive these needs is the proper stance for an attachment-focused therapist. Engaging in power struggles may be contraindicated.**

The autonomy of the child is an important consideration, but again one that must be considered within the overall context of the child's development and functioning. In the course of healthy development, autonomy is granted as a result of proven competence. For example the 12 year old with years of proven responsibility may be allowed to go to the mall with friends where a 16 year old with an attachment disorder and years of dangerous behaviors and poor choices may not be allowed to go to the mall except with an adult chaperone. Similarly, the parent of a child with only mild social anxiety may deem that the child's negative feelings toward therapy might outweigh any skill training to be learned and decide not to push the child. Yet a parent of a child with a much more disabling attachment disorder might well perceive that any negative feelings engendered in the short run are well worth the long term benefits of improved family functioning and supported developmental functioning. These negative feelings may increase the child's dysregulation. However, the parent and therapist realize this negative



reaction must still be handled sensitively and with constructive assistance to help move the child toward greater regulation within the context of the therapy. This is done by helping the child make meaning of the situation so as to begin to perceive the positive intentions of the adult while receiving active assistance to manage and cope with the feelings engendered. These efforts help the child stay within the “therapeutic window” and maximize the chance for successful resolution of the posttraumatic responses. Similarly, there are times during normal discipline when parents will knowingly increase dysregulation by normal disciplinary practices such as saying no or enforcing limits (for example, enforcing a reasonable bedtime). At these times, children need to be assisted to regain regulation without the parent giving up on the reasonable disciplinary point.

### ***Shame***

The role of shame is also important to take into consideration in this context. Children who have been abused or neglected or have had other adverse childhood experiences have experienced pervasive shame without interactive repair as a normal state of being. They bring this shame into new relationships and tend not to trust when a parent or therapist attempts to provide interactive repair. As a result, parents and therapists have a particular obligation to avoid any intervention that might increase the child’s shame. Moreover, if a child is seen as experiencing shame as the result of an adult’s behavior, the adult should immediately reach out to the child in interactive repair. Similarly, helping the child understand that the adults do not see the child as “bad” even when they discuss the child’s inappropriate behaviors is a primary goal of treatment. Without it the child will not be able to learn to trust and work cooperatively.

### ***Developmental level of functioning***

Another critical issue to consider is the child’s developmental functioning. Trauma tends to distort emotional and social development and the level of functioning may also fluctuate dramatically from one time to another depending on the degree to which traumatic triggers are affecting the child. (van der Kolk, 2005). One generally accepted psychometric instrument for assessing the level of developmental functioning is the Vineland Scales of Adaptive Behavior II (Sparrow, Balla, & Cicchetti, 1984). Proper assessment of social and emotional functioning can help guide selection of developmentally appropriate interventions. Activities that appear regressive given the child’s chronological age may be considered by some to be coercive; however, we believe that when an intervention is developmentally appropriate and provided in a sensitive and attuned way it is not coercive.

For example, a twelve-year-old child whose social and emotional functioning is at the four or five year old level may benefit from regressive activities if they are conducted in a voluntary and well attuned manner. Such activities are not inappropriately regressive but are

Giving a child a choice to play “momma-bird / baby-bird” and feeding the child by hand may be a delightful and relationship enhancing experience for parent and child.

Telling a 13 year old that she cannot go to the mall unsupervised or with peers because of her socially indiscriminate behavior is not coercive because the child lacks the ability to do what age peers do. Indeed she would be at risk in that situation.

*developmentally* appropriate and provide an emotional experience of attunement the child missed in early development.

Continuing this example, if the parent and child are involved in a nurturing activity and the parent is comfortable with offering a sippy cup or bottle and the child willingly accepts it and does not become dysregulated it is not coercive. If the activity comforts the

child, then the activity would not be coercive. On the other hand, if the child has a tantrum like a two year old, and the parent or therapist forces the child to drink from the sippy cup because he is “acting like a two year old” this would be coercive because it would intentionally increase the child’s shame, leading to dysregulation.

It is important that the parent and therapist are acutely sensitive to the child’s experience of such an activity. The power differential in the therapist (or parent)-child relationship makes it critical that the adults ensure that such an activity is truly voluntary on the part of the child. Due to the power differential the child may comply with such a request, and this might be interpreted as voluntary. Such compliance may be internally dysregulating to the child, and the intervention would be counter therapeutic. It may be difficult for the child to freely disagree to engage in the activity. Therefore the therapist and parent must pay careful ongoing attention to the child’s cues both verbal and nonverbal.

### ***Meaning of behavior***

A final consideration in determining whether an intervention is coercive is to focus on the deeper rather than the surface meaning of behavior.. In considering this issue, it is important to consider **intention, effect, and process**; and to focus on the effects of the behavior on the client. If one must force the child to engage in the activity despite the child’s protests, then the action is coercive.

Is asking a child to sit and think for a few minutes coercive and abusive or therapeutic? It is not the action that determines whether this request is coercive or supportive, but it is the **intention, effect, and process**. How the child is asked to sit quietly for a few minutes to contemplate some interaction, exchange, or choice is one factor. Is the action implemented to punish or dominate and is the action intended to enforce compliance for the sake of compliance? These would be factors that make the action coercive and not therapeutic. If the action is implemented to provide the child with a brief time-in or time-out to gather thoughts and the child is capable of self-regulating, then this action is therapeutic. Demanding rigid compliance and turning the interaction into a power struggle which must be “won” by the parent or therapist by having the child sit exactly as instructed turns a potentially therapeutic activity into a coercive power battle for compliance by domination. It is not appropriate to demand that a child sit “your way” as long as the child is sitting quietly. Similarly, forcing engagement on the adult’s terms is counter therapeutic. Of course, at times appropriate limits need to be set and enforced in the course of normal parenting (e.g., brushing teeth, going to bed, table manners) or in any situation where safety concerns exist.

**For any activity to be therapeutic it must be implemented in a developmentally appropriate manner, based on the child’s level of developmental functioning (Perry, 1995). For example, while it may be appropriate to ask a twelve-year-old child to sit and take a break in order to regulate behavior, it would not be appropriate to expect a child who is developmentally functioning as a five year old to sit quietly for twenty minutes.**

### ***Summary***

In summary, ATTACH recognizes that children with attachment disorders present with very challenging behaviors that are defensive reactions to profound fear and shame. It is the position of ATTACH that there is never a basis for the use of the described coercive interventions in parenting or psychotherapy. Instead these children need corrective experiences of attunement, security, and regulation to heal their posttraumatic reactions. ATTACH believes that addressing

the internal beliefs that drive these behaviors is the proper stance for attachment-focused treatment. Engaging in power struggles is, in most situations, contraindicated. The concept of a therapeutic window is vital to understanding effective therapy for victims of childhood maltreatment. The challenge is to activate conditioned emotional reactions (triggers) to access avoided emotional content, but to do so ONLY in a way that does not overwhelm the individual's coping resources and promotes a sense that the adult is an active source of support and assistance. In addition, all interventions should take into account the child's social and emotional level of functioning so that the approach is congruent with the child's developmental needs and provides corrective emotional experiences for reparation of the early experiences of maltreatment, insecurity, mistrust and fear.

ATTACH also recognizes that ongoing research in the fields of trauma, attachment, and neuroscience will and should continue to inform the practices of attachment-focused therapy. Best practice should always be dictated by state of the art knowledge. Given the many challenges of attachment therapy and the relative newness of the field, therapists who practice attachment therapy have a special duty to stay current with developments that affect the evolution of this field.

### **Therefore...**

As a matter of policy and practice, ATTACH does not support and indeed actively discourages the use of coercion in treatment. ATTACH does not condone its members, registered clinicians, registered agencies or presenters using coercive therapies or parenting techniques.

ACCEPTED BY ATTACH BOARD OF DIRECTORS: APRIL 21, 2007

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