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TO:
UTAH STATE SENATORS

FROM:
Robert Kinscherff, Ph.D., Esq.
Clinical Instructor, Harvard Medical School
Lecturer in Law, Boston University Law School
Director, Forensic Psychology Track, Massachusetts School of Professional Psychology

RE: The dangers of "holding therapy"

I currently serve as the Director of Juvenile Court Clinic Services for the Juvenile Court Department of the Massachusetts Trial Court. In this capacity, I oversee a statewide system of specialized Juvenile Court Clinics that conduct approximately 3900 court-ordered evaluation annually in cases involving child abuse and neglect, delinquency and status offenses. I also hold faculty appointments through Harvard Medical School, Boston University School of Law, and serve as the Director of the Forensic Psychology Specialization Track of the Massachusetts School of Professional Psychology. I am a past two-term Chair of the Ethics Commitee of the American Psychological Association, and currently am a member of it's Committee on Legal Issues (COLI) chairing the joint Working Group of the American Psychological Association and the American Bar Association.

I concur with the view held by a variety of responsible professional associations and researchers that there is no credible scientific support for coercive restraint as a therapeutic (as opposed to emergency containment) modality, nor its incorporation in putatively psychotherapeutic interventions known variously as "holding therapy," "rebirthing," "rage reduction" or "disturbed attachment" therapies. With colleagues, I have conducted and published research regarding traumatized children presenting with Posttraumatic Stress Disorder. I have also served as an editorial reviewer for papers on interventions and treatments for abused children for a journal published by a professional organization focusing upon such children (APSAC). As a clinician serving the Courts, I have routinely seen children with histories of severe trauma and indications of significantly disturbed attachment. Both theoretically and clinically, I am deeply concerned about putatively therapeutic modalities that systematically inflict upon already traumatized children experiences that even proponents acknowledge are certainly stressful and potentially traumatizing.

Given the extraordinary vulnerabilities of already traumatized and attachment-disturbed children, I am especially concerned should coercive restraint methods with children be utilized by adherents without careful attention to the legal duty of informed consent (including full disclosure of potential risks and alternatives), and meticulous data-gathering regarding the methods used. I have reviewed cases where the use of coercive

restraint techniques in the guise of psychotherapy appear to have either been utterly useless, or worse, significantly contributed to the deterioration of the function of already traumatized children, some of whom are now in institutional settings where I consult on their care.

Sadly, the history of psychotherapeutic treatment is replete with examples of efforts to help that were ineffectual. For example, it is not that long ago that schizophrenic patients were wrapped in sheets and placed in warm water for prolonged baths. More unfortunately, the history of psychotherapeutic treatment includes efforts by zealous adherents who harmed patients. For example, the inappropriate use of prefrontal lobotomy for psychiatric patients rendered many of them lethargic, unresponsive and incapable. The more intractable the difficulty (such as in the era of treating psychotic disorders before antipsychotic medications), the greater is the temptation to use methods that bear serious risks to patients. When the problem involves children (such as severely traumatized children and/or those with severe disturbances of attachment) the greater the putatively benign impulse of those who want to help (without a scientific basis for the help that will be provided) and the greater the desperation of the adults who care for these children (and thus the willingness to agree to experimental and potentially harmful interventions).