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Holding therapy in Britain: historical background, recent events, and ethical concerns

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Abstract
Holding therapy, an intervention often used in the treatment of foster and adopted children, has been rejected by professional groups on grounds of lack of evidentiary support and of potential harmfulness. Nevertheless, some British proponents have continued to advocate its use. Is this support brought about by the familiarity of concepts used in this treatment? This article reviews the history of related concepts and methods in Britain. It is concluded that a long history of British involvement with related ideas may have encouraged approval of holding therapy, but that ethical concerns argue against its use.

Keywords
holding therapy, adoption and fostering, history, ethics

Introduction

Both attachment theory and its applications have changed gradually over the last 30 years. For example, the concepts of monotropy in attachment and of determination of later development by attachment experiences have diminished in importance (Mercer, 2011a) whereas specific applications of the theory have been expanded with the founding of the journal, *Attachment & Human Development*, and more recently, in the devotion of two issues of *Family Court Review* to the use of attachment theory in child custody evaluations. Attachment-based interventions with sound evidentiary foundations are now emerging.

From the 1980s on, however, applications said to be based on attachment theory were already in use. One of these, often referred to as holding therapy, is a treatment that has been proposed and used primarily for children whose difficult family histories have culminated in fostering or adoption. Although holding therapy treatment methods may vary, there seem to be three points that are essential to its practice: (i) that emotional attachment

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of child to parent is the critical aspect of personality development, with mental illness resulting primarily from attachment problems and interventions being effective insofar as they correct attachment; (ii) that correction of personality problems depends on recapitulation of development following regression of personality to the stage in which the problem began, which can be brought about by re-enacting early childhood experiences; and (iii) that physical contact between therapist and client, sometimes amounting to physical restraint of the child, is essential to treatment. Some less basic tenets have to do with the beliefs that children's emotional development is blocked by rage persisting from earlier events, and that pain, discomfort and anger should be induced in order to 'drain' this emotion; accompanying these beliefs is the claim that sustained mutual gaze ('eye contact') is a factor in attachment.

As holding therapy has been questioned with respect to its evidence basis and its safety, it might well be expected that its use would diminish. However, the practice appears to have continued in Britain as well as in the US. Recent evidence for its use comes from sources such as a former client's statements on the blog www.invisibleengland2.wordpress.com. In addition, Sudbery, Shardlow and Huntington (2010) reported positive attitudes towards holding therapy from surveys of staff and former clients of an organisation that provides treatment.

Holding therapy has been described as having little or no evidentiary support (Mercer, 2001; Mercer and Pignotti, 2007) – an important issue in this era of encouragement of evidence-based practice. In addition, it has been rejected in position statements by the American Professional Society on Abuse of Children (Chaffin et al, 2006) and by the British Association for Adoption and Fostering (BAAF, 2006). A special issue of *Attachment & Human Development* in 2003 contained only one paper that was less than a clear rejection of the approach. Child deaths have also been associated with aspects of its implementation (Mercer, Sarner and Rosa, 2003).

How can we explain the paradox of continuing interest in and use of holding therapy in the face of strong professional rejection of the practice? This article will examine the possibility that the historical background of the treatment is such as to provide long-familiar ideas that therapists and caregivers may easily assume to be correct, and that Britain has been the source of many of these.

Basic ideas of holding therapy and their British backgrounds

It is important to stress that this discussion is not intended to claim that most of the authors mentioned were 'closet' holding therapists, or that they would have approved of the practice. The goal, instead, is to explore aspects of holding therapy in terms of their apparent historical predecessors.

Restraint as a historical tradition

Holding therapists in recent years have stated their opposition to restraint or coercion and argued that they used nurturing physical contact for which they had obtained a child's consent (Kelly, 2003). Be this as it may, there is no question that physical restraint has been a frequent feature of practices referred to as holding therapy, just as it was part of historical practices.

By the end of the 18th century, more humane treatment of mental patients was proposed and used, especially by Quakers who were involved in asylum care. Nevertheless, methods of restraint such as straitjackets and restraining chairs were very much a feature of treatment. The management of mental illness was under the direction of physicians and physical interventions like hydrotherapy (water treatments) were considered most appropriate. Many of these practices, including the use of straitjackets and of hydrotherapy in the form of 'wet packs' in which patients were restrained, continued until the 1950s and beyond. The idea that physical holding could have a therapeutic effect was familiar to anyone who was aware of the earlier use of restraint (the time interval being perhaps no more than 30 years when we consider early formulations of holding therapy).

Some history of attachment concepts

The development of attachment theory is a long story that can only be summarised here, and much, though not all, of it took place in Britain (Bretherton, 1992). Without attachment theory, holding therapy (which is sometimes even called attachment therapy) could not exist in the form it has taken or with the premises its proponents have typically accepted.

Object relations and attachment

As Freud's students and protégés left Germany and Austria to avoid the Nazis, Britain became the home of some of the psychoanalysts with strong interests in early life, whose work has been discussed in detail by Mary Ainsworth (1969). These thinkers were especially concerned with 'object relations', a psychoanalytic term that refers to social relationships and their development from early infancy.

The outstanding member of the British object relations school was John Bowlby, whose attachment theory is foundational to holding therapy as well as to a myriad of more conventional viewpoints. In essence, Bowlby's theory (Bowlby, 1969) stated that human beings are born with a readiness to interact socially with others, and that over the first six to eight months of life they develop more social skills and become ready for attachment. To use Ainsworth's definition, attachment is 'an affectional tie that one person . . . forms to another specific individual' (1969: 970). As emotional attachment develops between about eight and 15 months of age, the child's behaviour reflects the change; later, the toddler becomes less fearful and dependent, and develops an 'internal working model' of social relationships. This model, according to Bowlby, is the foundation of later attitudes and of the nature of future love relationships. In one paper, in which he speculated about the causes of criminality in a group of juvenile thieves, Bowlby (1944) argued that poor attachment experiences with unreliable caregivers had made the boys what they were – a point later accepted by holding therapists, who claimed that undesirable later behaviour was determined by poor early relationships (Cline, 1992).

Ethology and attachment. Bowlby's concept of attachment clearly emerged from psychoanalytic thought. However, a second influential source of thinking about attachment was the school of comparative animal behaviour called 'ethology', an approach that examined behaviours characteristic of a given species and described them as unlearned 'fixed action patterns'. Bowlby argued that human infants were born already prepared to respond to social signals and to develop a preference for specific other members of the human species.

Konrad Lorenz, a German, and his Dutch colleague, Nikolaas Tinbergen, were formulating ethology in their own native countries prior to World War II. The end of hostilities brought both men to Britain, at least briefly, and saw Tinbergen appointed to a faculty position at Oxford University in 1949. Tinbergen had some concerns about possible autistic-like features in one of his children and consulted Bowlby about this during the 1950s (van der Horst, 2011). This issue, and the interest of his wife Elisabeth in special education, drew Tinbergen to work on a connection between autism and other 'stress diseases' and ethological concepts. In 1972 the Tinbergens published a book discussing the ethological approach to autism, and much of Tinbergen's 1973 Nobel Prize acceptance speech was concerned with this condition, although, with relevance for the physical nature of holding therapy, he referred also to the 'Alexander method', a physical training treatment for minor emotional disturbances.

Tinbergen's interest in autism brought him into contact with a US psychiatrist, Martha Welch, who believed that autism and other childhood mental health problems were caused by a lack of attachment. Welch claimed that she could cause attachment to occur by a method of holding therapy she then called 'direct synchronous bonding'. In this treatment, mothers held children face to face with them (or half-lay on the reclining child) and insisted on eye contact; they continued this behaviour for periods of an hour or more in spite of the children's screaming resistance. In 1983 Nikolaas and Elisabeth Tinbergen published a book advocating this method and including a lengthy appendix by Welch, although they acknowledged that research evidence for the effectiveness of the treatment was lacking. Probably because of the Tinbergens' support, Welch later visited Britain on a book tour and made several BBC appearances around the publication of her own book describing her method (Welch, 1989).

Although attachment theory continued to stress the readiness of the human infant for social interaction, Bowlby did not maintain for long the idea that human attachment and caregiving were entirely matters of unlearned fixed action patterns of the kind the Tinbergens discussed. Nevertheless, the idea that an event can trigger a 'releaser' that causes specific behaviours has continued to be intriguing and may be behind some holding therapists' belief that attachment is influenced by sustained eye contact and by the feeding of sweet milky foods (Thomas, 2000).

Regression and recapitulation. An essential idea for holding therapists is that mental health issues caused by inadequate early experiences can be corrected by means of 'regression'. This is said to cause the personality to return to an earlier, immature stage, and enables the individual to recapitulate problematic development quickly and emerge with a more desirable level of maturity. Regression is thought to be brought about by re-enactment of early childhood experiences, such as being held, controlled and then comforted by therapists. US holding therapists have also used bottle-feeding and other 'baby care' routines for this purpose.

The concept of regression has a long British history (Mercer, 2011b). Herbert Spencer, in 1898, discussed normal progression and considered some form of regression to be a possible cause of mental illness. Following Spencer's suggestion, the British neurologist John Hughlings Jackson argued that the nervous system was hierarchically organised, with the highest layers normally in control, but could regress with illness or injury until lower layers

took over. Sigmund Freud adopted this concept as a way of describing some psychological events.

Some cases of 'war neuroses' or 'shell-shock' (now known as Post Traumatic Stress Disorder – PTSD) during World War I were treated at Maghull Hospital near Liverpool as 'regressive reactions'. From the 1940s, Michael Balint put some stress on regression in his work at the Tavistock Clinic in London. Balint had been a colleague in Hungary of Sandor Ferenczi (called a 'wild psychoanalyst' by Freud), who considered that therapists should foster regression by behaving like a loving parent, including hugging and kissing the patient. Balint, however, went no further than holding a hand or a finger.

By about 1950, a new and unorthodox view of regression was under consideration in Britain, primarily by those outside conventional psychological and psychiatric circles. Francis J Mott, a British psychologist and member of a Christian-Science-like religious group, proposed a theory of regression which he had developed from the dreams of his patients (Mott, 1960). These, he felt, indicated that in fact it was possible to remember one's birth and even earlier events. In 1958, Frank Lake, a British theologian and psychiatrist, began to conduct 'primal' workshops (focusing on birth memories) with the help of LSD (Lake, 1980).

Among psychologists and psychiatrists, regression approaches were particularly favoured by those working with children. Bowlby (1966) suggested that if a child is allowed to regress to completely infantile modes of behaviour, there is a chance of increased maturity. A long list of child therapists in the US agreed with this point.

No discussion of the regression concept would be complete without reference to RD Laing, a Tavistock associate trained by DW Winnicott, and an active proponent of regression in the 1960s and '70s (Kotowicz, 1997). Laing and other members of the 'anti-psychiatry' movement regarded emotional and behavioural regression – even to an infantile state – as part of a healing process by which patients could recover from the damage their families had done to them. One patient, Mary Barnes, was treated by bottle-feeding and the playing of games like mutual biting with her therapist (Barnes and Berke, 1971).

By the 1970s, then, British thinking about psychotherapy was strongly influenced by the regression concept without which holding therapy has little in the way of a rationale. Regression provides that rationale in one of two ways. Regression to early infancy can be considered as a way to re-work attachment along the timetable suggested by Bowlby. However, some holding therapists are convinced by the Mott-Lake argument. They maintain that attachment actually occurs before birth, is always to the birth mother and is ruptured by separation and adoption, even if those events occur much earlier than attachment theory would consider to be important (Verrier, 1993).

This history of the regression concept in Britain indicates that interested persons were well prepared, in 1985, to welcome a visitor from the US, Jacqui Schiff, a colleague of the transactional analysis theorist, Eric Berne. Schiff developed a new form of treatment based on a belief in regression (Schiff, 1977). This intervention, 'reparenting', was thought to bring about regression and recapitulation of development through the re-enactment of childhood experiences. Patients at Schiff's clinic in Virginia had been diapered/nappied, bottle-fed and held, in a parody of infant care. The clinic was closed as a danger to health and welfare, and Schiff went to California to open a similar facility where a tragic and culpable death occurred when Schiff's adopted son put a bound patient into scalding

water (Marlan, 2000). Schiff then travelled to India and Birmingham in the UK, where she lived and worked for some years.

A brief US history of coercive therapies

At this point it may be helpful to consider briefly what had been happening in the US with respect to holding therapy and similar treatments which use restraint or force. As readers may be aware, during much of the period US psychology had a strong behaviouristic/environmental or 'nurture' bias. The assumption was that individual differences, including mental illness, were determined by the person's experiences, and, as a result, it should be possible to use new experiences to correct mental problems.

Wilhelm Reich, a German psychoanalyst living in the US, suggested a powerful link between body and mind, such that mental problems were reflected by/caused by patterns of muscular tension. The treatment for this 'character armour' involved having a therapist poke and prod the torso and armpits of a near-naked patient (Reich, 1945). In the 1970s, a California psychologist named Robert Zaslow proposed a new form of treatment based on a combination of Bowlby's and Reich's theories. Zaslow attributed much emotional disturbance to a failure of attachment and consequent anger, and proposed that physical holding, combined with painful tickling and prodding with sustained eye contact, would correct the problem (Zaslow and Menta, 1975). Zaslow surrendered his California psychology licence following an incident in which an adult patient received injuries including kidney damage, but because of the US state-by-state licensing system he was able to travel and demonstrate his methods. One interested observer was Foster Cline, a Colorado physician, who by 1990 had systematised Zaslow's method into 'rage reduction therapy' or holding therapy. Cline (1992) argued that all bonding was trauma bonding, and that a child's emotional attachment to an adult was based on the demonstrated power of the adult.

Cline became the leader of a group of holding therapists in the small mountain town of Evergreen, Colorado, and helped to promulgate the belief that holding therapy was essential for adopted children or those with other difficult backgrounds who without treatment were very likely to grow up to be serial killers. Practitioners of related treatments, like Tinbergen's associate Martha Welch, visited Evergreen. A foster parent, Nancy Thomas, who worked closely with Cline, put forward a programme for 'therapeutic parenting' in which children received limited diets, carried out pointless and tedious work assignments and were required to ask permission before drinking water or using the toilet. A parent–professional association, the Association for Treatment and Training of Attachment in Children (ATTACh), was formed to support holding therapy; their diagnostic approach involved a 'checklist' of symptoms to be reported by the mother. These included 'crazy lying', cruelty to animals, firesetting and failure to make eye contact or hug on the parent's terms.[1] Because Colorado and some other state laws did not require psychotherapists to be licensed, holding therapy was able to develop as a successful, though little-known, cottage industry without regulation. But this success story came to an end in 2000 when Candace Newmaker, a 10-year-old adoptee from North Carolina, died of suffocation in the course of 'rebirthing', a variant of holding therapy. The responsible therapists were convicted and sent to prison. Investigations at that time and later revealed a number of child deaths at the hands of parents acting on the instructions of holding therapy practitioners.

Following Candace's much-publicised death, ATTACh began to minimise its association with holding therapy and produced a position paper rejecting coercive methods, while still approving 'nurturing' holding (Kelly, 2003).

More recent events in Britain

As holding therapy developed in the US, parallel events were underway in the UK. Although not given the name holding therapy, some of these closely resembled the procedure as practised in the US.

Schiff's 'reparenting'. According to an article by HealthWatch UK (1991), Jacqui Schiff, who had been forced to leave the US, was at that time living in Birmingham and carrying on a private 'reparenting' service. The organisation quoted an *Observer* article reporting that a Shropshire Social Services' residential facility was using her methods. A Birmingham clinic was said to be using similar methods that were attributed to Schiff's influence (*Birmingham Evening Mail*, 1991).

Pindown. In 1991, a report published by Alan Levy and Barbara Kahan detailed the development between 1983 and 1989 of a physical control method in Staffordshire children's homes. 'Pindown' described a disciplinary method in which children as young as nine were not only physically assaulted, but kept in solitary confinement without clothing and required to 'earn' every privilege, including conversation with a staff member. Pindown did not involve physical restraint of the holding therapy style, but did have characteristics of isolation, ignoring, exposure to cold and demands to 'earn' matters that ordinarily would be considered part of residential care (such as use of the toilet), all of which are associated with 'therapeutic parenting' as advocated by some US holding therapists (Thomas, 2000).

Regression therapy. In 1993, a report by Andrew Kirkwood described the use of 'regression therapy' by the manager of a Leicestershire children's home (see also Shaw, 2011; Stein, 2006). This treatment resembled in many particulars Schiff's reparenting efforts. Older children were put into nappies and bathed by staff members (D'Arcy and Gosling, 1998; *Various claimants v Leicestershire CC*, 1996). In addition, the treatment included features of holding therapy as practised by its US originators, Cline and Zaslow, such as provocation by name-calling, tickling and assault; when children became enraged, they were restrained physically. In 1994, *The Independent* reported a British child's being taken to Colorado to be treated by Foster Cline (Neustatter, 1994).

Holding Therapy per se. The term holding therapy has been used in Britain and the treatment as described in various places closely resembles that portrayed in US publications. What were the steps that led to this situation and the recent use of the treatment in Britain?

In 1994, the social worker and foster carer, Sheila Fearnley, and a colleague proposed and set up an 'attachment centre' in Lancashire under the aegis of a leading UK child care and education provider (Neustatter, 1994). The attachment centres advertised their use of holding therapy for some years (Prior and Glaser, 2006).

In an article in *Adoption & Fostering,* Fearnley discussed this approach to both diagnosis and treatment (Howe and Fearnley, 1999). The centre was said to use a diagnostic checklist

composed of material from the US *Diagnostic and Statistical Manual* in combination with material that largely resembled the ATTACh checklist mentioned earlier, including 'pre-occupation with blood and gore' and 'lacks cause and effect thinking'. With respect to treatment, reference was made to Cline, Orlans, Levy and other US holding therapists of the original 'rage reduction' school of thought.[2]

As in their previous article, Howe and Fearnley (2003) referenced US holding therapists in another paper published four years later. In addition, the authors described the treatment in terms identical to those used by Cline and others. For example, it was stated that:

> . . . attachment-disordered children remain at very early stages of their bio-psychological development – hence the need to recreate many touch, sensory, emotional and verbal exchanges with their carers not previously experienced by these children . . . Eye contact is extremely important and the therapist ensures that it is maintained . . . Eye contact aids cognition, bonding, and the recognition of internal mental states . . . Being held and contained in the therapeutic relationship therefore increases emotional arousal and provokes responses that are less likely to occur in less challenging treatments [in which children] remain stuck and locked behind their defenses. (Howe and Fearnley, 2003: 383).

The paper concluded that 'so far, research and theory seem to be supporting much of what these pioneering [holding therapy] clinicians and lobbyists have been claiming'.

That same year, a project report on the use of holding therapy was proposed by Shardlow and colleagues (2003). The report was later published in the *British Journal of Social Work* under the title 'To have and to hold: questions about a therapeutic service for children' (Sudbery et al, 2010). It described the results of a series of surveys and interviews with former child patients, parents and staff members, as well as examination of reports and other documents, and reported generally positive comments about the children's treatment with holding therapy and otherwise. Eight of 32 former residents agreed to be interviewed and other response rates were similar. Like other materials supporting holding therapy, the report stated that children were held only when they agreed to the treatment, a point to be discussed later. Although it was not clear when these patients had been treated in this way, it seems likely that the treatment was still going on in the year when the paper was written (2009).[3]

Comments on an associated website (keyschildcare.co.uk, 2011) quoted the organisation's Marketing Director as being pleased with an outcome study that looked at 33 patients who had been treated in 'attachment placement' in the previous four years. A success rate of 73% was claimed, but in fact six (almost 20%) had 'aged out' of treatment and eight others went to secure accommodation or specialist facilities rather than families. Successful treatment was defined here by the children's later placement rather than by any specific assessment of behaviour, mood or educational achievement.

Other recent approaches less directly relevant to the continuing use of holding therapy include the emphasis on regression, as in the work of Caroline Archer (2003: 154), who states the need for:

> developmental reparenting . . . that systematically allows the child to regress, enabling parent and child to experience and repair mother–infant interactions and relationships, from birth onwards . . . Reparenting is not simply a symbolic ritual, although this can be important; it can also heal hearts, change minds and rewire brain circuitry.

In 2008, the British Office for Advice, Assistance, Support and Information for Special Needs (OAASIS) posted an information sheet about attachment disorder with symptoms described by items drawn from the 'checklist' associated with holding therapy; the sheet also confused insecure attachments with actual attachment disorders. In 2009, a doctoral programme paper of Cardiff University (Logan, 2009) cited the work of holding therapists such as Cline and Keck without noting any related controversy; the paper was evidently accepted as it stood since it is accessible through the programme's website.

Ethical issues for holding therapy

The historical background of holding therapy outlined so far shows that related concepts may be familiar to British social workers, therapists and caregivers, and appear acceptable because of their familiarity. However, in light of ethical issues, such acceptance seems paradoxical. The association of child deaths with holding therapy is of course a major ethical problem for its practitioners and has led critics to class the intervention as a 'potentially harmful treatment' (Lilienfeld, 2007; Mercer and Pignotti, 2007). In addition, the absence of supportive evidence for the treatment indicates that its use with children is questionable. However, these serious difficulties are not the only ethical problems connected with holding therapy.

In January 2006, BAAF released a position statement that rejected the use of holding therapy and of associated diagnostic approaches. The statement addressed in detail the claim of holding therapists (including both ATTACh and representatives of a British organisation) that children are not held unless they have agreed to it. This point is a matter of consent to treatment, and more particularly, informed consent – a right of adults, and within developmental limits, of children as well. Professional ethics prohibit the use of physical or mental treatments against the will of a patient, except in cases of critical need and when the treatment has been demonstrated to be effective. Such ethics also require that consent for treatment be based on accurate information about its nature and effectiveness, as well as potential risks associated with it. The BAAF (2006: 5) statement notes:

> The giving of consent to any form of treatment requires that the person whose consent is sought understands the reasons for the proposed treatment, what it involves, the desired outcome and the likelihood of this being achieved. The more invasive the proposed treatment, the greater the onus on the therapist to provide a detailed explanation of what is involved, including any undesired or unpleasant outcomes or side effects. Where treatment is experimental, the person involved is entitled to be told what evidence, if any, exists to support or contradict its use and, in general, medical ethics do not permit unproven treatment to be provided to children . . . The methods advocated for holding therapy may make it effectively impossible to withdraw consent (even if this could have been validly given in the first place) since they involve compulsion on the part of the therapist.

The BAAF position statement assumed correctly that holding therapy is an 'unproven' treatment. Although proponents of the practice in the US have posted claims that the treatment 'works', and although some poorly designed outcome research took place in the late 1990s, the only possible conclusion is that holding therapy lacks any support based on empirical evidence; it is not an evidence-based treatment by any definition and its advocates rely, on the whole, on testimonials and anecdotes, or on the vague positive statements referred to earlier. This fact means that, ethically speaking, the treatment cannot be used

with children at all, and certainly could not be used without clear informed consent even if the need for it were deemed critical. But whether an incarcerated child is capable of consent at all is a difficult question. When patients or research subjects are implicitly coerced because of their dependence on the approval of caregivers, as is the case for prisoners or elderly or sick persons, for example, their freedom to withhold consent is questionable. When patients or research subjects lack the capacity to understand the information given to them, their consent – even if not coerced – must be uninformed.

A publication from the Department for Children, Schools, and Families (DCSF) noted the use of holding therapy in Britain, recommended against it and warned that children might experience the treatment as abusive and non-therapeutic (DCSF, 2007: 52). Referring to an earlier version of these practice guidelines, Simmonds (2007) pointed out that a requirement for informed consent and for adequate qualification of therapists was moot, in that an appropriate protocol for obtaining such consent would be difficult to create, that standards for qualification, training and supervision were unclear and that ethics committees were unlikely to permit research in this area. In Simmonds's view, the most troubling aspect was that the guidelines appeared to:

> . . . be handing over responsibility for making these decisions to adoptive parents or maybe young people themselves to make these decisions, when the desperation of their circumstances may well cloud their judgment. (2007: 247)

Conclusion

This article has outlined a British historical background that may militate in favour of the acceptance of holding therapy. It has been possible to trace a continuing British interest in certain ideas in a continuous line leading without interruption into the combination of those ideas into holding therapy in current organisations. A long history of interest in regression as a form of psychotherapy is one likely reason for the acceptance of this type of treatment, as is the attention paid to emotional attachment from Bowlby's time on.

The British historical precedents for holding therapy suggest that practitioners may be motivated by concepts that are familiar to them. However, that possibility – and the absence of British child deaths or known injuries in holding therapy – should not be taken as arguments that the treatment is acceptable. The expenditure of public funds on a potentially harmful, non-evidence-based treatment is in itself highly questionable. In addition, the issue of mental health disorders like PTSD and their possible causation by holding therapy remains to be examined. At least one US survivor of the treatment known to the present author developed a debilitating anxiety disorder for which she received successful intervention. Long-term concerns and preoccupation with holding therapy have been expressed by a young British man who experienced the treatment over a period of several years (Chaika, 2012). He was not alone in his experiences and may not be alone in the difficulties possibly caused by actions his therapists intended as treatment.

It is doubtful that most social workers in either the US or Britain are supporters of holding therapy, but neither are most of them actively involved with arguing against its use. In Britain, recent concerns about private fostering, foster carers locking out children in their care, and the handling of matters such as the deaths of children like Victoria Climbié have undoubtedly taken precedence over the holding therapy issue. Nevertheless, it is to be hoped

that those matters and the long history of holding therapy's predecessors in the UK will not be used to justify acceptance of the practice.

Notes

1. None of these are aspects of attachment-related psychopathology as described in the US *Diagnostic and Statistical Manual of the American Psychiatric Association* or in *ICD-10*, the international disease classification system.
2. UK newspaper articles during this period praised Fearnley's use of 'healing touch' (*The Independent*, 1996; Wertheimer, 2002).
3. As of this writing, the 2010 authors have not yet responded to comments on their work in the same journal (Mercer, 2012).

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