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). 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, 2003; Montagu, 1971, 1986). Touch has been an essential part of ancient

"Among all the senses,"
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 (1987) and Hunter and Struve’s, (1998) work, following are short descriptions of these cultural, mostly unspoken, taboos:

- "Don't touch the opposite gender!" This taboo is based on the belief or worldview that sexualizes all or most forms of touch.
- "Don't touch same gender friends!" This boundary is primarily based in the homophobic fears prevalent in our culture.
- "Don't touch yourself!" This injunction stems, in part, from some religious and puritanical doctrines and phobias around self-pleasure and masturbation.
- "Don't touch strangers!" This command is based on a cultural fear of "the other," a paranoid attitude towards unfamiliar persons and those who are outsiders of one's own group.
- "Do not touch the elderly, the sick and the dying!" This reflects a negative attitude in American culture towards the elderly, the sick, and the dying that manifests itself by segregating them from the rest of the population. The sick and the elderly are often housed away in specialized board and care facilities, where much of time hospital staff do not value touch as an essential part of care.
- "Do not touch those who are of higher status!" This unspoken rule is prevalent in our culture, where it has been documented that people of higher status or power touch those of lesser status significantly more frequently than the converse.

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 communications (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, refers primarily 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., 1998; Young, 2005; Zur, 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 at large has embraced the analytic hands-off approach.

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. 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-erotic 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 inundated 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 analysts" (cited in Horton, et al., 1995, p. 444). Simon, in a similar vein, instructs psychoanalytically oriented therapists to "treat only verbally, with clients... minimizing physical contact" (Simon, 1975).
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 misheld 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 Reichain (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, 1998; Satir, 1972). In spite of the numerous therapeutic approaches, theories and practices that systematically and effectively use touch in therapy, touch has nevertheless been marginalized, forbidden, called a taboo, often sexualized and at times, even criminalized by many schools of psychotherapy and ethicists (Young, 2005; Zur, 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. We cannot touch another without being touched ourselves, and it is in this sense that there is 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, and resolution of emotional experiences, to provide containment, and to restore significant and healthy dimensions in relationships. Glickauf-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" (Wilson & Masson, 1986, p.498). Wilson (1982) argues, "To disregard all physical contact between therapist and client may deter psychological growth" (p. 65).
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 established the Western split between body and mind/spirit.

Recent research done by the Touch Research Institute has demonstrated that touch triggers a cascade of chemical responses, including a decrease in urinary stress hormones (cortisol, catecholamines, norepinephrine, epinephrine), and increased serotonin and dopamine levels. The shift in these bio-chemicals has been proven to decrease depression. "In the (modern) technological view of the world, medicine is viewed as an industry and healing as a process to be adapted to the mechanical constructs of assembly-line production" (Hunter & Struve, 1998, p.48). Touch has become almost irrelevant.

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Massage therapy has been shown to reduce aversion to touch and to decrease anxiety, depression and cortisol levels in women who have been sexually or physically abused (Field, et. al., 1997). It decreases diastolic blood pressure, anxiety and cortisol (stress hormone) levels (Hernandez-Reif, et. al., 2000). One study examined the effects of massage therapy on anxiety and depression levels and on immune function. The subjects received a 45-minute massage five times weekly for a 1-month period. The findings were that: 1) anxiety, stress and cortisol levels were significantly reduced; 2) natural killer cells and natural killer cell activity increased, suggesting positive effects on the immune system (Ironson, et. al., 1996). Bulimic adolescent girls received massage therapy 2 times a week for 5 weeks. Effects included an improved body image, decreased depression and anxiety symptoms, decreased cortisol levels and increased dopamine and serotonin levels. In a study of children with ADHD, touch sensitivity, attention to sounds and off-task classroom behavior decreased and relatedness to teachers increased after massage therapy (Field, et. al., 1997). Following five 30-minute massages, children/adolescents had better sleep patterns, lower level of depression and anxiety and lower stress hormone levels (Field, et. al., 1992). Massage therapy also decreased the anxiety, depression and stress hormone levels of children diagnosed with PTSD, who survived Hurricane Andrew. In addition, their drawings reflected less depression (Field, et. al., 1996). 

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 babies show improved emotionality, sociability, soothability, temperament dimensions, and better face-to-face interaction behaviors (Field, et al., 1996). Many hospitals are now implementing Tender Touch parent education programs that promote the philosophy of developmental care in order to individualize infant care to maximize each baby's developmental potential. Other similar programs teach Tender Touch volunteers how to work with drug-exposed newborns. These programs were developed for at-risk infants and can be conceptualized as infant psychotherapy.

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 stability, sleep/alert cycles, and breathing regularity (Field, 1998, 2003). Touch attunement training is also beneficial for psychotherapists.

Trial programs, which teach parents infant massage in an effort to reduce the incident of child abuse, show promising preliminary results. In 1994, the Children's Trust fund of Oregon awarded a two-year, $20,000 grant to the Perinatal Bonding Project. The project's 40 volunteers provided training in attunement and massage to parents who were identified by social service agencies as being at high risk to carry out abuse. From 1994 to 1996, when the program was in effect, the number of confirmed cases of infant abuse in Douglas County dropped from 104 to 15 (Menehan, 1996).
Loving touch triggers the release of oxytocin, often referred to as the "bonding hormone" (Field, et al., 1997). Studies in bonding also show that human babies who are held often and touched frequently in their earliest stages of development have higher scores on physical, emotional, and interpersonal scales (Klaus & Kennell, 1976; Field et al., 1986). The opposite is true of abusive touch or lack of touch. In fact, the absence of loving touch has been documented to have profound impact on the will to live. Death rates for under-touched infants less than one year of age, in institutes during the 1920's ranged from 30% to 100% (Hunter & Struve, 1998). During the early 30's, Bellevue hospital in New York challenged the prevailing norms and authorized staff to incorporate physical contact in their care protocols. The mortality rate dropped on that unit from 30% to 10%, and the caregivers proposed the name marasmus (wasting away) for this disease of institutionalized touch depravation (Cohen, 1987). Developmental specialists agree that primary caretakers' attunement and appropriate response to their child's communication of needs during the first few years of life is essential to adequate neurological and emotional development (Bowlby, 1952; Field, 1998, 2003; Harlow, 1971). They agree, as well, that deficits in the satisfaction of basic needs results in the development of defense structures that complicate and inhibit relationship to self and others.

Ancient art depicts babies sucking at their mothers' breasts, held close against their skin, forming an intimate nurturing connection that communicates the promise of protection and immediate gratification of basic survival needs. These images of such earliest forms of communication depict our first language, the language of touch, as the essence of life (Montagu, 1971). For more than a million years mothers have held their infants close, responding to their basic needs with natural attunement and life affirming touch.

Un fortunately, American babies and children are among the least touched on earth. We live in a fast paced, goal directed, multitask oriented world, but our limbic system, that part of the brain which governs emotions and responds positively to the chemicals released by loving touch, remains as ancient as cave images uncovered by anthropologists (Heller, 1997).

Unfortunately, American babies and children are among the least touched on earth (Heller, 1997). We can look to developmental and evolutionary psychology to understand how social pressure and excessive valuing of early independence and self-sufficiency has resulted in American parents distancing themselves physically from their children (Mead, 1955). We can also look to the practices of parenting in higher touch cultures to appreciate the positive benefits of healthy psychological and emotional development.

Research indicates that we are hardwired to need touch in the earliest developmental stages (Field, 1995, 2003). And yet, with the onset of the industrial revolution and related changes in childrearing practices, the way in which modern westerners cared for and connected with their babies was altered radically. Extended families were split up, depriving babies and mothers of the multi-generational, extended familial support system that had been the ground of childrearing in traditional communities for centuries. Childrearing advice of the 1920's cautioned parents about spoiling their children: "Never hug and kiss them. Never let them sit on your lap. If you must, kiss them on the head when they say goodnight. Shake hands with them in the morning. Give them a pat on the head if they have made an extraordinarily good job of a difficult task" (Watson, 1928, cited in Heller 1997 p. 104).

Attachment and bonding, words that label the development of certain psychological processes, imply intimate touch, but it was not until the 1950's that the psychological community began to understand and appreciate the link between parent-child touch and attachment. We were familiar with Freud's concepts identifying the first year of life as the oral stage and for decades believed that our babies bonded with us because we fed them. Following World War II, psychologists John Bowlby (1969) and Mary Ainsworth (1978), conducted the first scientific study of love by exploring children's responses to separation and how parenting styles affect the quality of attachment. The foundation of attachment theory was developed by Bowlby in his book, Attachment, Separation, and Loss (1969). He concludes that bonding occurs, not only as a result of the reduction of primary drives, but also due to what he refers to as “primary object clinging,” a need for intimate contact, which is initially associated with the mother (Harlow, 1958, p.5).

Harlow took Bowlby's theory to the lab when he researched the importance of touch by conducting direct experimental analysis of the "affectational or love responses in neonatal and infant primates" (Harlow, 1958, p.3). He chose rhesus macaque monkeys as subjects for his analysis, as they share ninety-four percent of their genetic heritage with humans. The monkeys were offered access to two surrogate mothers: a "soft" terrycloth mother that was warmed by a light bulb that provided a positive tactile experience, and a wire mother with a bottle attached to it for feeding. The infants spent only the amount of time necessary for feeding with the wire mother and when left alone with her would cower in a corner. When given the choice of both mothers, they would cling to the "soft" mother for up to twenty-two hours a day and, in contrast, when left alone with her, would give her a few hugs and then felt secure enough to explore a strange object on their own. "These data make it obvious that contact comfort is a variable of overwhelming importance in the development of affectional response, whereas lactation is a variable of negligible importance" (Harlow, 1958, p.6). His observations of infant monkeys separated from their mothers at birth fundamentally changed our views. He discovered two very important things about development. Firstly, "comfort contact proved to be a more significant parenting quality than feeding... and... touch, not food, binds infant to caregiver" (Heller, 1997, p.55). The second finding was that even those monkeys that were reared on the soft mother, as adults, were neurotic, asocial, autistically self stimulating, self mutilating, and sexually inept. Subsequent studies involved providing the infants with a rocking surrogate. The infants in this study showed fewer abnormal developmental indicators. Normal functioning occurred, however, only in infants who were given contact with another live monkey for just one half hour a day. They needed interactive touch to support normal development.

"Everything that newborns and infants know about the universe they learn through their physical sensations." (Bar-Levav, 1998, p.53)
Developmental psychologist, Sharon Heller, writes that what distinguishes a securely attached baby from an insecurely attached baby is "the degree to which each could feel ownership of their mothers' bodies and therefore assurance of protection" (Heller, 1997 p.58). That feeling of ownership requires touch by sensitive, attuned parents. Through sensitive parental responding, infants receive accurate feedback about the effects of their behavior and they learn that, when they signal a need, they can expect a prompt, predictable, and soothing response. This makes it unnecessary to develop dysfunctional emotional defense systems. Infants who signal a need and are responded to by a sensitive, attuned parent feel a sense of control over their lives. The importance of this cannot be overemphasized. Feeling in control, one feels greater assurance of psychological survival. Feeling less need to control, one can more easily form closer relationships and benefit from the emotional satisfaction of bonding needs. One who feels in control is less likely to commit acts of violence, will have fewer physical problems, and live longer (Heller, 1997). The converse is true as well, just as sensitive, attuned touch gets etched in our developing neural pathways enabling us to reach out and touch in that same way throughout our lifetime, touch that is absent when necessary, inappropriately sexualized, cold or abusive, gets recorded in ways that cause us to draw inward or to strike out. Most abused children do not grow up to abuse their own children but those who do abuse their own children have almost always been abused in their own childhood: Violence begets violence. James Prescott (1975), a neuroscientist formerly with the U.S. Department of Health, Education, and welfare, reviewed forty-nine societies and concluded that a lack of bodily pleasure derived from touching and stroking during the formative periods of life was the primary cause of violent behavior in adults.

Unfortunately, 93 percent of American parents use physical punishments therefore there is a higher incidence of child beatings and murders by parents in the U.S. than anywhere else in the world, and a classic study of American childrearing practices shows harsh and punitive touch to outweigh warm and affectionate touch (Wolfgang, 1969).

Americans are considered by many other cultures to be independent to a fault, to be self centered, materialistic, lacking in reasonable social boundaries and somewhat abrasive. Why? Perhaps because we are a culture with a high population of insecurely attached persons. Object relations theory tells us that insecurely attached children often have a cool demeanor and focused involvement in activities that make them appear independent, although their independence may later become self-importance.

**Anthropological data reveal mainstream American mothers as being less affectionate toward their children, more likely to touch their children in public mainly as a means of control, and to expect children to entertain themselves.** (Heller, 1997).

John Bowlby (1969) sees this as pseudo-maturity and calls it compulsive self-reliance. Ambivalent or insecure attachment may or may not be the cause of our poor reputation but research indicates that the largest percentage of insecure infants are found in cultures that value and require the earliest self reliance, while those that value interdependence have the highest percentage of securely attached infants (Lamb, et. al., 1985). Anthropological data reveal mainstream American mothers as being less affectionate toward their children, more likely to touch their children in public mainly as a means of control, and to expect children to entertain themselves. They primarily reward their children with touch in response to acting out and generally tend to stimulate their children who, in response, become more active and vocal (Clay, 1966). They rely heavily on impersonal childrearing aids such as infant carriers, bottles, pacifiers, strollers, swings, playpens and cribs which limit the child's experience of human, soothing touch (Heller, 1997). Montague (1971) postulates that this type of parenting would produce individuals who are able to lead lonely, isolated lives in the crowded urban world, with its materialistic values and its addiction to things. American children rate high in insecure coercive, negative behavior. Similar words could be used to describe adults in American culture.

In contrast to American babies, 77 percent of Japanese babies are securely attached. Japanese mothers' attuned attention to their infants' needs is sited as the reason for these percentages. The bond between mother and infant is so intense that the Japanese literally call it "skinship." These mothers carry their infants on their backs for long periods, prolong breast feeding, co-sleep until their child is five years of age, co-bathe, and attempt to soothe their babies into a continual state of calm. Skinship makes a difference (Heller, 1997). Psychologist Elizabeth Ainsfeld (1990) of Columbia University tested this by distributing snuglies (soft, body baby carriers) to financially deprived American mothers whose infants were at high risk for insecure attachment. She gave the control group plastic infant carriers. Eighty-three percent of the snuggly infants were securely attached at one year of age compared to only 38 percent of the babies carried in the plastic infant seats. Abused, neglected or touch deprived children learn not to trust touch. They tend to have great difficulty feeling of value, feeling truly powerful, or of forming reciprocally supportive relationships as adults. They are injured by lack of touch or by abusive touch (Heller, 1997).

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. 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 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 relatively neglected aspect of training and education for most therapists.
Touch has a high degree of cultural relativity. Thus, the meaning of touch can only be understood in its cultural context (Halbrook & Duplechin, 1994; Phalan, 2009). Montagu (1971) 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), Mehrabian, (1971) and Scheflen (1972). In a study done by Jourard (1966), people from different cultures were observed in casual conversation. 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, 0 times in London, and 2 times in the U.S., respectively.

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). California 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).

### America in general is a low touch culture.

Midwesterners who are strongly rooted in German and Scandinavian cultures are relatively restrained in their touch behaviors. In contrast, Americans of Latino 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 higher 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 theory 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 & Duplechin, 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.

### 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 he couldn't rub his thighs together. They were advised to pin 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 a mother's 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 babies in secret, many of them feeling guilty for being unable to follow the dictates of the experts. As was noted above, Karbelnig, as recent as in 2000, shockingly stated: "Fourth, any type of touch by psychotherapists may be construed as incestuous" (p.33). One must wonder if this includes 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 reputation Americans have as being sexually obsessed and as having odd social customs related 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
The uneasiness 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 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. 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 sexual and physical abuse are raising. Clearly, touch is not inherently dangerous to our children and it holds enormous positive potential for development and growth. It is the small minority of childcare workers who act out of their own pathology who are dangerous, just as it is the small minority of therapists who use touch to violate the boundaries of psychotherapy clients who are dangerous. As a culture and in the profession of psychotherapy it is important to reevaluate our protective interventions, not ban touch.

Therapists, as this article articulates, also struggle with issues of touch in an increasingly adversarial legal and cultural environment. Because touch is often judged as generating from sexual motivation, therapist, like teachers, childcare workers and the American public in general, tend to avoid touching to minimize the risk of having their intentions misunderstood (Young, 2005; Zur, 2007a). Because of that, our clients and society in general are deprived of the potential healing that a more open and permission-giving climate would facilitate (Fagan, 1998; Smith et al., 1998).

Types Of Touch In PsychoTherapy

Touch, 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 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 in 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 dissociative state. Following are examples of different types of touch in therapy:

1. **Ritualistic or socially accepted gesture for greeting and departure**: This form of touch is used as a greeting or departure ritual. This might 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. Accentuated 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, anguish, agony, sadness or upset. This is one of the most important forms of touch and is likely to enhance therapeutic alliance.

4. **Reassuring touch**: This form of touch is geared to encourage and reassure clients and usually involves a pat on the back or shoulders.

5. **Playful touch**: This form of touch may involve play wrestling with a child in therapy or in family therapy involving children. It might also take place in non-traditional types of therapy, such as when a therapist plays basketball with an adolescent who has not been responding to traditional verbal only-in-the-office therapy.

6. **Grounding or reorienting touch**: This form of touch is intended to help clients reduce anxiety or dissociation. It usually involves helping a client be aware of his or her physical body by employing touch to the hand or arm. It can also be done by using touch to help the client feel grounded and more connected to the world around them.

7. **Consolatory touch**: This form of touch is intended to help clients reduce anxiety or dissociation. It usually involves helping a client be aware of their physical body by employing touch to the hand or arm. It can also be done by using touch to help the client feel grounded and more connected to the world around them.

8. **Supportive touch**: This form of touch is intended to help clients reduce anxiety or dissociation. It usually involves helping a client be aware of their physical body by employing touch to the hand or arm. It can also be done by using touch to help the client feel grounded and more connected to the world around them.

9. **Reassuring touch**: This form of touch is geared to encourage and reassure clients and usually involves a pat on the back or shoulders.

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ways to minimize its occurrence and provides guidelines for therapeutic interventions.

The experience of the initiator and the recipient are not always a match. This paper discusses this potential discrepancy, suggests

The above categories are all constructed around the intent of the therapist as the initiator of the touch. In reality, the intent of the

Therapeutic touch by Body Psychotherapies:

17. Therapeutic Intervention: Some somatic and body psychotherapies regularly utilize touch as part of their theoretically

18. Sexual Touch: The initiator of this form of touch intends to sexually arouse the therapist, the client or both. It often

19. Hostile-Violent touch: This form of touch involves a therapist being physically hostile or violent with a client. Physical

20. Punishing touch: This is another inappropiate form of touch where a therapist punitively punishes a client for "undesired

The above categories are all constructed around the intent of the therapist as the initiator of the touch. In reality, the intent of the

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.
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 reassure clients.

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The Prohibition Of Touch In PsychoTherapy

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 homophobically 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. Acceptable forms of touch for men also include contact involved in sports and military action.
- Attention to sexual abuse of children in general, heightened by the recent exposure of sexual exploitation of children by clergy, has given teachers, counselors, caregivers, ministers and other authority figures a new level of fear concerning touching.

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, see Bonitz, 2008)
- 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.

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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; Montagu, 1971). Using our senses, humans consciously or unconsciously employ many non-verbal forms of communication, primarily visual, tactical 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 courting 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 Men and Animals*. Since that time, thousands of research projects in a variety of fields, such as archaeology, biology, cultural and social psychology, have expanded our knowledge of non-verbal communication. Leading research in this area has revealed the importance of non-verbal cues in communication. Non-verbal communication is used in a variety of contexts, from everyday interactions to professional settings. The use of non-verbal communication allows individuals to convey a wide range of emotions and ideas, often more effectively than verbal communication alone.
highly appropriate in the course of child therapy, but not in the case of a borderline client. Hugging a child or letting him or her jump onto the therapist's lap may be inappropriate and even damaging with another. Koocher & Keith-Spiegel, 1998; Smith et al., 1998. What is highly appropriate and effective with one client in a certain situation can radically different contextual meanings amongst different clients, therapists, and settings (Hilton, 1997; Horton, et al, 1988, 1989). The meaning of touch can be only understood within the context of the client, the therapeutic relationship, and the therapeutic setting (Zur, 2007a, 2007b). 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, 1989; Koocher & 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 child therapy, but not in the case of a borderline client.

Troubleshooting

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 stimuli 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.

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.

- **Somatic Expression:** These "body voice" communications include: Blushing, perspiring, changes in breathing, flushing, muscle tension (constriction or expansion), moisture in eyes, blanching, flaring of nostrils, unconscious movement of body parts, visceral experience, numbing, and temperature changes (Blatner, 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 relations, 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 other 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 (Scheflen, 1972).

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

- **Facial Expressions:** Transient facial expressions may 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. (Blatner, 2002).

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.

The meaning of touch can be only understood within the context of the client, the therapeutic relationship, and the therapeutic setting (Zur, 2007a, 2007b). 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, 1989; Koocher & 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 child 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 recumbent 24-year-old female client he had only just met. Of course in a "standard" therapeutic situation, such a scene is likely 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, 2004).

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 constitute the context of touch and therefore are of extreme importance. They include presenting problem, diagnosis, personality, history, and in particular, history of abuse, culture and gender. Timing is as important. 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 of 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 moment. When solidly based upon clinical needs and a clinical rationale, touch can be exceptionally caring, comforting, reassuring, or healing (p. 170).

**Clients' Perceptions Of Touch**

Clients, sometimes independent of therapists' intentions, construct the meaning of touch. For example, a light touch on the arm by a therapist meaning to be supportive and affirming may be experienced by a client either, as intended, supportive, warm, encouraging and affirming, or it may be perceived as hostile, intrusive, controlling and disrespectful. Similarly, a handshake at the end of the session can be perceived as a gesture of respect and affirmation or as indication of the therapist's coldness, rigidity, distance or dislike of the client. A therapist's hug, meant to be supportive, may be experienced as affirming and calming, or as overwhelming, intrusive or as sexual harassment.

Non-erotic or non-sexual touch in therapy, like any other form of non-verbal communication, can complement, negate, reinforce or alter verbal communication in general and in therapy (Geib, 1982; Horton et al., 1998; Phalan, 2009; Smith et al., 1998; Young, 2005; Zur, 2007a, 2007b). Many of our clients, like people in general, are often more attuned to non-verbal cues such as body language and touch rather than to verbal communication (Givens, 2004). The quality of attunement between client and therapist is of utmost importance regarding the meaning of non-verbal cues and will determine the clients' response to touch.

Geib (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 Geib's finding that the degree of therapeutic alliance significantly influences the client's evaluation of touch.

**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," "deeper 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 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.

Therapists' congruent, invited, and appropriate non-sexual touch is likely to increase a sense of empathy, sympathy, safety, calm, and comfort for clients (Smith et al., 1998). It can also significantly enhance clients' sense of being heard, seen, understood and acknowledged by their therapists. As such, appropriate touch is likely to increase the sense of connection and trust between a therapist and a client. Research indicates that the clients' experience of touch in psychotherapy provides valuable information on assessing the therapeutic alliance and predicting therapy outcome (Garman, 1977; Harty & Strupp, 1983; Lambert, 1991; Marziali, 1984; Salvio, Beutler, Wood, & Engle, 1992). Hilton (1997) describes the importance of touch for transference and countertransference, and acknowledges the emotional significance of touch in the therapeutic relationship, and the therapeutic setting.
Surveys on Touch In Therapy

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. Tinnauer, 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.

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.
- Hugging clients was practiced by 44.5% of the respondents on a rare basis, and by an additional 41.7% more frequently. Few (4.6%) believed the practice to be clearly unethical, but 41.2% believed it to be ethical only under rare circumstances.
- The findings in the previous two categories may be compared to the results reported by Holroyd and Brodsky (1977) in which 27% of the therapists reported occasionally engaging in nonerotic hugging, kissing, or affectionate touching with opposite-sex patients, and 7% reported doing so frequently or always.
- Almost all respondents offered or accepted a handshake from a client, either rarely (48.9%) or more frequently (48.2%). Very few found the behavior to be ethically questionable (p.1001).

The study of attitudes towards touch in therapy primarily involves issues related to sexual feelings, sexual touch and sexual boundary violations. Most of these surveys present several methodological concerns either because they seem to lack clear differentiations between sexual and non-sexual touch or assume that, in most cases, non-sexual touch inevitably leads to sexual touch. The bias against boundary crossing in general and touch in particular, combined with sampling limitations have also been a concern with the validity of the surveys. Holroyd & Brodsky (1980) titled their article regarding their survey "Does touching patients lead to sexual intercourse?" Not surprisingly they also concluded that "is it difficult to determine where 'non-erotic hugging, kissing, and affectionate touching' leave off and 'erotic contact' begins" (p. 810). Similarly, Pope and various colleagues (Pope & Bouhoutsos, 1986; Pope, Schover, & Levenson, 1980; 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. The bias of Pope, Tabachnick and Keith-Spiegel (1987) in regard to touch is apparent as soon as one notices that under the heading "Do Not Exploit" they discuss the topics of "Sexual issues and physical contact" under one subtitle. In their conclusion, citing several of their colleagues, they state, "The focus on erotic contact in therapy has raised questions about the legitimacy and effects of ostensibly nonerotic physical contact" (p. 1001).

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 finding:

- That so many participants had been cradled or held by their therapists was surprising, in part, because of the attention paid, by both the public and the profession, to sexual contact. In light of the harm and penalties associated with sexual violations, it might be hypothesized that therapists would tend to avoid forms of physical contact such as holding and cradling (i.e., those beyond a handshake, reassuring touch, and other brief and limited forms of making contact). The finding is also somewhat surprising given the relevant lack of therapy research literature on the effects of nonphysical touch. That at least one fourth of the participants reported having been cradled or held by their therapists suggests that this form of therapist-client relationship deserves increased attention in systematic studies, graduate training programs, and continuing education courses (Pope & Tabachnick, 1994, p. 257)

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 on the healing effect of touch is as 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.

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. 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. The important conclusion of these finding 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. A more balanced view of touch and its potential benefits and risks is found in surveys of therapists and clients, presented in a series of chapters found in Smith et al.'s (1998) book.

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 (Geib, 1982; Horton, 1995). Positive functions of touch, as expressed 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 surveys of clients who have experienced touch in psychotherapy indicate that touch reinforced their 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).

Clinical Orientations on Touch

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 whole-heartedly.

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 (Milakovich, 1993; Williams, 1997; Young, 2005; Zur, 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.

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 (Bonitz, 2008; Hunter & Struve, 1998). Rogers (1970) 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 & Struve, 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.

Family therapists, including Satir (1972) often utilize touch as an element of engaging clients in therapy (Holub & Lee, 1990). Behavioral and cognitive behavioral therapists are likely to incorporate touch or any boundary crossing into therapy if it fits with their interventions, such as modeling or reinforcement (Lazarus & Zur, 2002).

Feminist therapists seem to have two camps when it comes to issues of boundaries, including touch. The more vocal, politically and professionally active faction focuses on issues of power, male dominance, sexuality, and oppressive patriarchal values. Predictably, they take a strong stance against most boundary crossings and dual relationships and advocate for the protection of, what they see as, vulnerable female clients sexually exploited by powerful male therapists. Borys, Bouhoutsos, Brown, Keith-Spiegel, Jorgenson, Kitchener, Sonne, and Vasquez are some of the authors who tend to align with this ideology (Zur, 2005). Alyn (1998) describes a kind of touch hierarchy in which it is more likely for a person of higher status to touch someone of lower status than the converse. In this context any touch, even non-sexual touch by male therapists of women clients is seen as disempowering and therefore harmful to women. The much less vocal faction of feminist therapy focuses on essential issues of inclusion, connection, mutuality, self-disclosure, and equality. The focus of these writers, as manifested in the important work of Greenspan (1995) and some contributions by The Stone Institute and The Feminist Therapy Institute (1987), relate how healing often entails tearing down rigid, arbitrary, professional boundaries rather than erecting them. Along these lines, appropriate touch, which is congruent with the therapist-client relationship, is seen as potentially healing.

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 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.

Milakovich (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 were 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.

Therapists who touch were more likely to experience body psychotherapies than therapists who do not touch.

Unlike therapists who do not touch, therapists who touch are (obviously) more supportive of models that use touch and employ body psychotherapy techniques.

Female therapists tend to touch their clients more often than do male therapists.

**Sexual And Non-Sexual Touch In Therapy**

Most writers have defined touch as the physical contact between a therapist and a client, either directly on the person's skin or through the person clothing (Pope, Sonne & Holroyd, 1993). However, many writers have struggled with mapping the boundaries between sexual and non-sexual touch in therapy. Some focus on the areas touched (i.e., hand vs. genitals). Others focus on whether the intent is to sexually arouse the client, oneself, or not. Yet others attempt to differentiate between overt vs. covert touching behavior. Some, like Brodsky (1985), propose an encompassing broad view that "erotic touch" should be defined as any behavior that leads to sexual arousal.

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 (2002), Smith et al., (1998), like many other writers, emphasize 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 feeling 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 untrained therapists who tend to deny difficult or unacceptable feelings in a process, which is likely to increase their vulnerability to violate their clients.

**Body-centered Therapies: History, Reichian, Bioenergetics, Radix, Somatic Experiencing**

Historically, there has been a centuries-long profound split between body and mind in Western thought and in psychotherapy in general. It has just been in the last twenty-five years that the correspondence between physiological and psychological processes has found form in somatically-based psychotherapies. Body-centered psychotherapies view the body/mind as a feedback loop or continuum rather than two separate systems, recognizing that any event experienced impacts us in a holistic way---physically, cognitively, spiritually, and emotionally. Healthy functioning, and dysfunction in any part of the organismic continuum will affect the whole system (Caldwell, 1997).

The United States Association For Body Psychotherapy (USABP) asserts "All experiences, as well as distortions and denials of reality and other defensive maneuvers, are reflected not only in peoples' thoughts and feelings but also in the way they move, how they breathe and how the structure of their bodies has evolved over the years. . . "(United States Association For Body Psychotherapy, 2003, Par. 1). Body psychotherapy assists people in healing and developing not only through the use of verbal interventions, but also through guiding them to a deeper awareness of their bodily sensations, images, behavior and feelings. There are many approaches to body psychotherapy just as there are multiple approaches in psychotherapy and a variety of techniques are employed. "These forms seek to re-sensitize our clients to their birthright of healthy and optimal functioning by using the direct physical experience of the body as a healing tool. These systems also advocate our continued growth and transformation as humans through reclaiming our integrative being" (Caldwell, 1997, p. 26). Techniques common to most body-centered psychotherapies include attention to somatic awareness, breath, movement, imagery, and touch which can vary from deep manipulation used to release body blocks to supportive hugs or holding.

Humanistic, Existential and Gestalt psychology, as well as dance and movement therapy, family therapy, systems theory, biology, and Far Eastern philosophy have all contributed to body psychotherapy approaches. All attempt to integrate the body and mind and take into account when problems began and how they affect a person's development over the years.

**Dr. Don Johnson** (Johnson & Grand, 1998) the director of the Somatic Graduate program at CIIS, (SF, CA), summarize well his attempt to integrate the field of somatic therapy:

Somatics is a generative concept like "cognitive science," "ecology," or QiGong, names whose function is to create
The term **Focusing** was popularized by Dr. Eugene Gendlin in 1960's. Focusing refers to the simple matter of holding an open, non-directive mind towards oneself and the present moment. It is not an approach that seeks to treat specific symptoms or conditions but rather a way of being present and aware in one's experience. For example, Reichian bioenergetics, Rolfing, and hatha yoga once seemed worlds apart. Now with the help of this new paradigm, we can now see how each can augment and make more effective the practice of the others.

**The History of Body Psychotherapy**

Surprisingly, it was Freud who laid the groundwork for body psychotherapy, as he identified the body and body processes as the foundation of psychological states (Caldwell, 1997). He described the ego as being first and foremost a body ego, and he taught that the physical blocking or discharge of energy is essential in the formation of psychological disorders. He subsequently became fascinated with verbal analysis and the only aspect of his somatic perspective that remained a part of his focus was his technique of working with his clients as they lay on a couch. He felt this position relaxed tense musculature and regressed clients to earlier states of development by lowering their defenses.

Ferenczi, originally trained in the psychoanalytic model, at one point spoke out as a proponent of hugging, holding, kissing and non-erotic fondling of clients, believing that the use of such therapeutic touch would provide corrective parenting to clients with early injuries. Initially, Freud was supportive of his experiential experiments but withdrew his support when he became aware that Ferenczi had become sexually and romantically involved with more than one of his clients. Ferenczi refused to discontinue his use of touch and was subsequently expelled from the ranks of orthodox psychoanalysis (Fosshage, 2000).

**Reichian Therapy**

Wilhelm Reich, a student of Freud, is often referred to as the grandfather of body-oriented psychotherapy, however, a long history of body-oriented approaches to healing, predates his work. One of Reich's most significant contributions has been his effort to dismantle the barriers and restrictions to touch that had been imposed by the domineering influences of psychoanalysis (Hunter, Struve, 1998). Reich's view that modern society functions as a repressive force that results in the basis for all illness (Reich, 1986) contrasted with Freuds' concept of libido, a form of unsocialized energy, which must be controlled (Freud, 1960). Reich also added the dimension of the body to Freud's model of ego and internal conflict, in that he saw the ego as controlling impulses and emotions through physiological patterns, e.g. a holding jaw, a tight belly etc. (Eiden, 2002). His development of character analysis correlated psychological and physical patterns. In this context, "character" is seen as a defense against strong emotions and has the function to bind anxiety in the form of muscular tension, e.g. the "fight or flight" response which is a specific reaction to stress, an instinctive reflex which, if unexpressed, stays in the body in the form of a postural holding pattern. Such holding patterns or "blocking" served to protect the individual against painful and threatening emotional experiences (Reich, 1972). Reich's basic technique was to reduce body armor by palpating or pressing certain muscle groups to dissolve muscle tension to free inhibited energy. This represented a radical departure from the rigid tenants of traditional psychoanalysis by initiating direct physical contact with his clients, for which he was censured and eventually excommunicated from the psychoanalytic community (Olser, 1982).

**Bioenergetics**

Lowen studied with Reich, but focused on the larger realm of pure feelings instead of emphasizing concerns with orgasmic performance as Reich had (Lowen, 1958). Reichians work with the hypothesis that there is one, fundamental energy in the human body whether it manifests itself in psychic phenomena or in somatic motion. This energy is simply called "bioenergy" (Hunter, Struve, 1998). Both Reich and Lowen believed that organistic potency was a criterion for cure, but Lowen included the ability to express all emotion fully. He worked to increase the client's awareness of unconscious fears and conflicts in relationship to tensions and rigidities in the body. To this end, he developed exercises to help the client magnify and release tensions in the body, freeing blocked emotions. He used pressure on muscles, expressive exercises, breath work, and worked with dreams, memories and emotions, which might emerge from the unconscious as a result of the bodywork (Lowen, 1976). Stanley Keleman (1987) broke from mainstream bioenergetics in his articulation of how movement creates the body and the body creates movement. He works with breath, movement and sound as he examines the vibratory processes of the body down to the cellular level. He believes that the quality of this pulsation shapes our physical form. He seeks to reestablish charge, formation, and discharge in a process that develops healthy tissue and holistically healthy individuals.

**Radix**

Charles Kelley, the founder of the Radix institute, describes "Radix" as the source from which energy, feeling, and movement are created and his work is less analytical and verbally oriented than Reichian therapy or Bioenergetics. There is more focus on how a person blocks fear, anger or painful emotions rather than on content. He uses visual techniques to open the ability to access deep, spontaneous emotion and to choose appropriate goals, increasing self-direction, control and significance in the life of his students. For Kelley, the focus is on education and growth. Most Radix work is done in groups (Caldwell, 1997).

**Somatic Experiencing (SE)**

Somatic Experiencing (SE) is a naturalistic approach to the resolution and healing of trauma developed by Dr. Peter Levine (1997), Founder and Senior Advisor for the Foundation for Human Enrichment in Niwot, CO. The SE modality is based on the observation that wild prey animals, though threatened routinely, are rarely traumatized. Animals in the wild, according to SE theory, utilize innate mechanisms to regulate and discharge the high levels of energy arousal associated with defensive survival behaviors. These mechanisms provide animals with a built-in, natural or innate immunity to trauma that enables them to return to normal in the aftermath of highly "charged" life-threatening experiences.

According to the Foundation for Human Enrichment Somatic Experiencing is not considered as a form of psychotherapy, it stands on its own as an approach to healing trauma. The Foundation is clear that SE is neither a psychotherapy nor a bodywork technique, but lends itself well to being integrated into these and other treatment modalities.

**Focusing**

The term **focusing** was popularized by Dr. Eugene Gendlin in 1960's. Focusing refers to the simple matter of holding an open, non-directed mind towards oneself and the present moment. It is not an approach that seeks to treat specific symptoms or conditions but rather a way of being present and aware in one's experience.
Dr. Stanley Keleman, Formative Psychology

Formative psychology, was developed by Dr. Keleman (1981, 1987). He describes as follows:

Formative psychology, is based in the evolutionary process in which life continually forms the next series of shapes, from birth through maturity to old age. Conception each person is given a biological and emotional inheritance, but it is through voluntary effort that a human fulfills the potential for forming a personal life. Form gives rise to feeling. When individual identity is grounded in somatic reality, we can say: I know who I am by how I experience myself.

Additional approaches to body psychotherapy
Other pioneers in the field have blended disciplines to form their work. This includes, but is not limited to, such disciplines as: The Lomi School, which mixes Gestalt therapy with Reichian breath work, body education, Meditation, Yoga and Tai Chi and Stanley Groff's Holotropic breath work.

New forms of body-centered psychotherapy are evolving 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 Caldwell's Moving Cycle (1997) and Rubenfeld Synergy System (Rubenfeld, 2000) among others.

Biochemical Links between Consciousnesses, 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. Chiropractors 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. Hence, one becomes stuck repeating old patterns of emotion and 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 neurochemicals. 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 its 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 may have been stimulated by negative experiences in childhood. . . Autopsies almost always show a tenfold higher level of CRF in the cerebrospinal fluid of those who killed themselves compared to those who died from other causes" (1997, p. 270). 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 cuddled 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 cures 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 network 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).
Touch With Special Population

Multiple factors effect the decision making process in forming a treatment plan that includes touch. It is crucial to address the specific touch experiences of special populations.

Survivors of Childhood Trauma
The use of touch with survivors of childhood trauma has been much debated. However, the clinically appropriate and ethical use of touch with survivors of childhood abuse can be invaluable in helping them heal and recover from their traumatic experiences (Hunter & Struve, 1998). Due to the nature of their original injuries, many of these clients are likely to feel intense vulnerability at the suggestion of touch in the intimate setting of psychotherapy. There is the possibility that touch used with clients who are survivors of childhood trauma may recreate, or evoke, previous client-experienced dynamics of submission and victimization, entrapment, anger, fear, vulnerability and feelings of worthlessness. Because of this, Lawry (1998) states that the use of touch is contra-indicated in early sessions due to the potential for retraumatization, and Cornell (1997) suggests 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)."

Studies done in the context of post-traumatic stress disorder have explored the relationship between trauma and memory (Allen, 1995; Herman, 1992; Van der Kolk, McFarland & Weisaeth, 1996). The concept of 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 document that traumatic memories are encoded in our sensorimotor system as kinesthetic sensations and images. 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 forms of memory that predominate in early life" (p. 39). This results in the client having great difficulty reconstructing a narrative of their traumatic memories as they experience them instead as emotional and sensory recall (Van der Kolk et. al., 1996). Due to the somatosensory experience of trauma, new forms of treatment are offered by body-oriented therapies (Hovdestad & Kristiansen, 1996). Bar Levav, (1998) reports that physiological patterns in the body can be changed by touch to correct early injurious experiences.

Since the nature of the original injury, physical and/or sexual assault, involved boundary violation, the therapist must be particularly careful to structure a foundation of client safety and empowerment. Most authors agree that a client must want to touch or be touched and understand the concepts of empowerment before it is clinically or ethically appropriate to begin the use of touch in session (Hunter et. al., 1998). To this end, clients should be encouraged to express their preferences, to practice boundary-setting exercises, and to participate in creating a treatment plan. Studies suggest that there is a positive correlation between a clients' perception that they are in control of touch and their positive evaluation of touch in psychotherapy (Geib,1998; Horton, et. al., 1995). Many abuse survivors respond to anxiety by having difficulty in protecting their boundaries. Therefore, it is helpful for the therapist to state clearly that he or she accepts full responsibility for ensuring that there will be no sexual contact with the client, and to be clear about the process and type of touch that will be involved. Hunter and Struve suggest that it is helpful to draft written ground rules as many survivors are highly dissociative and have difficulty retaining verbal information in stressful situations.

Helfer (1978) developed a program, which includes a series of graduated exercises through which a client can address developmental tasks, which were missed in childhood as a result of abusive or neglectful parenting. Since most survivors of abuse have learned to mistrust touch, he begins by helping the client get in touch with his or her five senses that may have been undeveloped, underdeveloped, or overdeveloped. These exercises explore the distinction between good touch and bad touch and help the client to enjoy the benefits of soothing supportive touch. The therapists may then guide the client in nurturing, supportive self-touch such as self-massage or self-stroking. Another approach is to direct the client in the use of imagery to reconnect with his body, to recognize bodily sensations and to name them. It can also be less threatening for a client to experience safe, nurturing, non-erotic touch through the use of imagery. Clients might further be instructed to deliberately engage in various types of touching activities, such as touching trusted friends or animals, massage, or contact sports.

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 hypothalamus, amygdala, hypothalamus and thalamus function by laying down memory 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 similar results to those of cognitive-behavioral interventions (Bremner, 2002), with the added benefit that most survivors of abuse report that touch in therapy helps them to feel "touchable" and that appropriate touch in psychotherapy helps them identify appropriate, connective, non-violating forms of touch. "The client can relearn to assimilate sensory data about physical contact only if they are processed concretely and with an intense focus on reality-testing feedback loops" (Hunter & Struve, 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, 1990, 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 communicates respect for her and her body; it says that her preference will be respected and that no intrusion (however slight) will occur against her will (Courtois, 1998).

Many therapists consider touch of any kind to be inappropriate with clients who have been abused through violations of the body. Many therapists and all somatic therapists believe that a client will have great difficulty in fully recovering from such trauma if only verbal or cognitive approaches to therapy are used. "...therapeutic efforts to help a client heal from touch-related wounds ultimately ought to include experiential approaches that directly access the body and that provide the client with real-life opportunities to feel nonabusive touch" (Hunter & Struve, 1998, p. 218). Clients traumatized in childhood are often unable to engage in activities, such as touching trusted friends or animals, massage, or contact sports.
Psychoanalytic Prohibition Of Touch In Therapy

Do not give or receive nonsexual touch, regression transference may be elicited by the use of nonerotic touch in psychotherapy with equal intensity to the expression of women (Hollender & Mercer, 1976). Clinicians are cautioned that for men, who generally psychiatric populations, women favor being held over holding, and men, although desiring to be held, do not express this longing non-sexual, non-violent touch...and may perceive every touch as either an attack or a come-on” (Redleaf, 1998 p. 44). In studies of yet affectionate touch that is allowed in sports and the military (Montague 1971). “Some men, therefore, may lack a repertoire of affectionate touch in infancy and early childhood and this has been linked with higher rates of violence and aggression in later life (Redleaf, 1998). For most men in our society, touch has been limited to violent and sexual encounters with the exception of rough and tumble play (Thayer, 1982).

Research shows that women respond more positively to touch than do men (Whitcher & Fisher, 1997). From birth, American women receive more affectionate touch from males and females and are given greater permission to touch either gender and be touched by either gender. They are more likely to have and expect a broader repertoire of touch. American males are given less affectionate touch in infancy and early childhood and this has been linked with higher rates of violence and aggression in later life (Redleaf, 1998). For men in our society, touch has been limited to violent and sexual encounters with the exception of rough yet affectionate touch that is allowed in sports and the military (Montague 1971). "Some men, therefore, may lack a repertoire of non-sexual, non-violent touch...and may perceive every touch as either an attack or a come-on" (Redleaf, 1998 p. 44). In studies of psychiatric populations, women favor being held over holding, and men, although desiring to be held, do not express this longing with equal intensity to the expression of women (Hollender & Mercer, 1976). 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, 2001).

Children and Adolescences
Clinicians who do use touch in session, tend to do so in ways that reflect biases inherent in the larger culture. In this regard, it has been found that therapists tend to touch child clients more often than they do their adult clients and that female therapists touch child clients more often than male therapist do (Cowen, Weissberg & Lotyczewsuki, 1983). Hyperactive children tend to have negative reactions to being touched (Bauer, 1977) and clinicians are alerted to be aware of the profound social implications of this sensitivity (Thayer, 1982).

Gender issues
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 (Brodsky, 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). The Report of the Task Force on Sex Bias and Sex-role Stereotyping in Psychotherapeutic Practice (Redleaf, 1998) appropriately cautions that any treatment modality reserved for only one sex may be interpreted as being sexist. Rigid application of touch along gender lines fits the definition of sexism and is clinically inappropriate.

The values of Americas' youth oriented culture result in many elders experiencing touch deprivation. This is in contrast to high touch cultures in which elders are generally cared for at home in the company of extended family.

Touch with Elders
The values of Americas' youth oriented culture result in many elders experiencing touch deprivation. This is in contrast to high touch cultures in which elders are generally cared for at home in the company of extended family. Most people experience some level of decrements in physical faculties and general perceptual skills but the sense of touch generally remains intact for most older people and actually is valued as increasingly important as a source of contact and communication (Hollinger, 1986). The soothing, affirming experience of touch is most important at the beginning and end of ones' life and generous, nurturing touch can gently facilitate the process of aging and dying with dignity (Hunter & Struve, 1998).

Adolescents may be particularly sensitive to dimensions of control with regard to touch and may react negatively to touch that could be interpreted as patronizing or unduly familiar (Smith, et. al., 1980; Jones, 1994).

A growing body of literature has linked aggressive, violent, and antisocial behaviors to early childhood touch deprivation (Mitchell, 1979; Older, 1982). These children grow up with a diminished ability to feel, and a reduced ability to initiate or receive touch (Hunter & Struve, 1998). In one study, the staff of an adolescent treatment program modeled nonsexual, nonviolent touch to incorporate physical contact as an acceptable aspect of the milieu. They found that the adolescents demonstrated a marked decrease in violent and sexual behaviors (Dunne, Breggen, & O'Bridge, 1982).

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Psychoanalysis traditionally has placed an almost total 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 elaborate form of communication. So important is tactile stimulation for development and maintenance of physiological and psychological regulations that recent research demonstrates that physiological and psychological regulations of persons of all ages are "righted" through physical holding and touch (Fosshage, 2000).

Psychoanalysis, from the days of its inception, has been highly concerned with the effect of physical touch in analysis. The issue erupted, beginning with Freud, back in 1931 scolding Ferenczi for letting a female client kiss him. Freud wrote to Ferenczi:

You have not made a secret of the fact that you kiss your patients and let them kiss you... Now I am assuredly not one of those who from prudishness or from consideration of bourgeois convention would condemn little erotic gratifications of this kind... But that does not alter the fact... that with us a kiss signifies a certain erotic intimacy... Now picture what will be the result of publishing you technique... A number of independent thinkers will say to themselves: Why stop at a kiss? Certainly one gets further when one adopts "pawing" as well, which after all doesn't make a baby. And then bolder ones will come along who will go further, to peeping and showing and soon we shall have accepted in the technique of analysis the whole repertoire of demivierge and petting parties, resulting in an enormous interest in psychoanalysis among both analysts and patients. (Jones, 1957, pp. 163-164, cited in Marmor, 1972, cited in Koocher & Keith-Spiegel, 1998, p. 207).

Clearly Freud felt that physical contact would almost certainly lead to sexual enactments. By his own admission, he was equally concerned with the reputation of psychoanalysis and forced the issue of touch to go underground.

As psychoanalysis emerged, an entire analytic ideology was created around the prohibition of touch. It is based on the conviction that any touch is likely to gratify sexual and instinctual infantile longings or drives, subsequently contaminating the analytic container and nullifying the possibilities for analysis to help the clients work through their issues. (Fosshage, 2000).

The effects of touch, like any boundary crossing, such as self-disclosure, gift giving or home visits, is a major concern in therapy, for almost all psychoanalysts and psychoanalytically oriented therapists. Many of them conceive these effects to be intrinsically negative and hence believe that they invariably interfere with and undermine clinical work (Epstein & Simon, 1990; Langs, 1976; Simon, 1992). Psychoanalytic theory emphasizes the importance of boundaries and the neutral stance of the analyst. According to traditional analysts, effective management of transference and other therapeutic work requires clear and consistent boundaries and therefore no physical contact so the analyst can preserve the analytic frame of therapy (Langs, 1988). Transgressions that detract from therapists' neutrality, such as touch, are said to contaminate the transference and hence are a detriment to analysis. Langs, (1976), an avid supporter of rigid and inflexible boundaries, testifies that "poor boundary management" impedes transference work and has other serious ramifications, such as the dilution of the therapist's influence.

Simon (1995) operates from a similar perspective and has numerous publications that epitomize the case against boundary crossings. Adhering to traditional analytic principles, his main guidelines state: "Maintain therapist neutrality... foster psychological separateness of the patient... interact only verbally with clients... minimize physical contact (Simon, 1994, p. 514).

The theoretical rationale for barring physical touch in the analytic process is based on the assumption that, in keeping with the pleasure principle, physical touch gratifies the client's infantile sexual longings and, thereby, fixates the client at an infantile level. Refusal to touch and refusing to provide gratification, forces infantile sexual wishes into awareness that ultimately facilitates their renunciation. To achieve this goal, the analyst must stay neutral and provide a blank screen onto which the client's childhood fantasies are displaced and projected. Within the classical conception of transference, the goal is to prevent or remove any possible contribution from the analyst to the client's experience in order to illuminate the client's intrapsychically generated projections and displacements. Touch is viewed as "muddying the transferrencial waters," and is likely to nullified analytic effectiveness. Touch is prohibited for it is viewed as an intrusion of the analyst and an interference with the free associational process and therefore the transference analysis (Fosshage, 2000).

While Freud's rule of abstinence and interdiction on touch has, thus, predominated in the psychoanalytic literature, there have been notable exceptions where physical touch is seen as not only appropriate, but as necessary when dealing with periods of deep regression (Balint, 1968); Winnicott, 1958, 1975), with psychotic anxieties and delusional transference, and with deeply disturbed clients (see Mintz, 1971 who describes the work of Fromm-Reichman and Searles). More recently, additional reports of the facilitative use of touch have emerged in the literature (Fosshage, 2000). Hilton (1997) has also added the importance of touch in psychodynamic psychotherapy and its inclusion in the transference and countertransference analysis.

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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; Herlihy & 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 the 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 (1988) 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, 2002; 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). What 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, 2009). Power is, in itself, neither positive nor negative; 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.

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 resolved 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 patients are portrayed as malleable, weak, and defenseless 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, 2007a). 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 them as more powerful and successful than they. Such cases are a prime example of when therapists have to work hard at cultivating an aura of power so as to appear credible.

In summary, therapists must be very careful not to abuse the trust and power 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".

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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
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) have emphasized the lack of definition of what constitute appropriate boundaries 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. Traditionally, boundary crossings in psychotherapy have been defined as any deviation from traditional, strict, hands-off, ‘only in the office,’ emotionally distant forms of therapy (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, 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, such as 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. 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 bed-ridden 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 and most other boundary crossings as transgressions and as potential precursors to harm, exploitation and sexual relationships 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 crossing. In fact, many analysts have viewed even appropriate and helpful boundary crossing, 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; Kagle & 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 Latino, 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 most 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 boundary crossings 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 mental health conditions, is not necessarily harmful or inappropriate. At times, it is essential for the therapeutic process. However, it is critical to maintain a distinction between boundary violations and boundary crossings. Boundary violations, such as therapists' sexual touch with current clients, are harmful to clients and must be avoided. Boundary crossings, such as a comforting hug or hand holding, may be helpful and beneficial in the therapeutic process.
Risk management has become one of the most influential 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. (Gutheil & Gabbard, 1993; Williams, 1997). While the conscientious 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 "risky behavior" regardless of the likely positive results (Bonitz, 2008; Lazarus, 1994, 1998; Williams, 1997; Zur, 2007a).

Touch has often been placed at the top of the 'Do not do' list. "From the viewpoint of current risk-management principles" Gutheil & Gabbard stated, "a handshake is about the limit of social physical contact at this time" (1993, p. 195). Similarly, WebMD (1992) announces "A Hug-Free Zone: The threat of lawsuits, the already strong language in the APA code, and the general litigiousness of society have prompted many therapists to erect barriers between themselves and their clients when it comes to any physical contact. No more hugs for a sobbing client. No encouraging pats on the back" (section 2, Para. 1).

Like male preschool teachers who no longer hug young children, or camp counselor who would no longer hold a child in their lap for fear of being accused of inappropriate sexual behavior, many therapists, for similar reasons based on fear, have generally abandoned the practice of touching their clients. Defensive medicine, fueled by fear, is the defining forces behind risk management practices. The teaching of risk management principles seems to dominate ethics classes in graduate school and legal-ethical continuing education workshops. They are the foundation of endless attorneys' columns in our professional organization newsletters and a more recent breed of risk management presentations at our professional conferences. In all these formats, we are told never to hug, pat or hold our clients. Basically, we are told not to touch beyond a handshake and when possible even to avoid a handshake too. Beware! We are told, the slightest deviation from these ersatz commandments will set us on the 'slippery slope' to perdition. But even if one has not slipped uncontrollably down the slippery slope, the sheer idea that an action may appear improper in front of judges, juries, licensing boards or ethic committees has prompted many therapists to erect barriers between themselves and their clients when it comes to any physical contact. No more hugs for a sobbing client. No encouraging pats on the back".

When we listen closely to the risk management dogma, it is clear that no one really disputes the scientific fact, and the common knowledge, that touch is one of the most elemental human ways to relate and can be a powerful method for healing. Nevertheless, we have been frightened out of employing touch and most other forms of boundary crossings, such as self-disclosure, home visits, accepting gifts, bartering and many other behaviors frowned upon by the so-called "risk management" experts. These experts' advice often goes specifically against the practices of humanistic, cognitive-behavioral, family, feminist and group therapists. Ironically, these are also the orientations most practiced by psychotherapists.

Misleadingly, many of these therapists, ethicists and so called risk management experts have mislead the therapeutic community, clients and licensing boards and courts to believe that non-sexual touch is unethical and below the standard of care. Unlike most commonly held beliefs, boundary crossings, such as touch are neither unethical nor below the standard of care. Ethics codes of all major psychotherapy professional associations (e.g., AAMFT, 2012; ACA, 2005; APA, 2010; NASW, 2008) neither prohibit boundary crossings in general nor do they prohibit the use of appropriate touch in therapy. All psychotherapy professional codes of ethics view sexual or violent touch with a current client as unethical. For specific details refer to the ‘ethics codes’ stance on touch in therapy (Zur, 2004).

The obvious question then becomes, "Why are behaviors and interventions, such as touch, that are known to be clinically helpful, as well as very natural elements of human interaction, banned from our practices or, at best, driven underground?" The answer lies primarily in the concept, practice and teaching of defensive medicine or risk management.
In principle, nothing is wrong with managing risk if it is done thoughtfully by applying sensible clinical judgment and employing critical thinking rather than paranoid thinking. There must also be a sound knowledge of the professional codes of ethics and laws of states. All actions and clinical interventions involve some risk. For that matter, we often forget that inaction can be risky and even damaging to clients, as well. For example, I have been working with a woman who, 10 years prior to our first session, lost her infant son in an automobile accident. In an emergency appointment with a psychiatrist right after the death of her son, as she sobbed uncontrollably, she begged him to hold her. He refused, citing something about professional boundaries. Instead, he prescribed Valium. Eight years later, addicted to Valium and alcohol, she began therapy with me. After an intense few months of therapy, we visited her son's grave. It was the first time she had visited the grave. There we stood, holding each other and both weeping as she finally started facing her baby's death and grieving for him and for her years lost in drugged denial. While the psychiatrist followed risk management guidelines to perfection, he also may have inflicted immense harm. Did he sacrifice his humanity and the core of his professional being, to heartless protocol?

All therapists may, of course, with due consideration, attempt to reduce their own risks and the risks to their clients when employing touch in therapy. This is especially important when working with cases involved borderline or dissociative proclivities. This attempt to reduce risk goes side by side with clinical integrity, relevant training, and sound employment of treatment plans. Appropriate, risk-benefit analysis, requires that therapists ask themselves basic questions, such as, "What is to be gained by employing touch and what is there to lose? What do I risk if I do not touch and what do I risk if I do?" It is very important that such an analysis be made for each client and each clinical situation taking into account the specific client's mental state, presenting problem, history, culture, personality, communal support, class, gender, etc. (Complete guidelines for the use of touch in therapy will be found at the end of this article.)

Malpractice insurance carriers represent the primary force behind risk management, or what some attorneys call "healthy defensiveness". While the actual likelihood of a lawsuit or of licensing discipline for psychotherapists is extremely low (Williams, 1997), in the rare event that it takes place, it can be very costly to the insurance company and emotionally and financially devastating to the practitioner. The rare, but nevertheless outrageously costly, judgments drive the malpractice insurance companies to advocate strict risk management practices and the avoidance of any behavior that may give a jury reason to suspect inappropriate behavior and levy an expensive penalty. Ironically, this strategy, as will be discussed later, is more likely to backfire on the insurance companies.

Aiding and abetting the insurance companies and attorneys has also fueled the risk management fire, inspiring paranoia and widespread instruction in risk avoidance behavior. Attorneys' advice columns seem to have become a regular feature in our professional journals. Scheduled sessions with legal professionals abound at our professional conferences. Often, without any clinical training whatsoever, they sternly give us long lists of what we should avoid. At the top of the list is, of course, "Do not touch!" Obviously the list does not stop there. They tell us never to leave the office even though going to an open space with an agoraphobic client, as part of a systematic desensitization is the appropriate, if not mandated, clinical intervention. They tell us never to socialize with clients even though it is often impossible to avoid doing so in rural areas and in small communities. They tell us never to share a meal with a client even though an "anorexic lunch" can be part of a perfectly executed family system-based treatment plan. When it comes down to it, risk management can be also defined as attorneys' advice overriding clinical judgment.

Risk management and the fear it induces effects not only mental health, but also our entire society. It is part of a bigger and more complex phenomenon: the American litigation explosion and the rights movement. Even though, as has been stated, litigation is rare in our profession, the mere possibility of such a consequence is daunting and affects us strongly. We have become a culture where everyone tramples everyone else in the fight for his or her rights and entitlements (Etzioni, 1987, Zur, 1994).

We have become a culture where everyone tramples everyone else in the fight for his or her rights and entitlements.

While accountability is an important civic quality, this lawsuit-happy culture, combined with the culture of victims, creates an atmosphere of dread that changes the way we do (or don't do) business, play or healing. We all know about the playgrounds across the country that have been stripped of monkey bars, high slides and fun swings due to the thousands of lawsuits filed by parents after their children have 'gotten hurt' while playing. Ministers, teachers, and youth counselors avoid touching - especially children or women. People have actually sued McDonald's for the obesity resulting from too many Big Macs! Litigation gone wild, indeed.

Flowing directly from this trend, fear-induced risk management has driven physicians to practice defensive medicine' and to routinely order a huge number of diagnostic tests, such as lab and radiology investigations, not because they believe they are medically necessary but as part of their risk management strategy. The rationale is that the physician will not be accused of not having done everything in his power to rule out even the most unlikely diagnosis. Some estimate that doctors waste between $50 to $100 billion annually on defensive medicine. Shockingly, some also estimate that this is the amount that could buy health care nationally with clients even though it is often impossible to avoid doing so in rural areas and in small communities. They tell us never to share a meal with a client even though an "anorexic lunch" can be part of a perfectly executed family system-based treatment plan. When it comes down to it, risk management can be also defined as attorneys' advice overriding clinical judgment.

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across the country, I (O.Z.) have noted that older (non-analytically oriented) therapists seem to be less concerned about risk
attorneys a regular column in their newsletters or journals where this paranoiac thinking is disseminated. As risk management
practice of defensive medicine through their own risk management workshops and seminars. Some, as we see monthly, have given
insurance for the 40 million uninsured Americans. While attorneys laugh all the way to the bank, our risk management-
intoxicated, phobic culture ends up settling for inferior care of every kind; children are deprived of touch and opportunities for
play; and spiraling medical costs continue to bankrupt the country.

One of the major concerns inherent in risk management is that fear induced, defensive behaviors, and the systematic avoidance of
many behaviors have gradually stolen in through the back door to become the perceived standard of care in medicine and mental
health (Zur, 2007a). The standard of care is not anything that can be found in a textbook; it evolves as more and more
professionals adopt certain practices, which then acceptence 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 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. 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. However, today, not having a witness is considered practicing
below the standard of care. The danger that we face in mental health these days is that more and more risk management
proscriptions may metamorphose into the standard of care.

Bear 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 and attorneys, supposedly 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 continuous rising of the
risk management bar as to what constitutes acceptable clinical behavior. Expert witnesses have often encountered testimonies 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 uncritically
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 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
unforeseen 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 ethicists and "risk management experts" has too often succeeded in
paralyzing therapists and forcing them to restrict themselves to rigid and constipated 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 injunction against 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 then a reassuring or comforting hug, pat or hand holding. All of this may not be effective 'risk
management', but it is basic good therapy.

Very regrettably, 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. Some, 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 effect is clearly seen on new therapists. In the numerous Ethics with Soul workshops I have conducted
across the country, I (O.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. Alarmingy, 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, hired and paid to provide 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 protective measures.
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 precedence 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 hands off, 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 physical touch 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.
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, consoling, soothing, grounding, 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 these 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 clients' sense of trust, comfort and ease with their therapists. 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 the client, the therapeutic relationship, and the therapeutic setting. Accordingly, before employing touch, it is essential that the clinician consider unique treatment elements for a client in a specific therapeutic relationship. The meaning of touch can only be understood within the context of who the client is, the therapeutic relationship, and the therapeutic setting.
TOUCH AND HEALING

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.

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 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.
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 medicine 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 CONSIDERATION OF NON-SEXUAL TOUCH IN THERAPY

- Touch in therapy is not inherently unethical.
- None of the professional organizations code of ethics (i.e., APA, ApA, 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.
- Seeking ethical consultation is important in complex and sensitive cases.
- Ethical therapists should thoroughly process their feelings, attitudes and thoughts regarding touch in general and the often, unavoidable attraction to particular clients.
- Critical thinking and thorough ethical-decision making are most important processes preceding the ethical use of touch in therapy.
- Documentation of type, frequency and rationale of extensive touch is an important aspect of ethical practice.

CLINICAL CONSIDERATIONS FOR TOUCH IN PSYCHOTHERAPY

- The meaning of touch can only be understood within the context of who the patient is, the therapeutic relationship, and the therapeutic setting.
- Touch, like any other therapists' behavior and interventions should be employed if they are likely to help clients.
- Touch increases therapeutic alliance, the factor found to be the best predictor of therapeutic outcome.
Touch can help therapists 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.

Clinically appropriate touch must be employed with sensitivity to clients' variables, such as history, gender, culture, diagnosis, etc.

Sensitive, attuned touch gets etched into our developing neural pathways enabling us to feel of value, and to connect emotionally with others. As such, touch can be a powerful method of healing.

Language never completely supersedes the more primitive form of communication, physical touch. As such it can have a significant therapeutic value.

The unduly restrictive analytic, risk management or defensive medicine emphasis on rigid and inflexible boundaries and the mandate to avoid touch interferes with human relatedness and sound clinical judgment.

Due to the absence of attention to touch in most training programs, clinical supervision, research and testing, the majority of therapists tend not to incorporate the use of touch in therapy.

Fear, misguided beliefs and lack of training often lead to therapists employing an approach of "touch but don't talk."

Touch that is inappropriate, sexual, cold or abusive can be harmful.

Traumatic memories are encoded in our sensorimotor system as kinesthetic sensations and images, while the linguistic encoding of memory is suppressed. Therefore, appropriate touch can have a significant therapeutic value.

Disturbances in non-verbal communication are more severe and often longer lasting than disturbances in verbal language. Using touch in therapy may be the only way to heal some of these disturbances.

To disregard all physical contact between therapist and client may deter or limit psychological growth.

GUIDELINES FOR CLINICAL AND ETHICAL TOUCH IN THERAPY

- Touch should be employed in therapy if it is likely to be helpful and clinically effective.
- Avoiding touch due to fear of boards and attorneys is unethical and a betrayal of our clinical commitment to aid clients.
- Touch in therapy must always be employed with full consideration to the context of therapy and clients' factors, such as presenting problems and symptoms, personal touch and sexual history, ability to differentiate types of touch, the clients level of ability to assertively identify and protect his or her boundaries as well as the gender, and cultural influences of both the client and the therapist.
- Touch should be used according to the therapists training and competence.
- Extensive touch should be incorporated into the written treatment planning.
- 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 therapists.
- 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.


Menehan, K. *The Perinatal Bonding Project: Infant Message to Reduce child Abuse,* Massage magazine. Spokane, WA.


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