

# A Brief Treatise on Coercive Holding

## *Immobilizing, Tickling, Prodding, Poking, and Intimidating Children into Submission*

by Dr. Beverly James

*Of all tyrannies, a \*tyranny exercised for the good of its victims, may be the most oppressive. Those who torment us for our own good will torment us without end, for they do so with the approval of their own conscience. -C.S. Lewis*

Children and caregivers who deal with serious attachment problems are desperate for professional help and are often vulnerable to quick-fix solutions. Fear and desperation can lead parents as well as trained clinicians to try radical techniques that have no place in child therapy. Several approaches have been developed that practitioners claim are the only way to cure attachment disordered children. Their methods include:

- prolonged restraint other than for the protection of the child;
- prolonged noxious stimulation; and
- interference with body functions, such as vision and breathing.

These coercive interventions are variously called holding therapy, attachment therapy, and rage therapy, among other things. Some therapists employ these same names for noncoercive techniques and actually use other methods. It is thus prudent to talk about the actual techniques, and not the name given to the technique. I believe the phrase "coercive techniques" accurately describes the listed procedures.

Prolonged restraint as used by coercive therapists is unrelated to the child's immediate behavior. The intervention is arranged by appointment, usually continues for several hours, and often is repeated daily for weeks. The child is held immobile by one to six adults who may include the parents. The clinician typically places his or her face, bearing a deliberately angry expression, within inches of the child's face. In a harsh, angry voice he or she repeatedly yells at the youngster, stimulating him to a high level of arousal. The youngster fights against the restraint and anger; he screams and cries; and he may experience uncontrollable urination. The child, still being restrained, might be momentarily soothed, rocked, given sips of water, and told he is "doing a good job" before the coercive holding resumes.

Some practitioners also advocate prolonged noxious stimulation while the child is restrained. This includes such actions as poking the child's ribs, continuously tapping the youngster's chest or the bottom of his feet, tickling, pulling toes, or continuously moving the child's head from side to side.

In addition, the child's eyes might be covered and his nose pinched for more control. The practitioner yells at him to breathe through his mouth, then covers his mouth and yells at him to breathe through his nose.

Practitioners of these techniques often claim they are treating "attachment disorders," explaining that the child's repressed rage interferes with formation of an attachment and that prolonged restraint, noxious stimulation, and interference with body functions release the rage and tell the youngster that adults can and will control him. When the child totally surrenders, he is placed in the arms of the parents, and the practitioners claim that the child instantly attaches to the parent, now free of rage.

Children subjected to coercive techniques often have

histories of severe abuse, neglect, multiple out-of-home placements, and adoption. Practitioners of coercive therapy often tell desperate, frustrated, and frightened parents these methods are the only ones that will work to keep their child from becoming a serial murderer or sociopath.

I believe these coercive techniques are **cruel, unethical**, and potentially **dangerous** and must not be used unless and until they are shown to be safe. Heart rate and blood pressure are elevated during arousal. Incidents of cardiac arrest in children undergoing painful and frightening medical procedures are well documented. While it may be impossible to directly attribute the arrests to pain and fright, common sense advises against taking such a risk in the absence of compelling documentation of their safety and effectiveness.

We have already been shown that there are long-lasting, enduring neurological changes in children who experience prolonged stress and psychological trauma (Perry, 1993). It is also not unusual for children to dissociate when faced with inescapable frightening situations (Ferr, 1981). We know that people with a history of abuse and traumatic losses are more sensitized to traumatic experiences and retraumatization when exposed to stimuli or physical coercion that is likely to remind them of the original abusive situation.

Coercive therapy is **terroristic** and **abusive** as well as **dangerous**. Literature confirms that similar techniques are used in **brainwashing**: The subject is degraded, belittled, may be physically abused, is told it is for his benefit, and is thus coerced to consent. Hacker (1976), an acknowledged expert in terrorism, writes, "Coercion, having obscured its brutal origins, is then at its most triumphant when the victims are compelled to experience submission as a voluntary decision. This is **rape of the mind**."

We would not be permitted to use these methods on prisoners of war or convicted felons, but we permit it for our children--children who have no voice.

Coercive techniques are **antithetical** to all we know about helping survivors of trauma. Trauma treatment is intended to empower survivors--not to frighten them, have them give up control, and make them assume a submissive posture. Coercive techniques foster the development of trauma bonds based in terror; they do not facilitate healthy attachment.

We have an ethical obligation to take a strong, well-voiced position against coercive techniques. We are responsible for the well-being of our children. These techniques have no place in our clinical armamentarium for treating wounded children.

-Handbook for Treatment of Attachment-Trauma Problems, 1994

**\*Tyranny:** Absolute power, especially when exercised unjustly or cruelly: Extreme harshness or severity; rigor.