Clinical Validation and Application of Touch as a Psychotherapeutic Intervention in Public Mental Health Settings

Somatic Psychotherapy within Colorado Coalition for the Homeless (CCH)

Sabrina S. Santa Clara, LPC, R-DMT, CACII, CIFST, RYT, RMT

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Author contact:

303.304.7880 Sabrina@CCREAT.org

ABSTRACT OF ARTICLE

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This article reviews current research and professional writings related to touch in psychotherapy. The author coins and defines the term psychotherapeutic touch and makes the point that harmful and erotic touch is counterpsychotherapeutic. The benefits and potential harm are elucidated, as are ethical guidelines for the use of touch, which are likely to minimize potential harm. The author asserts that the refusal of touch by mental health workers may cause just as much harm as nonpsychotherapeutic touch and debunks the notion that no-touch policies in public mental health settings are effective tools for litigation avoidance. The author makes a compelling case for the use of psychotherapeutic touch in Mental Health Settings and makes four recommendations for public mental health organizations: (1) allow psychotherapeutic touch for those who are trained; (2) provide basic touch training for all mental health workers; (3) provide somatic supervision; and (4) create documentation standards for touch interventions.

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Introduction

This article is intended to educate clinical managers within Colorado Coalition of the Homeless about the practice of Somatic Psychotherapy and the use of touch as one intervention that somatic psychotherapists may use in working to repair client wounding. In the following pages I will review several key points: touch is essential to the human experience; touch has many benefits as a therapeutic intervention; client harm can occur from both withholding touch and touching inappropriately; ethics of touch, including cultural considerations and special ethics in working with children; touch in public mental health settings; and the need for psychotherapeutic touch training for all therapists.

Since the turn of the century, there has been an "exponential increase in highly innovative and diverse research devoted to the sense of touch" (Lederman & Klatzky, 2007, p. 169) and to the use of touch in psychotherapeutic settings. This article serves to summarize the most relevant research in order to assist clinical managers in public mental health settings in making informed decisions and policies regarding the use and limitations of psychotherapeutic touch.

Key Terms

Somatic Psychology. Somatic Psychology involves the study of the body, psyche, somatic experience, and the embodied self, which is to say that it takes a holistic and integrative approach to psychotherapy. Naropa University, which offers Masters degrees in Somatic Counseling Psychology, and the alma mater of this author, states:

> Somatic Counseling Psychology uses the unique role of the body and its movement to understand and transform human behavior. In this way, somatic psychotherapy, which includes dance/movement therapy and body psychotherapy, is a holistic approach to personal growth and change. The challenge of the somatic psychotherapist is to engage the client in verbal and non-verbal processes that transform embodied experience into knowledge for choice and change." (2011)

There are four schools in the US that offer masters degrees in Somatic Counseling. Each of these is rooted in developmental psychology and the fundamental role of the body in ego-formation, embodiment, the importance of bodily experience in affect-regulation, as well as recent research in neuroscience (Röhricht, 2000). There are a variety of terms that are associated with Somatic psychology: body oriented psychotherapy, body psychotherapy, body-centered psychotherapy, somatic therapy, and somatic psychotherapy. While there are some differences of definition, for the purposes of this paper, and so as not to confuse the reader, the author will primarily use the term "somatic psychotherapy" unless she is referring to or quoting from an external source that uses different terminology.

The United States Association of Body Psychotherapy (USABP), one of the major professional associations for somatic psychotherapists, has adapted its definition of Body Psychotherapy from the European Association of Body Psychotherapy. It states that Body Psychotherapy is:

> a distinct branch of the main body of psychotherapy with a long history and a large body of knowledge based upon a sound theoretical position. At the same time, it involves a different and explicit theory of mind-body functioning that takes into account the complexity of the intersections of and interactions between the body and the mind, with the common underlying assumption being that a functional unity exists between mind and body…
>
> Body Psychotherapy involves a developmental model, theory of personality, hypotheses about the origins of psychological disturbances and alterations, as well as a rich variety of diagnostic and therapeutic techniques used within the framework of the therapeutic relationship. Many different and sometimes quite separate approaches are found within Body Psychotherapy, as there are in the other main branches of psychotherapy. Body Psychotherapy is also a science, as well as an art, having developed over the last seventy-five years from the results of research in biology, anthropology, proxemics, ethology, neurophysiology, developmental psychology, neonatology, perinatal studies, and many more disciplines.
>
> A wide variety of techniques are used within Body-Psychotherapy, including those involving touch, movement and breathing…Body Psychotherapy recognizes the continuity and the deep connections that all psycho-corporal processes contribute, in equal fashion, to the organization of the whole person. There is no hierarchical relationship between mind and body, between psyche and soma. They are both functioning and interactive aspects of the whole (2011).

Psychotherapeutic Touch. Psychotherapeutic touch is any touch provided by a mental health professional trained in the use of touch as a psychotherapeutic intervention. The touch must be for the psychological benefit of the client (rather than the mental health professional) and the therapist must have clear clinical justification for the use of such touch. Ethical guidelines of touch in psychotherapy (see USABP, 2007) must be followed for touch to be psychotherapeutic.

Discriminative Touch is a term that is sometimes erroneously used to refer to psychotherapeutic touch. The Discriminative Touch System is the bodily system that allows humans to sensate, for example, to feel the difference between light touch and pressure. Awareness of the Discriminative Touch System is critical for clinicians using advanced psychotherapeutic touch, however, working with the Discriminative Touch System, does not necessarily mean the touch is psychotherapeutic (e.g. physical therapy, massage therapy).

Note that that psychotherapeutic touch is not to be confused with Therapeutic Touch (TT), a technique used to shift the *bioenergy* of the patient with hands either on the client or off the client but on their *energy field*. The technique is most commonly used by nurses and is

controversial as there are studies that both support (Moore, Ting, & Rossiter-Thornton, 2008) and refute its efficacy (Rosa, Rosa, Samer, & Barrett, 1998). Intentions of the TT practitioner can be physical, energetic, and/or psychological. As such, it may be a technique used while providing psychotherapeutic touch.

Somatic Attunement. Soma refers to the body while "attunement means to adjust or accustom something to become receptive or responsive to something else" (Rand, 2002, ¶ 1). Somatic attunement, a critical component of somatic psychotherapy and psychotherapeutic touch, indicates that that the therapist is attuned to both her body and the body of her client. Humans continually affect each other's psychobiological states. The therapist skilled in somatic attunement uses her own body as a therapeutic tool for the psychobiological regulation of her client.

Touch Is Essential to the Human Experience

Early Childhood Development.

The first language of all human beings is the somatic language. Before we learn to cognate and ask for what we want, we fuss and tighten little squirmy bodies and scrunch tiny faces. The natural inclination of a psychologically healthy adult is to pick-up a wailing child, to hold and soothe, to mirror the narrowing of the infant's face, and to use her or his voice and body to touch and to down-regulate an upset infant. Without this most basic of parental interventions, infants do not attach. Attachment and attachment wounds occurred well before Bowlby created a theory of attachment. Humans touched and soothed before we developed the concept of body-psychotherapy. Touching is, and has always been, fundamental to human experience and survival.

Toronto (2001) states that one cannot underestimate the "significance of the nonverbal experience in human development. The explosion of research on the human infant has illuminated the astonishingly rich and complex nature of the continuing social dialogue that takes place between the infant and the mothering one, a dialogue that, at least on the part of the infant, is primarily nonverbal" (p. 40). Barnett (1972) describes touch as the most fundamental means of contact with the world. Field (2001) clarifies how touch is essential to infant and child social, cognitive and physical development, and notes that growth deprivation, suppressed immune response, sleep disturbances, and physical violence are all associated with touch deprivation.

Phelan (2009) reviews other's work when he summarizes that "bodily touch is an important element among humans. Vulnerable infants will die without touch (Spitz, 1957, 1965) and it is touch that allows them to thrive (DeAngelis & Mwakalyelye,1995)". It is considered the

'mother of all senses,' and is the first sense developed in the embryo; it is also the last sense to go in the slow dying process (Montagu, 1971).

Touch Across the Lifespan.

Kertay & Reviere (1993) note that touch is vital to human development, not only in infancy and childhood, but also across the lifespan. Bowlby (1969) believed that our early association with attachment and maternal needs continued throughout the lifespan in our drive for intimate contact. Humans need touch with other humans for comfort, to express care and concern, to protect, to bond, to create social connections, and to procreate. McGlone, et al. (2007) states, "our interaction with the environment is essentially a multisensory one" (p. 173). Limiting therapeutic interventions to auditory, verbal and visual domains eliminates one of the most fundamental of human needs.

Touch as a Psychotherapeutic Intervention

History of Psychotherapeutic Touch

The field of psychotherapy began with psychotherapeutic touch as a valid intervention. Freud used touch with clients (Breuer & Freud, 1955) then later rejected it. Freud's denunciation of psychotherapeutic touch began the taboo against touch in psychotherapeutic settings (Horton, Clance, Sterk-Elifson, & Emshoff, 1995). Sandor Ferenczi recognized the use of touch, particularly hugging and holding, as essential in repairing early childhood wounding (Smith, Clance, & Imes, 1998). Other psychotherapy pioneers who advocated for and used touch in their therapy sessions were D. W. Winnicot, Wilhelm Reich, and Fritz Perls (Smith, et al., 1998). It was Wilhelm Reich, in fact, who paved the way for the use of applied somatics in Body Psychotherapy.

Positive Effects of Psychotherapeutic Touch on the Therapeutic Relationship

As noted previously, touch creates bonding in the infant-caretaker dyad; it also creates bonding and strengthens the therapeutic relationship as it limits the distance between therapist and client, both literally and figuratively (Phelan, 2009). Touch in the psychotherapeutic setting, according to Smith, et al. (1998) leads to improved trust and connection in the therapeutic dyad and lends to a sense of nurturance and support for the client.

Client Benefits of Psychotherapeutic Touch

There is now sufficient research and theory to support the use of psychotherapeutic touch. Phelan (2009) refers to Caldwell's (2002) suggestion that psychotherapeutic touch has a variety of positive uses including "symbolic mothering; communicating acceptance to the client…; strengthening reality contact when anxiety threatened; and help with controlled expression of aggression" (p. 98). Mintz (1969) & Durana (1998) both report that

psychotherapeutic touch can be beneficial to the client in a variety of ways: Psychotherapeutic touch serves as a form of nonverbal communication; It can help the client to reestablish a sense of reality; it can allow the client to explore aggressive feelings in a controlled manner (e.g. arm wrestling); it can communicate acceptance to clients who are self-loathing; and it can focus a client's attention, which is critical to positive outcomes. Additionally, Pattison (1973) showed that therapist use of touch was positively correlated with client self-exploration and self-disclosure. Gestalt therapist, Imes (1998) states that "Combined with solid training, a commitment to ongoing learning, a large quantity of humility, skilled clinical judgment, and finely tuned intuition, touch in the context of overall good psychotherapy can be immensely effective" (p.198).

Richards (1997) stated, "touch…has been shown to provide information of a subtle and powerful kind about the external world" (P. 2). Toronto (2001) stated that

> It is the mother or mothering one whose capacity to provide empathic attunement, regulation of affect, and a safe space or holding environment that allows the child's early developmental needs to unfold. It is similarly the ability of therapists to provide this kind of safe space, to resonate to the patient's affective states, and to respond affectively and even cross-modally from their own inner store of feeling memories as they strive to comprehend the patient's experience. (pp. 40-41)

Toronto (2001) further states that "Therapists must frequently provide the reparative holding, the empathic attunement, the affirmation of continuous existence, much of which must be communicated nonverbally, before the symbolic conflict-based work can proceed" (p. 39) and that "verbal means of communication are insufficient" (p. 39). He further states, "physical touch…may provide a unique kind of learning and…a route to the unconscious that is difficult to achieve through verbal means" (p. 41). Toronto incites therapists to think critically about clients' needs which run deeper that verbal and cognitive interventions can address when he states:

> How does one work with those patients for whom consequential aspects of their experience remain at the nonverbal level? How does one address early prerepresentational issues such as safety, regulation, engagement, and acceptance versus rejection, much of which is communicated nonverbally? How does one ensure that those early experiences do not remain unconscious, disavowed, a part of the split-off 'not me' self? (p. 42)

Why Therapists Use Psychotherapeutic Touch. In order for a therapists' touch to be psychotherapeutic, the therapist must be conscious of their use of touch and have clear clinical reasons for the use of touch. McNeely (1987) stated that touch may be used for a variety of purposes…to meet clients' need for affection, to decrease body armoring, to mirror the client and to provide containment and parenting. Geib (1982) notes touch as a significantly healing for the client and that leads to positive outcomes in a variety of domains.

In Hunter and Struve's (1998b) pivotal work on ethics and touch, five functions of touch are named:

1. To provide real or symbolic contact.
2. To provide nurturance.
3. To facilitate access to, exploration of, and resolution of emotional experiences.
4. To provide containment.
5. To restore touch as a significant and healthy dimension in a relationship.

They also delineate nine situations in which psychotherapeutic touch is appropriate:

1. To reorient a client.
2. To emphasize a point.
3. To access memories or emotions.
4. To communicate empathy.
5. To provide safety or to calm a client.
6. To assist in enhancing ego strength.
7. To change the level of intimacy.
8. As an adjunct in hypnosis.
9. To assist in working with past traumatic experience.

Hunter and Struve provide guidelines for the clinical appropriateness of psychotherapeutic touch:

1. The client wants to touch or be touched.
2. The purpose of the touch is clear.
3. The touch is clearly intended for the client's benefit.
4. The client understands concepts of empowerment and has demonstrated and ability to use those concepts in therapy.
5. The therapist has a solid knowledge base about the clinical impact of using touch.
6. The boundaries governing the use of touch are clearly understood by both client and therapist.
7. Enough time remains in the therapy session to process the touch interaction.
8. The therapist-client relationship has developed sufficiently.
9. Touch can be offered to all types of clients.
10. Consultation is available and used.
11. The therapist is comfortable with the touch.

"According to a national study of social workers by Strozier, et al. (2003), the top reasons for use of touch with clients were: to let the client know the worker was with him or her;

to express empathy to the client; to help facilitate healing; to communicate acceptance to the client; to model healthy touch; to express symbolic parenting; to focus on the client; to help the client release repressed emotions; to communicate affection for the clients; and to remove barriers to work" (Phelan, 2009, p. 99). Bar-Levav (1998) states that "physical touch, with the explicit permission of the patient each time anew, is the most reassuring intervention when the body undergoes [crisis]…patients naturally want to avoid [crisis and] verbal reassurance is not always enough…Touch at the right moment allows a patient to endure such experiences of extreme panic and pain without bolting" (p. 54-55).

To be untouched is to be unclear on where one begins and the other ends. To be denied touch is to deny bonding, nurturance, soothing, containment, and care. As psychotherapists and mental health professionals, our commitment is to provide these qualities to our clients. Clients enter therapy with a variety of relational wounds; the job of the therapist is to repair those wounds through corrective experiences. Clients who have never been touched or have been inappropriately touched can be greatly healed via therapist care via the medium of touch as a psychotherapeutic intervention.

Child Clients. Therapists working with children tend to put a lot of their energy into teaching children how to not express negative feelings with inappropriate behaviors. However, it is just as important for children to learn how to express positive emotions. According to Aquino and Lee (2000), touch can be used towards that purpose. The uses and boundaries around psychotherapeutic touch with children will be further discussed under the ethics section.

Client Perception of Touch

Positive Experiences. Regardless of the intent of the therapist, touch is only psychotherapeutic if the client receives it as such; therefore, the client's perception of touch is critical in making the clinical decision to use or to avoid touch interventions. Many clients have reported therapeutic benefits of touch (Horton, Clance, Sterk-Elifson, & Emshoff, 1995), such as: feeling that the therapist cared; feeling connection and closeness with the therapist; helping to "create a new mode of relating" (p. 451); communicating acceptance by the therapist for the client; enhancing clients sense of strength; and providing the client with a felt sense of comfort, assurance, and healing.

In a small study, Geib (1982) found common factors in how clients received touch as therapeutically positive. Those who felt the touch was positive felt that the touch was within their control, the touch intervention was openly discussed, felt that the touch was for their benefit (not for the therapist's benefit), and the touch felt appropriate to the level of trust and intimacy in the

therapeutic dyad. Therapists using touch with clients need to continually check-in with clients regarding their perception of the touch being provided.

Negative Experiences. On the other hand, not all clients will perceive of touch as beneficial, which is why it is so important that the therapist using psychotherapeutic touch be highly skilled in somatic attunement and continually seek client feedback. In the same study by Geib (1982) clients who received touch as therapeutically negative by and large felt that touch was invasive when it felt like they had to protect the therapist from their negative feelings. They also found touch countertherapeutic when their negative feelings and experiences were eclipsed by the gratification they felt from having received the touch. Lastly, those who had conflictual family histories around touch found touch interventions unhelpful.

As with all therapeutic interventions, even the most skilled therapist who strictly adheres to ethical standards of psychotherapeutic touch will occasionally misattune with a client in their use of psychotherapeutic touch. One of the ethical guidelines that can minimize such misattunement is asking the client for permission each time before a touch intervention is used and making sure the client has the capacity to refuse touch. The later can be done via experiential interventions in which the therapist works with the client to refute therapist initiated touch. Even with such precautions, misattunements can occur. The therapist skilled in psychotherapeutic touch need not be frightened of such misattunements, as they can be critical in teaching the client that repair can be made when relational ruptures occur.

Types of Touch

Phelan (2009) refers to Totton's (2003) discussion of five types of psychotherapeutic touch: "(1) touch as comfort; (2) touch to explore contact…; (3) touch as amplification; (4) touch as provocation; (5) touch as skilled intervention" (p. 100). Smith, et al. (1998) also denotes five types of psychotherapeutic touch: (1) inadvertent touch; (2) conversational markers; (3) touch as an expression of therapeutic relationship; (4) socially stereotyped touch; and (5) touch as a technique.

Phelan (2009) lays out types of touch used in psychotherapeutic settings as based on the work of Zur and Nordmarken (2004), Downey (2001), and Smith, et al. (1998). They are: (1) ritualistic or socially accepted gestures for greeting or departure; (2) consolation touch; (3) reassuring touch; (4) grounding or reorienting touch; (5) touch intended to prevent a client from hurting self or others; and (6) corrective experience.

Harm in Withholding Touch. Insufficient touch and play are correlated with antisocial and violent behavior (Caldwell, 2002; Field, 2001). Caldwell suggests that touch in the therapeutic setting can be reparative because if lack of touch leads to violent and antisocial behaviors,

perhaps reparative touch can decrease such behaviors. Wilson (1982), as well as Zur and Nordmarken (2004) made the point that "not touching was risky because it robbed the client of contact that could lead to psychological growth (Phelan, 2009, p. 99). Ferenczi (1930) and Wilson and Masson (1986) "felt that if therapists withheld touch, clients would see them as cold and withholding parental modeling" (Phelan, p. 99). Clients who come from high touch cultures (e.g. Mexican) may find the lack of social touch disruptive to the therapeutic relationship. Children, or adults in child-like states, who reach out for touch but are refused, are likely to experience rupture in the refusal, especially for those who already have touch refusal wounds.

Psychotherapeutic touch is critical in repairing touch-mediated wounding. For example, clients who have been touch-deprived as children tend to have a felt sense of themselves as being untouchable, a physical pariah of sorts. The thoughtful use of psychotherapeutic touch can help the client reenter the land of the living, in which human beings connect and are felt and received by other humans.

Prior to first initiation of touch, therapists must ascertain that clients have the capacity to refuse touch. While this is critical with every client, it can be particularly useful with clients who have been sexually violated and young women who may not somatically understand their rights to their own bodies. Withholding the practice of touch refusal training is a significant disservice to clients. Touch refusal training provides the client with the opportunity to reject the therapists' request for touch, thereby increasing the client's experience of her own capacity to chose. One cannot assent to touch until one is clear that they have the capacity to reject touch.

Ethics of Psychotherapeutic Touch

The American Psychology Association, The American Counseling Association, and the National Association of Marriage and Family therapists do not discuss touch as a boundary violation nor do they prohibit touch in psychotherapy. The National Association of Social Workers (1996) does address touch in its code of ethics. It states "social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern physical contact" (Standard 1.10).

The Ethical Guidelines of The United States Association of Body Psycho-therapists (2007) recommends that clients sign a written consent for touch in the therapeutic dyad (pp. 4) and states that:

> the use of touch has a legitimate and valuable role as a body-oriented mode of intervention when used skillfully and with clear boundaries, sensitive application and good clinical judgment. Because use of touch may make clients especially vulnerable, body-oriented therapists pay particular attention to the potential for dependent, infantile or erotic transference and seek healthy containment rather

> than therapeutically inappropriate accentuation of these states. Genital or other sexual touching by a therapist or client is always inappropriate. (pp.7-8)

A variety of articles (Aquino & Lee, 2000; Durana, 1988; Hunter & Struve, 1998a; McNeil-Haber, 2004; Zur, 2008) and several books (Hunter & Struve, 1998b; Smith, et al., 1998; Zur & Nordmarken, 2004) have been written on the ethics of touch in psychotherapy. Durana's (1988) article and Hunter and Struve's book are (1998b) considered by the author to be essential reading on this topic.

Verbal and Nonverbal Touch Contracts

The majority of authors who discuss psychotherapeutic touch advocate for both verbal and nonverbal touch contracts (Hunter & Struve 1998a; McNeil-Haber, 2004; USABP, 2007). A written contract should contain basic information on psychotherapeutic touch, its uses, intents, and contraindications. It should denote the client's rights to refute touch and the client's responsibility to inform therapist should touch be unwanted. Some version of a touch contract should be provided to all clients, whether or not the therapist uses psychotherapeutic touch. This gives the client an orientation to touch within the psychotherapeutic setting and clarifies to the client why a therapist does or does not use touch. An example of a 'Consent to Psychotherapeutic Touch Contract' for therapists using psychotherapeutic touch can be found in Appendix C.

Verbal contracts should be received prior to each therapist-initiated touch. Verbal contract includes therapist elicitation of feedback from the client during the course of the touch to ascertain her or his experience of the touch. The nature and details of the verbal contract should clearly be outlined in the clinical documentation notes.

Working with Children

In addition to the types of touch noted on pages 12-13 of this paper, McNeil-Haber (2004) notes four additional types of touch with children. They are: (1) assisting the child; (2) protecting the child; (3) playful touch; and (4) normative touch initiated by the child. McNeil-Haber also notes that, "it would be inappropriate in many circumstances to withdraw from a young child's hug" (p. 126).

It is almost impossible to avoid touch while working with children. At minimum, children may need to be touched in order to prevent harm (for example, a child climbing on a bookshelf who will not cease with verbal direction). Touch with children is seen as normative (McNeil-Haber, 2004; Phelan, 2009). Phelan notes that this is particularly true when children are quite needy according to their developmental age/stage and that "children often initiate touch and adults who shun their initiations can appear cold" (Phelan, p. 98-99). Therapist touch refusal of

child clients who have been touch deprived, touch wounded, and touch refused can deepen an already toxic wound. McNeil-Haber expounds on touch with children, stating that it is "important for practitioners to have a way to think about touch with young children that considers the child's needs, boundaries, developmental level, and ability to communicate yet does not confuse the child with inconsistent responses or shame the child" (p. 124).

Psychotherapeutic touch with children, however, is not without limits. Clear boundaries help…"to create a safe, nonexploitative, predictable, and agreed on environment for the child-patient, the parent, and the therapeutic process" (McNeil-Haber, 2004, p. 123). According to McNeil-Haber, children can consent to therapy, but as cognitive/emotional development is not yet complete, they are unable to make reasonable boundary judgments; therefore, therapists and parents must hold this role. Therapists must consider whether or not touch is appropriate for the child and to weigh the potential risks and potential benefits of psychotherapeutic touch. According to McNeil-Haber, the therapist must consider:

1. Possible positive role of touch.
2. The child's perceptions of touch.
3. Considerations related to the therapist.
4. The child's safety.
5. A child's history of abuse.
6. The child and family's background [abuse history, culture, gender, etc.].
7. Practical considerations [e. g. Documentation]" (p. 128).

Children touch therapists as well. Child-initiated touch can be appropriate, as often occurs with emotional expression, or inappropriate, such as in physical aggression and oversexualized behavior (McNeil-Haber, 2004). Therapists working with children then, must be prepared for responding therapeutically to child-initiated touch and in creating non-shaming touch boundaries.

Psychotherapeutic Touch Contraindications

All therapeutic techniques have limits to their use and psychotherapeutic touch is no different. Contraindications for psychotherapeutic touch are:

1. The therapist doubts the client's ability to refuse touch (Hunter & Struve, 1998b). Before beginning touch with clients, therapists should provide experiments to provide the client with opportunities to refute touch. The client must feel that they are in control of the touch (Geib 1982; Horton et al., 1995); one cannot know they are in control of the touch until they are certain they can refute it.
2. Touch occurs to meet the therapists' need, not the client's need (Shaw, 2003). The client must perceive that the touch is for their benefit, not for the benefit of the therapist. (Geib, 1982; Horton et al., 1995).

3. The client does not want to touch or be touched (Hunter & Struve, 1998b)
4. The client has a contrary attitude towards touch and/or has religious or cultural values that prohibit touch.
5. The client has an expectation that touch will be limited in a particular setting. An example would be touch in military mental health clinics as touch is somewhat of a military culture taboo (Suiter & Goodyear, 1985).
6. The therapist has been manipulated or coerced into the touch (Hunter & Struve, 1998b).
7. The touch is used to replace verbal therapy (Hunter & Struve, 1998b).
8. The therapist is not comfortable using touch (Hunter & Struve, 1998b), is unclear about the therapeutic intent of touch, or has insufficient training in psychotherapeutic touch.
9. The risk of violence exists (Hunter & Struve, 1998b).
10. The touch occurs in secret (Hunter & Struve, 1998b).
11. The client has a touch abuse history and is "too wounded to tolerate or trust touch" (Imes, 1998, p. 170). Note this does not mean that people with touch abuse histories should not receive psychotherapeutic touch. On the contrary, touch can be very healing for this population. However, psychotherapeutic touch is contraindicated until the client has sufficient recovery for touch to be healing, rather than rewounding.
12. The client has a physical condition which makes touch painful or poses a risk to client or therapist. Note that in the later, skin barriers often make touch possible with these clients.
13. The focus of therapy involves sexual content prior to touch (Hunter & Struve, 1998b).
14. The clinician has had a romantic or sexual counter-transference with the client.
15. The use of touch is clinically inappropriate (Hunter & Struve, 1998b).

Other Precautions. Touch has been shown to increase compliance in a variety of domains (Clements & Tracy, 1977; Guéguen, Meineri, & Charles-Sire, 2010; Kleinke, 1977). While this can be therapeutically beneficial, therapists need to be aware of the power differential in their roles as therapists and how such power differential combined with touch may manipulate clients into compliance. Because of the potential for manipulation, therapists must use psychotherapeutic touch judiciously.

Cultural Competency

Some cultures (e.g. European) are much more accepting of touch within the psychotherapeutic setting (Rowan, 2000). Those who come from high-touch cultures (e.g. Mexican, Italian) may find the absence of touch cold and uncomfortable. Therapists working with clients from low-touch cultures (e.g. US American) must exercise more forethought in using touch in therapy. The reader should note that cultural norms around social touch and psychotherapeutic touch may not be synonymous. For example, Germany is considered to be a significantly low-touch culture, but touch in therapeutic settings is very well accepted by most Germans.

Therapists using touch must also consider their own gender and the gender of their client and how this may affect the client's perception of touch and power imbalances (Summerhayes & Suchner, 1978). Gender norms of other cultures are also important in deciding whether or not to use touch. For example, it many never be appropriate for a therapist to touch a Muslim client of a different gender.

As a low-touch culture, US Americans are relatively touch-deprived, relatively uncomfortable with touch, and have significant cultural taboos surrounding touch (Hunter & Struve, 1998). Being a competent therapist means that the therapist is not only aware of their clients' culture, but is also aware of their own cultural norms and how those norms affects their capacity to interact with clients from different cultures. American mental health professionals need to be aware of their own cultural touch norms and taboos.

Psychotherapeutic Touch in Public Mental Health Settings

Prohibition of Psychotherapeutic Touch: No-Touch Policies.

Many organizations have instituted no-touch policies out of fear of possible litigation. While organizations must be careful to protect their clients and the sustainability of the organization, this fear-based approach to mental health policy is reactionary, unnecessary, is contrary to client needs. Toronto (2001) sates that "there is no logical basis from which to exclude actual physical contact, when it is used with judicious self-restraint as one of the tools of the more 'human' analyst" (p. 39). Phelan (2009) states:

> The main reasons for prohibitions are fear; risk management – the worry that the therapist's contact will be miscued and questioned, and the possibility of going to court or facing ethics boards or committees; ignorance; tradition; gender roles [power differences in the use of touch, particularly related to patriarchal values]; and bias – the therapist's or the client's personal bias against touch, or their internalized societal view that touch is taboo, clouds the use of it. The biggest fear is that touch will lead to sexual contact or claims of it" (p. 98-99).

It is due to this fear that no-touch policies are initiated. Lazarus (1994) and Guntrip make an important point when they state:

> When taken too far, certain well-intentioned ethical guidelines can become transformed into artificial boundaries that serve as destructive prohibitions and thereby undermine clinical effectiveness. Rigid roles and strict codified rules of conduct between therapist and client can obstruct a clinician's artistry…It is my contention that one of the worst professional/ethical violations is to permit current risk=management principles to take precedence over human interventions. (p.255)

US Americans tend to have hypersexualized associations with touch, as such, there are many taboos and restrictions around touch. Additionally, with the increased awareness of touch violations, US Americans have seen an increase in "touch paranoia" (Caplan, 2002, p. 87). Bogdanoff and Elbaum (1979) believe that touch in medical and psychiatric settings would be an accepted intervention if Western society itself were more tactilely permissive.

It is not psychotherapeutic touch that is the problem – it is touch that is nonpsychotherapeutic. Phelan (2009) paraphrases Hunter and Struve's 1998 article when he states, "the unethical misuse of any technique ought to be the cause for the indictment, not of the technique, but rather of the clinician who misused it" (p. 100). Phelan is not downplaying the very real wounding that occurs when a therapist does make sexual contact with a client, rather, he is stating that psychotherapeutic touch, by its very nature, is nonerotic. Furthermore, the fact remains that therapists *are* touching their clients. "It is at our own peril that practitioners continue to ignore the significance of simple human touch within the psychoanalytic dyad. The importance of touch must be acknowledged if for no other reason than the plain fact that it is occurring" (Toronto, 2001, p. 38). It is harmful touch, not psychotherapeutic touch, which needs to be eradicated.

Alcohol prohibition in the United State in the 1920s resulted in a thriving underground alcohol sale and consumption industry. A similar process occurs with the prohibition of psychotherapeutic touch. No-touch policies do not eradicate touch in therapeutic settings. Instead, they eradicate training, acknowledgement and documentation of touch, all of which increase the likelihood of nonpsychotherapeutic touch and litigation. Furthermore, policies and "laws for psychotherapists and counselors prohibiting touch are deemed to protect the public; however, these laws may in fact be implemented more to protect the insurance companies who have to pay out large sums of money from such litigations" (Masse, 2009, p. 15). Again, it is not

psychotherapeutic touch that poses the greatest risk for litigation; rather, it is nonpsychotherapeutic touch.

Touch is the norm with children; because of this, its therapeutic validity generally isn't questioned. The therapeutic community seems to have ignored the reality that many adults in therapy are stuck in earlier developmental stages. Clients who are developmentally delayed or who enter into child-like states during the therapeutic process are just as likely to need psychotherapeutic touch as a clinical intervention as are children. Furthermore, adults who were touch-deprived and/or touch-abused as children can find significant healing through psychotherapeutic touch. Additionally, touch is an essential component of psychological health across the lifespan – to eradicate touch as a valid intervention is to ignore one of humans' most primary needs and means of communication.

Toronto (2001) states that "The clinician's response to the patient have come to be viewed as important pieces of data that must be explored and understood as vital parts of the treatment process" (p. 38). How we respond to a client's initiation of touch is vital. As mentioned earlier in this paper, not touching can cause just as much harm as inappropriate touch. Therefore, "if the therapist works in an institution with a no-touch policy, the therapists should make it clear that the no-touch policy is a clinical stance…[however]…children are likely to forget the no-touch policy. Having to frequently address inadvertent and appropriate touch may distract from the therapeutic process" (McNeil-Haber, 2004, p. 132). While naming the no-touch policy to a client may take the sting out of the touch refusal, it may not avoid the wound of refutation, especially for those who have been previously touch abandoned.

Somatic Psychotherapy and The Use of Psychotherapeutic Touch

While touch is an important therapeutic tool, therapists must be skilled in their clinical judgment and training in order to know when, how, and in what context touch is therapeutically appropriate (Caldwell, 2002). This means that therapists who use touch must be appropriately trained in the use and nonuse of psychotherapeutic touch. In making corporate policy around the use of touch in psychotherapy, clinical managers must consider two basic classifications of therapists: those who have specialized training in psychotherapeutic touch and those who do not.

Somatic Psychotherapists use a variety of sensory awareness techniques to help the clients become more conscious of their physical body and it's messages. There is a quote attributed to the famous modern dancer, Martha Graham, which has been adopted into the lexicon of somatic psychotherapy: the body never lies. Human beings can lie to themselves about what may be happening in their psychological world, but their bodies will always speak to

the reality of our experience. If anxious, there will always be underlying tension; if depressed, an underlying collapse. Somatic psychotherapists use the body and awareness of physical sensation to get to the truth of the client's experience and to help them sequence through difficulties that may be keeping them stuck. One of the intents of somatic psychotherapy is "for the client to be in touch with his or her feelings though the use of their own bodies" (Phelan, 2009, p. 101). The body psychotherapist helps the client to do this via expression (movement, voice, art), verbal direction, and sometimes with touch.

Somatic Psychotherapists work to somatically attune to their clients; they use their own bodies as a therapeutic tool. Human beings' first language is somatic. The capacity for fluency is not lost as we age. In fact, all humans are, to some extent, bilingual. It has been estimated that 93% of communicated and received language is nonverbal (Goman, 2008). Most people, however, are unconscious of the somatic ways in which they receive and transmit information. A foundational understanding of somatic psychotherapists is that we are all psychobiological regulators for each other. Our biology, what happens at the physical level, affects not only our own psychology, but the psychology of others as well. If we are around someone who is anxious, we tend to exhibit physical and psychological symptoms of anxiety. Likewise, while being in the presence of someone who has more relaxed energy, our own nervous systems are likely to down-regulate. Somatic psychotherapists are acutely aware of their own somatic responses to their clients, which often provides insight into their state of being. Somatic Psychotherapists consciously use their bodies as a therapeutic tool. For example, somatic psychotherapists working with an anxious client may place their body into a relaxed position, my emphasis the rhythm of their slow breath, and to breath a deeper and fuller breath.

Many Somatic Psychotherapists use touch as a psychotherapeutic intervention, though the degree and frequency of touch varies greatly. This often depends upon the clinician's experience and comfort with touch as an intervention. Some limit the use of touch to social convention (e.g. handshake) or comfort touch (e.g. a hand on the upper back, a hug), some use touch more actively, particularly those of use with extensive experience in palpatory healing (massage therapy, etc.).

Whether or not a clinician has a degree in Somatic Psychotherapy is not necessarily an indicator of the depth of their knowledge in the use of psychotherapeutic touch. Those who have completed their Masters in Somatic Psychotherapy will have some (likely limited) education on touch in therapy. Many therapists who have more traditional psychotherapeutic training have received supplemental training in other forms of therapy that use psychotherapeutic touch (e. g. Somatic Experiencing). Therapists who are not trained in body psychotherapy should receive

basic psychotherapeutic touch training to appropriately assess the limited use of touch, the ethical and cultural concerns in the use of touch, and appropriate documentation of touch. When non body-centered therapists use touch, they may not be fully aware and may not be clearly orienting to touch as an intervention. All touch with clients should be clinically justified and each touch encounter should be clearly documented.

Recommendations

Allow Psychotherapeutic Touch for Those Who Are Trained. Somatic Psychotherapists are specifically trained in the ethics of touch, whether or not they chose to use touch in their practice. Some therapists who do not have degrees in Somatic Psychotherapy, have sufficient supplemental training in psychotherapeutic touch to make touch a valid application of their skills. There is sufficient research and documentation to support the use of psychotherapeutic touch and clear protocol for limiting potential litigation. There is little clinical validation for no-touch policies in public mental health settings.

Provide Basic Touch Training for Mental Health Workers. According to Tirnauer, Smith and Foster (1996), 87% of therapists use touch in their therapeutic practice. In a 1987 study by Pope, Tabachnick, and Keith-Spiegel, it was discovered that 85% of therapists hugged their clients. There are many other surveys that indicate that a large percentage of therapists are touching their clients (Holroyd & Brodsky, 1997; Pope, Tabachnick, & Keith-Spiegel, 1987; Strozier, Krizek & Sale, 2003). The problem is not that therapists are touching their clients, it is that they are not admitting it (Wilson, 1982; Stenzel & Rupert, 2004) nor documenting it.

The many benefits of psychotherapeutic touch have been outlined in this paper; however, touch may also be misinterpreted by the client and make therapeutic boundaries murky. For this reason, training in psychotherapeutic touch is essential for therapists who use touch. Unfortunately, there is a dearth of training and education in the use of psychotherapeutic touch for most therapists (Caldwell, 2002; Burkholder, Toth, Feisthamel, & Britton, 2010). Because touch is intrinsic to the human experience, because therapists *are* touching their clients, and because not touching clients during critical therapeutic points can create rupture and wounding, all therapists should have minimal training in psychotherapeutic touch. This does not mean that all therapists should use touch as a therapeutic intervention, but rather, therapists need to be educated as to when, how and why to use touch, and, how to refuse client initiated touch in a nonwounding manner.

I suspect that if therapists were trained in touch interventions and contraindications there would be less litigation. The solution to erotic touch litigation is not to forbid touch, but to train in the clinical use of psychotherapeutic touch. Touch is essential to the human experience; Human

beings cannot develop strong ego-formation without touch. Touch is the physical connection that informs one where one's body ends and another's body begins and provides the first sense of self as a separate entity (Cozolino, 2006; Montagu, 1986). The felt experience of both separation and connection is critical to psychological health.

Provide Somatic Supervision. All therapists should have access to a clinician trained in psychotherapeutic touch. The knowledge base of psychotherapists who are trained in psychotherapeutic touch often exceeds the knowledge base of their managers; therefore, experts in the field of somatic psychotherapy may need to be contracted to provide supervision for somatic psychotherapists working in public mental health settings. Nonsomatic psychotherapists should also have access to clinical supervision (and training) on psychotherapeutic touch as befits their training and experience. A licensed somatic psychotherapist on staff would likely be able to provide this supervision, otherwise, and outside expert may be contracted for such purposes.

Create Documentation Standards for Touch Interventions. At minimum, all therapists using any kind of touch, be it handshakes or more advanced psychotherapeutic touch, should have a written touch contract with their clients (or guardians). Every clinicians should include in their clinical notes a touch section which specifies: (1) was touch used; (2) if so, what type of touch was used (pressure, location, duration, etc.); (3) clinical purpose of touch; (4) whether the touch was client-initiated or therapist initiated; (5) if the later, was the client was asked permission and/or offered an opportunity to decline the touch; and (6) the client's response to the touch intervention .

Conclusion

Psychotherapeutic touch research has increased exponentially over the last two decades. Research has occurred cross modally in biology, anthropology, proxemics, ethology, neuropsychology, developmental psychology, neonatology, sociology, and massage (Davis, 1999; Field, 2001). There has been a plethora of research on touch and it's implications in psychotherapeutic practices. Touch is essential to human development, both in infancy and across the lifespan. Touch deprivation is associated with psychological detriment, while psychotherapeutic touch is associated with a many therapeutic benefits.

A common phrase in Naropa University's Somatic Counseling program was, "wounding happens in relationship, healing must then also occur in relationship." Deepening on that phrase, this author would also say, wounding that occurs via touch, is best healed via reparative touch.

This article makes a case for the use of psychotherapeutic touch within public mental health settings. As such, the inherent bias is to focus on the benefits of psychotherapeutic touch. This is in part because, when touch is harmful to the client, it ceases to become psychotherapeutic. It is not the intervention of psychotherapeutic touch that is in question, but clinicians' use of counter-psychotherapeutic touch that leads to client harm and litigation.

About the Author

Sabrina S. Santa Clara, MA, R-DMT, IFSCP, CAC II, RYT, RMT

Sabrina is a Massage Therapists and Certified Addictions Counselor II registered in the State of Colorado. She is a registered yoga instructor and a Certified Internal Family Systems Therapist. She received her Masters in Somatic Counseling Therapy from Naropa University in 2009 where she received a dual-track degree in Body Psychotherapy and Dance/Movement Therapy.

Sabrina is bicultural and bilingual and works part-time with underserved populations in Denver through the Colorado Coalition for the Homeless. In her private practice, Sabrina specializes in Medical Somatic Psychotherapy. As a Medical Somatic Psychotherapist, Sabrina helps relieve physical and psychological suffering of people who have had trauma and who have chronic pain, chronic illness, injury, and other physical symptoms that may or may not have known etiology.

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Appendix A: Additional Resources

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Appendix B: USABP Ethical Guidelines

UNITED STATES ASSOCIATION OF BODY PSYCHOTHERAPY ETHICS GUIDELINES
Approved October 2001 - Revised September 2007

INTRODUCTION

The United States Association for Body Psychotherapy (USABP) is an association of body-oriented psychotherapists, allied somatic practitioners, and interns trained in related modalities. The purpose of the USABP is to support the practice and further evolution of the field of body psychotherapy.

Body psychotherapists recognize the intrinsic unity of the human being in our somatic nature. Body psychotherapists, therefore, work in ways that foster the integration of bodily sensation, thought, affect, and movement to promote more integral human functioning and the resolution of psychotherapeutic concerns. Bodypsychotherapeutic methods, including language, gesture and touch, when used in responsible, ethical and competent ways, make an essential contribution to the psychotherapeutic process by including the missing and often alienated aspects of our being which are rooted in our bodily nature and experience.

These ethical guidelines set forth the principles and standards which guide the practice of this profession. These principles and standards represent a cumulative lived wisdom in the field of body psychotherapy. They are not meant to be all-inclusive. The principles in this code are intended to be aspirational, while the standards are directive. Members of the USABP seek consultation with health care and other professionals, and consider cultural and contextual factors, other certification and licensure regulations for their professions, state and federal laws, and the dictates of their own consciences when determining ethical conduct.

Body psychotherapists recognize their ethical responsibility to maintain the standards of conduct and care, and of personal and professional development. Thus, body psychotherapists commit themselves to the continual examination of their actions, motives and attitudes in their professional relationships to support the safety and welfare of their clients and to nurture the effective practice of their profession. Body psychotherapists likewise expect, encourage and support ethical behavior and self-examination from their students, supervisees, employees, and colleagues.

GENERAL PRINCIPLES OF BODY PSYCHOTHERAPISTS

Principle A: Competence

Body psychotherapists strive to maintain high standards of competence in their work and to recognize the boundaries of their competence and the limitations of their expertise. Body psychotherapists recognize the need for ongoing education and keep abreast of and utilize scientific, professional, technical and administrative resources to inform their work with clients.

Principle B: Integrity

Body psychotherapists seek to promote integrity in the science, art, teaching, and practice of body psychotherapy. In these activities, body psychotherapists strive to be honest, fair and respectful of others and to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work.

Principle C: Professional and Scientific Responsibility

Body psychotherapists are committed to upholding professional standards of conduct; clarifying their professional roles and obligations; accepting appropriate responsibility for their behavior; and adapting their methods to the needs of different clients. When undertaking research, Body psychotherapists strive to advance human welfare and the science and art of Body psychotherapy. They try to avoid misuse of their work. They recognize the need to consult with, refer to, and cooperate with other professionals and institutions to the extent necessary to serve the best interests of their patients, clients or other recipients of their services.

Principle D: Respect For People's Rights And Dignity

Body psychotherapists strive to be respectful of the fundamental rights, dignity and worth of people. Body psychotherapists are aware of cultural, individual, and role differences and strive to be non-discriminatory regarding age, gender, race, ethnicity, national origin, religion, sexual orientation, disability, and socio-economic factors. They respect the rights of individuals to privacy, confidentiality, self-determination, and autonomy.

Principle E: Concern for Others' Welfare

Body psychotherapists seek to contribute to the welfare of those with whom they interact professionally. In their professional actions, they weigh the welfare and rights of their patients or clients, students, supervisees, human research participants, and other affected persons and the welfare of animal subjects of research. Body psychotherapists are sensitive to real and ascribed differences in power between others and themselves and they strive not to exploit or mislead people before, during or after professional relationships.

Principle F: Social Responsibility

Body psychotherapists are aware of their professional and scientific responsibilities to the community and the society in which they work and live. They apply and make public their professional knowledge in order to contribute to human welfare. They are concerned about and work to mitigate the causes and effects of human suffering. They encourage the development of law and social policy that serves the interests of their patients, clients and the public. They consider the realities of social injustice, and strive to have a positive impact on these concerns, as professionals and as individuals.

Principle G: Adherence to Professional Codes, and to Local, State, Federal Law

Members of USABP follow the principles and guidelines outlined in this code. They also comply with local, state and federal law and regulations regarding professional practice, as well as codes of ethics of their professional associations, organizations, and accrediting boards. Where there are variations in codes or guidelines, *licensed practitioners, who are bound by other ethical codes, strive to balance the requirements of the various codes in a way that best embodies ethical behavior and resolves the conflict in a responsible manner. If the conflict is unresolvable, the body psychotherapist adheres to the requirements of the law, regulations, or other governing legal authority.

ETHICAL STANDARDS

I. COMPETENCE

Practitioners seek to perform their responsibilities at the highest level of competence. In areas of practice where professional standards are in evolution, they obtain adequate training and utilize appropriate consultation in order to protect the welfare of those with whom they work. They refer clients to appropriate professionals in their own as well as other fields of expertise as needed.

1. Body psychotherapists do not diagnose, treat or advise on concerns outside the recognized boundaries of their competence. Recognizing the limitations of their expertise, they only provide those services and use those techniques for which they are qualified by education, training and experience.
2. Body psychotherapists provide services, teach or conduct research in new areas or involving new techniques only after first undertaking appropriate study, training, supervision, and/or consultation from persons who are competent in those areas or techniques. If they are forging new paradigms, they proceed with caution and seek appropriate advice and support as needed and obtain appropriate informed consent.
3. Body psychotherapists strive to remain reasonably current regarding new developments in body psychotherapeutic knowledge and practice through educational activities, supervision and/or consultation. They obtain professional or peer supervision-consultation as a standard part of professional practice.
4. Body psychotherapists seek appropriate professional assistance for personal problems or conflicts that may impair work performance or clinical judgment.
5. As teachers/supervisors/researchers dedicated to high standards of scholarship and the presentation of accurate information, body psychotherapists make every effort to present accurate and cogent information to students, supervisees, colleagues, and the public and to prevent the distortion or misuse of their clinical and research findings. They rely on scientifically and professionally derived knowledge in their teaching practice. They present themselves and the field accurately and professionally to the public.
6. When presenting information that lies outside the boundaries of the generally recognized professional and/or scientific knowledge base, body psychotherapists so identify it, specify the data base on which the information rests, and provide access to that data base should it not be generally available.

II. INTEGRITY

Body psychotherapists seek to promote integrity in the science, art, teaching, and practice of body psychotherapy. In these activities, body psychotherapists strive to be honest, fair and respectful of others and to be aware of their own belief systems, values, needs, and limitations and the effect of these on their work.

1. Body psychotherapists seek to communicate honestly and truthfully in all their public statements regarding their work and work-related activities. This includes their research, practice, or other work related activities or those of persons or organizations with which they are affiliated. Public statements include but are not limited to paid or unpaid advertising, product endorsements, grant and credentialing applications, personal resumes or curriculum vitae, or comments for use in the media such as print or electronic transmission, statements in legal proceedings, lectures and public oral

presentations and published materials. Body psychotherapists do not knowingly make public statements that are false, deceptive, or fraudulent.

2. Body psychotherapists communicate honestly and truthfully concerning their training, experience, and competence. Likewise they make truthful and accurate statements regarding their credentials, their academic degrees, their institutional or association affiliations, their services, the scientific or clinical basis for, or results or degrees of success of, their services, their fees, or their publications or research findings.
3. Body psychotherapists, in their reports to payors, accurately state the nature of the service provided or research conducted, the fees, charges, or payments, their academic degrees, and when applicable, the identity of the provider, the findings, and the diagnosis.

III. INFORMED CONSENT

Body psychotherapists provide services to clients only in the context of a professional relationship based on valid, on-going informed consent. Initial informed consent to use body psychotherapy is expected and should be updated and documented as appropriate during the relationship. Informed consent requires that the person haves the capacity to consent, has been informed of and understands necessary information concerning the course of their treatment, and that this consent has been given without undue influence.

1. Body psychotherapists use clear, understandable language to inform clients of the purpose of treatment, the risks related to treatment, reasonable alternatives to the proposed treatment, limits to the provision of treatment, and the right to seek a second opinion. Recommended additional topics for consent and/or discussion include but are not limited to: confidentiality and its limits, client's right to refuse or withdraw consent, nature of the business contract, health care benefits, fees, record keeping, termination, supervision, use of touch, complaint or disagreement process and contact information. Ample opportunity for the client to ask questions is provided.
2. In the event that a client is legally incapable of giving informed consent, body psychotherapists obtain informed permission from a legally authorized person, if applicable laws permit such substitute consent. When proceeding with substitute consent, they inform those legally unable to give informed consent about the proposed interventions in a manner commensurate with the person's mental and cognitive capacities, seek their agreement to those interventions, and take into account their preferences and best interests.

IV. AVOIDING HARM

Body psychotherapists avoid engaging in any activities which are harmful or exploitative or which could reasonably be expected to be harmful or exploitative. Body psychotherapists are sensitive to issues of possible harm, solicit discussion of such situations, as appropriate, even when they are not directly raised by the client, and take appropriate action to prevent and minimize harm that might occur.

1. Body psychotherapists are professional in attitude and conduct, reliable about agreements and appointments. They are clear about their policies regarding cancellations and work within the frame of that agreement in good faith with their clients.
2. Sexual relationships between body psychotherapists and their clients are prohibited during the therapeutic relationship and for a minimum of 2 years following the termination of that professional relationship. A body psychotherapist who considers

engaging in sexual intimacy with a former client after the 2 years following cessation or termination of treatment bears the burden of demonstrating that there has bee no exploitation, in light of all relevant factors that would influence the client's ability to freely enter such a relationship.

3. Body psychotherapists do not engage in sexual intimacies with individuals they know to be the parents, guardians, spouses, partners, offspring, or siblings of current clients. Body psychotherapists do not terminate therapy to circumvent this rule.
4. Body psychotherapists do not accept as therapy clients persons with whom they have engaged in sexual intimacies.
5. Body psychotherapists refrain from engaging in any behavior which could reasonably be interpreted as harassment, sexual or non-sexual. They monitor their therapeutic relationships to ascertain if clients perceive any harassment and address that concern promptly.
6. Body psychotherapists make reasonable efforts to ensure continuity of treatment. When services must be terminated for a legitimate reason, the therapist makes every reasonable effort to insure that appropriate referrals are made for the ongoing needs of the client prior to termination and makes reasonable efforts to terminate the relationship satisfactorily.
7. Should a client desire to terminate the therapeutic relationship, body psychotherapists provide professional insights into the benefits and consequences of this course of action without explicit or implicit coercion to maintain the relationship against the client's wishes. At all times they make clear the client's right to terminate when he/she chooses.
8. Body psychotherapists seek appropriate consultation and/or supervision for any circumstance in which the ethics of their behavior comes into question.

V. MULTIPLE RELATIONSHIPS

Body Psychotherapists avoid exploitive multiple relationships. A multiple relationship occurs when a Body Psychotherapist is in a psychotherapeutic relationship with a person and is at the same time, or sequentially, in another relationship with the same person. Body Psychotherapists make a distinction between normally occurring community interactions and multiple relationships. Body Psychotherapists do not accept as a client anyone with whom they have had a sexual, close personal or financial relationship or family or relatives of such persons. The boundaries of the therapeutic relationship should be clearly defined otherwise they have the potential to impair judgment, cause damage and undermine the purpose of the therapy.

1. Considerations about potential exploitation include the: nature and intensity of the professional relationship and of the secondary relationship, stage of therapy, amount of transference, degree of the role conflict, level of communication skills, and existence of an evaluative role.
2. Body Psychotherapists are aware of the differences in power that may exist in their relationships with clients, students and supervisees. Body Psychotherapists will be sensitive to the real and ascribed differences in power, be responsible for bringing potential issues into the awareness of those involved, and be available for reasonable processing with those involved.
3. In some situations, for example in small geographical or modality communities, a multiple relationship that is nonexploitive may be undertaken. In these cases, the Body Psychotherapist takes precautions to protect the client from exploitation and damage. Such precautions may include, but are not limited to, acknowledgment of the multiple

relationship and its inherent risk to the client, ongoing dialogue, informed consent, documentation, and case consultation and/or supervision.

4. In the event that a Body Psychotherapist is providing services to several persons who have a relationship (partners, parents and children, siblings, families) the therapist attempts to clarify at the onset of the therapy, the relationship they will have with each individual. At any time, if it becomes apparent that the Body Psychotherapist is in multiple relationships which compromise the treatment situation or threaten to impair the objectivity or judgment of the therapist in any way, they clarify, adjust or withdraw from conflicting roles.
5. Barter is the acceptance of goods or services from clients in return for psychological services. Body Psychotherapists do not barter (including work exchange) unless the bartering arrangements are appropriate in the context of the therapeutic relationship, indicated by the needs of the client, and for the welfare of the client. Where bartering is used, the therapist and client make agreements in writing related to the exchange of goods or services to ensure that both understand the scope and limitations of the agreement. Body Psychotherapists consult or obtain supervision to ensure that the bartering arrangement is not harmful to the client, that the client is being given fair value in the exchange, and that no exploitation of and/or damage to the client is involved.
6. As teachers, Body Psychotherapists acknowledge that their relationships with students and/or supervises include factors which often make avoiding multiple relationships difficult. They monitor their teaching and supervision relationships to ensure that they do not become exploitive and/or damaging. Body Psychotherapists do not have sexual relations with students or supervisees and do not subject them to sexual harassment.

VI. COLLEGIAL RELATIONSHIPS

Body psychotherapists maintain respect for colleagues. They refrain from the exploitation of professional relationships for personal gain, whether financial, personal, professional or for research purposes.

1. Body psychotherapists try to avoid entering into a therapeutic relationship with someone who is currently seeing another therapist without the knowledge of that therapist. However, they acknowledge that it is the clients' right to seek out treatment which they feel best meets their needs. Body psychotherapists inform the client of the potential problems in precipitous terminations and urge them to complete the termination process with their former therapist if it will not be detrimental to the client to do so.
2. If it appears that a client has been abused in a former or concurrent professional relationship, body psychotherapists inform the client how to seek appropriate recourse.
3. The Ethical Guidelines of the USABP makes no attempt to limit the free speech of its members. In exercising their right to free speech, body psychotherapists ensure that their statements are professional and noncombative in tone, balanced, and factually accurate.
4. If a body psychotherapist believes that there has been an ethical violation by a colleague, he/she may bring it to the attention of the individual and seek resolution provided such action does not violate any confidentiality rights. Colleagues should seek counsel, guidance, supervision, and consultations as needed in relation to the process and/or issues.

5. If disputes of a serious nature arise between body psychotherapists regarding professional matters, they utilize outside consultation if unable to settle the matter between themselves.
6. When involved in professional writing for publicity, for inclusion in training programs, or for publication in journals and books, body psychotherapists do not take credit for the intellectual work of others but accurately credit their sources and influences.

VII. PRIVACY AND CONFIDENTIALITY

Body psychotherapists have a primary obligation and responsibility to take precautions to respect the confidentiality of those with whom they work or consult.

1. Confidential information includes all information obtained in the context of the professional relationship. They maintain the confidentiality of clients and former clients. Body psychotherapists take appropriate steps to protect their confidential information and to limit access by others to confidential information.
2. Body psychotherapists disclose confidential information without the consent of the client only as mandated by law, or where permitted by law. Such situations include, but may not be limited to: providing essential professional services to the client, obtaining appropriate professional consultation, or protecting the client or others from harm.
3. Unless unfeasible or contraindicated, the discussion of confidentiality and its limits occurs at the beginning of the professional relationship and thereafter as circumstances may warrant. When appropriate, body psychotherapists clarify at the beginning of treatment issues related to the involvement of third parties
4. Body psychotherapists may disclose confidential information with the appropriate consent of the patient or the individual or organizational client (or of another legally authorized person on behalf of the patient or client), unless prohibited by law.
5. When agreeing to provide services to several persons who have a relationship (such as partners or parents and children), body psychotherapists attempt to clarify at the outset 1) which of the individuals are clients and 2) the relationship body psychotherapy will have with each person. This clarification includes the role of the body psychotherapist and the probable uses of the services provided or the information obtained.
6. If and when it becomes apparent that the body psychotherapist may be called on to perform potentially conflicting roles (such as marital counselor to husband and wife, and then witness for one party in a divorce proceeding), body psychotherapists attempt to clarify and adjust, or withdraw from, roles appropriately.
7. In cases where there is more than one person involved in treatment by the same therapist (such as with groups, families and couples), the therapist obtains an initial agreement with those involved concerning how confidential information will be handled both within treatment and with regard to third parties.
8. Body psychotherapists maintain and retain appropriate records as necessary to render competent care and as required by law or regulation.
9. Body psychotherapists are aware of the possible adverse effects of technological changes with respect to the confidential dissemination of patient information and take reasonable care to ensure secure and confidential transmission of such information.
10. Body psychotherapists take steps to protect the confidentiality of client records in their storage, transfer, and disposal. They conform to applicable state laws governing the length of storage and procedures for disposal.
11. Body psychotherapists take appropriate steps to ensure, as far as possible, that employees, supervisees, assistants, and volunteers maintain the confidentiality of

clients. They take appropriate steps to protect the client's identity or to obtain prior, written authorization for the use of any identifying clinical materials in teaching, writing and public presentations.

12. When working with groups, body psychotherapists explain to participants the importance of maintaining confidentiality and obtain agreement from group participants to respect the confidentiality and privacy of other group members but they also inform group members that privacy and confidentiality cannot be guaranteed.
13. Body psychotherapists obtain written consent from clients/students before taping or filming any session, such consent to include the intended use of the material and the limits of confidentiality.

VIII. ETHICS OF TOUCH

The use of touch has a legitimate and valuable role as a body-oriented mode of intervention when used skillfully and with clear boundaries, sensitive application and good clinical judgment. Because use of touch may make clients especially vulnerable, body-oriented therapists pay particular attention to the potential for dependent, infantile or erotic transference and seek healthy containment rather than therapeutically inappropriate accentuation of these states. Genital or other sexual touching by a therapist or client is always inappropriate, never appropriate.

1. Body psychotherapists evaluate the appropriateness of the use of touch for each client. They consider a number of factors such as the capacity of the client for genuine informed consent; the client's developmental capacity and diagnosis; the transferential potential of the client's personal history in relation to touch; the client's ability to usefully integrate touch experiences; and the interaction of the practitioner's particular style of touch work with the client's. They record their evaluations and consultation in the client's record.
2. Body psychotherapists obtain informed consent prior to using touch-related techniques in the therapeutic relationship. They make every attempt to ensure that consent for the use of touch is genuine and that the client adequately understands the nature and purposes of its use. As in all informed consent, written documentation of the consent is strongly recommended.
3. Body psychotherapists recognize that the client's conscious verbal and even written consent for touch, while apparently genuine, may not accurately reflect objections or problems with touch of which the client is currently unaware. Knowing this, body psychotherapists strive to be sensitive to the client's spoken and unspoken cues regarding touch, taking into account the particular client's capacity for authentic and full consent.
4. Body psychotherapists continue to monitor for ongoing informed consent to ensure the continued appropriateness of touch-based interventions. They maintain periodic written records of ongoing consent and consultation regarding any questions they or a client may have.
5. Body psychotherapists recognize and respect the right of the client to refuse or terminate any touch on the part of the therapist at any point, and they inform the client of this right.
6. Body psychotherapists recognize that, as with all aspects of the therapy, touch is only used when it can reasonably be predicted and/or determined to benefit the client. Touch may never be utilized to gratify the personal needs of the therapist, nor because it is seen as required by the therapist's theoretical viewpoint in disregard of the client's needs or wishes.

7. The application of touch techniques requires a high degree of internal clarity and integration on the part of the therapist. body psychotherapists prepare themselves for the use of therapeutic touch through thorough training and supervision in the use of touch, receiving therapy that includes touch, and appropriate supervision or consultation should any issues arise in the course of treatment.
8. Body psychotherapists do not engage in genital or other sexual touching nor do they knowingly use touch to sexually stimulate a client. Therapists are responsible to maintain clear sexual boundaries in terms of their own behavior and to set limits on the client's behavior towards them which prohibits any sexual touching. Information about the therapeutic value of clear sexual boundaries in the use of touch is conveyed to the client prior to and during the use of touch in a manner that is not shaming or derogatory.

IX. EDUCATION AND TRAINING

Body psychotherapists who are responsible for education and training programs seek to ensure that the programs are competently designed and provide appropriate experiences and training to fulfill the stated objectives. They recognize the power they hold over students and supervisees and therefore make reasonable efforts to engage in conduct that is personally affirming and respectful toward students and supervisees.

1. Body psychotherapists attempt to ensure that any education and training programs for which they are responsible have accurate descriptions of the program content, training goals, objectives, and requirements that must be met for satisfactory admission to and completion of the program. This information is made readily available to all interested parties.
2. When engaged in teaching or training, educators present pertinent information accurately and objectively with respectful critiques when appropriate. The educational content in their programs is based on information that has some form of valid, publicly available evidence and/or investigation behind it. Educational programs provide exposure to varied theoretical positions as well as scientifically and professionally derived knowledge.
3. Body psychotherapists establish appropriate processes for providing feedback to students and supervisees. They evaluate students and supervisees on the basis of their actual performance on relevant and established program requirements. Additionally, they seek, encourage and utilize feedback from students and supervisees. This feedback may be written, verbal, formal, or informal.
4. When performing the role of teacher or trainer, body psychotherapists maintain a level of confidentiality appropriate for the teaching environment. Teachers and trainers discuss trainees and supervisees only in accord with publicly stated policy or mutual agreement and for the purpose of enriching the educational opportunities of the individual.
5. Body psychotherapists inform trainees and supervisees of the legal/ethical prohibition against representing themselves as competent to perform professional services beyond their level of training, experience or competence.
6. Educators must be able to present adequate credentials that demonstrate that their teaching is within their scope of learning and expertise.

X. RESEARCH

Body psychotherapists design, conduct and report research in accordance with recognized standards of scientific competence and ethics, minimizing the possibility that the results might be misleading. If an ethical issue is unclear, body psychotherapists resolve the issue through consultation with institutional review boards, peer consultations, or other proper mechanisms. They take reasonable steps to implement appropriate protections for the rights and welfare of human participants, other persons affected by the research, and animal subjects.

1. Body psychotherapists conduct research competently and with due concern for the dignity and welfare of the participants.
2. Body psychotherapists are responsible for the ethical conduct of research implemented by them or by others under their supervision.
3. Researchers and assistants are permitted to perform only those tasks for which they are appropriately trained and prepared.
4. As part of the process of development and implementation of research projects, body psychotherapists consult those with expertise concerning any special population under investigation or likely to be affected.
5. Body psychotherapists plan and conduct research in a manner consistent with federal and state law and regulations.
6. Prior to conducting any research (excluding anonymous surveys, naturalistic observations, or similar research) body psychotherapists enter into an agreement with participants that clarifies the nature of the research and the responsibilities of each party. They take special care to protect the prospective participants from adverse consequences of declining or withdrawing from participation. Whether research participation is an academic course requirement or a voluntary activity, the prospective participant is given the choice of equitable alternative activities.
7. Body psychotherapists use language that is understandable to research participants in obtaining their appropriate informed consent. Such informed consent is appropriately documented.
8. For persons who are certified legally incapable of giving informed consent, body psychotherapists provide an appropriate explanation, obtain the participant's assent, and obtain appropriate permission from a legally authorized person, if such substitute consent is permitted by law.
9. When offering professional services as an inducement to research participants, body psychotherapists make clear the nature of the services, as well as the risks, obligations and limitations. They do not offer excessive or inappropriate financial or other inducements to obtain research participants, particularly when it might tend to coerce participation or distort the results.
10. Body psychotherapists never deceive research participants about aspects that would affect their willingness to participate, such as physical risks, discomfort or unpleasant emotional experiences. Any other deception that is an integral and necessary feature of the design and conduct of an experiment must be explained to participants as early as is feasible, preferably at the conclusion of their participation, but no later than at the conclusion of the research.
11. Body psychotherapists inform research participants of the anticipated sharing or further use of personally identifiable research data and of the possibility of unanticipated future uses.
12. Body psychotherapists provide a prompt, clear opportunity for participants to obtain appropriate information about the nature, results and conclusions of the research and

make a good faith attempt to correct any misconceptions that participants may have. If scientific or humane values justify delaying or withholding this information, they take reasonable measures to reduce the risk of harm.

13. When conducting research involving animals, body psychotherapists treat them humanely. They ensure that all individuals using animals under their supervision have received instruction in research methods and in the care, maintenance and handling of the species being used, to the extent appropriate to their role.
14. Body psychotherapists do not fabricate data or falsify results in publications. If they discover significant errors in their published data, they take reasonable steps to correct such errors in every situation where the errors have material effect.
15. Body psychotherapists do not present substantial portions or elements of another's work or data as their own. When they do present aspects of another's work, they provide clear and obvious attribution.
16. Body psychotherapists take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have contributed. (A student is usually listed as principal author on any multiple-authored article that is substantially based on the student's dissertation or thesis.)
17. When reviewing material that has been submitted for publication, grant or research proposal review, body psychotherapists respect the confidentiality and proprietary rights of the authors.

ADDENDUM

* When codes have differed in content the ethics committee has chosen to follow the code of the American Psychological Association. Portions of this code have been adapted from existing professional codes including: American Psychological Association, Ethical Principles of Psychologists and Code of Conduct; American Association for Marriage and Family Therapy Code of Ethics; The National Association of Social Workers Code of Ethics; The International Institute for Bioenergetic Analysis Code of Ethics; The Hakomi Institute Code of Ethics.

Appendix C: Informed Psychotherapeutic Touch Consent (Limited Use of Touch)

WORK IN PROGRESS

I am a somatic (body-centered) psychotherapist. Somatic psychotherapy is a holistic approach to personal growth and change that incorporates the use of talk, breath, movement, attention to internal sensations, and sometimes touch. Somatic psychotherapists generally believe that the body and mind are inseparable: what happens in the mind shows up in the body, and what happens in the body will also show up in the mind. Somatic psychotherapists believe that working with the bodily experience is essential to the healing process.

Ethical Guidelines

- Touch must be for the benefit of the client, not the therapist
- Therapist must have valid clinical justification for the use of touch

Benefits of Psychotherapeutic Touch

- Can soften the adversarial relationship the client has with her/his body.
- Communicates acceptance, caring, reassurance, and consolation to the client.
- Can deepen the therapeutic relationship and therefore, the clinical work that happens within that relationship.
- Can help the client come back to reality when they are dissociating.
- Can help the client to downregulate an overactive nervous system (e.g. to reduce fears, worries, anger, etc)
- Can help the client to access unconscious material that has been stored in preverbal states.
- Can help the client to become aware of their physical boundaries, thereby creating a stronger sense of self.
- Can release psychophysiological holding patterns & decrease body armoring.
- Can help to heal and repair previous touch related wounds (abuse, neglect, abandonment, etc.).
- Can provide symbolic mothering and corrective experiences.

Contraindications/Limitations of Touch:

- The client is unable to refuse touch.
- The client has refused touch.
- The client's cultural norms/values prohibit touch.
- Erotic/genital/sexual touching by a therapist (or client) is never appropriate.

Your Rights

- You have a right to rescind this authorization at any time.
- You have a right to stop touch at any moment.
- You have a right to your own body and what happens to it.

My Commitment

- I will ask your permission each time before I use touch as a therapeutic intervention.
- I will check-in with you during and/or after the touch about how you received the touch.
- I will receive clinical supervision related to psychotherapeutic touch.
- I will respect your body.

I consent to the use of psychotherapeutic touch in therapy. I understand that I have a right to revoke this written consent at any time. I may also refuse consent to touch at any given moment during the therapeutic session.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Appendix D: Informed Psychotherapeutic Touch Consent
Advanced Pychotherapeutic Touch

WORK IN PROGRESS

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- Communicates acceptance, caring, reassurance, and consolation to the client.
- Can deepen the therapeutic relationship and therefore, the clinical work that happens within that relationship.
- Can help the client come back to reality when they are dissociating.
- Can help the client to downregulate an overactive nervous system (e.g. to reduce fears, worries, anger, etc)
- Can help the client to access unconscious material that has been stored in preverbal states.
- Can help the client to become aware of their physical boundaries, thereby creating a stronger sense of self.
- Can release psychophysiological holding patterns & decrease body armoring.
- Can help to heal and repair previous touch related wounds (abuse, neglect, abandonment, etc.).
- Can provide symbolic mothering and corrective experiences.

Contraindications/Limitations of Touch:
- The client is unable to refuse touch.
- The client has refused touch.
- The client's cultural norms/values prohibit touch.
- Erotic/genital/sexual touching by a therapist (or client) is never appropriate.

Your Rights
- You have a right to rescind this authorization at any time.
- You have a right to stop touch at any moment.
- You have a right to your own body and what happens to it.

My Commitment

- I will ask your permission each time before I use touch as a therapeutic intervention.
- I will check-in with you during and/or after the touch about how you received the touch.
- I will receive clinical supervision related to psychotherapeutic touch.
- I will respect your body.

I consent to the use of psychotherapeutic touch in therapy. I understand that I have a right to revoke this written consent at any time. I may also refuse consent to touch at any given moment during the therapeutic session.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date