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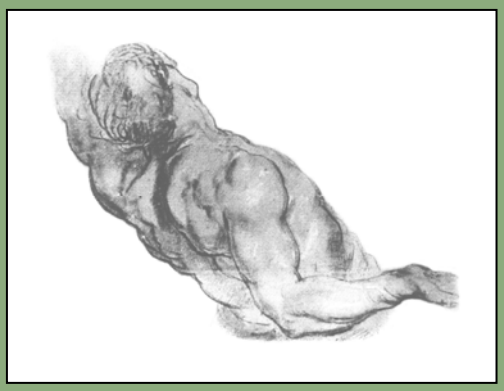

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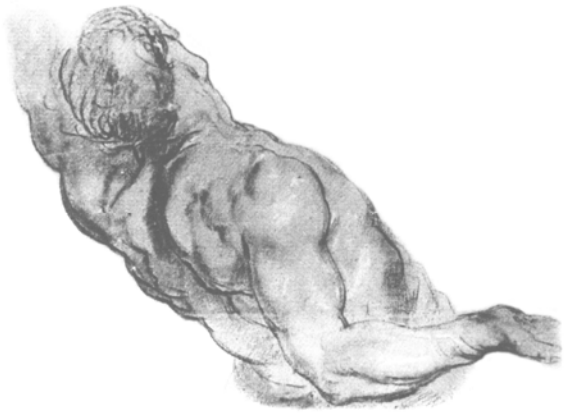

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A Study of Ethical and Clinical Implications for the Appropriate Use of Touch in Psychotherapy

Kerstin E. White

Abstract

The appropriate use of touch in psychotherapy offers new treatment opportunities. However, historical, cultural and legal influences have contributed to the taboo on touch in psychotherapy. The author reviews current research on touch and investigates its appropriate use in a clinical and ethical context. Based on the APA guidelines, the study examines the impact of touch on the client, the therapist and the therapeutic relationship. The author calls for an inclusion of specific guidelines on the use of touch in the APA Code of Ethics, and recommends increased education, training, research, and a dialogue between traditionally trained and body-oriented therapists.

Keywords

Psychotherapy – Touch – Touch therapy- Treatment

The discussion of touch in psychotherapy and its implication for ethical conduct and clinical practice were for a long time neglected in professional literature and traditional graduate training programs (Fagan, 1998; Geib, 1982; Hunter & Struve, 1998; Mandelbaum, 1998). For a long time touching patients has been considered a taboo in clinical circles. Fortunately, touch in psychotherapy has received much wider attention in recent years by researchers, such as Field (2000), Holub & Lee (1990), Horton, Clance, Sterk-Elifson & Emshoff (1995), Kertay & Reviere (1993, 1998), and Smith (1985, 1998a, 1998b). As clients are continually seeking new ways to feel whole and heal from psychological wounds, traditionally trained therapists need to stretch their horizons and seek innovative healing modalities. Yet, many clinicians refrain from using touch because of their own discomfort with this issue and the current adversarial legal and cultural environment (Fagan, 1998). At the other end of the spectrum, body-oriented therapists (Allison, 1999, Caldwell, 1997) reflect the trend to move beyond verbal therapy into the realm of including touch as a way to access feelings and thoughts held secret in the body. In this context, it is all the more important for therapists who use touch within the verbal, as well as body-centered framework, to be aware of its ethical and clinical implications (Smith, 1998b, Kertay et al., 1993, 1998).

DEFINITION OF TOUCH

Smith (1998b, pp. 38-40) proposes a "taxonomy of touch" in psychotherapy, which is useful for this discussion. He describes several types of touch considered acceptable or unacceptable depending on the circumstances. First, he mentions "inadvertent touch" like bumping into or brushing up against a person while moving about. Second, he refers to touch as "a conversational marker" designed to get someone's attention by touching a hand, knee, or shoulder. The third type of touch in this taxonomy is "socially stereotyped touch," a highly ritualized touch, such as a handshake or embrace when greeting or saying good-bye to a client. A fourth type of touch, which is particularly valuable here, is "touch as an expression of the therapeutic relationship." This includes a comforting gesture like putting an arm around a client's shoulder while he or she is grieving. The therapist might also act as a parental figure in regressive work by holding, rocking or embracing the client like a child. In the fifth category, Smith describes "touch as technique," which is the clearly defined touch in various body-oriented therapies, designed for therapeutic purposes. In addition to these five types of touch, Smith adds hostile and aggressive touch and sexual touch as being absolutely taboo.

APA PRINCIPLES AND TOUCH

It is the erotic kind of touch that has received attention in the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992): "Psychologists do not engage in sexual intimacies with current patients or clients" (4.05). In addition, "Therapy with former sexual partners" (4.06) and "Sexual intimacies with former therapy patients" (4.07) are discussed. No guidelines exist for the use of touch as an intervention that may contribute to positive therapy outcome. Some researchers, such as Holub & Lee (1990) and Kertay et al. (1993), have pointed to general ethical principles (American Psychological Association, 1981), such as protection and welfare of the client and the community, competence, and exploitation with regard to touch. The purpose of this investigation is to take a closer look at the general ethical principles (American Psychological Association, 1992), and to focus on ethics codes 1.19 (Exploitative Relationships), 4.01 (Structuring the Relationship), 4.02 (Informed Consent to Therapy), 6.01 (Design of Education and Training Programs), and 6.05 (Assessing Student and Supervisee Performance) with regard to the client, the therapist and their therapeutic alliance. Current

writings and research on touch in therapy will be explored in the context of ethical and clinical interventions.

HISTORICAL, CULTURAL AND LEGAL CONTEXT

Ethical guidelines do not exist in a vacuum, but are shaped by forces within a societal context. Therefore, historical, cultural and legal aspects, which have influenced the use of touch in psychotherapy, need to be discussed as a backdrop to the interplay of clinical and ethical guidelines and its application to verbal and body-centered therapies. Recommendations for future research and current training programs will also be included. The underlying tenor of this investigation is to provide clinicians with adequate information for an ethical decision-making process in either using or avoiding this important intervention of touch. In order to understand the longstanding taboo against touch, we need to first look at its historical roots.

The debate whether to touch or not to touch clients can be traced back to the early psychoanalytic movement. Freud, who initially touched and massaged his patients, contributed later to the taboo against touching among psychoanalysts. When he started to focus on the dynamics of transference, which are feelings and reactions toward significant others from the clients' past that are projected on the analyst (Corey, 1996), a blank-screen approach, characterized by the therapist's neutral stance, became necessary to facilitate this process. Freud eventually changed his views on this subject and refrained from touching his clients. Touch was considered a way to gratify the patient's desires and thus would lead to a contamination of transference (Hunter et al., 1998, pp. 53-54). Ferenczi, who was one of Freud's most faithful disciples, continued to touch his clients, which led to a deep rift between the two. Ferenczi continued to experiment with different analytic techniques, including kissing patients, but eventually came to the conclusion that touching his patients was after all counter-therapeutic (Hunter et al., 1998, p. 56). Reich, another early psychoanalyst, broke completely with the psychoanalytic community by making touch his major focus of treatment. He coined the concept of character armor, which reflects the tensions in the body created by inner conflicts. He used massage, pressure and breathing techniques to release bound up emotion. He is considered the driving force behind the proliferation of current body-oriented psychotherapies (Hunter et al., 1998, p. 57). Reich later influenced Fritz Perls, the founder of Gestalt therapy (Smith, 1998). Whereas the Reichian followers used focused touch as their major modality for relating to their clients, the humanistic tradition saw touch as "a natural and spontaneous expression of genuine (nontransferential) relationship" (Smith, 1998a, p. 12). Fernald (2000) points to the similarities in Rogers' and Reich's views on the importance of the body and to Rogers' views on the therapeutic self-actualizing process as a "total, organismic, frequently non-verbal type of thing" (Rogers, 1961, p. 86). Behaviorists and later cognitive-behaviorists did not believe in the therapeutic values of transference, and hence did not discuss the value of touch in psychotherapy (Hunter et al., 1998, p. 61). This brief historical overview reveals how classical psychoanalysis and its emphasis on transference has greatly shaped our view on touch in psychotherapy and how other therapeutic approaches have moved away from this stance. Current social forces seem to mirror the psychoanalysts' taboo against touch.

Compared with many European cultures, America is very much a "hands-off" society. Affection between lovers is shown mostly in private and greeting people does not necessarily involve human contact. Hunter et al. (1998) maintain that "This general stance of touch abstinence seems to be one of the traits that characterizes the Anglo-Saxon and Puritan heritage" (p. 64). Heights (1999) conducted a multicultural study involving American and French adolescents. In studying peer interaction in a McDonald's restaurant in Paris and Miami, she concluded that American adolescents spent less time leaning against, stroking, kissing, and hugging their peers than did the French adolescents. Instead, they showed more self-touching and more aggressive verbal and physical behavior. This is an interesting finding in light of frequent incidents of teenage violence, which have ravaged American schools. Teachers are afraid to touch children for fear of litigation.

The litigious climate in American society has without doubt influenced therapists and their views on using touch with clients. Imes (1998) states that some insurance companies have included questions about touching clients in their applications for liability insurance. Mandelbaum (1998) noticed that an affirmative answer to the question whether he practiced sex therapy, body work, and hypnosis increased his liability insurance significantly. He concludes that this kind of questioning reflects the assumption that therapists who choose to touch their clients are more likely to be sued. Unfortunately, reported incidents of sexual misconduct by unethical therapists have imposed a burden on liability insurance (Cummings & Sobel, 1985) and have shed a negative light on the use of touch all together. In order to protect the profession from infractions of sexual misconduct, Gottlieb, Hampton & Sell (1995) have studied guidelines for sanctions by state-licensing boards.

BENEFITS OF TOUCH

Nurturing touch is crucial for our emotional and physical well-being and lays the foundation for a healthy personality. Our earliest experiences of touch "create a template by which subsequent interpersonal relationships will be formed" (Hunter et al., p. 21). Touch is our first means of communication and as crucial for our survival as food and water. Harlow's study (1962) showed the importance of touch in the development of monkeys. Through

touch, children learn to self-regulate and cope with life stressors. When children are deprived of touch the consequences are severe. Spitz (1945) coined the term hospitalism to describe the physical and emotional disturbances of children raised in orphanages. Bowlby (1973) explored the devastating effects of separation on child attachment behavior.

Given that touch is part of our human fabric and constitutes a basic human need, its benefits for psychotherapy can no longer be overlooked. Hunter et al. (1998) summarize the positive functions of touch by underlining that it may help the therapist to provide real or symbolic contact and nurturance, to facilitate access to, exploration of, and resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships (pp. 107-110). Some critics like McNeely (1987), and Glickauf-Hughes et. al (1998) have pointed to the importance of touch in ego development. In a multicultural context, knowledge about the role of touch in different cultures can be translated into the therapeutic relationship and provide opportunities for effective treatment (Clance & Petras, 1998).

The potential benefits of touch are specifically relevant for the treatment of trauma victims. The relationship between trauma and memory has been explored in the context of post-traumatic stress disorder (Allen, 1995, Herman, 1992, Hunter et al., 1998, van der Kollk, McFarlane & Weisaeth, 1996). It has been documented that traumatic memories are encoded in our sensorimotor system as kinesthetic sensations and vivid images. Referrring to van der Kolk's work (1988), Herman (1992) reports that "in states of high sympathetic arousal, the linguistic encoding of memory is inactivated, and the central nervous system reverts to the sensory and iconic form of memory that predominate in early life (p. 39). Traumatized victims have difficulties reconstructing personal narrative of their traumatic memories, experiencing them instead on an emotional and sensory level (van der Kolk et al., 1996). Given the somatosensory nature of trauma, body-oriented therapies offer new avenues for treatment and healing (Hovdestad & Kristiansen, 1996).

Through touch, physiological patterns in the body can be changed to correct old and harmful experiences (Bar-Levav, 1998). Esthelle (1998) describes such an example in her work with the Rubenfeld Synergy method. Her middle-aged client, a well-educated, successful therapist, reported constant tension and fears and "seemingly, random, small, involuntary movements of his wrists, feet, and head" (pp. 73-74). While the synergist's healing hands rested beneath her client's back, he verbalized that his fears were related to his identification with his mother's fears as a three-year-old. He was not aware of the causes of his mother's fears, but he saw himself as a little child fighting for his mother's safety with clenched fists and tensed muscles in his whole body. The synergist guided her client though a dramatic session, in which he was able to express his pent-up anger with deep-growling cries. After this session, the client felt a deep sense of relaxation and joy, and his tics had stopped. Given the great healing potential for touch in psychotherapy, it is all the more important to turn our attention to clinical and ethical guidelines that govern its judicial use.

CLINICAL AND ETHICAL IMPLICATIONS FOR THE USE OF TOUCH

When discussing clinical and ethical guidelines, one has to be aware that they are tightly interwoven and inform each other. Kertay & Reviere (1993) point out that "theoretical justifications do not automatically comprise ethical justifications: a given theoretical position advocating touch in psychotherapy may or may not be ethically defensible" (p. 32). While their discussion applies to more traditional verbal therapies, many of the points discussed here will be also useful for therapists interested in body-oriented therapies.

Touching a hand or shoulder, holding a client who is in the throes of emotional pain, or other forms of physical contact are all clinical interventions as part of the therapeutic process. Therefore, psychotherapists need to conceptualize when it is clinically appropriate or inappropriate to physically reach out to their clients, while never losing sight of the ethical implications. Taking these considerations into account, therapists should focus on their clients' sense of empowerment and autonomy, on their own competence and integrity and finally the good of the therapeutic relationship.

Client Autonomy and Touch

Principle D: Respect for People's Rights and Dignity (American Psychological Association, 1992) states that psychologists need to "respect the rights of individuals to … self-determination, and autonomy…." and should be "aware of cultural, individual, and role differences, including those due to age, gender, race, ethnicity, national origin…" Using touch in therapy becomes then clinically and ethically appropriate when the client first wants to touch or be touched and understands the concepts of empowerment (Hunter et al., 1998). The authors also stress that it is crucial for clinicians to find out the client's values, biases, past experiences and expectations connected to touch (p. 139). Kertay et al. (1998) and Geib (1998) agree that the use of touch has to be congruent with the client's perceived needs. Gender issues regarding touch have been raised by Hollender & Mercer (1976), who observe that, in the psychiatric population they studied, women favor being held over holding, and men do desire being held, but their longings are not expressed with the same intensity as it is the case with women. Alyn (1988)

draws attention to power dynamics where higher status individuals touch lower status individuals. Women touched by male therapists might feel devalued because of social stereotypes. In addition to gender awareness, therapists need to show cultural sensitivity. Clance & Petras (1998) interviewed therapists with regard to their decision-making process when using touch. The issue of ethnicity came up in one therapist's response:

> Because I am a Latina, the issue of touch in psychotherapy for me intricately intertwined with ethnicity – mine and the client's. Two clients I have touched in therapy have both been Latinos, and the idea of not touching in therapy would have been quite foreign and would undoubtedly be perceived as cold, distant, and uncaring. (p. 101)

Geib (1998) and Horton, Clance, Sterk-Elifson & Emshoff (1995) have positively correlated patients' perception of being in control of the physical contact with patients' positive evaluation of touch in psychotherapy. Kertay et al. (1998) advise the therapist "to avoid touch that deflates rather than enhances the internal resources of the patient" (p.30). Clients who are highly dependent on their therapists for nurturance, love and support are not good candidates for the use of touch, at least not in the beginning of therapy until they have developed better self-empowered skills (Imes, 1998, p. 197). Client autonomy becomes both an ethical principle as well as a therapeutic goal. The therapeutic process presupposes that clients are considered autonomous individuals, who should be encouraged to express their preferences freely and to show active involvement in charting their treatment.

Therapist and Touch: Personal Background and Clinical Training

As much as therapists are advised to focus on the clients' needs and wishes, they should also explore their own motivations, background and training related to touch. Principle B: Integrity (American Psychological Association, 1992) states that "Psychologists strive to be aware of their own belief system, values, needs, and limitations and the effect of these on their work." Holub et al. (1990) indicate that touch should only be used when it is clearly intended for the client's benefit, and Torrace (1998) states that touch should not be used because it just feels good to the therapist. Fagan (1998) stresses that a therapist who uses touch has "to have his or her own nurturing and sexual needs met outside of therapy, and to be absolutely certain that ritual or nurturing touch is not an entrée to sexual touch" (p. 150). While discussing research on sexualized touch in psychotherapy, Kertay et al. (1998) point out that "these studies suggest that there is no relationship per se between non-erotic touch in psychotherapy and sexual acting out on the part of the therapist" (p. 21). However, one might surmise that therapists who are not aware of their own needs and issues might go down that road of sexual conduct more easily than others. Macram, Smith & Stiles (1999) report that personal therapy helps therapists establish appropriate boundaries. The Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) requires psychologists to respect their clients' welfare (Principle E), and to avoid exploitative relationships (1.19). From a clinical standpoint, clients need to feel secure and trusting, knowing that psychologists act for their therapeutic benefit.

The decision about touch in psychotherapy should also guided by the therapist's own sense of comfort with touch (Hunter et al., 1998; Fagan, 1998; Fosshage, 2000; Smith, 1985, 1998b). Smith's observation (1985) summarizes this point.

> The first ethical duty which I see is what I term the ego-syntonic imperative. By this term I mean that for one to function optimally in the therapeutic role it is essential that he or she relate to the patient only in ways that are congruent with who that therapist is. (p. 148.

Smith continues that "Another face to the ego-syntonic imperative is that the patient must work in the therapist's way, a way which allows the therapist to keep her or his own integrity" (p. 148). Smith discusses this issue in connection with body-oriented therapies, but also recognizes that it is a fundamental principle that applies to verbal therapies as well (1998b). Hunter et al. (1998) and Kertay et al. (1993), among others, have argued that physical contact which is not genuine can be perceived as insincere by clients and hamper the therapeutic relationship.

Apart from being comfortable with the use of touch, therapists also have to demonstrate a solid knowledge base concerning touch (Fagan, 1998; Hunter et al., 1998; Smith, 1998b), which raises the issue of competence (Principle A) and education and supervision (6.01) in the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992). Fagan (1998) laments that traditional training programs for therapists often don't offer adequate training and supervision and that the American Psychological Association has failed to put forward adequate guidelines and suggestions for training in the use of touch. He thinks that much confusion exists around the issue of dependency in relation to touch and that this confusion combined with cultural values is responsible for the paucity of guidelines in training (p. 151).

Geib (1998) found that touch is often used with patients, but rarely discussed among colleagues and supervisors.

The Latina therapist whose experience with touch was mentioned previously described her supervisor's reaction as being insensitive to her culturally motivated use of touch with her clients (Clance et al., 1998). In fact this study, which focuses on the decision-making processes regarding the use of touch in psychotherapy, grew out of Clance's own struggles regarding the adequate training and supervision of Ph.D. students in her program.

Malkovich (1998) found in her study that therapists who touch also "had supervisors and teachers who advocated touch as a legitimate practice" (p. 89). Therapists who don't use touch were directly influenced by their experience in training and supervision. This shows that training and supervision have a great impact on the use of touch, and raises the ethical question of withholding treatment. One therapist in Malkovich's study said, "Touch is therapeutically important. It is the most effective means with some clients. I think it is unethical in these cases to not touch the client" (p. 80). Fosshage (2000) also raises this issue in questioning the psychoanalytic stance to not use touch for fear of contaminating transference. He presents a case where an analyst refused to hold his client's hand, when she asked him to do so. She needed the reassuring touch in order to relive a traumatic experience lying on an operating table as a child and feeling her mother's hand slip away as her mother fainted. Fosshage (2000) argues that this kind of refusal can lead to replicating a traumatic event (p. 13).

Therapists who work with transference also need to be aware of their own countertransference, which refers to reactions therapists have toward their clients that may interfere with their objectivity (Corey, p. 115, 1996). For example, the therapist could develop "perpetrator countertransference," which describes therapists who might feel anger and personal hurt if clients are not recognizing their efforts, or "victim countertransference," which might emerge when therapists are undergoing a high level of personal stress and then feel victimized by their patients' demands (Hunter et al., 1998, pp. 250-251). Hunter et al. (1998) suggest that touch is ill-advised in these circumstances and urge the ethical psychotherapist to monitor these often unconscious reactions through proper supervisory relationships and personal awareness (p. 246).

The scope of this study does not allow for a detailed discussion of the different theoretical orientations and their individual use of touch. However, object relations theory can provide useful insights here because it focuses on early attachment as an imprint for future relationships. As Glickauf-Hughes et al. (1998) pointed out, children learn to attach through nonverbal communication, in particular through touch (p. 157). Geib's research on touch was influenced by the object relations theorist Winnicott (1986), who wrote about how therapists could create a holding environment during a client's regressive work. Bar-Levav (1998) is another critic who focused on his clients' preoedipal experiences. He stressed the importance of touch to help clients experience preverbal trauma. Glickauf-Hughes et al. (1998) make suggestions, based upon the personality styles of clients, which serve as a useful guide for therapists when it comes to deciding whether to use or not to use touch.

In their discussion of clients for whom touch can be useful, the authors mention unbonded clients who have not been able to form secure attachments in childhood. These clients often develop a schizoid personality disorder which Halgin & Whitbourne (1997) characterize as "an indifference to social and sexual relationships, as well as a very limited range of emotional experience and expression" (p. 189). Glickauf-Hughes et al. (1998) point out that it is sometimes difficult for the clinician to diagnose this disorder because these clients seem often quite socially adept. Therapists need to go by their own feelings and reactions, which might reveal their own disengagement from these clients as a signal to diagnose this disorder. The authors continue that "nonverbal relating that includes touch can be useful and even a necessary component of treatment" (p. 158). In illustration of this point, they discuss the case of a schizoid woman who had grown up with a very disengaged mother. The therapist was at an impasse in her treatment, yet once she suggested to her client to place her head in her therapist's lap while talking, the client experienced an emotional release and asked her therapist for a hug at the end of the session. It is important, however, not to introduce touch too early in the treatment until the client has developed sufficient ego-functioning.

Neurotic and overly cognitive clients can benefit from touch to learn spontaneity. The authors describe clients with a neurotic level of ego organization as having a clear sense of identity and a better ability to cope with relationships. However, the clients often show obsessive-compulsive features, are rigid, lack spontaneity and intellectualize emotional problems. A case in point is the example of a man in a group dealing with an obsessive behavioral style. The therapist suggested to him to allow a group member to massage his shoulder while he talked about his problems with his boss. This intervention helped the client to become more emotionally expressive and less rigid. On another occasion, the therapist threw a pillow at a client and helped him to become more playful.

For counterdependent clients, the use of touch can make dependence needs ego-syntonic. The authors describe these clients as having developed an oral and masochistic/self-defeating character style because their dependency needs were shamed by their parents. Instead, taking care of their parents was rewarded and prevented them from being in touch with their own needs. Touch can help these clients to bypass their defenses and become more aware of their own needs and feelings. The authors caution however, that masochistic clients have problems with self-soothing, since "they have failed to internalize the soothing and empathic functions of caretakers" (p. 163). With these clients the therapist should not rely overmuch on touch for soothing, but rather use it for breaking down a barrier.

Touch should not be used with clients who have a borderline level of ego organization. These clients often have unstable interpersonal relationships, experience depression characterized by feelings of emptiness, and are confused about their own identity (Halgin et al. 1997). Glickauf-Hughes et al. (1998) describe a high-functioning

borderline patient, who asked for a hug from her therapist after four months of therapy. The request was granted with the result that the borderline patient called the therapist four times the next day. Once this incident was processed, the therapist realized that touch had triggered a deep sense of longing in the client, as well as the "fear of merging with the therapist and losing her sense of self" (p. 164). Touch with these clients serves as a reminder to establish very clear boundaries.

Touch should also be avoided with clients who have engulfment issues. These clients were not allowed to develop their own needs, but had to satisfy their parents' needs. Children with narcissistic parents often develop narcissistic tendencies themselves. Hence, "Affectionate gestures, including ones by the therapist, are consequently interpreted as efforts to 'use' such a client in some way and are often experienced as impingements" (p. 166).

For touch with sexual abuse survivors, Glickauf-Hughes et al. (1998) advise caution and indicate several principles: 1. Therapists should not touch if they feel any reservations; 2. Touch should not be used in the beginning of treatment; 3. Touch should be initiated by the client; 4. Touch with a borderline sexual abuse survivor might lead to strong countertransference in the therapist, who needs to process his or her reaction and set proper limits (p. 167).

Other critics also discuss this topic. Fagan et al., (1998) show in their studies that sexually abused clients are more likely to misinterpret touch. Clance et al. (1998) observe that therapists who touch are more likely to have been abused themselves and have significantly more experience with body therapies than therapists who have not been abused. From the clients' perspective, Horton et al.'s (1995) research revealed that 87 subjects who had been abused wrote that "touch repaired self-esteem, trust, and a sense of their own power and agency" (p. 132). The weighing of the pros and cons of touch with clients representing varying levels of pathology needs to be stimulated by this type of discussion. Awareness of different theoretical orientations and their implications for touch need to be made an integral part of the training and supervision of therapists for the benefit of astute clinical interventions and ethical conduct.

Touch and the Therapeutic Alliance

Ethical and clinical considerations regarding respect for clients' autonomy and self-determination and therapists' self-awareness and training are all factors that help form the therapeutic alliance. In fact, Horton et al. (1995) found that the quality of the therapeutic alliance predicted patients' positive evaluation of touch. When discussing the therapeutic relationship, we need to keep in mind the difference between touch as communication in verbal therapies, and touch as technique in body-centered psychotherapies. This distinction can have implications for short-term versus long-term treatment. Lawry (1998) cautions against using touch too early in the treatment and maintains that "the relationship needs to be developed and balanced enough to withstand the potential intensity of touch" (p. 208). This view is also reflected by Hunter et al. (1998), who recommend not to use touch until the relationship is in place. There seems to be a general consensus among more traditionally trained therapists (Lawry, 1998; Torraco, 1998; Hunter et al., 1998) that touch should preferably be used in long-term therapy, whereas specific touch techniques in body-oriented therapies can actually accelerate the therapeutic process, and aid short-term therapies (Mandelbaum, 1998). Thus, the timing of touch and the length of the therapeutic approach, as well as ethical guidelines, need to be considered as factors strengthening the therapeutic alliance.

In the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) guidelines are established for "Structuring the Relationship" (4.01). It is advised that "Psychologists discuss with clients or patients as early as feasible in the therapeutic relationship appropriate issues, such as the nature and anticipated course of therapy…" and that "Psychologists make reasonable efforts to answer patients' questions and to avoid misunderstandings about therapy." Another important component is "Informed Consent to Therapy (4.02)," which requires that "Psychologists obtain appropriate informed consent to therapy or related procedures…" These ethical factors play an important role for the therapist who decides to use touch in psychotherapy, and they are also tied to clinical considerations pertaining to setting boundaries, processing touch, respecting client autonomy, and engaging in trust-building.

When clients engage in body-oriented therapies, they expect that touch is an integral part of the treatment, whereas in verbal therapy touch is generally not presumed. For this reason, therapists should discuss the issue of touch with their clients and explore their feelings and fears about it. Kertay et al. (1998) state that "The parameters of the intended touch should be discussed, including a clear statement of safety with regard to sexual boundaries" (p. 30). Giving the client the opportunity to either accept or decline touch sets the stage, right at the outset, for empowerment and allows the client to lead the therapist in the course of the treatment. Respecting clients' physical and emotional space signals clear boundaries, which are themselves therapeutic, especially for victims of abuse (Whitehead, 1993). Furthermore, this kind of modeling allows clients to learn proper boundaries, a lesson they can apply in outside relationships. Ethically, psychologists are required to answer patients' questions as they start to structure the therapeutic relationship. For the therapeutic relationship to blossom, this dialogue needs to continue, meaning that touch needs to be processed each time it occurs. In the literature on

touch, including Geib, 1998, Horton et al. (1995), and Kertay et al. (1993) this point is continually emphasized. Kertay et al. (1993) also stress that "the general issue of touch should be processed, and with each occurrence of touch it seems appropriate to ask permission or state intention to touch before making contact" (p. 38). This view is also mirrored by Smith (1998b, p. 47) with regard to body-oriented therapies. Clinically, this is vital because it helps the client and clinician relate thoughts and feelings triggered by touch to the issues discussed and treated in verbal as well as body-oriented therapies.

In addition to asking verbal permission for touch, Hunter et al. (1998) explore the possibility of including a written informed consent. However, as much as this procedure is recommended, Hunter et al. (1998) warn clinicians that informed consent is not a guarantee for avoiding malpractice suits because clients cannot relinquish their rights. They also add that a consent form might be actually used against them, because it might imply that this is a controversial technique. Yet, this voice of caution should not shroud the benefits included in valuing the clients' autonomy. Haas & Malouf (1995) state, " The obligation to inform the patient sufficiently that he or she can make a reasoned judgment about accepting or rejecting treatment is a significant one for the ethical mental health practitioner" (p. 52).

SUMMARY

This discussion has explored how the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 1992) offers general principles and guidelines concerning clients' rights, therapists' values, training, qualifications, and the structure of the therapeutic relationship, which can be applied to the use of touch in therapy. The use of touch has to be adapted to clients with different degrees of psychopathology. Ethical therapists need to be aware of their own issues and reactions when touching their clients. Some therapists use touch as communication, whereas others make it an integral part of their treatment with specific techniques. This distinction can have implications for the length of treatment and the guidelines that need to be established at the outset of therapy.

RECOMMENDATIONS

Based on the positive impact touch can have on clients' process of change, a shift in thinking needs to occur away from the mind/body dualism. By including guidelines for touch in the Ethical Principles of Psychologists and Code of Ethics, the American Psychological Association could establish standards of practice, which would sanctify the appropriate use of touch and send the message to consider its potential benefits for the healing process. This, in conjunction with further research on this topic, could appease the insurance companies in their fear of malpractice suits. Milakovich (1998) expresses this view in the following remark:

> One of the ways a therapeutic practice is judged ethical or not is by comparing it against 'standards of practice.' Touch has been for the most part, a hidden practice, and standards for its use are not available. Managed care companies and health maintenance organizations demand to see data. A positive result of third-party interest in how psychotherapists do what they do could be that if the efficacy of touch techniques can be empirically proven, such techniques will be supported. (p. 75)

One way to raise consciousness about touch in therapy is to offer courses or training seminars in body-oriented therapies. The recently founded United States Association for Body Psychotherapy (Dennehy, 2000) offers detailed guidelines on the use of touch techniques. The American Psychological Association should consult these guidelines and incorporate them into their ethical framework. It seems that a crossover has already occurred in that many traditionally trained therapists and psychologists are seeking to integrate body-oriented therapies into their practice. A case in point is McNeely (1987), who combines Jungian analysis with body therapy. In order to assess this trend further, this phenomenon could provide an interesting topic for research. Given that body-oriented therapies originated within the school of psychoanalysis, it seems that we are finally coming full circle, which started with a rift between Freud and Reich with transference as the culprit. As transference continues to be reevaluated (Fosshage, 2000), further studies are needed to assess the impact of touch on transference and countertransference. Smith (1998b) concludes:

> Our ethics evolve. Societal consciousness changes; the position of psychotherapists in society changes; and research informs us of false beliefs that have been translated into ethical pronouncements. (p. 50)

Letting go of a taboo that started with Freud and raising awareness through proper guidelines, education and research on the use of touch might not only provide a wider arena for healing, but also prevent sexual misconduct by therapists. In doing so, the professional community has the opportunity to lay the groundwork for the proper

use of touch, instead of letting the legal system decide (Hunter et al., 1998, p. 70).

A clear and honest discussion of touch could open a dialogue between traditionally trained therapists and body-oriented therapists. Both could benefit from each other's wisdom and knowledge by never losing sight of the importance of clinical and ethical implications.

References

Allen, J.G. (1995). Coping with trauma. A guide to self-understanding. Washington, DC: American Psychiatric Press, Inc.

Allison, N. (Eds.). (1999). The illustrated encyclopedia of body-mind disciplines. New York, NY: The Rosen Publishing Group, Inc.

American Psychological Association (1992). Ethical principles of psychologists and code of conduct. (Pamphlet)

Alyn, J. H. (1998). The politics of touch in therapy: a response to Willison & Masson. Journal of Counseling & Development, 66, 432-433.

Bar-Levav, R. (1998). A rationale for physical touching in psychotherapy. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 52-55). New York, NY: The Gillford Press.

Caldwell, C. (Eds.). (1997). Getting in touch: the guide to new body-centered therapies. Wheaton, IL: The Theosophical Publishing House.

Corey, G. (1996). Theory and practice of counseling and psychotherapy (5th ed.), Pacific Grove, CA: Brooks/Cole Publishing Company.

Clance, P. R. & Petras, V. J. (1998). Therapists' recall of their decision-making process regarding the use of touch in ongoing psychotherapy: a preliminary study. In E. W. L. Smith, P.R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 92-108). New York, NY: The Gillford Press.

Cummings, N. A., & Sobel, S. B. (1985). Malpractice insurance: Update on sex claims. Psychotherapy, 22, 186-188.

Dennehy, V. (2000). Draft: USABP ethics section on touch [e-mail]. Available: gdennehy@worldnet.att.net (Virginia Dennehy).

Esthelle, B. (1998). Embodied memories. In Mechner, V. (Eds.), Healing journeys (pp. 73-75). Chappaqua, NY: Omniquest Press.

Fagan, J. (1998). Thoughts on using touch in psychotherapy. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 145-152). New York, NY: The Gillford Press.

Fagan, J & Silverthorn, A. S. (1998). Research on communication by touch. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 59-73). New York, NY: The Gillford Press.

Fernald, P. S. (2000). Carl Rogers: body-centered counselor. Journal of Counseling & Development, 78 (2), 172-179.

Fosshage, J. L. (2000). The meaning of touch in psychoanalysis: A time for reassessment. Psychoanalytic Inquiry, 20 (1), 1-18.

Geib, P. (1998). The experience of nonerotic physical contact in traditional psychotherapy. In E.W. L. Smith, P. R. Clance& S. Imes (Eds.), Touch in psychotherapy (pp. 109-126). New York, NY: The Gillford Press.

Glickauf-Hughes, C. & Chance. (1998). An individualized and interactive object relations perspective on the use of touch in psychotherapy. In W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 153-169). New York, NY: The Gillford Press.

Gottlieb, M. C., Hampton, B. R. & Sell, J. M. (1995). Discipline of psychologists held in violation for sexual misconduct. Psychotherapy, 32, (4), 559-567. Haas, L. J. & Malouf, J. L. (1995). Keeping up the good work: a practitioner's guide to mental health ethics. Sarasota, FL: Professional Resource Press.

Halgin, R. P. & Whitbourne, S. K. (1997). Abnormal Psychology. The human experience of psychological disorders. Madison, WI: Brown & Benchmark Publishers.

Harlow, H. F., & Harlow, M. K. (1962). Social deprivationin monkeys. Scientific American, 207, 136-146.

Herman, J. (1992). Trauma and recovery. The aftermath of violence – from domestic abuse to political terror. New York, NY: Basic Books.

Heights, R. (1999). American adolescents touch each other less and are more aggressive toward their peers as compared with French adolescents. Adolescents, 34, (136), 753-758.

Hollender, M. H. & Mercer, A. J. (1976). Wish to be held and wish to hold in men and women. Archives of General Psychiatry, 33, 49-51.

Holub, E. R. & Lee, S. S. (1990). Therapists' use of nonerotical physical contact: ethical concerns. Professional Psychology: Research and Practice, 21 (2), 115-117.

Horton, J. A., Clance, P. R., Sterk-Elifson, C. & Emshoff, J. (1995). Psychotherapy, 32 (3), 443-457.

Hovdestad, W. E. & Kristiansen, C. M. (1996). Mind meets body: on the nature of recovered memories of trauma. Women & Therapy, 19 (1), 118-125.

Hunter, M. & Struve, J. (1998). The ethical use of touch in psychotherapy. Thousand Oaks, Ca: SAGE Publications, Inc.

Imes, S. (1998). Long-term clients' experience of touch in gestalt therapy. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 170-200). New York, NY: The Gillford Press.

Kaplan, P. S. (1998). The human odyseey: Life-span development (3rd ed.), Pacific Grove, CA: Brooks/Cole Publishing Company.

Kertay, L. & Reviere, S. L. (1993). The use of touch in psychotherapy: theoretical and ethical considerations. Psychotherapy, 30, (1), 32-40.

Kertay, L. & Reviere, S. L. (1998). Touch in context. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 16-35). New York, NY: The Gillford Press.

Lawry, S. S. (1998). Touch and clients who have been sexually abused. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 201-210). New York, NY: The Gillford Press.

Macran, S., Smith, J., & Stiles, W. B. (1999). How does personal therapy affect therapists' practice. Journal of Counseling Psychology, 46, (4), 419-431.

Mandelbaum, D. (1998). The impact of physical touch on professional development. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 211-219). New York, NY: The Gillford Press.

McNeely, D. A. (1987). Touching: Body therapy and depth psychology. Toronto, Canada: Inner City Books.

Milakovich, J. (1998). Differences between therapists who touch and those who do not. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 74-91). New York, NY: The Gillford Press.

Myers, D. G. (1993). Exploring Psychology (2nd ed.). New York, NY: Worth Publishers.

Rogers, R. C. (1961). On becoming a person. New York, NY: Houghton Mifflin Company.

Smith, E. W. L. (1998a). Traditions of touch in psychotherapy. In E. W. L. Smith, P. R. Clance& S. Imes (Eds.), Touch in psychotherapy (pp. 3-15). New York, NY: The Gillford Press.

Smith, E. W. L. (1998b). A taxonomy and ethics of touch in psychotherapy. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 36-51).

Smith, E. W. L. (1985). The body in psychotherapy. Jefferson, NC: McFarland & Company, Inc., Publishers.

Spitz, R. (1945). Hospitalism: An inquiry into the genesis of psychiatric conditions in early childhood. Psychoanalytic Study of the Child, 1, 53-71.

Torraco, P. (1998). Jean's legacy: On the use of physical touch in long-term psychotherapy. In E. W. L. Smith, P. R. Clance & S. Imes (Eds.), Touch in psychotherapy (pp. 220-237).

Van der Kolk, B. A. (1988). The trauma spectrum: the interaction of biological and social events in the genesis of the trauma response. Journal of traumatic stress, 1, 273-90.

Van der Kolk, B. A., McFarlane, A. C., &Weisaeth, L. (1996). Traumatic Stress. The effects of overwhelming experience on mind, body, and society. New York, NY: The Guilford Press.

Whitehead, T. (1993). Boundaries and Psychotherapy. In Hakomi Forum (On-line). Available: http://goodandwell.com/survivor/bound1.html
Winnicott, D.W. (1986). Holding and interpretation. New York: Grove Press, Inc.

Biography

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