Introduction

Touch is one of the most essential elements of human development, a profound method of communication, a critical component of the health and growth of infants, and a powerful healing force (Bowlby, 1952; Harlow, 1971, 1986; Barnett, 2005). Ample research has demonstrated that tactile stimulation is extremely important for development and maintenance of physiological and psychological regulation in infants, children and adults (Field, 1998, 2014; Jean, Stack, & Arnold, 2014; Montagu, 1971, 1986; Siegel, 2010; O'Brien & Lynch, 2011). Touch has been an essential part of ancient healing practices. Touch has roots in shamanic and religious practices, and is reported to have been an integral part of health care practices and medicine since their emergence from the realms of religion and magic (Levitan & Johnson, 1986; Smith, Clance & Imes, 1998).

In his seminal work, Touching: The Human Significance of the Skin, Ashley Montagu (1971) brings together a vast array of studies shedding light on the role of skin and physical touch in human development. He goes on to illuminate how the sensory system, the skin, is the most important organ system of the body, because unlike other senses, a human being cannot survive without the physical and behavioral functions performed by the skin. "Among all the senses," Montagu states, "touch stands paramount" (1986, p. 17). Before Montague published his classic book in 1971, Harlow (1958) set the stage for our understanding of the importance of touch for emotional, physiological and interpersonal development in human and non-human infants. In line with Harlow, Montagu concludes: "When the need for touch remains unsatisfied, abnormal behavior will result" (1986, p. 46). Primarily Euro-American cultures in general, particularly that of North American white-Anglos, have developed a set of unspoken taboos in regard to touch. Based on Cohen's (1987) and Hunter and Struve’s (1998) work, following are short descriptions of these cultural, mostly unspoken, taboos:
Touch, in this article, refers to any physical contact occurring between a psychotherapist and a client or a patient in the context of psychotherapy. Touch is one of many non-verbal modes of communication (i.e., Fridlund, 1994; Young, 2005). This paper looks at touch as an adjunct to verbal psychotherapy. However, it also reviews the literature on body psychotherapies where touch is a key therapeutic tool. This paper explores the rich duet of talk and touch and articulates how such a duet can significantly increase a sense of empathy, sympathy, safety, calm, and comfort, as well as enhancing a client’s sense of being heard, seen, understood and acknowledged by their therapist (Hunter & Struve, 1998). Touch is also likely to increase the sense of connection and trust between a therapist and a client (Phalan, 2009; Smith et al., 1998). The enhancement of the therapeutic alliance is of utmost importance, and as has been extensively documented, the quality of the relationship between therapist and client is the best predictor of therapeutic outcome (Lambert, 1992).

Touch, in this paper, primarily refers to touch initiated by the therapist. However, when a client initiates or requests touch, the therapists must use his or her clinical judgment to ascertain whether providing or withholding touch is ethical and clinically advantageous in each therapeutic situation.

Regardless of the vast scientific knowledge and data on the importance of touch for human development, communication, and its effectiveness in healing, the field of psychotherapy has generally shunned its use (Bonitz, 2008; Hunter & Struve; 1998; Smith et al., 1999, 2005, Zer, 2007A, 2007b). Starting with Freud, traditional psychoanalysis looks at touch as an obstacle to analysis and cure of neurosis (Fosshage, 2000). For a variety of reasons, the field has at large embraced the analytic handoffs. More recently, risk management guidelines, attorneys’ advice columns and ethical and legal experts have joined the psychoanalysts to warn us about the perils of touch. Touch in therapy has joined the list of modern risk management inspired taboos: do not leave the office, minimize self-disclosure and avoid dual relationships (Williams, 1997). Even those who endorse risk management reluctantly agree that a courteous handshake may be unavoidable. Viewing any non-touch as the first step on the slippery slope towards sexual relationships is one of the major erroneous beliefs and obstacles to understanding the importance of touch in therapy. Such sexualization of all forms of touch is embedded in the culture at large and manifested in faulty beliefs prevalent in the field of psychotherapy (Lazarus & Zur, 2002).

Some of the negative and frightening messages we have been bombarded with come from prominent therapists, many of whom are psychoanalytically oriented. One example is Menninger, who asserts that physical contact with a patient is “evidence of incompetence or criminal ruthlessness of the analyst” (cited in Horton et al., 1995, p. 444). Simon, in a similar vein, instructs therapists to “foster psychological separateness of the patient... interact only verbally with clients... minimize physical contact” (1994, p. 55). Since it may mobilize sexual feelings in the patient and the therapist, or bring forth violent outburst of anger” (1967, p. 606). Similarly Karbelnig (2000) shockingly stated: “Fourth, any type touch by psychotherapists may be construed as incestuous” (p.33). He summarizes his list of nine arguments against physical touch by stating “Most likely, physical contact at the very least risks adversely affecting the psychotherapeutic relationship in any number of ways...” (p.34).

There are many different approaches to touch in therapy. One approach, often referred to as body psychotherapy, or somatic psychotherapy, sometimes uses touch as one of its primary tools while also employing verbal communication. It is a commonly held belief that all somatic or body psychotherapists utilize physical touch in psychotherapy. While many do, there are others who advise against touch. The concept that we are embodied beings, and the respect for the unity between psychological and bodily aspects of being, is common to all forms of somatic body psychotherapy. These schools of thought recognize the body as a vehicle of communication and healing. Another approach, and the focus of this paper, employs touch as an adjunct to verbal psychotherapy or counseling. Body psychotherapies include schools, such as Reichian (Reich, 1972) and its numerous branches, Bioenergetics (Lowen, 1976), Somatic (Caldwell, 1997) or Hakomi (Kurtz, 1990). These approaches focus on harnessing the healing power of touch. There are numerous other psychotherapeutic orientations that have embraced touch. These orientations formalized the use of touch in therapy as an adjunct to verbal therapy. They include Gestalt therapy (Perls, 1973), several variations of humanistic psychology (Rogers, 1970) and group therapy (Edwards, 1984). They also include some parts of feminist, child, family therapy and dance and movement therapy (Smith, et al., 1999; Satir, 1972). In spite of the numerous therapeutic approaches, theories and practices that systematically and effectively use touch in therapy, touch has never been marginalized, forbidden, called a taboo, often sexualized at and times, even criminalized by many schools of psychotherapy and ethics (Young, 2005, Zer, 2007a).

This article reviews the general importance of touch for human development, secure attachment, communication, the development and maintenance of physiological and psychological regulation, and the formation of therapeutic alliance. Types of touch employed in psychotherapy are discussed, as well as the main professional sources for the prohibition of touch in therapy. The western cultural context and its relationship to touch are also discussed as an additional source of the prohibition on touch. It then discusses the psychotherapeutic benefits of touch, and finally provides a summary and a set of guidelines for the use of touch in therapy.

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The Importance Of Touch

Touch is often referred to as the "mother of all senses" as it is the first sense to develop in the embryo (Montagu, 1971), and all other senses-sight, sound, taste, and smell are derived from it. Within three weeks of conception, we have developed a primitive nervous system which links skin cells to our rudimentary brain. "The tactile system is the earliest sensory system to become functional (in the embryo) and may be the last to fade" (Fosshage, 2000). It remains a potent and some would say the most powerful form of communication throughout the course of one’s life, holding immense potential for use and misuse, for healing and for harm.

Touch is our first language. Long before we can see an image, smell an odor, taste a flavor, or hear a sound, we experience others and ourselves through touch, our only reciprocal sense. Touch is the oldest sense and it is this sense that has great positive potential in forming a strong therapeutic bond and a vehicle for healing injuries created by early touch violations or lack of necessary touch. Hunter & Struve, (1998) summarize the therapeutic effects of touch by suggesting that touch may help the therapist to provide real or symbolic contact and nurturance, to facilitate access to exploration, of resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships. Gluckauf-Hughes, and Clance (1998) point to the role of touch in ego development.

Of course, the potency of touch holds the potential for harm as well as healing. Because of this, touch in psychotherapy has long been held to be dangerous and taboo or at the very least, legally risky, or a threat to the integrity of the therapeutic process. Risk, however, is not a valid reason to avoid an important therapeutic modality. Not touching has powerful effects as well and this aspect of treatment is ignored by mainstream psychotherapy literature. However, not touching is also risky. "Absence of any physical contact is likely to cause transference distortions (i.e. the client may view the therapist as a cold, withholding parent figure" (Wllison & Masson, 1986, p.498). Wilson (1982) argues, “To disregard all physical contact between therapist and client may deter psychological growth” (p. 65).

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Medical And Psychological Effects Of Massage

Earliest recorded medical history dates from 25 centuries ago, including references to medical treatment utilizing touch in Eastern cultures (Miller, 1997). Shamans, in many cultures, used touch as one of the healing practices used to heal mind, body and spirit. Healing practices began to evolve into the science of medicine in the middle ages. Touch healers who had long been honored by their communities gradually lost clout. They were negatively stigmatized by both medical and religious proponents (Cohen, 1987). By the 17th century, the Christian Church conceded control over the physical body and this important historical compromise was acknowledged by their therapist (Hunter & Struve, 1998). Touch is also likely to increase the sense of connection and trust between a therapist and a client (Phalan, 2009; Smith et al., 1998). The enhancement of the therapeutic alliance is of utmost importance, and as has been extensively documented, the quality of the relationship between therapist and client is the best predictor of therapeutic outcome (Lambert, 1992).
Recent research on pregnancy and infant massage documents benefits of touch that might allow us to consider this form of touch to be labeled as psychotherapy at the earliest stages of human development. Massaged preemies fare better than those in incubators on many counts: decreased stress hormones, temperature regulation, heart rate, sleep/awake cycles, and breathing regularity (Field, et al., 1998, 2004). Touch attenuation training is also beneficial for psychotherapists.

Instruction begins by teaching a kind of attunement, training the caregiver to be observant of cues that indicate if the baby is being soothed or stressed by the type of touch. Caregivers are taught simple stroking techniques involving the amount of pressure, pace and consistency. Touch is adjusted as the caretaker responds to communication from the baby. Massaged preemies fare better than those in incubators on many counts: decreased stress hormones, temperature regulation, heart rate, sleep/awake cycles, and breathing regularity (Field, et al., 1998, 2004). Touch attenuation training is also beneficial for psychotherapists.

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The above discussion of touch, culture, and bonding has direct implications for psychotherapy and counseling. The cultural taboo against touch in psychotherapy encourages therapists to perpetuate the neglect that originally caused the injury. Therapists tend to avoid touch, to neglect consideration of touch in a well thought out treatment plan and to avoid talking about this with clients. Touching clients can hurt them if done in the wrong way but touch can also heal old touch injuries. Not touching can cause injury to certain clients in certain situations. The silence about this in our education and training programs of therapists, in supervision, or in actual therapy with clients often results in less effective therapy (Westland, 2015). A dialogue regarding touch should be expanded amongst therapists and between clients and therapists in general. The touch needs of a securely attached client will be different than the touch needs of a client who was attached in an insecure or avoidant way as an infant. Programs in attunement training, for parents and babies with attachment problems, have proven to be effective. Since babies lack language and conceptual skills, these parents are trained to “listen” to the body and to respond through appropriate touch. Although this is slowly changing, traditional training of therapists focuses very little on the body and hardly at all on touch. Touch attunement is a particularly neglected aspect of training and education for most therapists.

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**Touch And Ethnicity, Region, Class And Sexual Identity**

Touch has a high degree of cultural relativity. Thus, the meaning of touch can only be understood in its cultural context (Halbrook & Dulphie, 1994; Phalan, 2009). Montagu (1973) brought together emergent studies related to the function of skin and touch in the role of human development in his seminal work, *Touching: The Human Significance of Skin*. Among other things, Montagu observed cultural attitudes towards touch by developing a continuum of tactility. People of Germanic and Anglo-Saxon origin were placed on the low end of the continuum. Americans ranked only slightly higher than their English ancestors, while Scandinavians occupied the middle position. People of Latin, Mediterranean, and Third World ancestry were placed at the high end. This is further substantiated in studies done by Argile (1988), Mehraian, (1971), and Schellen (1972). In a study done by Jourard (1966), people from different cultures were observed in casual conversations. He counted the number of times they touched during a one-hour period. Touching occurred 180 times an hour in Puerto Rico, 110 times in Paris, in London, 0; and in the U.S., 2.

America in general is a low touch culture. Within the American culture there are differences regarding touch between different regions, ethnic or minority groups. For example, Californians touch each other more casually and more often than New Englanders (McNeely, 1987). Clarence is an ethnically diverse state, however, and Californians whose heritage is linked to the Far Eastern cultures generally engage in less touching behaviors than do citizens of other Ethnic origins (Samovar, Porter, & Jain, 1981). Midwesterners who are strongly rooted in German and Scandinavian cultures are relatively restrained in their touch behaviors. In contrast, Americans of Latin heritage, a population found most often in southern regions of the country, touch easily and often. Americans of Mediterranean heritage touch and kiss freely (McNeely, 1987). Americans of Indian heritage are more likely to be sensitive to class distinction with regard to touch. Unspoken social taboos are reflected in touch behaviors. Persons of a high class may touch persons of a lower class, but not vice versa. Despite alleged advances in civil rights for African Americans since the mid-1960s, many of the unspoken protocols and fundamental biases continue to inhibit touch between Caucasians and African Americans in modern U.S. (Hunter & Struve, 1998).

It is believed that the unspoken rules regarding touch between different classes is related to the history of the master-slave relationship in the U.S.

The relationship between ethnicity and touch has direct implications for touch in psychotherapy. While there is a growing body of literature on multicultural therapy and counseling (Aponte & Wohl, 2000; Sue, Ivey, Pederson, 1996), little has been written specifically on the use of touch in psychotherapy with ethnically diverse populations. It is well documented that due to a history of oppression in the United States, as well as ongoing racism and discrimination, members of a minority group often experience therapy with a Caucasian clinician as a recapitulation of the power differentials that exist in society at large (Comas-Diaz & Green, 1994; Greene, 1997; Pedersen, et. al., 1996). Touch has layers of meaning, depending on one's culture, socialization and individual experience (Halbrook & Dulphie, 1994). How personal space is defined within a culture affects the interpretation of therapeutic touch. Cultural and sub-cultural power differentials, of both gender and class must be considered. Hence, as Smith (1998) points out, a therapist may be seen as "distant, respectful, or invasive" depending on the socialization and experience of the individual client. It is essential that clinicians inform themselves of their clients’ cultural context before using the power of touch in session.

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**Sexualization Of Touch**

Americans, in general, have difficulty conceptualizing physical contact as nothing more than emotional nurturance and tend to avoid touch for fear of being misunderstood (Hunter & Struve, 1998; Zur, 2007a, 2007b). Sexualization of innocent touch has a long history. The restrictive idea that sensual pleasures were dangerous and sinful was brought to this country by our puritanical founding fathers and held throughout the Victorian era (Hunter & Struve, 1998). In 1906, for example, mothers were told to keep a careful eye on their children, even infants, to guarantee that they would not sin against themselves and lose their sexual purity (Watson, 1928). To "avoid masturbation," mothers were advised to tie their babies’ feet to opposite sides of the bed so that the couldn't rub their thighs together. They were advised to pin to his nightgown sleeves to the bed so that he couldn't touch himself (Heller, 1997). John Watson, the parenting expert for the first quarter century, and the author of *Psychological Care of the Infant and Child*, judged mother love as inherently sexual and warned that an affectionate touches and kisses were a cover for “a sex-seeking response” (Heller, 1999). Diaries from the time show poignant entries by mothers who guiltily cuddled and kissed their mother's affectionate in baby in secret, many of them feeling guilty for being unable to follow the dictates of the experts. As was noted above, Karbing, as recent as in 2000, shockingly stated: “Fourth, any type of touch by psychopathologists may be construed as incestuous” (p.33). One must wonder if this a handshake or reassuring pat on the back.

Although Harlow's advice replaced Watson's, the legacy of these repressive attitudes continue to haunt us and may account for the currents Americans have as being sexually obsessed and as having odd social rules connected to touch. Within large portions of American culture, there is a propensity to either infantilize or sexualize physical contact (Hunter & Struve, 1997; Young, 2005, Zur, 2007a). Most public displays of affection are held suspect, especially males touching males. While most boys learn that affectionate touch between males is taboo, their girls are taught that affectionate touch within the family is acceptable. They are taught that, as their bodies develop, they will be desired by others. Children are more able to form a cultural script of their bodies. They compare their flat chests to a woman’s rounded breasts, a flat tummy to a pregnant belly or a sagging one, a child’s small penis to an elongated one in a crop of hair. This helps them to also develop a part of the cultural role for themselves and a relaxed attitude about the naked body.

The uneariness about child development related to healthy sexuality, nudity and touch is likely to escalate. Alarmingly, up to 30 percent or more of all children are sexually abused (Heller, 1999). The uncovering of instances of child abuse, such as at the church and the foster care system, has fueled our vigilance. We do need to protect our children. And sometimes we need to address the backlash. Innocent acts by parents, day care staff, and teachers are often falsely misinterpreted as sexual abuse. Although less than 1 percent of all reported child sexual abuse cases occur in childcare settings, fear of lawsuits has resulted in the institution of restricted touch policies (Heller, 1999). For example, the National Education Association advises teachers of elementary and high school children to “Teach but don’t touch.” In spite of this “hands off” policy, instances of child abuse in institutional abuse of children, such as the church and the foster care system, has fueled our vigilance. We do need to protect our children. We also need to address the backlash.

The above discussion of touch, culture and bonding has direct implications for psychotherapy and counseling. The cultural taboo against touch in psychotherapy encourages therapists to perpetuate the neglect that originally caused the injury. Therapists tend to avoid touch, to neglect consideration of touch in a well thought out treatment plan and to avoid talking about this with clients. Touching clients can hurt them if done in the wrong way but touch can also heal old touch injuries. Not touching can cause injury to certain clients in certain situations. The silence about this in our education and training programs of therapists, in supervision, or in actual therapy with clients often results in less effective therapy (Westland, 2015). A dialogue regarding touch should be expanded amongst therapists and between clients and therapists in general. The touch needs of a securely attached client will be different than the touch needs of a client who was attached in an insecure or avoidant way as an infant. Programs in attunement training, for parents and babies with attachment problems, have proven to be effective. Since babies lack language and conceptual skills, these parents are trained to “listen” to the body and to respond through appropriate touch. Although this is slowly changing, traditional training of therapists focuses very little on the body and hardly at all on touch. Touch attunement is a particularly neglected aspect of training and education for most therapists.

**Types Of Touch In PsychoTherapy**

The context, in the context of this article, refers to any physical contact occurring between therapists and clients. This section outlines several types of touch that are initiated by the therapist as an adjunct to verbal therapy. It generally refers to touch initiated by the therapist, rather than by client. Based partly on formulations by Downey (2001) and Smith et al. (1998), the following are descriptions of the types of touch most frequently used by therapist-client relationships:

**Therapeutic touch as an adjunct to verbal therapy**

Therapists can deliberately employ many forms of a touch as part of verbal psychotherapy. These forms of touch are intentionally and strategically used to enhance a sense of connection with the client and/or to soothe, greet, relax, quiet down or reassure the client. These forms of touch can also reduce anxiety, slow down heartbeat, physically and emotionally calm the client, and assist the client in moving out of a disengaged state. Following are examples of different types of touch in therapy:

1. **Ritualistic or socially accepted gesture for greeting or departure:** This form of touch can also reduce anxiety to a greater or lesser degree as well as create a sense of normalcy. It may include a handshake, greeting or departing embrace, a peck on the cheek, tap on the back, and other socially and culturally accepted gestures. These gestures vary from culture to culture and from sub-culture to sub-culture.

2. **Conversational Marker:** This form of touch, which takes place during a conversation, is intended to make or highlight a point, or to get the client’s attention. It often manifests as a light touch on the arm, hand, back or shoulder. When a therapist and client are in sitting positions, as they mostly are in psychotherapy, the touch may be on a knee. Accented touch or physical punctuation can also take place at times of silence or stillness, often with the purpose of accentuating the therapist’s presence and conveying attention.

3. **Consolation touch:** Holding of the hands or shoulders of a client, or providing a comforting hug usually constitutes this kind of supportive or soothing touch. It is most often done in response to grief, sorrow, distress,
behaviors. Very little of the resulting knowledge, however, has been incorporated into traditional psychotherapy training or practice. Most psychotherapists are wedded to the spoken word and often rigidly focus on and adhere to verbal communication. Verbal communication is only one of many forms of human communication (Knapp & Hall, 2001; Cultural-political-religious forces:

Numerous cultural, political, religious and professional forces affect our attitudes toward touch in general and in psychotherapy in particular. These forces co-contribute to the general sense that touch in therapy is an inappropriate, even dangerous behavior that should be avoided or at the least, when unavoidable, held to a minimum.

The Prohibition Of Touch In PsychoTherapy

The above categories are all constructed around the intent of the therapist as the initiator of the touch. In reality, the intent of the therapist-initiator may vary from the impact on, or the experience of, the client. As we are all aware, therapists may intend to soothe a client by holding their hand but clients may experience such a gesture as controlling, violating, restricting or as a sexual overture. The experience of the initiator and the recipient are not always a match. This paper discusses this potential discrepancy, suggests ways to minimize its occurrence and provides guidelines for therapeutic interventions.

Therapeutic touch by Body Psychotherapies:

17. Therapeutic Intervention: Some somatic and body psychotherapies regularly utilize touch as part of their theoretically prescribed clinical intervention. This would include Reichian, Bioenergetics, Gestalt and hypnotherapy among others. Massage, Rolfing or other hands-on techniques incorporated or implemented consequtively with psychotherapy also fit into this category.

18. Sexual Touch: The initiator of this form of touch intends to sexually arouse the therapist, the client or both. It often manifests itself in a therapist touching the client’s sexual organs, buttocks, breasts, stomach or mouth. However, sexual touch has been reported to manifest in many other forms such as rubbing on client’s ears or stimulating a man’s nipples. This form of touch between therapists and current clients is always unethical, counter-clinical and also illegal in many states.

19. Hostile-Violent touch: This form of touch involves a therapist being physically hostile or violent with a client. Physical assault is always highly inappropriate, unethical and, depending on the state, may be illegal.

20. Punishing touch: This is another inappropriate form of touch where a therapist punishes a client for “undesired behavior.” This form includes slapping a child-client on the buttock or slapping a client on the hand. While preventing a client from hurting him or herself or others may require some physical intervention, physical punishment by a therapist is never appropriate in the context of psychotherapy.

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In summary, this article focuses on the forms of touch described in the first category, therapeutic touch. That is, touch that is intentionally incorporated as part of verbal therapy and most often includes a hug, light touch, stroke of head, rubbing of a client’s back, shoulder or arm, rocking or hand-holding. The intent of these forms of touch, which are an integrated aspect of therapy, is to increase the sense of connection and relatedness with clients and/or to calm, soothe or reassurance clients.

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Numerous cultural, political, religious and professional forces affect our attitudes toward touch in general and in psychotherapy in particular. These forces co-contribute to the general sense that touch in therapy is an inappropriate, even dangerous behavior that should be avoided or at the least, when unavoidable, held to a minimum.

Cultural-political-religious forces:

- The general western culture and its emphasis on autonomy, independence, separateness and privacy results in restricting interpersonal physical touch to a minimum.
- The cultural tendency in the US to sexualize most forms of touch facilitates confusion differentiating between medical, sensual and erotic or sexual types of touch.
- The lack of differentiation between sensual and sexual touch is more pronounced for men in this culture than for women, as boys are homophobia-socialized to avoid gentle and sensual forms of touch. American men are socialized to be more familiar with violent, aggressive, drunken, reckless or sexual forms of touch.
- Corrective experience:
- Inadvertent touch:
- Celebratory or congratulatory touch:
- Self-defense:
- Autonomy touch:
- Hostile-Violent touch:
- Sexual Touch:
- Punishing touch:
- Inappropriate forms of touch:

Professional psychotherapeutic forces:

- The traditional dualistic Western mind-body or mental-physical split manifests itself in Western medicine, including psychotherapy. Typifying this split, are questions that are common in the field of therapy, such as “Is it organic or functional?” or “Is it mental or physical?” The lack of integration of the physical and mental models makes the exploration of touch difficult.
- The traditional psychoanalytic emphasis on the analyst’s neutrality and distance and the focus on clear, rigid, inflexible boundaries omit touch as a therapeutic possibility. (For an excellent historical review of attitudes toward touch in therapy, seeBonitz, 2006)
- Several feminist scholars have asserted that due to patriarchal values and inherent differences in power between men and women, most, if not all touch by male therapists of female clients has a disempowering effect on the woman.
- The fear-based paranoid notion, promoted by the slippery slope idea, that non-sexual touch on the part of the therapist inevitably leads to sexual relationships and exploitation, discourages therapists from utilizing touch.
- Risk management or defensive medicine, focuses on avoiding any therapist conduct that may appear questionable in court or in front of boards or ethics committees, regardless of clinical appropriateness and effectiveness.

Beyond Verbal Communication

Most psychotherapists are wedded to the spoken word and often rigidly focus on and adhere to verbal communication. Verbal communication is only one of many forms of human communication (Knapp & Hall, 2001; Montagui, 1971; Westland, 2015). Using our senses, humans consciously or unconsciously employ many non-verbal forms of communication, primarily visual, visual, tactile and intuitive. Frank (1970) asserts that language never completely supersedes the more primitive forms of communication, such as voice tone and physical touch. Still, graduate and professional education pays almost no attention to non-verbal communication. Most psychotherapists are wedded to the spoken word and often rigidly focus on and adhere to verbal communication. Researchers have intensely studied non-verbal communication with children, adults and in coacting behaviors. Very little of the resulting knowledge, however, has been incorporated into traditional psychotherapy training or practice.
Charles Darwin published the first scientific study of non-verbal communication in 1872 in, *The Expression of the Emotions in Man and Animals*. Since that time, thousands of research projects in a variety of fields, such as archaeology, biology, cultural and physical anthropology, linguistics, primatology, psychology, psychiatry, and zoology have been conducted. The results of this research have established a generally recognized body of knowledge of non-verbal cues and communication. Recent discoveries in neuroscience provide us with an even clearer picture of the importance of non-verbal communication. Because we now know how the brain processes non-verbal cues, body language has come of age in the 21st Century as a science to help us understand what it means to be human (Givens, 2004). Early theorists attended to non-verbal cues, but little was written regarding ways in which these elements could be brought into sharper awareness and focus until the pioneering works of Reich (1972) and Perls (1973). Few modern clinical training programs give this vital dimension in much depth (Blatter, 2002; LaPierre, 2012).

Psychiatrists and psychologists have found that disturbances in non-verbal communication are more severe and often longer lasting than disturbances in verbal language (Batson, 1979). From paleocircuits in the spinal cord, brain stem, basal ganglia, and limbic system, cues are produced and received below the level of conscious awareness. Non-verbal communication gives us the sense and the feel we remember long after words have died away (Givens, 2004). Many cultural influences involve an unspoken rule that people should ignore non-verbal elements of communication, so the task of incorporating conscious sensitivity and awareness to non-verbal communication is often limited. Generally speaking, women are superior to men in decoding non-verbal cues, most likely for biological evolutionary reasons.

### Categories of Non-Verbal Communication

Categories of non-verbal communication include internal cues and physiological responses. The elements of these categories are often not practiced voluntarily. Somatic and body psychotherapists assist their clients in becoming more aware of these subtle signs of emotion. Over 80 non-verbal elements of communication arising from the face and head and a further 55 produced by the body have been documented. Clinicians can learn to be aware of these reactions in themselves and educate their clients in “body voice” awareness. This can lead to rich discussion and gained insights regarding the meaning of what these emotional communications could mean. Following are several categories and their elements.

**Somato-Affect:** These “body voice” communications include: Blushing, perspiring, changes in breathing, flushing, muscle tension (construction or expansion), moisture in eyes, blanching, flushing of nostrils, unconscious movement of body parts, visceral experience, numbness, and temperature changes (Blatter, 2002).

**Personal Space:** Personal space is also a form of non-verbal communication. Many factors affect the distance in which individuals experience comfort in approaching or being approached by others. Power structures, role relationships, gender, cultural factors, social relationships, location (e.g. public or private), personal and familial factors, and past experience with boundary violations are all included in this category.

**Eye Contact:** Eye contact modifies the meaning of non-verbal behaviors. For example, people on elevators or in crowds adjust their sense of personal spacial comfort if they agree to limit their eye contact (Scheffen, 1972).

**Paralanguage:** “Non-lexical” vocal communications suggest emotional nuances. These include, but are not limited to, inflection, intensity, tone, pitch or pauses.

**Facial Expressions:** Temporal facial expressions can communicate emotions that are not intended or conscious. The face is an extremely developed organ of expression.

**Gestures:** Gestures are also often unconscious or unintended modes of non-verbal communication. These might include, among many others: raised eyebrows, narrowing eyes, touching one’s face, folding arms, pursing lips, self-hugging, or changes in breathing.

**Adornment:** Semiotics is the science of the emotional and psychological impact of signs and appearances. These elements might include: clothing, makeup, pens, pipes, belts, pillows, etc. (Blatter, 2002).

### Therapeutic Goals

Therapeutic goals can be served when therapists increase their awareness of these forms of non-verbal communication and educate their clients about them as well. This self-knowledge is empowering to clients. People vary in regard to the mode they primarily rely on, whether it is auditory, visual, olfactory or tactile. It is essential to pay careful attention to the type of communication that is most effective which each client. A therapist who is sensitive to this issue might sit with a family and ask the father “Did you hear what was just said?” Then ask the mother “Did you see what just happened?” Then ask the son “Did you notice what just took place?” And finally ask the daughter “Did you sense what just happened?” Similarly, people will react to the same stimulus by using different terms, such “bad taste,” “ugly looking,” “stinks” or “sounds horrible.” The intent to honor individual differences is compromised in an exclusive focus on verbal communication.

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**Touch In Context**

The meaning of touch can only be understood within the context of the client, the therapeutic relationship, and the therapeutic setting (Zur, 2007a, 2007b; Warnecke, 2011). Accordingly, the employment of touch must be carefully considered in its context. Touch can have radically different contextual meanings amongst different clients, therapists, and settings (Hilton, 1997; Horton, et al., 1988; Kloser & Keith-Spiegel, 1998; Smith et al., 1998). What is highly appropriate and effective with one client in a certain situation may be inappropriate and even damaging with another. Hugging a child or letting him or her jump onto the therapist’s lap may be highly appropriate in the course of therapy, but not in the case of a borderline client. Reaching out gently and respectfully to hold the hand of a grieving mother may not have the intended positive effect if the same is done in early stages of therapy with a female survivor of sexual abuse.

Following, is an example of the importance of context. Imagine a 50 something male therapist who tells you that he spent a recent therapy session holding hands with a recent 24-year-old female client he had only just met. Of course in a “standard” therapeutic situation, such a scenario is to evoke associations of an unethical, unprofessional, most likely illegal and inappropriate sexual mode. Now, imagine that this exchange takes place in a hospital room, the patient has cystic fibrosis, severe lung disease, and struggles mightily to breathe and speak despite the oxygen pressure mask she wears. The therapist asks how he can help and she grips his hand tightly saying, “Don’t let go.” (Koocher, personal communication, 1984).

Gender issues are extremely important in understanding the context of touch. As noted above, men in general are more likely to sexualize touch unless it is hostile or aggressive (Smith et al., 1998). Along the same line, Abbey and Melby (1986) found that men are more likely to perceive sexual intent when women touch them, while women are less likely to perceive such sexual intent in men, especially when the situation is ambiguous or casual.

In large part, clients’ individual factors contribute to the context of touch and therefore of extreme importance. They include presenting problem, diagnosis, personality, history, and in particular, history of abuse, culture and gender. Timing is important (Warnecke, 2011). While a handshake may be appropriate at the beginning of treatment, other forms of touch, such as a hug or a kiss on the cheek may not be. It is essential for the therapist to have explored his or her own relationship to touch issues as well.

Even Pope and Vasquez (1998), with their major concerns about boundaries and dual relationships, have articulated the potential benefits of touch in psychotherapy:

*If the therapist is personally comfortable engaging in physical contact with a patient, maintains a theoretical orientation for which therapist-client contact is not antithetical, and has competence (education, training and supervised experience) in the use of touch, then the decision whether or not to make physical contact with a particular client must be based on a careful evaluation of the clinical needs of the client at that time.*

Pope and Vasquez emphasize that the quality of touch in psychotherapy is very much related to the quality and fitness of the therapists’ relationship with the client. As mentioned earlier, the relationship between client and therapist is of utmost importance regarding the meaning of non-verbal cues and will determine the clients’ response to touch.

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**Clients’ Perceptions Of Touch**

Clients, sometimes independent of therapists’ intentions, construct the meaning of touch bound by personal need and the relational needs of the client. In therapy, touch can have radically different contextual meanings amongst different clients, therapists, and settings (Hilton, 1997; Horton, et al., 1988; Kloser & Keith-Spiegel, 1998; Smith et al., 1998). If the therapist is personally comfortable engaging in physical contact with a patient, maintains a theoretical orientation for which therapist-client contact is not antithetical, and has competence (education, training and supervised experience) in the use of touch, then the decision whether or not to make physical contact with a particular client must be based on a careful evaluation of the clinical needs of the client at that time. As mentioned earlier, the relationship between client and therapist is of utmost importance regarding the meaning of non-verbal cues and will determine the clients’ response to touch.

Gelb (1982) conducted one of the first phenomenological studies of the meaning attributed by clients with regard to non-sexual touch and isolated four factors that are associated with a client’s positive evaluation of touch in therapy: Congruence of touch; clarity regarding boundaries in therapy; client’s perception of being in control of the physical contact, and client’s perception that the touch was for his/her benefit rather than the therapist’s. A study done by Horton et al. (1995) supported Gelb’s finding that the degree of therapeutic alliance significantly influences the client’s evaluation of touch.

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**Touch And The Therapeutic Alliance**

Several researchers report how touch enhances therapeutic alliance. In Horton’s et al. (1995) study, clients used terms and phrases, such as “bond,” “safety,” “closeness,” “there for me,” “on my side,” “deepened trust” and “my therapist really cares about me” to describe feelings associated with being touched by the therapist. Some considered being touched an indication of the therapist’s emotional availability and others described
In their survey of therapists, Pope, Tabachnick, Keith-Spiegel (1987) report the following from their survey of psychotherapists:

About one fourth of our respondents reported kissing their clients, either rarely (23.5%) or more often (5.0%). About half viewed this practice as unethical. An additional 36.6% believed it to be unethical in most circumstances.

In an interesting twist of logic, while professional literature, ethics classes and risk management principles advocate avoiding touch as much as possible, many surveys report that most therapists touch their clients in a non-sexual manner. Tinsley, Smith and Foster (1996) report that 87% of therapists touch their clients. A total of 85% reported by Pope, Tabachnick, Keith-Spiegel (1987) hug their clients rarely or sometimes. Schultz (1975) found that 65% of therapists approve of touch as an adjunct to verbal psychotherapy. Holroyd and Brodsky (1977) found that approximately one third of psychologists reported using some form of touch with their clients.

In their national survey, Pope & Tabachnick (1994) were admittedly surprised to find that nonsexual physical touch in the form of being cradled or held by their therapists was reported by about one fourth of client-participants. They also found that about 1 in 20 (6%) reported that the therapist touched the client in a sexual way. These researchers’ bias in regard to the issue of touch in therapy becomes apparent when one reads their following reflection and their alarm at the their finding:

As was cited above, several factors have been found to significantly correlate with a client’s positive evaluation of touch, such as clarity regarding boundaries, congruence of touch, client’s sense of being in control and the client’s perception that touch is for his/her benefit (Gelb, 1982; Horton, 1995; McGuirk, 2012). Positive functions of touch, as experienced by clients who have experienced touch in psychotherapy, include providing a link to external reality, increasing self-esteem, and inviting the experience of new modes of relating. Other scholars have reported that clients touch each other to be of mutual benefit and that touch reinforced the sense of the therapist’s caring and involvement. The findings also “support the judicious use of touch with clients who manifest a need to be touched, or who ask for comforting or supportive contact” (Horton et. al., 1995, p.455).

The important conclusion of these findings is that therapists’ own attitudes towards touch and their tendency to sexualize touch are the key factors in contributing to sexual misconduct rather than the touch itself. This has been interpreted by most researchers to mean that therapists who differentiate between those with whom they will employ touch in therapy are sexualizing touch and are also more likely to violate the sexual boundaries of therapy. The same study did not find any correlations between non-sexual touch and sexual touch when therapists touched men and women equally.

Perhaps one of the more important significant findings is reported by Holroyd and Brodsky (1980). Their study relates to the differential treatment of female and male clients with regard to non-erotic touch, which was systematically related to therapist-client erotic involvement. The important conclusion of these findings is that therapists’ own attitudes towards touch and their tendency to sexualize touch are the key factors in contributing to sexual misconduct rather than the touch itself. The prevalent biased view in the field has, in part, been perpetuated by these writers who do not consider touch as an important and basic healing method, or recognize it as one of the most basic forms of human communication. Like so many others in the field, they associate or link non-sexual touch with sexual touch. Additionally, their statement that there is a ‘lack’ of research of the healing effect of touch as is surprising as it is inaccurate. This attitude goes along with Pope’s (1982) and his followers’ assertion that non-sexual dual relationships often lead to sexual dual relationships.

The human potential movement and the humanistic movement of the 1960s introduced a whole new approach to touch and boundaries in therapy. This movement endorsed appropriate non-erotic touch and viewed it as an enhancement of the therapist-client connection (Boneit, 2008; Hunter & Struze, 1998). Rogers (1975) discusses the value of touch and describes specifically how he has soothed clients by holding, embracing and kissing them. Gestalt therapy incorporates numerous forms of touch as an integral part of therapy (Perls 1973). Gestalt practitioners place a special importance on non-verbal communication and non-verbal intervention. Unfortunately, Gestalt practices in the 60’s and early 70’s, under Perls’ leadership went too far and at times, included unethical sexual touch in conjunction with therapy (Hunter & Struze, 1998). Lazarus and Zur (2002) note how the promiscuous practices in the 1960s around touch, nudity and sexuality have resulted in some form of backlash, where touch and other boundary crossings have since been viewed as harmful.

In their survey of therapists, Pope, Tabachnick and Keith-Spiegel (1987) report that therapists of differing theoretical orientations have very different beliefs about the effect and practice of touching clients. They report experiencing “parity” with the therapist. The same survey also found that many clients stated that touch reinforced their sense of the therapist’s caring about them, which in turn allowed them to open up and take more risks in therapy, hence increasing the benefits of treatment.

Surveys on Touch In Therapy

Body psychotherapists’ clinical orientation, such as Reichian (Reich, 1972) or Bioenergetics (Lowen, 1958, 1976) use touch as their primary tool in psychotherapy. They see the value of touch and endorse it as a therapeutic tool wholeheartedly.

Most psychoanalysts, as noted earlier, are highly opposed to any form of touch in therapy (Menninger, 1958, Wolberg, 1967, Smith, et. al. 1988). However, many other orientations support the clinically appropriate use of touch (Milakowitch, 1993; Williams, 1997; Young, 2005; Zuur, 2007a, 2007b). Very few modern analysts, such as Fosshage (2000) have differed with the main line analytic doctrine and advocate a clinically responsible use of touch in psychoanalysis.
that 30% of humanistic therapists indicated that nonerotic hugging, kissing and affectionate touching might frequently benefit clients in psychotherapy. In contrast, only 6% of psychodynamic therapists indicated the same. While most psychodynamic therapists thought touch could be easily misunderstood, humanistic therapists did not share this view.

Milakovitch (1998) compares therapists who touch and those who do not touch. The following are some of his findings:

- Therapists who touch are likely to subscribe to a humanistic theoretical orientation, while therapists who do not touch usually subscribe to a psychodynamic orientation.
- Therapists who touch, obviously value touch in therapy and believe that gratifying the need to be touched is important. Therapists who do not touch believe that gratifying the need to be touched is detrimental to therapy and the client.
- Unlike therapists who do not touch, therapists who touch are more likely to be touched by their own therapists and had supervisors and professors who believe in the legitimacy of touch as a therapeutic tool.

Part of the problem with differentiating sexual and non-sexual touch in therapy stems from the lack of differentiation between sexual feeling and sexual activity. While about 90% of therapists report being sexually attracted to their clients at some time (Pope & Vasquez, 1998), less than 10% have ever violated their clients sexually (Lazarus and Zur [2000], Smith et al, [1998]). Since it is possible that the problem of such lack of differentiation is rooted in insufficient professional education. Part of the problem with differentiating sexual and non-sexual touch in therapy stems from the lack of differentiation between sexual feeling and sexual activity. They view the problem as starting with graduate schools, which focus on rigid, restrictive ethical education and the teaching of risk management practices rather than providing a focus which will assist students in recognizing and processing their sexual feelings towards clients; something, which most would agree, is a common element in the therapist/client dynamic (Pope, Sonne, & Holroyd, 1993). Such lack of education undoubtedly exacerbates the problem, resulting in untreated therapists who tend to deny or suppress the natural and healthy needs of clients, which is likely to increase their vulnerability to violate their clients.

Part of the problem with differentiating sexual and non-sexual touch in therapy stems from the lack of differentiation between sexual feeling and sexual activity.
Any touching in therapy should be solely for the benefit of the client and great caution must be taken if the client is dissociated. The hypocampus, amygdala, hypothalamus and thalamus function by laying down memory and trauma is highly controversial. A balanced view is provided in a monograph published by The International Society for Traumatic Stress Studies (Childhood Trauma Remembered (ISTSS, 1998). Many studies suggest that language based interventions may allow more adequate time for developing rapport, trust and a sense of safety in which deeper affect and profound pain can be released and tolerated. Once a strong therapeutic alliance has been formed, “the use of touch will evoke, address and hopefully help correct such historical experiences and distortions as: deprivation and neglect; over stimulation, intrusion and bodily violation, sexualization, parental narcissistic use of the child; deadening of vitality or use of the body as an instrument (Cornell, 1997, p.33).”

New forms of body-centered psychotherapy have been developed which apply softer techniques and less analytical methodology. These forms use less exploitive, stressful postures, invasive touching, or breathing to extreme states. There is less of a focus on analysis as the client takes more responsibility for finding meaning in the communication from their body voice. These new forms, yet to be thoroughly researched, include Kurtz’s (1990) Hakomi Therapy, Gay and Kathy Hendricks’ Radiance Method, Amy and Arnold Mindells’ (1983) Process Therapy, and Christine Caldwells’ Moving Cycle (1997) and Rubenfeld Synergy System (Rubenfeld, 2000) among others.

Biochemical Links between Consciousness, Mind & Body Energy

Somatic therapists refer to “energy” and associate it with the release of emotion and the restoration of health. This is a foreign concept to most Western traditionally trained practitioners but ancient and alternative healing methods refer to a force of energy that animates the entire organism. Chiropactors refer to it as “innate intelligence”, Hindus call it Prana, Chinese, chi, Freud, libido, Reich, orgone energy. Candace Pert, a neuroscientist, states, “it’s my belief that this mysterious energy is actually the free flow of information carried by the biochemicals of emotion, the neuropeptides and their receptors” (Pert, 1997, p. 288). The limbic system, often referred to as the part of the brain that controls emotions, has forty times more neuropeptide receptors than other parts of the brain. Blood flow is closely regulated by emotional peptides, which signal receptors on blood vessel walls to constrict or dilate, and so influence the amount and velocity of blood flowing through them from moment to moment. The brain requires a plentiful source of glucose in order for the neurons and glial cells to perform their function. When emotions are blocked due to denial, repression, or trauma, blood flow can become chronically constricted, depriving the frontal cortex, as well as other organs, of vital nourishment. This can cause one to feel foggy and less alert, limited in awareness, with diminished ability to facilitate the body-mind conversation in order to make conscious decisions that alter physiology or behavior. “Work that is both somatic and emotional fosters self-healing by giving clients access to the limbic system” (Caldwell, 1997, p. 193). The nervous system learns from pleasure, as well as pain. Each time we make sense of new information, the brain rewards us by releasing endorphins and other pleasure-producing chemicals. We are familiar with these concepts as they relate to behavioral classical conditioning, and we are familiar with the common “aha” experience in psychotherapy. Touch is a very sophisticated language that is communicated through our skin, both receiving and giving information. It bypasses words and rational concepts housed in the neocortical brain (Caldwell, 1997).

Pert postulates “The limbic system, and it’s neurons have axons that extend into the pituitary gland, these axons secrete a neuropeptide called CRF. … We could say that CRF is the peptide of negative expectations, since it both receives and transmits information from the thalamus to the hypothalamus and pituitary gland.” Animal studies show that monkey babies deprived of maternal nurturing, neglected or abused have high levels of CRF. These baby animals were cured by an older ‘monkey hug therapist’ who simply held and hugged the stressed out baby monkeys causing their chronically elevated CRF levels to go down. “In the case of treating mood disorders and other mental unwellness, the mainstream misses a lot by excluding touch, by ignoring the fact that the body really is a gateway to the mind, and by refusing to acknowledge the importance of emotional release as a mind-body event with the potential to supplement or even sometimes replace talk cure and prescription pills” (Pert, 1997, p. 274). Feeling is healed through somatic experience because our minds and our feelings reside in our bodies.

Pert (1997) writes of accessing ones’ psychosomatic stress and entering the bodymind’s conversation and redirecting it as a way to keep information flowing, feedback systems working, and natural balance maintained. She asserts that we are literally able to consciously and intentionally intervene at the level of our molecules, making significant changes in our physiology, releasing certain biochemicals into our systems. The well-known tools of traditional psychotherapeutic trade, such as dreams and the symbolic meaning of words, as well as touch do, in fact, access the psychosomatic network.

There is no doubt that these traditional tools have their place and their effectiveness but it is necessary to acknowledge other effective points of entry as well: the skin, spinal cord, and organs are all nodal points of entry into the system. The deepest oldest messages are stored and must be accessed through the body. “Your body is your unconscious mind, and you can’t heal it by talk alone.” (Pert, 1997, p. 306).

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traces that are subsequently regulated by stress hormones. Flashbacks can occur when a current stressor activates traumatic memory traces and the client dissociates and loses full contact with essential details in the current environment. Positive therapeutic results have been demonstrated in the cognitive-behavioral treatment of psychological trauma survivors. Touch, used in a non-structured, organic manner can yield results that are subsequently regulated by stress hormones. Flashbacks can occur when a current stressor activates traumatic memory traces and the client dissociates and loses full contact with essential details in the current environment. Positive therapeutic results have been demonstrated in the cognitive-behavioral treatment of psychological trauma survivors. Touch, used in a non-structured, organic manner can yield results.

Many therapists consider that touch of any kind is to be avoided with clients who have been abused through violations of the body. Many therapists and all somatic theorists believe that a client will have great difficulty in fully recovering from such trauma if only verbal or cognitive approaches to therapy are used...[and therapists] help them identify appropriate, connective, non-violating forms of touch. "The client can relax and assimilate sensory data about physical contact only if they are processed concretely and with an intense focus on reality-testing feedback loops" (H的にK & Huntre, 1998, P. 217). It is essential that the therapist be familiar with the dynamics of dissociation before working with a trauma survivor. (See Steele & Colrain, 1994, for an extensive list of dissociative signs.) When working with clients who have a history of abuse, it is of crucial importance that the client's permission be requested prior to making any physical contact. Asking for consent respect for her and her body, it says her preference will be respected and that no intrusion (however slight) will occur against her will (Courtois, 1998).

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Touch in psychotherapy occurs between female and male clients as well as same-sex therapist-client dyads, but the highest frequency of physical contact occurs between male therapist and their female clients (Brodky, 1985). In this context, attention should be paid to power dynamics whereby women touched by male therapists might feel devalued because of social stereotypes (Alyn, 1998). Clinicians are cautioned that for men, who generally do not give or receive nonsexual touch, regression transference may be elicited by the use of nonerotic touch in psychotherapy (Downey, 1986). The soothing, affirming experience of touch is most important at the beginning and end of one's life and, nurturing touch can gently facilitate the process of aging and dying with dignity (Hunter & Struve, 1998).

Gender issues

Touch in psychotherapy has been described as a powerful means of communication between psychological and emotional levels. Touch is often seen as a way of expressing emotional and psychological needs, and it can be used to establish a connection between therapist and patient. However, the use of touch in psychotherapy is not without its controversies. For example, the use of touch can be perceived as an invasion of the patient's space, which can lead to feelings of discomfort or anxiety. Additionally, the use of touch can be seen as a form of power dynamics, with the therapist in a position of control over the client. Therefore, it is important to establish clear boundaries and consent for touch in the therapeutic relationship. The use of touch in psychotherapy is a complex issue, and clinicians must be aware of the potential risks and benefits before deciding to use touch in their practice.

Psychoanalytic Prohibition Of Touch In Therapy

Psychoanalysis traditionally has placed almost an absolute interdiction on physical touch between client and analyst within the analytic arena. Yet touch, based on our largest sensory organ, the skin, provides a fundamental and a wide variety of forms of communication. It is important to consider the tactile experiences of the client and the analyst in the context of the therapeutic relationship. The use of touch in psychoanalysis has been a topic of discussion and debate, with some proponents arguing for its use and others opposing it. The use of touch can be seen as a way of establishing a connection between the therapist and the client, but it can also be perceived as an invasion of the client's privacy. Therefore, it is important to establish clear boundaries and consent for touch in the therapeutic relationship. The use of touch in psychoanalysis is a complex issue, and clinicians must be aware of the potential risks and benefits before deciding to use touch in their practice.
On Power And Touch In Therapy

The concern with therapist’s power has been a major focus around the issue of touch due to the related concern with exploitation and sexuality (Zur, 2009). The primary rationale for the argument to abstain from touching is that therapists may misuse their power to exploit clients for their own benefit and to the clients’ detriment (Bersoff, 1999; Borys, 1992; Hertly & Corey, 1992; Pope & Vasquez, 1998; Woody, 1998). The argument is that the power differential enables and, some argue, encourages therapists to sexually exploit their clients.

Kitchener (1988) describes the power differential between therapists and clients as one of the three most important factors in determining the risk of harm to clients engaged in exploitative relationships with their therapists. Similarly, Gottlieb (1993) lists power differentials as a first dimension in the decision-making model for avoiding exploitative relationships in therapy. Pope (Pope & Vasquez, 1998), like his many followers, maintains that because of the power differential, the client is vulnerable and largely incapable of free choice.

The argument of power differential put forth by feminists like Alyn (1998) or Brown (1985) does not view women as capable of asserting or having power in therapeutic relationships. Instead, it views them as weak and defenseless in the hands of their powerful, dominant male therapists.

The concern with therapists’ power is important, as the power differential is true for many (but not necessarily always) therapist-client relationships. Therapists are generally hired for their expertise and this, in most cases, gives them at least some measure of being an expert, with knowledge and information that increases the power advantage over their clients. Additionally, many of our clients seek our help in times of crisis, confusion and increased vulnerability (Hunter & Struve, 1988; Lazarus & Zur, 2000; Smith et al., 1998).

The term ‘power differential’ between therapists and clients has almost become interchangeable with exploitation and harm in the psychotherapeutic ethics literature (Lazarus & Zur, 2002). This is often forgotten in such discussions is that many relationships with a significant differential of power, such as parent-child, teacher-student or coach-athlete, are not inherently exploitative (Zur, 2000, 2007a). Power, is, in itself, neither good nor bad, it is neutral. Parental power facilitates children’s growth, teachers’ authority enables students to learn, and the influence of coaches, helps athletes to achieve their full athletic potential. Few, if any, marriage, business, friendship, or therapy relationships are truly equal. Therapists’ power, like that of parents, teachers, coaches, ministers, politicians, policemen, attorneys or physicians, can be used or abused. The Hippocratic Oath, which states, ‘first do no harm’ attends exactly to such dangers. The problem of abusive or exploitative power in therapy is not going to be avoided by avoiding all touch and other boundary crossing in therapy. Tomm (1993) adds “It is not the power itself that corrupts, it is the disposition to corruption (or lack of personal responsibility) that is amplified by the power” (p. 11).

The problem with the argument of power differential is that all clients are portrayed as weak, defenseless, and powerless in the hands of their powerful, dominant, compelling therapists. The disparity in power is regarded as extreme, which is disempowering to the client. It is possible that many therapists cling to the false ideals of the segregated therapy session and avoid dual relationships because it increases their professional status (Dineen, 1996; Zur, 2000, 2001). These therapists are thereby imbuing themselves with undue power that can all too easily be translated into exploitation (Zur, 2001). Many therapists work with clients who are much more powerful than they. Some clients are CEO’s of large corporations, judges, powerhouse attorneys, master mediators or successful entrepreneurs. Often, these clients do not regard their therapists as particularly powerful or persuasive, and their therapists experience themselves as more powerful and successful than their clients. Such is a prime example of when therapists have to work hard and cultivating an aura of power so as to appear credible.

In summary, therapists must be very careful not to abuse the power and trust they often have in the therapeutic relationships. At the same time it is important that therapists humbly accept that some clients are more powerful than they are and acknowledge the limitation of how much power and influence they really have. We must all remember that power by itself does not corrupt, but lack of personal integrity does. Instead of banning touch so therapists will not misuse their power, we must increase the therapist’s ‘Integrity Quotient’.

Touch As A Boundary Issue

The intersection of boundaries, touch and psychotherapy presents a unique and complex matter as it involved two types of boundaries (Zur, 2007a). The first one is the distinct boundary of the physical body and the second one is the more illusive concern with psychotherapeutic boundaries. The boundary of the body is clear and well defined by the skin. It is, at, once, the demarcation of physical, separate identity as well as the reciprocal experience of connection. While the skin is physically, distinctively defined, the numerous physiological and emotional regulatory systems affected when the skin is touched, are extremely complex and mysterious. Boundaries in therapy are, at least as complex as the body boundary. Similar to the body boundary, they seem simple to define at first, but a deeper investigation reveals an extremely intricate and mysterious web of connections between therapeutic boundaries and interventions and clients’ emotional, physical and spiritual wellbeing. This section will focus on the boundary issue aspect of touch in psychotherapy.

Boundaries in psychotherapy have been a topic of growing debate in the last two decades, with touch being a central element of the issue. Therapists who touch their clients, have often been viewed as problematic and their actions judged as a boundary problem that is often linked to, or equated with, sexuality and harm. Lazarus and Zur (2002) describe the inappropriate boundary crossings in psychotherapy. They illuminate that there is a lack of differentiation between boundary crossing and boundary violation. As a result, confusion, false accusations and fear run rampant.

In the field of psychotherapy, there is neither agreement nor a single definition of what constitute clinically and ethically appropriate boundaries between therapists and clients. Boundary crossing has been confused and equated with boundary violations (McGuirk, 1992). Traditionally, boundary crossings in psychotherapy have been defined as any deviation from traditional, strict, hands-off, ‘only in the office,’ emotionally distant forms of touch (Lazarus & Zur, 2002; Zur, 2007a). Besides physical touch, boundaries in therapy generally refer to issues of therapists’ self-disclosure, length and place of sessions, activities outside the office, gift exchange, bartering, social and other non-therapeutic contact, and various forms of dual relationships.

As Lazarus and Zur (2002) articulated in their book, Dual Relationships and Psychotherapy, boundary violations in therapy are distinctly different from boundary crossings. While boundary violations by therapists are harmful to their clients’ guidance, boundary crossings are not and can prove to be extremely helpful. Harmful boundary violations occur typically when therapists and clients are engaged in exploitative relationships, while therapists’ sexual touch with current clients. In contrast to boundary violations, boundary crossings can be an integral part of well-formulated treatment plans. Examples are: a. Reichian or Bioenergetics therapist who used hand-on techniques; b. Handshake, an appropriate pat on the back, handholding or a non-sexual hug are all also legitimate and often helpful boundary crossings. These forms of touch are similar to other common boundary crossings, such as when a therapist makes a home visit to a bedridden or immobile elderly client or when a behavioral therapist, as part of systematic desensitization, flies on an airplane with a client who suffers from a fear of flying (Zur, 2002, 2007a). Boundary crossing may be simply seen as a departure from the traditional, rigid psychoanalytic approach or inflexible risk management proceedings.

At the heart of the opposition to touch in therapy is the argument that places immense importance on separation and clear and inflexible boundaries in therapy. Most of the support for this argument comes from ethicists, attorneys, licensing boards, psychoanalysts, and rigid proponents of clinically restrictive risk management practices. These professionals generally view any deviation from these rigid boundaries as a threat to the therapeutic process. They view touch as a central concern with exploitation and sexual relations between therapists and clients (Borys, 1994; Brown, 1994; Katherine, 1993; Pope & Vasquez, 1998; Sonne, 1989; Strasburger, Jorgenson, & Sutherland, 1992).

As noted throughout this paper, the concern with boundaries has been intricately integrated as a primary focus of psychoanalytic theory and practice. For example, Menninger (1961), Epstein (Epstein & Simon, 1990), Langs (1976) and Simon (1992), view any boundary crossing as detrimental to the therapeutic process and to clients themselves. They have advocated an adherence to rigid therapeutic boundaries and oppose most boundary crossings. In fact, many analysts have evaluated even appropriate and helpful boundary crossings, such as a comforting hug or hand holding as poor boundary management. The concern with boundaries is not limited to analytically oriented therapists. Most ethics texts advocate quite rigid adherence to strict boundaries and view most boundary crossings as detrimental to therapy (Borys & Pope, 1989; Brown, 1985; Kape & Geibelhausen, 1994; Katherine, 1993; Kitchener, 1988; Pope & Vasquez, 1999; Sonne, 1989).

What is often ignored by almost all analysts, ethicists and risk management experts is the basic fact that therapeutic orientations, such as humanistic, behavioral, cognitive, behavioral, family systems, feminist or group therapy are inclined to endorse boundary crossings, such as physical touch as part of effective treatment (Williams, 1997; Zur, 2007a). Even though cognitive behavioral, family systems and group therapy are currently the most practiced orientations, they are ignored and marginalized when it comes to ethical discussion of boundaries.

The discussion of boundaries almost completely ignores the fact that non-Western cultures often have a different attitude towards boundaries in general and touch in particular (Lazarus & Zur, 2002). They, therefore, judge the appropriateness of touch differently. Cultures such as Latin, African American or Native American, are more likely to integrate touch into the communication between therapists and clients.

Another unfounded belief about boundaries in general, and specifically about touch, is the belief in the ‘slippery slope’ idea. As articulated above, this belief claims that minor boundary crossings inevitably lead to boundary violations and sexual relationships (Lazarus, 1994). A rigid attitude towards boundary crossings in general and particularly towards touch in therapy stems in part from what has been called “sexualizing boundaries.” This is a distorted cultural and professional view that sees all boundaries as sexual in nature (Zur, 2007a).

Touch and many other boundary crossings with certain clients, such as those with borderline personality disorders or other severe disorders must be approached with caution. Effective therapy with borderline clients, for example, often requires a clearly structured and well-defined therapeutic environment. Boundary crossings should be implemented according to the client’s unique needs and the specific situation. It is recommended that the rationale for boundary crossings be clearly articulated and, when appropriate, included in the treatment plan.

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Boundaries in psychotherapy have been a topic of growing debate in the last two decades, with touch being a central element of the issue.
Before chaperoning became part of the standard of care, some women preferred not to have such a witness, especially if they had a long, trusting relationship with their physician or if the physician was a woman. Providing some comfort to the female client, the chaperone's primary role is to protect the physician from false accusation, criminal complaint or lawsuit. The witness also reduces the risk that misconduct may occur.

The acceptance as the "standard" in the community. A prime example of how risk management affects the standard of care is the requirement that a woman chaperone be present during a gynecological pelvic exam. Besides

Risk management has become one of the most powerful forces in medicine in general including psychotherapy. Risk management is the process whereby therapists avoid certain behaviors and clinical interventions—not because they are clinically ill advised, unethical, harmful or wrong, but because they may appear improper in front of judges, juries, licensing boards or ethic committees. (Guthiel & Gabbard, 1993; Williams, 1997). While the clinically ill advised and ethical therapist carefully weighs the possible risk of any therapeutic intervention, including touch, against its potential benefits, risk-management frightens us into avoiding all "risks behavior" regardless of the likely positive results (Bonitz, 2008; Lazarus, 1994; Williams, 1997; Zur, 2007a).

Risk management, Prohibition Of Touch & Slippery slope Argument

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Bearing in mind, though, that risk management is neither part of the ethics codes nor part of any treatment standard. Risk management is merely a set of precautions advocated by malpractice insurance vendors, sometimes, though, to minimize the chances of being sued. When it comes to touch, good treatment and good risk management may sometimes call for mutually exclusive decisions regarding a given client. For example, it would probably be good risk management never to touch children and for male therapists never to touch female clients. Most of us would agree that such risk management advice is utter nonsense, since helping those in need is a fundamental ingredient of the psychotherapy professions. This example, like the case of the psychiatrist who refused to hold the grieving mother, illustrates the faulty logic and drawbacks of risk management and its single-minded devotion to avoiding lawsuits and its equally single-minded lack of regard for the primary goals of our work.

We have seen how, over time, a new standard of care insinuates itself into psychotherapy. This results in a continuing rise of the risk management bar as to what constitutes acceptable clinical behavior. Expert witnesses have often encountered testimonials by prominent experts that boldly and falsely asserted that touch, like gifts, extending a session beyond the allotted time or bartering always fail to meet the standard of care (Williams 1997). Similarly and dangerously, many licensing boards have unctually accepted risk management recommendations as their guidelines. Paradoxically and ironically, as the bar is raised and more interventions seem frowned upon by the boards, courts and attorneys, there is an increased likelihood that insurance companies and therapists will be sued or sanctioned. Risk management, without any doubt, has come to haunt the insurance companies, an unforseen retribution for their shortsighted, cost-saving strategies. Sadly, it also impacts our profession negatively and often reduces our creativity and effectiveness, thus depriving our clients of the fullest measure of care.

The fear campaign by the insurance carriers, attorneys and many ethics and ‘risk management experts’ has too often succeeded in paralyzing therapists and forcing them to restrict themselves to rigid and trustworthy ways of relating to clients and avoiding any physical contact with their clients. As a result, clinical effectiveness is compromised. The danger that risk management poses to clinical effectiveness can be clearly seen in its impact. ‘Aggressive touch’ which obviously has a significant negative effect on therapeutic alliance, the number one predictor of effective therapy (Lambert, 1991). We cannot think of any more effective ways to enhance therapeutic alliance than a reassuring or comforting hug, pat or hand holding. All of this may not be effective ‘risk management’, but it is basically good therapy.

Very regrettable, most professional organizations have jumped on the bandwagon and joined the fear campaign. They promote the practice of defensive medicine through their own risk management workshops and seminars. As we see monthly, have given attorneys a regular column in their newsletters or journals where this paranoiac thinking is disseminated. As risk management becomes more prevalent, its effects is clearly seen on new therapists. In the numerous Ethics with Soul workshops I have conducted across the country, (O.C.Z.) have noted that older (non-analytically oriented) therapists seem to be less concerned about risk management practices. The opposite is true of the new graduates. Alarmingly, through the fault of most graduate schools and their ethics professors, many of the newer therapists believe that risk management practices are part of the standard of care.

In summary, a risk managed practice may sound as if it adheres to practical or pragmatic advice but, in fact, it is a misnomer for a practice in which fear of attorneys, and boards, rather than feeling, caring and intelligent clinical considerations, determine the course of therapy. As therapists, we are trained, paid and provided the best care possible for clients. We are not paid to act defensively. This fear of board investigations and malpractice lawsuits pushes therapists to take precautions. Consequently, we lower the quality of care for our clients.

Arnold Lazarus (1994) appropriately claims, “One of the worst professional or ethical violations is that of permitting current risk management principles to take preception over humane interventions.” Clinical interventions must be determined by empirically-based treatment plans, clinicians’ intuitive and creative sensitivities, and specific client factors, such as the client’s problems, situation, personality, degree of functionality, history, and culture — never by fear of boards and courts. We must remember that the therapeutic effect of touch has been scientifically and clinically proven. We must also remember that we are hired to help rather than being hired to practice risk management. Therefore we must touch clients when appropriate in a way that will help them grow and heal.

**Slippery Slope Argument Around Touch**

The term ‘slippery slope’ refers to the idea that failure to adhere to touch guidelines, rigid standards, most commonly based on analytic and risk management approaches, will undeniably harm clients, nullify therapeutic effectiveness and often leads to therapist-client sexual relationships. This fear-based view has been most dominant in the discussion of employing or incorporating touch in psychotherapy. It underlines most arguments against the use of psychotherapy by therapists. It asserts that a handshake, non-sexual hug or a re-assuring pat, are all just the first downhill steps towards inevitable deterioration, towards full “fledged” sexual relationships.

The slippery slope process is described by Gabbard (1994) as follows: “. . . the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary” (p. 284). Pope (1990-b), whose endorsement of the slippery slope theory has significantly contributed to its popularity, expresses a similar opinion: “. . . non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships” (p. 68). Strasburger et al. (1992) conclude, “Obviously, the best advice to therapists is not to start (down) the slippery slope, and to avoid boundary violations…” (p. 547-548). Sonne (1994) adds her version of the slippery slope: “With the blurring of the expected functions and responsibilities of the therapist and client comes the breakdown of the boundaries of the professional relationship itself” (p. 338).

In agreement is Simons (1991), who decrees that “The boundary violation permissions of therapist-client sex can be as psychologically damaging as the actual sexual involvement itself” (p. 614). This poignant statement summarizes the opinion that the chance for exploitation and harm is reduced or nullified only by refraining from engaging in physical touch or any other boundary crossing. Many writers describe a long list of therapists’ behaviors (e.g. self-disclosure, hugs, home visits, socializing, longer sessions, lunching, exchanging gifts, walks, playing in recreational leagues) that they believe to be precursors to sexual dual relationships (Borys & Pope, 1989; Craig, 1991; Lakin, 1991; Pope, 1990; Pope & Vasquez, 1989; Rutter, 1989; St. Germaine, 1996). Without doubt, touch tops this list.

The link between non-sexual touch and sexual violation is almost an epidemic in the field. In 1980 Holroyd & Brodsky titled their article regarding their survey “Does touching clients lead to sexual intercourse?” Not surprisingly, the therapists that they surveyed stated that “it is difficult to determine where ‘non-erotic hugging, kissing, and affectionate touching’ leaves off and ‘erotic contact’ begins” (p. 810). Similarly Pope and colleagues (Pope & Bouhoutsos, 1986; Pope, Schever, & Levenson, 1980; Pope & Tabachnick, 1993; Pope & Vasquez, 1998) have conducted several surveys that gave much more weight to the potential dangers of touching and how it is likely to lead to sexual intimacy rather than the more inquisitive balanced stance of looking at the positive and negative potentialities and unique complexities that touch introduces into therapy, Pope, Tabachnick and Keith-Spiegel (1987) citing several of their colleagues state clearly that the attention to erotic contact in therapy has raised doubt about the “legitimacy and effects of ostensibly non-erotic physical contact” (p. 1001).

Almost all ethics texts, like the widely used one by Koehler and Keith-Spiegel (1988) place the section of touch in the midst of chapter on sexual violation. The opposite is true of the new graduates. Alarmingly, through the fault of most graduate schools and their ethics professors, many of the newer therapists believe that risk management practices are part of the standard of care.

**The slippery slope argument is grounded primarily in the assumption that touch or any boundary crossing, however trivial it may be, inevitably leads to sex and other boundary violations.**

It is important to reiterate that whereas the analytic contingently underscores that crossing boundaries will nullify therapeutic effectiveness and hence cause harm, many other orientations have a different viewpoint. Behavioral, humanistic, group, family, existential, feminist or gestalt therapists at times stress the importance of tearing down interpersonal boundaries and strongly dispute the implication that most therapists who were engaged in boundary violation had been engaged in boundary crossings prior to their engagement in boundary violations. However, to quote Keith-Spiegel (1986), “. . . that an actors’ behavior, whether it be sexual or non-sexual, ‘leads to’ or ‘causes’ death because most people see a doctor before they die” (Zur, 2000). Lazarus calls this thinking “an extreme form of syllogistic reasoning” (1994, p. 257). We learn in school that sequential statistical relationships (correlations) cannot simply be translated into causal connections.

The slippery slope notion that primarily, in fact but most boundary crossing, will inevitably end up with sex has been identified by Dinien (1996) as part of the more inclusive problematic of psychotherapists’ sexualizing of all boundaries.

It is important to reiterate that whereas the analytic contingently underscores that crossing boundaries will nullify therapeutic effectiveness and hence cause harm, many other orientations have a different viewpoint. Behavioral, humanistic, group, family, existential, feminist or gestalt therapists at times stress the importance of tearing down interpersonal boundaries and strongly dispute the assumption that this will lead to exploitation and harm (Greenspan, 1995, Williams, 1997; Zur, 2000, 2001, 2007a, 2007b).

**Summary**

Touch is extremely important for health, healthy development and healing. The medicinal aspect of touch has been known and used since earliest recorded medical history, 25 centuries ago. Touch triggers a cascade of healing chemical responses including a decrease in stress hormones and an increase in serotonin and dopamine levels. Additionally, touch has been shown to increase the immune system’s cytotoxic capacity, thereby helping our body maintain its defenses and decreasing anxiety, depression, hyperactivity, inattention, stress hormones and cortisol levels.

In psychotherapy, there are many forms of touch. Among others, there are greeting, soothing, guiding, holding, modeling and reassuring kinds of touch. In addition to the use of touch as an adjunct to psychotherapy there are several schools of thought, which are part of body psychotherapy orientations. These include Reichian, Radix and several other somatic therapies. Most of them use touch as a therapeutic technique. Erotic or sexual touch are always unethical and can be harmful.

There is a growing body of research that identifies the important clinical potential of touch as an adjunct to verbal psychotherapy. Clinically appropriate touch increases a client’s sense of trust, comfort and ease with their therapist. As a result, touch is highly effective in enhancing therapeutic alliance, which is the best predictor of positive therapeutic outcome.

The meaning of touch can only be understood within the context of who the client is, the therapeutic relationship, and the therapeutic setting. Accordingly, before employing touch, it is essential that the clinician consider unique treatment elements for each client including factors, such as culture, history, presenting problem, diagnosis, gender, history, etc. One must also consider the therapists’ education, training, theoretical orientations and comfort with non-sexual touch. Systematic touch should be employed in therapy only when it is well thought out and is likely to have positive clinical effects. Touch must be approached with caution with borderline or narcissistic clients. Special sensitivity is also required when working with people who tend to sexualize relationships and/or have been abused, molested or raped. There is also a growing body of knowledge that shows the damage done by the systematic and rigid avoidance of all forms of touch in therapy.

The field of psychotherapy appears to be becoming increasingly polarized regarding the use of touch in psychotherapy. At the extremite end of one pole are the proponents of risk management practices and the “slippery slope” ideology whereby the most form of social touch, a handshake, a pat on the back, a comforting hug are seen as the first dangerous, incremental steps in the direction of the extreme misuse of power that will inevitably and unalterably result in sexual violation and psychological injury to the client. Many therapists are motivated by fear of the appearance of wrongdoing and therefore avoid all forms of touch. For theoretical reasons, psychoanalytically orientated therapists are opposed to any form of touch. At the opposite end of the pole are those therapists from traditions, which have historically valued touch as a congruent aspect of the therapeutic bond and as an acceptable tool in assisting a client to reach therapeutic goals. These therapists train in traditions that value and address the complex issues involved in utilizing touch with multiple therapies.
Unfortunately, due to the absence of attention to touch in most training programs, clinical supervision, outcome research and testing, most therapists do not think critically about incorporating the use of touch into their treatment plans. When they do touch they employ “touch but don’t talk.” Some touch in response to their own unexamined neurotic needs. Of course, these are the practitioners who are most likely to cause real injury to their clients. Additionally, the possible negative consequences of never touching our clients must be taken into consideration. Other therapists intuitively touch in a way that is supportive of the therapeutic bond, triggering the release of natural anti-depressant and stress reducing chemicals, increasing a client’s sense of self esteem, and helping the client move toward therapeutic goals. A professional responsible solution would be for all therapists to receive education and training that will allow the powerful therapeutic aspects of touch to be used responsibly and discriminatively in the care of their clients.

In summary, touch is important for healthy development and healing. Looking critically, not paradoxically, at the issue of touch in therapy one can easily see the fallacy and danger of the slippery slope ideology, risk management practices or rigid adherence to analytic guidelines. The decision to touch or not to touch is dependent upon the client’s personality, diagnosis, symptoms, culture, gender, history, etc, as well as the context of the relationship and the training and awareness of the therapist. Touching inappropriately can be damaging, as can be, the rigid and indiscriminant avoidance of touch. Touch, is one of the most basic forms of human relatedness, and has immense importance and positive potential for inclusion in psychotherapy.

**General Points And Ethical And Clinical Guidelines About Touch In Psychotherapy**

**THE GENERAL SIGNIFICANCE OF TOUCH**

- Touch is one of the most essential elements of human development: a form of communication, critical for healthy development and one of the most significant healing forces.
- In his seminal work, Touching: The Human Significance of the Skin, Ashley Montagu (1971) brought together a great array of studies demonstrating the significant role of physical touch in human development.
- The effects of touch deficiencies can have lifelong serious negative ramifications.
- Bowlby and Harlow, among many others, concluded that touch, rather than feeding, bonds infant to caregiver.
- Touch has a high degree of cultural relativity. People of Anglo-Saxon origin place low on a continuum of touch while those of Latin, Mediterranean and third world ancestry place on the high end.
- The general western culture and its emphasis on autonomy, independence, separateness and privacy have resulted in restricting interpersonal physical touch to a minimum. America is a low touch culture.
- In Western society, sex, love, power and dominance are dangerously confused.
- Americans tend to sexualize or infantilize the meaning of touch and as a result tend to avoid touch. Watson, parenting expert of the early 1900’s, cautioned mothers not to sexualize their infants by kissing or hugging them affectionately.

**TOUCH AND HEALING**

- The medicinal aspect of touch has been known and utilized since earliest recorded medical history, 25 centuries ago.
- Touch unleashes a stream of healing chemical responses including a decrease in stress hormones and an increase in serotonin and dopamine levels.
- Touch increases the immune system’s cytotoxic capacity thereby helping our body maintain its defenses.
- Massage has been shown to decrease anxiety, depression, hyperactivity, inattention, stress hormones and cortisol levels.
- Massaged babies are more sociable and more easily soothed than babies who have not been massaged.

**TYPES OF TOUCH IN PSYCHOTHERAPY**

- Ritualistic or socially accepted gestures
- Conversational Marker
- Consoling or reassuring
- Playful touch
- Grounding or reorienting
- Task-Oriented
- Corrective experience
- Instructional or modeling
- Celebratory or congratulatory
- Experiential
- Referential
- Inadvertent
- Preventing someone from hurting self or others
- Self-defense
- Therapeutic intervention – A bodytherapy medical technique
- Inappropriate, unethical and probably illegal forms of touch include sexual, hostile-violent and punishing touch.

**SOURCES OF THE PROHIBITION OF TOUCH IN THERAPY**

- The general western culture and its emphasis on autonomy, independence, separateness and privacy.
- The cultural tendency in the USA to sexualize most forms of touch.
- The traditional dualistic Western mind-body or mental-physical split.
- Homophobia.
- Some fundamentalist religious denominations that have a highly restrictive view of all forms of touch.
- The litigious culture and the resulting risk management and defensive medical practices.
- Psychoanalysis and its emphasis on neutrality, distance and rigid boundaries.
- Those feminist scholars who assert that any touch by male therapists of female patients is disempowering and injuring to the women.
- The fear-based, illogical slippery slope idea that non-sexual touch inevitably leads to sexual exploitation.
- The more recent crisis in the clergy and the not too distant daycare hysteria in regard to sexual exploitation.

**ETHICAL CONSIDERATIONS OF NON-SEXUAL TOUCH IN THERAPY**

- Touch in therapy is not inherently unethical.
- None of the professional organizations code of ethics (i.e., APA, ACP, ACA, NASW, CAMFT) view touch as unethical.
- Touch should be employed in therapy when it is likely to have positive therapeutic effect.
- Practicing risk management by rigidly avoiding touch is unethical. Therapists are not paid to protect themselves, they are hired to help, heal, support, etc.
- Avoiding touch in therapy on account of fear of boards or attorneys is unethical.
- Rigidly withholding touch from children and other clients who can benefit from it, such as those who are anxious, dissociative, grieving or terminally ill can be harming and therefore unethical.
- Sexual, erotic or violent touch in therapy is always unethical.
- Stopping therapy in order to engage in sexual touch or sexual relationships is unethical and often illegal.
- Ethical touch is the touch that is employed with consideration to the context of the therapeutic relationship and with sensitivity to clients’ variables, such as gender, culture, history, diagnosis, etc.
GUIDELINES FOR CLINICAL AND ETHICAL TOUCH IN THERAPY

- Therapists have a responsibility to explore their personal issues regarding touch and to seek education and consultation regarding the appropriate use of touch in psychotherapy.
- Therapists should not avoid touch out of fear of boards, attorneys or dread of litigation. Therapists are paid to provide the best care for their clients not to practice risk management.
- Special care should be taken in the use of touch with people who have experienced assault, neglect, attachment difficulties, rape, molestation, sexual addictions, eating disorders, and intimacy issues.
- Permission to touch should be obtained from clients in a form of a written consent if therapy involves extensive use of touch, such as is utilized in some forms of body psychotherapy.
- The therapist should state clearly that there will be no sexual contact and to be clear about the process and type of touch that will be used.
- The decision to touch should include a thorough deliberation of the clients’ potential perception and interpretation of touch.
- Therapists must be particularly careful to structure a foundation of client safety and empowerment before using touch.
- Factors that are associated with congruence are: clarity regarding boundaries, patients’ perception of being in control of the physical contact, the patient’s perception that the touch is for his/her benefit rather than the therapist’s.
- The therapist should state clearly that there will be no sexual contact and to be clear about the process and type of touch that will be used.
- Permission to touch should be obtained from clients in a form of a written consent if therapy involves extensive use of touch, such as is utilized in some forms of body psychotherapy.
- Touch is usually contraindicated for clients who are highly paranoid, actively hostile or aggressive, highly sexualized or who implicitly or explicitly demand touch.
- Special care should be taken in the use of touch with people who have experienced assault, neglect, attachment difficulties, rape, molestation, sexual addictions, eating disorders, and intimacy issues.
- Therapists should not avoid touch out of fear of boards, attorneys or dread of litigation. Therapists are paid to provide the best care for their clients not to practice risk management.
- Consultation is recommended in complex cases.
- Therapists have a responsibility to explore their personal issues regarding touch and to seek education and consultation regarding the appropriate use of touch in psychotherapy.

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References

To Touch Or Not To Touch: Exploring the Myth of Prohibition On Touch In Psychotherapy And Counseling. Article. Full-text available. This paper attempts to shed light on the illusive and complex nature of the standard of care in psychotherapy and counseling. It defines the standard of care, outlines its most important elements and explains what the standard is not. Additionally, it differentiates between risk management and the standard of care and gives a basic idea of what it takes to practice within the Psychotherapy or Somatic Touch Therapy Single Session Regular single session rate $125 USD/ 50 minutes Discounted rate of $110 per session when 3 sessions paid in advance at $330. Psychotherapy via Skype Regular rate. $125 USD/ 50 minutes Discounted rate of $110 per session when 3 sessions are paid in advance at $330. Psychotherapy Couples & Family Single Session Rate Regular rate $150 USD/ 50 minutes Discounted rate of $130 per session when 3 sessions are paid in advance at $390. To touch or not to touch: Exploring the Myth of Prohibition On Touch In Psychotherapy And Counseling by Zur Institute. Somatic Touch Bibliography. Polyvagal Explanation by Seth Porges on YouTube. Polyvagal Website of Stephen Porges.