

To whom it may concern:

I am writing at the request of the Board of Directors of the New Jersey Association for Infant Mental Health, to express our organization's opposition to coercive restraint practices in psychotherapy and our support for Utah House Bill 5.

The New Jersey Association for Infant Mental Health (NJAIMH) is an affiliate of an international body, the World Association for Infant Mental Health, as are similar organizations in a number of states. One of the major objectives of NJAIMH is the promotion of awareness of public policy and its effect on the mental health of children from birth to three years of age; we are also interested in mental health issues that begin in early life but are apparent in later childhood. Members of NJAIMH are professionals from a variety of disciplines, including developmental psychology, clinical psychology, psychiatry, nursing, pediatric medicine, and social work. More information about NJAIMH can be found at our web site, [www.njaimh.org](http://www.njaimh.org).

NJAIMH has felt serious concern about the practice of coercive restraint therapies such as "holding therapy" and has actively opposed them for several years. In April, 2002, we sponsored a major conference in which Dr. Charles Zeanah of Tulane stated his opposition to the use of such treatments. In November, 2002, our annual meeting featured videotapes of restraint practices which so distressed the audience, a group of experienced therapists and caseworkers, that they asked the speaker to end the video portion of the presentation.

NJAIMH supports HB 5 and the prohibition of coercive restraint practices for several reasons, including research evidence, the lack of congruence of the philosophy behind "holding" with established facts about child development, and the documented occurrence of injuries and deaths in association with coercive restraint and related practices.

*Research evidence.* The claims of coercive restraint therapists that evidence supports the efficacy of their treatment are mistaken, and appear to be based on a poor understanding of the concept of evidence-based treatment. The one study repeatedly presented as evidence by this group fails on a number of grounds, discussed by this writer in professional publications, to meet the standards required for a claim that a treatment has caused a change in a mental health condition.

There is no question that this type of outcome research is difficult to do properly; however, proponents of holding therapy have failed to show the public so much as a simple case study that meets modern research standards. Instead, they have asserted over all objections that their study is clear evidence.

Although the issue is too complex to go into here, we should note that even the research involving the diagnosis of Reactive Attachment Disorder or Attachment Disorder is open to serious question. It is very possible that "holding" is "a cure without a disease."

*Incongruence with the realities of child development.* The claims of coercive restraint advocates are at odds in almost every way with what is known from systematic child development research. Each of the following points is an assumption made by “holding” practitioners, and not one agrees with child development research over the last half-century or more.

“Holding” therapists believe that:

1. It is possible to rework or recapitulate an error in emotional development by a ritual repetition of events that would normally take place much earlier in life.
2. Emotional attachment to parents begins prenatally rather than in the second half-year of life.
3. Post-natally, attachment progresses as a result of the satisfaction of physical needs.
4. Healthy attachment causes children of all ages to be affectionate and cheerfully obedient to their parents and others in authority.
5. Parental authority must be absolute in order for a child of any age to develop good mental health.
6. Children who have been separated from their birth parents, even immediately after birth, react to this event with continuing rage and are unable to form new attachments without treatment; the same is true of children who have experienced painful and traumatic early lives.
7. Rage can be neutralized by physical and verbal expression, but remains present and prevents affectionate relationships if unexpressed.
8. The expression of rage can be forced by physical and emotional discomfort, which the child resists out of a desire not to change; the child’s complaints of fear or pain reflect the resistance to change rather than any genuine harm.
9. Neutralization of rage is followed by a brief period in which a child of any age is ready to form an emotional attachment.
10. Eye contact and sweet foods are powerful instruments in the formation of emotional attachment and can be used for this purpose in a child of any age.
11. Children who are unhappy, disobedient, and difficult to deal with are suffering from attachment disorders; all adopted children also suffer from attachment disorders.
12. If attachment disorders (as described above) are not treated through coercive restraint techniques, the children will grow up to be vicious criminals, possibly serial killers.

Again, none of these ideas are accepted by child psychiatrists or by clinical or developmental psychologists trained at the doctoral level in accredited university programs.

*Deaths and injuries.* In a number of cases, courts have determined that the deaths of children resulted from practices either directly involving coercive restraint or associated with it. Both parents and therapists have been culpable in these cases. This matter has been well-documented elsewhere and we need not go into detail in this statement. However, it is important to realize that these deaths and injuries are the direct result of the eighth assumption described above, which implies that children’s complaints of fear

and pain during restraint are always manipulative and never genuine.

In conclusion, I reiterate the contention of NJAIMH that coercive restraint therapies should be prohibited on the grounds discussed above. We offer our strong support for House Bill 5, and believe that the passage of this bill will be an important step toward the protection of the children of Utah and of other states that will follow Utah's lead.

Sincerely yours,

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Feb. 7, 2003