WHATS WRONG WITH NO-TOUCH POLICIES?

Many (and possibly the majority of) mental health organizations have instigated no-touch policies based on two main beliefs: 1) no-touch policies will prevent expensive litigation; 2) touch within therapeutic settings is inherently unethical. Neither of these belief systems is actually true.

Refuting the Litigation Safety Belief. Regardless of no-touch policies, many clinicians *do* touch clients (or vice versa) but may not be doing so consciously or with clear intent, which violates one of the primary ethics of psychotherapeutic touch. Clinicians who work for organizations with no-touch policies do not document touch as doing so would incriminate themselves. Furthermore, most clinicians do not know the necessary components of a good clinical touch note. Absent or inadequate clinical documentation is one of the primary deciding factors in litigation outcome in cases where touch between a clinician and client has occurred. No-touch policies do not eradicate touch in therapeutic settings. Rather, they eradicate training, acknowledgement and documentation of touch, all of which increase the likelihood of nonpsychotherapeutic touch and litigation

Refuting the Touch is Unethical Belief. Touch is the first sense developed in utero and often the last sense to leave before death. Vulnerable infants die without touch. It is our primary and most fundamental means of communication. It is critical to emotional development and the development of a sense of self. To hold touch as unethical is contrary to basic human biology.

One of the main arguments is the “slippery slope” argument, which essentially states that any sexual encounter between clinician and client began with touch; therefore, any touch in therapy is a slippery slope towards sexual violation. This argument is like saying that every alcoholic has drunk water; therefore water is the gateway drug to alcoholism. Touch is as essential to human biosocial development as water is to human physical development.

Psychotherapeutic Touch has many clinically proven benefits and has well-defined ethical guidelines. For example, psychotherapeutic touch has to be for the benefit of the client and the purpose of the touch has to be clear. It also has to be intentional and

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discussed with the client both before and after the intervention. It is not Psychotherapeutic Touch that is unethical, it is nonpsychotherapeutic touch and the clinicians that use it.

Refusing touch can be just as unethical as inappropriate touch. Withholding touch can cause clients to view the therapist as cold and can limit the use of the therapeutic relationship in parental modeling. Clients who come from high touch cultures 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. In fact, Psychotherapeutic Touch is effective in repairing touch-mediated wounds.

Touch, as a primary and basic human need, has a valid place in psychotherapy. Every clinician should have some basic psychotherapeutic touch training that covers ethics, indications, contraindications, touch refusal, and clinical documentation of touch.

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For more extensive information on psychotherapeutic touch and an exhaustive reference list, please go to the website and look under the publications tab.