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See Also:
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Attachment Therapy Using Deliberate Restraint: An Object Lesson on the Identification of Unvalidated Treatments.

Jean Mercer. ***Journal of Child and Adolescent Psychiatric Nursing.*** **July-Sept 2001 v14 i3 p105.**

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TOPIC. An unusual and potentially dangerous intervention called attachment therapy, used for children and adolescence.

PURPOSE. To help clinicians understand the nature of attachment therapy and the ways in which it exemplifies unvalidated treatment approaches.

SOURCES. Internet and published articles on evaluation of treatments.

CONCLUSIONS. Attachment therapy has many characteristics associated with warning signals of an unvalidated treatment. Mental health professionals have responsibilities to educate individuals and the community about unvalidated treatments such as attachment therapy and to work toward legislation and policy change to make such treatments unavailable.

Search terms: Attachment disorders, restraint, unvalidated treatments

Outside the psychiatric hospital, seclusion and restraint (S/R) are used with the frank intention of changing the behavior of children or prisoners. When psychiatric hospitals claim to use S/R only for the safety of patients and staff, they seem to be out of step with the assumptions of the rest of the culture about the effect of these practices. Most of us would be surprised, however, at a claim that restraint has a therapeutic effect on psychiatric patients.

It is equally surprising, but nevertheless true, that a treatment for emotionally disturbed children deliberately uses restraint and psychological seclusion, and claims to achieve important therapeutic benefits as a result (and, curiously enough, points to the use of "safe restraint" as an argument for its practices) (Hage, 1997). This treatment involves several techniques that can be grouped under the rubric attachment therapy (AT).

Attachment therapists speak of themselves as using an "unconventional" or "controversial" or "alternative" treatment. They class their approach with a variety of other treatments supported enthusiastically by their adherents, but without respectable empirical credentials. Sadly, AT has been associated with more than one death, and its practitioners have not presented acceptable evidence of therapeutic success.

For the purposes of this paper, I refer to AT and similarly unconventional, unsupported approaches as unvalidated treatments (UTs), and take the position that these treatments should not be used until their validity is established.

What Is Attachment Therapy?

AT involves three basic techniques, which vary in their use of S/R. Rebirthing involves the highest level of restraint, is the least often used, and is most often repudiated by attachment therapists. Rebirthing was apparently the cause of a child's death in April, 2000 (Crosson, 2000). Holding therapy involves less serious restraint, is much more frequently used, and appears to have been associated with deaths only when used by parents of children being treated by attachment therapists (Horn, 1997; Smith, 1996). Therapeutic parenting does not appear to involve much direct restraint, but is coercive in nature and employs both physical and psychological (e.g., ignoring, refusal to make eye contact) seclusion of the child (Thomas, 2000).

Rebirthing

People who employ the term rebirthing most often are referring to an apparently harmless "New Age" practice related to Yogic breath control techniques. While there may be some physical contact between teacher and student in this practice, there is no restraint, nor are children treated in this way (Therapist says rebirthing procedure is valuable tool, 2000).

Attachment therapists, on the other hand, use rebirthing to refer to a procedure in which the child is wrapped tightly in blankets, covered with pillows, and held by several adults who push on the pillows in imitation of uterine contractions (Crowder, 2000a). The child is to work to escape from the restraint and to be "reborn." Parents may be present in the room or may watch on a video monitor. The claim is that, when successful, the process deletes negative emotions left over from the past and creates a readiness to enter positive relationships. In the April 2000 death, the child vomited and was asphyxiated (Crowder, 2000b). She had told the therapists seven times that she could not breathe (Robinson, 2000). Although attachment therapists other than those on trial have stated they did not know what rebirthing was or have any awareness of what the principal therapist involved was doing (Attachment Center at Evergreen, 2000), there is a good deal of evidence that the latter had been working closely for years with those who repudiated her (Crowder, 2000b).

Holding Therapy

Holding therapy involves restraint that is sufficient to frighten and enrage the child (DeAngelis, 1997; James, 1994). It is intended to stimulate the release of old anger and to ready the child for the formation of good relationships. It usually is done in the presence of the parents. While holding therapy initially stressed the idea of "rage reduction" to free the child to have good relationships, more recent writings by attachment therapists (Levy & Orlans, 2000a) have modulated this view and attempted to present holding in more positive terms, often relating the goals to concepts connected to Bowlby's (1977) attachment theory. For example, the treatment is said to "re-create the elements of secure attachment which were unavailable in the child's early developmental stages" (Levy & Orlans, 2000b, p. 16).

Attachment therapists claim to use holding to reproduce a series of events they call "the bonding cycle," which is said to be based on an infant's experience of frustration and distress and high arousal, followed by a posited unusual receptiveness to parental comforting. "Presenting a valuable opportunity for attaching between parent and child, these acts allow the child to begin to trust that her parents can and will care for her and protect her. The cycle is repeated thousands of times in the first two years of an infant's life, forming the foundation of every other developmental task of human life" (Keck & Kupecky, 1995, p. 2). Some people claim that holding therapy with older children and adolescents imitates these events and causes attachment to parents.

Holding therapy appears to vary from one practitioner to the next. One Web site describes the use of "high energy, intense focus, close proximity, and holding. Frequent touch, confrontation, and almost constant eye contact are used to mimic cues in the normal bonding cycle" (Adoptive Family Treatment Center, 2000).

Descriptions of other techniques include having the child do a scissors kick while lying in the therapist's lap (Levy & Orlans, 1998) and having the child lie across the laps of two adults, with the right arm behind the back of one adult and the left arm restrained if the child fidgets or tries to hit (Keck, quoted by Helding & Cline, 2000).

Practitioners of holding therapy differ in their concern with the child's consent to treatment. Some believe the child's agreement is essential before holding is done; others contend that the presence of emotional disturbance means the child cannot make a reasoned judgment and give consent (Helding & Cline, 2000). Some attachment therapists have compared their treatment to chemotherapy and claimed that it would be morally wrong to withhold it from a disturbed child (Hage, 1997).

Therapeutic Parenting

Therapeutic parenting techniques may be used either by parents in the child's own home or by specially trained foster parents who care for children while they are receiving other forms of AT. One practitioner has said that "[a]ttachment therapy is required to dissipate enough of the internalized rage to make room for love to enter" (Thomas, 2000, p. 81).

A recent account of therapeutic parenting (Thomas, 2000) is quite remarkable in its detailed picture of coercion of the disturbed child or adolescent through the use of deprivation and physical or psychological seclusion; however, physical restraint is never mentioned, nor is it clear how the child is forced or persuaded to carry out some of the required actions. Stress is placed on Bowlby's statement that attachment occurs to a person "who is usually conceived as wiser" than the child (Bowlby, 1977, p. 203). Parents are thought to achieve the position of "stronger and/or wiser" person by commanding and demanding respect and by using eye contact to assure the child of their presence, love, and attentiveness (Thomas, p. 85). Respectful speech is greatly emphasized, and children are required to say "Yes, Mom!" or "Yes, Dad!" using the parent's "title of honor" and confirming his or her authority.

One assumption mentioned by Thomas (2000) is that the children she works with occasionally "have a depletion of oxygen to their brain and that this causes them to stare at parents and answer or say `What?' or `I don't know' instead of answering respectfully" (p. 87). Parents are instructed to respond to this by requiring the child to do two jumping-jacks or push-ups per year of his or her age, in order to increase the flow of oxygen.

Therapeutic parenting is intended to teach the child self-control, and this is thought to be done by means of "power sitting." "Parents select a `think spot' according to visibility, convenience, safety, distractions, and destructibility.... A spot on the floor with a small washable, rubber-backed rug for children over 4 is best. Correct body position is with legs folded, hands folded, back straight, head straight, and nothing moving especially the mouth. Having them face a blank wall is safer than ... a wall covered with wallpaper, which is easily destroyed. Begin with 5 consecutive minutes of power sitting. Build up to 1 minute per year of life" (Thomas, 2000, pp. 72-73). The child is to be given positive attention only when doing this properly and no privileges are to be allowed until the sitting is completed; this is to be done three times a day. The child is given the choice between the prescribed period of power sitting or 2 hours of "wimpy sitting," for lack of compliance with the power sitting rules (Thomas, p. 73).

Other forms of parental control are seen as necessary for the child's establishment of self-control. If a child resists or disparages a meal, the food is to be thrown out or given to the dog, and no more food is to be available until the next meal. Children may not be allowed to speak until spoken to in the car. If they speak, they must be required to hold their hand over their mouths for 5 to 15 minutes. A child who hits other children in the car is required to hold both hands on top of her head for 10 to 15 minutes. Practice sessions at home may be done in a chair, for twice the time originally asked, while "parents wait calmly by enjoying the time reading a good book or playing with other children" (Thomas, 2000, p. 76). Seclusion in the child's room is another important tool, and older children are always to retire to their rooms at 8 P.M.

In addition to their assertion of power, therapeutic parents are expected to use nurturing tools such as touch, smiling eye contact, hugs, snuggling when the parent chooses to give them (whether the child asks for them or tries to reject them), and sweet foods.

Maintaining such a therapeutic parenting environment is obviously very hard work. Parents need a relief care provider who is to maintain the usual structure and "must do no bonding activities with the child such as eye contact, touch, and smiles, and sharing sugared foods" (Thomas, 2000, p. 75).

Who Are the Children in Attachment Therapy?

AT is intended as a treatment for children who have a history of severe attachment disorders, resulting from experiences such as adoption (with a stress on later adoptions), abuse, neglect, and multiple changes of caregiver. Experiences with neonatal intensive care also have been suggested as a cause of attachment disorders (Levy & Orlans, 2000b; Thomas, 2000).

The great stress of AT is on violent behavior stemming from poor early attachment experiences. School shootings by adolescents are attributed to attachment problems, for example. The children are said to attack their parents and to attack or kill pets and younger children, as well as set fires.

Adopted children also are brought to AT when they seem aloof, unreachable, and unable or unwilling to love their adoptive parents, but are charming "con artists" who get what they want without real emotional involvement. Drug use, lying, stealing, and other aspects of conduct disorders are considered symptomatic of attachment problems. Recently, symptoms of ADHD have been discussed as a type of attachment disorder, to be treated through AT (Ladnier & Massanari, 2000).

A type of holding therapy has been used with autistic children (Sainsbury, 2000), but attachment therapists do not generally consider autism within their brief. Curiously, attachment therapists rarely mention a concern with children who show indiscriminate friendliness, which other clinicians often consider as a problem resulting from attachment disorders (Boris, Aoki, & Zeanah, 1999).

Generally, children brought into AT are older preschoolers, school-age children, and adolescents. One adherent of this approach suggests that parents of normal infants carry out a type of holding therapy, deliberately restraining the baby until he or she is angry in order to facilitate attachment (Welch, 1989).

There seems to be no way of ascertaining how many children have received any of these types of treatment. A paper by one AT clinic reported data collected on 29 7- to 12-year-old children during a 2-year period (Myeroff, Mertlich, & Gross, 1999), and some sources speak of hundreds of children treated (Kreck, 2000).

Who Are the Attachment Therapists?

Some attachment therapists are psychiatrists, some doctoral-level psychologists, some social workers, and some are without any academic background. Training in AT is carried on outside recognized academic institutions, by groups such as the Attachment Center at Evergreen, CO. Some organizations offer scholarships to support training in AT (see www.healtheheart.org).

AT has received public support through state funds and contracts. New Hampshire has appropriated money to pay for training in AT (New Hampshire Executive Council Minutes, 1999), and Iowa has a bill before the state legislature proposing appropriations to pay for a pilot program to train attachment therapists (Iowa State Legislature House File 623, 2000). One clinical psychologist in Colorado, following the child's death in 2000, was quoted as saying "Clear Creek County's Department of Social Services hires me all the time to do attachment work on their severely attachment-disordered kids. They have a social worker in the room to hold the kid with me" (Kreck, 2000).

National and state organizations connected with adoption have been supportive of AT. The Association for Treatment and Training in the Attachment of Children (ATTACh), has Web links to the Attachment Center at Evergreen, as do several state adoption organizations. Groups supporting adoption of children from Eastern European and Chinese orphanages are strongly supportive of AT (see http://members.aol.com/RADchina).

Attachment Therapy and Other Unvalidated Treatments: Commonalities

Why do I classify AT with other UTs, labeling it an unacceptable treatment for the serious disorders it claims to help? The fact that deaths have been associated with it is the first and most obvious reason. Although death due to accident or existing medical problems could occur during psychotherapy there is no generally acceptable level of deaths caused by psychotherapy. (Some proponents of attachment therapy have actually argued that a few deaths are acceptable when so many emotional lives are salvaged [see Kreck, 2000], but there is no evidence that any salvaging occurs.)

The Daubert Decision as a Guide

A useful guide to acceptance or rejection of a treatment can be derived from a judicial decision in the case of Daubert v. Merrell Dow Pharmaceuticals, Inc. in 1993. This decision established new guidelines for the admissibility of scientific evidence in the courtroom and can be helpful when considering evidence outside the courtroom.

The Daubert decision held that scientific evidence can be admitted into court if it passes examination on four factors (Kesan, 1996):

1. The ideas involved must be falsifiable; it must be possible to test predictions about them and conclude that the predictions were not correct.

2. Material related to the evidence must have been subjected to peer review.

3. There must be standards related to the ideas or techniques involved, and the real or potential rate of error must be taken into account.

4. The disciplinary community must generally accept the ideas behind the evidence.

Red Flags

We do not have to wait for deaths to decide that a treatment has not been validated. We can check the evidence about a treatment against a number of red flags. Nickel (1996) noted many of these listed in a thoughtful article about therapy for developmental disabilities, as well as those suggested by the Daubert decision. These warning signals have been associated with craniosacral therapy, patterning, and facilitated communication, among others, and they are to be found in association with AT.

UT red flag: Harmful side effects. Death or injury to a patient are obvious harmful side effects, and both have been documented with respect to AT (Bowers, 2000). Less obvious harmful side effects to families result from expenditure of family time and money, which are diverted from more positive and constructive family goals. AT often is done in a 2-week intensive session at a treatment center. This involves travel expenses, and a fee of about $7,000 (Crowder, 2000b). Health insurance does not reimburse costs for this treatment.

The practice of therapeutic parenting techniques by a child's parents involves a reorganization of family life and the complete devotion of one parent to maintaining the social structure, much as was seen among parents who used the patterning technique for brain-damaged children.

UT red flag: Broad claims of effectiveness. UTs tend to claim they help or cure a variety of different problems. Although attachment therapists initially focused their claims on children who had had unstable early lives and showed aggressive behavior, they have broadened their approach to include children with NICU experience in their background and those who show ADHD symptoms. Even children of divorced parents are said to need AT (Rhodes, 1997).

UT red flag: Sources of information. Information about UTs is not usually found in peer-reviewed journals or books published for professionals. Popular books, magazines, self-published documents, and the Internet

are the usual sources of material. Most of the available information about AT is on the Internet, and much of that is derived from newsletters of interested clinics and support groups or from personal Web sites. It should be noted that two books written or edited by attachment therapists have recently appeared, one published by Academic Press (Levy, 2000) and the other by the Child Welfare League of America (Levy & Orlans, 1998). On-line programs for the American Psychological Association (APA) conferences of 1997 and 1999 also list workshops to be given by Levy.

UT red flag: Association with other UTs. Although it seems unfair to find either a person or a therapy guilty because of association with guilty people or inappropriate therapies, associations do tell us something. When proponents of a treatment recommend other treatments that do not deserve support, we are led to wonder whether the proponents are evaluating their own therapy any more effectively than they are judging others. Some attachment therapists suggest the use of a variety of fringe approaches as adjuncts to their own treatments, for example, eye movement desensitization and reprocessing (EMDR), thought-field therapy, and brain gym or educational kinesiology (Ladnier & Massanari, 2000).

UT red flag: Cultlike defensiveness. Modern scientific research depends on public discourse about data and the possibility of correcting mistaken conclusions by gradual incorporation of new information. The writings of attachment therapists suggest, instead, a tendency to circle the wagons in response to outside criticism. A frequent statement is that outsiders do not know what is needed in therapy with severely disturbed children because they have never lived or worked with them. Another theme is the need for legal guidelines to be changed to protect attachment therapists, because treated children have begun to bring lawsuits when they are older (Helding, 1999).

UT red flag: Absence of empirical support. The absence of empirical support for a treatment is obviously a warning signal, suggesting that the treatment should not be considered valid. However, the reality of interpreting the red flag is not as simple as this statement or the Daubert decision might make it appear. Clinical outcome studies are notoriously difficult to carry out and interpret, and modern rethinking of research approaches provides an additional confusion to those seeking empirical evidence.

The gold standard of empirical support for a treatment involves an experimental design, with random assignment of subjects to a treatment group and one or more comparison groups, sometimes including a sham-treatment or placebo group. An APA Task Force has suggested that empirical support for a mental health intervention requires that a treatment be shown to have a statistically significant effect in a randomized trial with a control group and reliable and valid outcome measures, and that the effect be replicated in at least two independent studies (Chambless & Hollon, 1998).

Real problems make it difficult to achieve such a design to test psychotherapy, however, especially with respect to treatment of children. There often is resistance on ethical grounds to the withholding of treatment from children. A sham-treatment group may be difficult to establish, since parents are likely to have some idea of what their children are experiencing, look up related material, and even manage to talk to parents of other children in the study. (This would be a particular problem for studies of AT, because the families are likely to have traveled some distance and to be aware of the other strangers in town. In addition, the parents participate rather directly in the treatment and would know exactly which group their children were in.) Parents whose children are not in the treatment group may respond by withdrawing their child or by trying to carry out the treatment themselves, so their children will not be at a disadvantage.

One additional hurdle for an experimental design of psychotherapy for children is the requirement for institutional review board approval in publicly supported institutions, certifying that the study complies with human subjects guidelines. (It is doubtful that any IRB would give approval to a study of holding therapy, especially now that some of the possible outcomes are known; a hypothesis that has the characteristic of falsifiability in the abstract may thus lack it in practical reality.)

Randomized experimental studies carry a high degree of credibility and are considered to allow a logical interpretation of cause and effect relationships; they also give us the lowest probability of random error However, there is increasing interest in the use of qualitative studies as well as in case studies and N = 1 studies, especially for purposes of program evaluation (Murray, 1992). Qualitative, nonrandomized studies can be the only practical methods of investigating treatments, but they do not allow us to make cause-and-effect interpretations or even decide which of many factors are involved in causing change. These studies

allow many sources of random error to intrude. In studies involving children and adolescents, an important source of error is the natural course of developmental change that proceeds over time whether therapy occurs or not, so that "before" and "after" measures are likely to be different even if the treatment is completely ineffective.

The kinds of mistakes we could make as the result of a study may determine whether we demand evidence at the level of the randomized experimental study or whether it is acceptable to use more qualitative or nonrandomized approaches. When an incorrect conclusion from research leads to minor errors of treatment that can easily be corrected, we may settle for a less stringent demonstration; when an incorrect conclusion could cause decisions that produce harmful side effects without beneficial main effects, we had better require the strictest standards. The evidence of harmful side effects from AT places that treatment in the second category, while many conventional treatments are in the less demanding first category.

Only two reports of outcome studies of AT appear to be available, and neither is a randomized experimental study. One is a simple before-and-after study of symptoms of 12 children brought for AT to the Attachment and Bonding Center of Ohio (Lester, 1997). The author does not report results of statistical tests, gives a general conclusion supporting the effectiveness of the treatment, and notes that some of the changes may have to do simply with contact with supportive people.

A second, more extensive study (Myeroff et al., 1999) reported significant positive changes over the course of a year in 25 children receiving holding therapy, relative to a comparison group. Unfortunately, the comparison group was comprised of children whose parents had applied for them to enter holding therapy but whose families for various reasons were not able to arrange to come for treatment. Differences between the groups of children might thus have been brought about by differences in marital functioning, finances, the needs of other children, and similar factors that could affect both the children's symptoms and the chances of entering treatment.

UT red flag: Relationship to accepted theories. When a treatment is clearly based on generally accepted theory, we have some assurance that it belongs to the universe of discourse shared by the relevant professions. When it is not based on such theory, and especially if its theoretical basis is unusual, we need to be alert to this warning.

Writings on AT commonly relate the treatment to the attachment theory of John Bowlby (1977). Although attachment therapists use many of Bowlby's terms, such as "secure base" and "disorganized attachment," a careful reading of the materials shows little relationship between the two sets of ideas. Bowlby's theory has a moderate, human-oriented ethological basis that stresses the connection between specific attachment processes and particular chronological periods in individual development. Attachment processes continue to be fine-tuned throughout life, but the related events are very different at different developmental stages. (For example, attachment processes during the later toddler period focus on negotiation of separation, rather than the secure base issues of infancy.) Drive reduction plays little or no role in Bowlby's thinking, and its absence is an important marker of the differences between Bowlby's and Freud's attachment concepts.

AT, on the contrary, is based on two different but related sets of assumptions. Writings on therapeutic parenting and some aspects of holding appear to assume that drive reduction is the reason for attachment (see the description of the "bonding cycle" above) and that attachment can thus be brought about at any time during development. Discussions of AT do not include considerations of the need for developmentally appropriate practice that Bowlby implies. A second source of ideas for AT is a school of thought known primarily in Germany and based on some of the later writings of the ethologist Tinbergen (Tinbergen & Tinbergen, 1983), who wrote a preface for one of the most influential books on the holding practice (Welch, 1989).

Further examination of the drives that attachment therapists assume to be reduced reveals some other ideas from which the treatment is actually derived, and shows it to be grounded in a quite different universe of discourse than the one shared by the helping professions. AT is based on the assumption that there are at least two processes involved in the development of early emotional relationships. One, referred to as "bonding" (a term that is presently little used by U.S. psychologists and used with this meaning primarily by a group of German therapists with connections to Janov's primal-scream approach [see Dreschler, 2000]),

involves both a genetic connection based on shared ancestry, occurring prior to birth, and "an intensely emotional shared experience during pregnancy and birth between mother and infant" (Levy & Orlans, 2000a, p. 244). This belief in bonding is the source of the assumption that all adopted children are suffering from grief and rage at the loss of this primary connection, no matter how early the separation and adoption took place--a view completely at odds with Bowlby's observations on the most sensitive period for reactions to loss.

Bibliographies given by attachment therapists often cite two relevant works. The Secret Life of the Unborn Child (Verny & Kelly, 1981), claims that the fetus has conscious awareness of the mother's attitudes toward the pregnancy, with negative maternal reactions a source of later rage and grief. The Primal Wound (Verrier, 1993) asserts that all adopted children mourn the loss of the birth mother (again, without reference to the child's age at separation). Needless to say, these ideas are completely at variance with available information about infants' cognitive abilities and emotional reactions at various points in early life.

UT red flag: Comparison to accepted therapeutic practices. Members of the helping professions share ideas about general guidelines for therapy, even when they prefer different specific techniques. When a treatment does not adhere to similar guidelines, we may take this as a warning about its status.

AT has two unusual characteristics in addition to the questions of safety and effectiveness. First, the available written material fails to note the need for developmentally appropriate practice and fine-tuning of techniques to suit the cognitive and emotional characteristics associated with a child's developmental age. There is also a lack of concern with other individual differences, such as the previous history of physical or sexual abuse. Most therapists are very concerned about the impact of touch or restraint on abused children, but some attachment therapists consider the point irrelevant (Hage, 1997). Attachment therapists also group children adopted from foreign institutions and others, whereas many therapists consider postinstitutionalized children to have special needs with respect to education and physical health in addition to emotional issues (Johnson & Dole, 1999).

Second, attachment therapists do not share the concern of the helping professions with the ethicality of physical contact during therapy. Early interventionists and infant-mental health specialists use physical contact, but psychotherapists generally consider it unsuitable and possibly ethically objectionable after about 7 years of age (Gerard Costa, personal communication, July 20, 2000). The Code of Ethics of the National Association of Social Workers (NASW) states the need to set clear boundaries governing physical contact with clients, but it should be noted that in an exchange of letters between the founder of an AT program and a NASW official, the latter apparently did not say she found physical contact in AT to be unacceptable (Combs, 1999).

Of all the aspects of AT, therapeutic parenting seems to come closest to an accepted practice; in many ways it appears to resemble applied behavior analysis. However, the stress on the power and authority of the therapeutic parent makes many of the possible reinforcers noncontingent on the child's behavior. Written material on this practice also fails to clarify how behaviors such as power sitting are actually induced.

Professional Responsibilities

How should professionals use their understanding of UT red flags? Using the warning signals noted above allows us to recognize UTs. They are associated with many red flags (although we should note there may be one or two linked with commonly accepted treatments, as well; strong empirical evidence is often difficult to come by). We have a real responsibility not to recommend treatments that fall in the UT category.

Discussion with patients and families. When patients or their families express an interest in a UT, we may have the difficult task of advising them realistically while keeping their confidence. Some suggestions about managing this problem have been offered by Nickel (1996). He stressed the need to be knowledgeable about UTs and to understand the sources of a family's information (including the opinions of relatives). Nickel emphasized families' need for active involvement in treatment decisions and access to appropriate services. He suggested UTs be discussed as part of the initial management plan and whenever the family asks about them. Plenty of time should be allowed for this discussion, which should include reference to the

importance of controlled research and the nature of placebo effects. Families can be alerted to warning signals about UTs, such as claims that every child will benefit or that many problems can be treated in the same way. Finally, Nickel suggested professionals should support a trial of the UT if that is what the family really wants, but should help the family to establish clear treatment objectives and to compare pre- and posttreatment symptoms.

Educate the community. We have a responsibility to educate the community on UTs rather than allowing the public to depend on the mass media for information. Television and print materials all too often imply there are professional controversies about UTs, when in fact a professional group is quite prepared to condemn them and only their practitioners support them. We also have the responsibility of monitoring our own professions and working with professional organizations to regulate the use of UTs. This may require the development of recommendations for legislation and work with state legislators to emphasize the need for control of UTs. All this is additional hard work for overworked professionals, but our alternative may be to see UTs do no good and much possible harm.

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References

Adoptive Family Treatment Center, Kansas City, MO. (2000). Corrective attachment therapy [On-line]. www.crn.org (Retrieved July 12, 2000)

Attachment Center at Evergreen. (2000). Press release [On-line]. www.attachmentcenter.org (Retrieved July 10, 2000)

Boris, N., Aoki, Y., & Zeanah, C. (1999). The development of infant-parent attachment: Considerations for assessment. Infants and Young Children, 11(4), 1 - 10.

Bowers, K. (2000). Attachment therapy deaths beyond Evergreen [On-line], http://golden.net/~tpolevoy/Quackerywatch/Attachment-therapy/(Retrieved March 10, 2001)

Bowlby, J. (1977). The making and breaking of affectional bonds: I. Aetiology and psychopathology in the light of attachment theory. British Journal of Psychiatry, 130, 201-210.

Chambless, D., & Hollon, S. (1998). Defining empirically supported therapies. Journal of Consulting and Clinical Psychology, 66, 7-18.

Combs, D. (1999). NASW code of ethics: Implications for holding therapy. Connections, Newsletter of the Association for Treatment and Training in the Attachment of Children [On-line]. www. attach.org (Retrieved July 10, 2000)

Crosson, J. (2000, May 22). "Rebirthing" halted after a death. Philadelphia Inquirer, A5.

Crowder, C. (2000a, May 21). Evergreen chock-full of therapists. Denver Rocky Mountain News [On-line]. www.insidedenver.com/ news/0521girl4.shtml (Retrieved July 28, 2000)

Crowder, C. (2000b, July 29). Prosecutors add charges for rebirthing therapist. Denver Rocky Mountain News [On-line]. www. insidedenver.com/news/0729char0.shtml (Retrieved July 29, 2000)

DeAngelis, T. (1997). When children don't bond with parents. APA Monitor [On-line]. www.apa.org/monitor/jun/97/disorder.html (Retrieved July 16, 2000)

Dreschler, S. (2000). Festhaltetherapie [On-line]. www.bnvbamberg. de/home/ba4183/refsab.htm (Retrieved October 25, 2000)

Hage, D. (1997). Holding therapy: Harmful? ... or rather beneficial! Roots and Wings Adoption Magazine, 9 (1), 46-49 [On-line]. www.debrahage.com/pwp (Retrieved June 15, 2000)

Helding, C. (1999). Will they sue you? Today's kids ARE different [On-line]. www.cathyhelding.com/different.htm (Retrieved August 19, 2000)

Helding, C., & Cline, F. (2000). Choosing to use confrontive therapies with attachment disordered children [On-line]. http://cathyhelding. com/(Retrieved July 11, 2000)

Horn, M. (1997). A dead child, a troubling defense. U.S. News Online. www.usnews.com/usnews/issue/970714/14atta.htm (Retrieved July 21, 2000)

Iowa State Legislature House File 623 (2000). [On-line]. www.legis. state.ia.us/61/78ga (Retrieved July 23, 2000)

James, B. (1994). Handbook for treatment of attachment-trauma problems in children. New York: Lexington.

Johnson, D., & Dole, K. (1999). International adoptions: Implications for early intervention. Infants and Young Children, 11(4), 34-45.

Keck, G., & Kupecky, R. (1995). Adopting the hurt child: Hope for families with special-needs kids. Colorado Springs, CO: Pinon Press.

Kesan, J. (1996). Note: An autopsy of scientific evidence in a post-Daubert world. Georgetown Law Journal, 84, 1985-2041.

Kreck, C. (2000, June 4). "Rebirth" death spurs warning [On-line]. Denver Post. www.denverpost.com/new/news0604a.htm (Retrieved August 17, 2000)

Ladnier, R., & Massanari, A. (2000). Treating ADHD as attachment deficit hyperactivity disorder. In T. Levy (Ed.), Handbook of attachment interventions (pp. 27-66). San Diego: Academic.

Lester, V. (1997). Behavior change as reported by caregivers of children receiving holding therapy [On-line]. www.attach.org/lester.htm (Retrieved August 4, 2000)

Levy, T. (Ed.) (2000). Handbook of attachment interventions. San Diego: Academic.

Levy, T., & Orlans, M. (1998). Attachment, trauma, and healing. Washington, DC: Child Welfare League of America.

Levy, T., & Orlans, M. (2000a). Attachment disorder and the adoptive family. In T. Levy (Ed.), Handbook of attachment interventions (pp. 244-260). San Diego: Academic.

Levy, T., & Orlans, M. (2000b). Attachment disorder as an antecedent to violence and antisocial patterns in children. In T. Levy (Ed.), Handbook of attachment interventions (pp. 1 - 16). San Diego: Academic.

Murray, A. (1992). Early intervention program evaluation: Numbers or narratives? Infants and Young Children, 4(4), 77-88.

Myeroff, R., Mertlich, G., & Gross, G. (1999). Comparative effectiveness of holding therapy with aggressive children. Child Psychiatry and Human Development, 29(4), 303-313.

New Hampshire Executive Council Minutes, Item #85A [on-line]. (1999). www.state.nh.us/council/min092899.html (Retrieved August 19, 2000)

Nickel, R. (1996). Controversial therapies for young children with developmental disabilities. Infants and Young Children, 8(4), 29-40.

Rhodes, J. (1997). Attachment disorder: Why divorce and adoption can mean trouble [On-line]. www.lrhodes.com/attachment.html (Retrieved August 19, 2000)

Robinson, M. (2000, May 19). 3 jailed in child's therapy death. Denver Post [On-line]. www.denverpost.com/news/news0519c.htm (Retrieved July 28, 2000)

Sainsbury, C. (2000). Holding therapy: An autistic perspective [On-line]. www.oneworld.org/autism_uk/archive/hold.html (Retrieved August 19, 2000)

Smith, L. (1996, July 12). Full of woe. Los Angeles Times, E1.

Therapist says rebirthing procedure is valuable tool in right hands (2000, May 24). WRAL Online. www.wraltv.com/news/wral/2000/ 0524-rebirthing-conflict/(Retrieved August 19, 2000)

Thomas, N. (2000). Parenting children with attachment disorders. In T. Levy (Ed.), Handbook of attachment interventions (pp. 67-111). San Diego: Academic.

Tinbergen, N., & Tinbergen, E. (1983). "Autistic" children: Hope for a cure. London: Allen & Unwin.

Verny, T., & Kelly, J. (1981). The secret life of the unborn child. New York: Dell.

Verrier, N. (1993). The primal wound. Baltimore, MD: Gateway Press.

Welch, M. (1989). Holding time. New York: Fireside.

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