

Ofer Zur

Touch In Therapy and the Standard of Care in Psychotherapy and Counseling: Bringing Clarity to Illusive Relationships

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Editor's note: This article is reprinted from *The USABP Journal, Vol.6(2)*, pp. 61-93, and is used with permission. It can also be found on the Zur Institute website at <http://www.zurinstitute.com/articles.html#touchsub>. It is perhaps the most complete and best-referenced article on the psychotherapeutic use of touch and the standard of care available today from which Hakomi therapists and practitioners can benefit greatly. For those readers interested in additional material on the use of touch see also the article "Helping Through Touch: The Embodiment of Caring" by Suzanne M. Peloquin in the 1990 Issue 8 of the *Hakomi Forum*, available on the www.hakomi.org website.

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ABSTRACT: The question of touch in therapy has been debated since the inception of the field early in the last century. The main concern about physical contact in therapy has focused on sexually exploitative therapists and the concern that a client may interpret touch as having sexual intent. Ignoring years of clinical and developmental research, many risk management experts, traditional psychoanalysts, consumer protection agencies, insurance companies, and malpractice attorneys have promoted the notion that any touch beyond a handshake is clinically inappropriate, unethical, or below the standard of care. Drawing on the faulty slippery slope theory that even appropriate boundary crossings are likely to lead to boundary violations, they assert that even scientifically proven, appropriate, and clinically helpful touch is likely to lead to unethical sexual touch. The aim of this paper is to clarify the relationship between professional therapeutic touch and the standard of care. To achieve this goal the paper defines the standard of care in psychotherapy, details the elements of the standard, and articulates what the standard is and is not. It then briefly reviews the clinical research on touch in therapy and identifies the different types of touch employed in therapy. It is then articulated, in detail, how non-sexual, clinically appropriate, and therapeutic touch falls within the standard of care of psychotherapy and counseling. Additionally, issues related to touch in therapy, of theoretical orientation, codes of ethics, risk management, differences between sexual and non-sexual touch, and a review of the slippery slope are discussed. Finally, an outline of how therapists who appropriately use touch in therapy can demonstrate compliance with the standard of care is provided.

KEY WORDS: professional therapeutic touch, psychotherapy, standard of care, codes of ethics, risk management

Introduction: Forces and Influences in the Battle of Touch

While touch has been part of most healing traditions throughout human history, it has been controversial in western medicine and more so within the field of psychotherapy and counseling (Aposhyan, 2004; Smith, Clance, & Imes, 1998; Totton, 2005; Young, 2005). The main concern around the issue of therapeutic touch has been that psychotherapists and counselors may use their power and influence to sexually exploit their clients (Pope & Vasquez, 2007; Rutter, 1989). The second concern has been that a client may interpret touch as having sexual intent. As a result, since the field's inception, the application of touch in psychotherapy has been one of the most hotly debated topics (Hunter & Struve, 1998; Zur, 2007).

While Freud initially endorsed the use of touch as part of psychotherapy, he changed his position entirely in the early 1920s when he became worried how the use of touch might tarnish the reputation of the new field. The issue erupted when Freud, back in 1931, scolded his star student and disciple, Ferenczi, for letting a female client kiss him (Young, 2005). Freud felt that physical contact would lead to sexual enactments, and, by his own admission, he was equally concerned with the reputation of psychoanalysis, thus forcing the issue of touch to go underground. Ferenczi refused to stop touching his clients altogether and was subsequently expelled from the ranks of orthodox psychoanalysis (Fosshage, 2000). Wilhelm Reich (1972), who developed the most comprehensive method of clinical touch, was, like Ferenczi, one of Freud's inner circle and prominent in the prestigious International Psychoanalytic Association (IPA). He, too was ousted from the International Psychoanalytic Association for his professional stance on touch in therapy.

As Fosshage (2000) asserts, while Freud's rule of abstinence on touch has, thus, predominated in the psychoanalytic literature, there have been more notable exceptions where physical touch is seen as not only appropriate, but as necessary when dealing with periods of severe regression (Balint, 1952; Winnicott, 1958), with psychotic anxieties and delusional transference (Little, 1990), and with disturbed patients (see Mintz, 1969, who describes the work of Fromm-Reichman and Searles). However, as psychoanalysis emerged, an analytic ideology was created around the prohibition of touch. It was based on the conviction that any touch is likely to gratify sexual and instinctual infantile longings or drives, subsequently contaminating the analytic container and nullifying the possibilities for analysis to help the clients work through their issues (Langs, 1982; Simon, 1994).

The conflict around the use of touch in therapy has stayed with the field since that time. In recent years the primary tension has been between, on one side, the long-established scientific knowledge that has consistently proven that touch is essential for healthy human development and human relationships, and, on the other side, the ethical concerns with exploitative and harmful sexual touching of clients by therapists. A great amount of scientific data has been acquired in the last half century on the importance of touch for human development, bonding, communication and healing by the classic work of Bowlby (1969), Harlow (1971), and Montagu (1986), and more recently, the extremely prestigious Field (2003). The clinical use of touch in therapy has also been studied extensively and has conclusively determined that touch can enhance the therapeutic alliance as well as increase a sense of trust, calm, and safety (Smith, et al., 1998). Touch has also been shown to be effective in the treatment of depression, anxiety, PTSD, and other mental disorders and conditions (e.g., Aposhyan, 2004; Field, 1998, 2003; Hunter & Struve, 1998; May, 2005; Young, 2005). On the other side there is a major concern, raised mainly by risk management experts, ethical review boards, insurance companies, and consumer protection agencies, that nonsexual touch can lead to sexual touch and exploitation of clients (Bersoff, 1999; Gabbard, 1994; Pope & Vasquez, 2007; Rutter, 1989; Simon, 1991, 1994). There is little evidence for this fear, though. As in any profession, an occasional therapist has been successfully charged with inappropriate touch.

Another rift in the field stems from different therapeutic philosophies. On one side there are the analytic practitioners, on another those who focus on biological-pharmacological intervention, and who advocate a hands-off approach for philosophical-clinical reasons. On another side of the debate are humanistic, group, family, cognitive-behavioral, and feminist therapists who see value in appropriate touch and other boundary crossings, such as self-disclosure, gift exchange, bartering, and dual relationships (Williams, 1997; Zur, 2007). These greatly outnumber the first group. Body psychotherapists, many of whom use touch as a primary clinical tool, obviously believe in the importance of touch in general and in its scientifically established clinical utility in particular (Aposhyan, 2004; Nordmarken & Zur, 2004; Young, 2005).

Several psychotherapists' surveys over the years revealed that 87% of therapists touch their clients (Tirnauer, Smith, & Foster, 1996), 85% hug their clients (Pope, Tabachnick, & Keith-Spiegel, 1987), and 65% approve of touch as an adjunct to verbal psychotherapy (Schultz, 1975). In a more recent survey, Stenzel and Rupert (2004) reported a decrease in the general reporting of the use of touch in therapy, which they, reasonably, partly attributed to the increase in the dominance of risk management training.

They also reported a significant increase in reporting of female therapists touching female clients. The reported decrease may also be the result of a biased sample, as more therapists are not only trained in risk management but also have been intimidated by it and, therefore, are less likely to admit to touching clients, by either refusing to participate or by declining to admit to touch practices.

Some of the negative and frightening messages regarding touch that psychotherapists have been inundated with come from prominent therapists, many of whom are psychoanalytically oriented. One example is Menninger (1958) who asserts that physical contact with a patient is “evidence of incompetence or criminal ruthlessness of the analysts” (cited in Horton, Clance, Sterk-Elifson, & Emshoff, 1995, p. 444). Simon, in a similar vein, instructs therapists to “Foster psychological separateness of the patient. . . interact only verbally with clients. . . minimize physical contact” (1994, p. 514). Wolberg (1967) agrees: “Physical contact with the patient is absolutely a taboo (since it may) mobilize sexual feelings in the patient and the therapist, or bring forth violent outbursts of anger” (p. 606). These extremely small, but biased perspectives, have created an inappropriately weighted bias, both in the minds of professionals and the public.

Similarly to the psychoanalytic attitude towards touch in therapy, strong messages were pronounced by risk management or defensive medicine experts who often placed touch at the top of the “Do not do” list. “From the viewpoint of current risk-management principles,” Gutheil and Gabbard (1993) stated, “a handshake is about the limit of social physical contact at this time” (1993, p. 195). Similarly, the popular Web site, WebMD (1992), announced “A Hug-Free Zone: The threat of lawsuits, the already strong language in the APA code, and the general litigiousness of society have prompted many therapists to erect barriers between themselves and their clients when it comes to any physical contact. No more hugs for a sobbing client. No encouraging pats on the back” (section 2, para. 1). Risk management has been defined in realistic and pragmatic terms by Gutheil and Gabbard (1993) and Williams (1997, 2003) as the course by which therapists refrain from implementing certain interventions because they may be misinterpreted and questioned by boards, ethics committees, and courts. Obviously, these practices almost exclusively serve to protect the practitioners, not the consumers. At the core of the risk management injunctions against touch in therapy is the belief in the slippery slope. This is the idea that failure to adhere to hands-off, rigid standards will most likely lead to therapist-client sexual relationships.

Historically, the 1960s and 1970s witnessed a general increase in litigious attitudes in the culture at large and in the rise of defensive medicine and risk management

practices in the field of medicine, including psychotherapy and counseling. Following the sexual revolution of the 1960s and sexual digressions by some sections of Gestalt Therapy and Humanistic Psychology at Esalen in CA, risk-management teachings have strongly encouraged psychotherapists to avoid almost all forms of touch and most other boundary crossings or deviation from analytic hands-off practices. The concern during this time, as was also reflected in the professional associations’ codes of ethics, was that any deviation from analytic-type practices were likely to lead to sexual and other violations of clients by permissible therapists. A “bogey-man” attitude had therefore been created, based almost totally on bias and fears of litigation.

At the end of the 20th century and the beginning of the new millennium, there have been two significant and contradictory forces that have affected the relationships between boundaries in general, including touch and the attitudes towards therapeutic boundaries, and the perception of the standard of care. On the one hand, risk management in regard to touch issues and other boundary considerations, has continued to be a concern for professional organizations and consumer protection agencies. On the other hand, there has been a significant increase in the number of publications that associate boundary crossings with increased therapeutic effectiveness (e.g., Younggren & Gottlieb, 2004; Zur, 2007). During this period of time we also saw shifts within the analytic community towards more openness regarding the clinical utility of touch. In addition to Fosshage (2000), other reports of the facilitative use of touch have emerged in the analytic literature by scholars, such as Bacal (1997), Hamilton (1996), LaPierre (2003), and McLaughlin (1995). As articulated below, a similar shift has taken place regarding touch in therapy as illustrated by the 1998 *American Psychologist* publication of Field’s article, “Massage Therapy Effects,” and several other publications (e.g., Hunter & Struve, 1998; Smith, et al., 1998; White, 2002; Young, 2005), along with the establishment of *United States Association of Body Psychotherapists Journal* and the European Association of Body Psychotherapists, which both advocate that properly trained, body-oriented psychotherapists are not only the only people “qualified” to touch, but that a body-oriented approach which might involve touch is considerably as effective, and some (i.e., Young, 2005) say even more effective than a psychotherapy that totally ignores or that does not relate to the patient’s body in any way.

Therapeutic Boundaries and Touch in Therapy

Boundaries in therapy, including the boundary issues that involve touch, are extremely important. They define the therapeutic fiduciary relationships and distinguish

psychotherapy from social, sexual, business, and many other types of relationships also having a direct impact on the effectiveness of therapy. There are two types of boundaries. One type is where boundaries are drawn around the therapeutic relationship and involve issues of fees, privacy and confidentiality, and place and time of therapy. Boundaries of another sort are drawn between therapist and client rather than around them. Touch between therapist and client is an obvious boundary of this latter kind as well as therapists' self-disclosure and giving and receiving gifts (Gutheil & Gabbard, 1993). Touch between therapist and client represents one of the most recognized psychotherapeutic boundaries, as it reaches across the professional-interpersonal space separating therapist and client (Zur, 2007).

Boundaries in therapy have been regarded as the "edge" of appropriate behavior (Gutheil & Gabbard, 1993) and involve two types of boundaries: boundary violations and boundary crossings. A boundary violation occurs when a therapist crosses the line of decency and integrity and misuses his/her power to exploit a client for the therapist's own benefit. Therapist-client sexual relationships are a prime example of boundary violations. Such violations may also involve any exploitive business or other relationships and are always counter-clinical, unethical, and are often illegal. In contrast, boundary crossings involve courtesy or ritualistic gestures, such as a handshake or a pat on the back. They have been defined as any deviation from traditional psychoanalytic practices (Zur, 2007). Boundary crossings also involve clinically effective interventions and are part of a well-constructed treatment plan, such as clinically and ethically appropriate self-disclosure, home visits, gift exchange or bartering (Herlihy & Corey, 2006; Lazarus & Zur, 2002). As will be articulated in this paper, while boundary violations are inherently unethical and always below the standard of care, boundary crossings are neither unethical nor below the standard of care.

Boundary crossings are often an integrated part of most practiced therapeutic modalities, such as humanistic, somatic, cognitive behavioral, or group therapy. Following are just a few examples of beneficial boundary crossings and the corresponding theoretical orientations that are likely to support them. Behavioral therapy readily endorses flying on an airplane with a fear-of-flying client as part of an exposure or in-vivo intervention. Cognitive, behavioral, and cognitive-behavioral therapies endorse self-disclosure as a way of modeling, offering an alternative perspective, or exemplifying cognitive flexibility. Humanistic, feminist, and existential therapies endorse self-disclosure as a way of enhancing authentic connections and increasing therapeutic alliance, the best predictor of therapeutic success. A client-initiated handshake at the beginning or end of a session, an appropriate and encouraging pat on the client's back, supportive handholding or a nonsexual hug can be

exceedingly clinically helpful. They are all considered boundary crossings and are endorsed by most therapeutic modalities. Not to put a consoling arm around a client who has suddenly burst into tears might be seen, not only as uncaring, but in fact a rigid application of therapeutic boundaries. Additionally, specially trained body psychotherapists, such as Reichian or bioenergetic therapists, who use thoroughly researched and established hands-on techniques, are also engaged in therapeutic boundary crossings.

Dual relationships are a type of boundary consideration that often has been misunderstood and mischaracterized. Dual relationships take place when therapists and clients engage in additional social, business, or professional relationships other than the traditional one-on-one therapist-client relationship (Lazarus & Zur, 2002). Sexual relationships between therapists and current clients are obviously totally inappropriate dual relationships and are also boundary violations, always counter-clinical, unethical, and illegal in most states (Pope & Vasquez, 2007). Non-sexual and non-exploitative social and other dual relationships are often unavoidable in rural communities, university and college campuses, and other small communities, and they can also be beneficial to therapy (Herlihy & Corey, 2006; Schank & Skovholt, 2006; Younggren & Gottlieb, 2004; Zur, 2007). While ethical or unavoidable dual relationships are technically boundary crossings, exploitative dual relationships, including sexual dual relationships, are definitely boundary violations. It is important to understand that therapeutic and ethical touch, like clinically appropriate boundary crossings, such as self-disclosure or making a home visit (done exclusively for clinical reasons and are not involved in a secondary relationship), are neither dual relationships nor unethical.

The difference between boundary crossings and boundary violations when it comes to touch often relates to the differences between sexual and non-sexual touch (Pope, Sonne, & Holroyd, 1993; Zur, 2007). Some differentiations between sexual and nonsexual touch in therapy focus on the areas touched (i.e., hand vs. genitals), others focus on whether the intent is to sexually arouse the client or the therapist, and yet others propose an encompassing view that "erotic touch" is any behavior that leads to sexual arousal (e.g., Brodsky, 1985). A few analytically oriented scholars take the extreme position that—in the context of transference—even what attempts to be a nonsexual touch is almost inevitably sexual or erotic (Gabbard, 1996; Wrye & Welles, 1994). However, this is a perspective that is almost exclusive to the pure, traditional psychoanalysis. Help with differentiation between sexual and nonsexual touch in therapy comes from one of the key studies that found correlations between nonsexual touch and sexual touch. The study showed that the sexual boundary violation was positively correlated, not with touch per se, but with the

frequency that therapists touched clients of the opposite sex in comparison with the frequency of touch of clients of the same sex (Holroyd & Brodsky, 1980). The important conclusion of these findings was that therapists' own attitudes towards touch and whether they tend to generally sexualize all forms of touch is the determining factor in whether they are likely to blur sexual and nonsexual forms of touch. Therefore the most productive preventative measure is probably good therapist education in appropriate use of therapeutic use of touch.

As was noted above, professional attitudes towards therapeutic boundaries in general has shifted significantly during the end of the last century and the beginning of the 21st century. An increase in the number of publications that associate boundary crossings and touch to increased therapeutic effectiveness has linked them to the most commonly practiced theoretical orientations, such as cognitive, cognitive-behavioral, and humanistic psychotherapies (Williams, 1997). Illustrating the shift in mainstream psychology and counseling towards more context-based and less rigid attitudes towards boundaries is the flexibility advocated by American Psychological Association's (APA) revised code of ethics of 2002 and similar changes included in the American Counseling Association's (ACA) code of ethics of 2005. Just as telling is the fact that the APA and ACA have published several texts in the beginning of the 21st century that have taken a clear, flexible, and context-based stance in regard to therapeutic boundaries (i.e., Herlihy & Corey, 2006; Knapp & VandeCreek, 2006; Schank & Skovholt, 2006; Zur, 2007). Additionally, during this period there was an increased realization of the potentially immense clinical usefulness or benefit of ethical professional touch (Field, 1998, 2003; Hunter & Struve, 1998; May, 2005; Smith, et al., 1998; Young, 2005). In the beginning of the new century there were a few influential papers that re-introduced the importance and clinical utility of touch within the analytic context (i.e., Fosshage, 2000; LaPierre, 2003; Schore, 2003; Toronto, 2001). The *United States Association of Body Psychotherapy Journal*, created in 2002, has made a continuous and extensive contribution to the professional literature on clinical, ethical, and legal issues that pertain to touch in therapy. An additional rich resource of body psychotherapy has become available through European Body-Psychotherapists (2006).

The Standard of Care: What it is and What it is Not

The standard of care is one of the most important constructs in medicine and mental health. It guides practitioners in their practices, provides a minimum professional standard, and is an essential element in malpractice suits and hearings

of state licensing boards. Because the standard of care is both important and elusive, it is the subject of much debate and controversy. Surprisingly, there is no one national or universally accepted standard of care that can be found in any agreed upon text. The standard of care is primarily determined in courts by juries, judges, and by licensing board hearings, which often rely on the testimony of expert witnesses. In these hearings attorneys on both sides routinely present conflicting expert testimonies about the standard of care (Gutheil, 1998; Hedges, Hilton, Hilton, & Caudill, 1997). The fact that there are hundreds of different psychotherapeutic orientations (Lambert, 1991) and as many different types of settings, communities, cultures, and subcultures makes the concept of a psychotherapeutic standard of care extremely complicated and controversial (Caudill, 2004; Williams, 1997). It seems that beyond "do no harm," "do not engage in sexual relationships with current clients" and "preserve clients' dignity and protect their privacy when possible," there is very little agreement on what falls within the accepted understanding of standard of care.

The standard of care is a legal term and has been defined as the customary professional practice in the community. It describes the qualities and conditions that prevail, or should prevail, in a particular (mental health) service that a reasonable or average practitioner follows. Most commonly, the standard is defined in legal terms as, "that degree of care which a reasonably prudent person would exercise in the same or similar circumstances" (Black, 1990, p. 1405). As a legal term, the standard of care is subject to state laws and, accordingly, the official definition of the standard of care varies somewhat from state to state. Massachusetts case law, for example, defines the standard of care as, "the average reasonable practitioner at that time and under the circumstances and taken into account the advances in the field" (Gutheil, 1998, p. 44). The standard of care is thus largely a standard of reasonable care and a professional duty of psychotherapists to their clients once the therapist-patient relationship has been established (Simon, 2001). Several scholars emphasize that the standard is based on community and professional standards, and as such, professionals are held to the same standard as others of the same profession or discipline with comparable qualifications in similar localities (Bersoff, 2003; Caudill, 2004; Doverspike, 1999; Woody, 1998).

It is very important to understand that the standard of care is a minimum and reasonable standard. It is neither an ideal standard nor a standard of perfection (Gutheil, 1998). It calls on practitioners to act in a reasonable, average, or "good enough" manner rather than in ideal or perfect ways. An error in judgment or simply making a common, careless mistake does not automatically put a therapist's actions below the standard of care (Simon, 2001). However, making a careless mistake or several careless mistakes that

probably would not have been made by reasonable practitioners *does* put a therapist below the standard of care. Gross negligence, which is an extreme departure from the standard of care, has been differentiated from a simple departure from the standard and from common or normal, unavoidable mistakes or errors in judgment.

Basic Elements of the Standard of Care

The standard of care is derived from the following six elements: state law, licensing board regulations, professional organization codes of ethics, case laws, consensus of the professionals, and consensus in the community.

1. Statutes: Each state has many statutes concerning child abuse, elder abuse, domestic violence reporting and other issues. If the statute mandates that therapists do not act or should act in a certain way, such as reporting a suspicion of child abuse, acting against that prohibition, or neglecting to so act, is clearly below the statutory standard of care.

2. Licensing board regulations: In most states there are extensive regulations governing many aspects of mental health practices. These often include rules for continuing education, supervision, etc. Some licensing boards have adopted numerous additional regulations that range from how to engage in e-counseling or telehealth, to how to respond to a client who discloses in therapy that he or she had sexual relations with a former therapist. In all states and in the District of Columbia, there are strict regulations against a therapist having sexual relationships with a current psychotherapy client.

3. Ethical codes of professional associations: The codes of ethics of professional associations are another important component of the general standard of care, however, they are also controversial. In most situations, codes of ethics of professional organizations apply to members and non-members of the organization. APA (2002), National Association of Social Workers (NASW, 1999), ACA (2005), and the American Association of Marriage and Family Therapists (AAMFT, 2001) ethical principles apply to all licensed psychologists, social workers, counselors, and marriage and family therapists, respectively, regardless of whether they are members of the organizations or not, unless there is a state law or board regulation stating otherwise. Some states adopted other professional organizations' codes of ethics as their standard. An example is the California Board of Behavioral Sciences (CA-BBS)—which regulates California Marriage and Family Therapists (MFTs)—adopted the California Marriage and Family Therapists Association (CAMFT) code of ethics as their standard rather than the AAMFT code of ethics.

Translating most codes of ethics or licensing board regulations, or using them to clarify the standard of care can be a complex and challenging task. The codes are generally not specific about which behaviors are prohibited, and most codes include aspirational goals, which must be viewed differently than the enforceable ones (Bersoff, 1994; Fleer, 2000; Williams, 2003). While many state licensing boards have adopted the codes of ethics of major professional organizations as their enforceable guidelines, the APA Ethics Code of 2002 clearly states, “The Ethics Code is not intended to be a basis of civil liability” (p. 1061). In other words, the codes of ethics are not supposed to be simply equated with the standard of care, which is the basis for civil liability.

Another area of uncertainty is whether practitioners who practice in a more specialized field or present themselves as specialists are to be held, not only to national professional organization ethical standards (i.e., AAMFT, ACA, APA, NASW, NBCC), but also to standards put forth by their specialty (i.e., child custody evaluation, forensic psychology), specialized professional association (i.e., U.S. Association of Body Psychotherapists; Academy of Sports Psychology) or institutions they are closely affiliated with (i.e., Jung Institute of San Francisco, Gestalt Institute of Los Angeles, The Reichian Institute of Sacramento).

4. Case law: Case law is one of the cornerstones of the standard of care. No case is more famous for having created a duty (to warn) for psychotherapists than the Tarasoff decision of the California Supreme Court in *Tarasoff v. Regents of the University California* (1976).

5. Consensus of the professionals: In a field that is comprised of hundreds of therapeutic orientations and even more jurisdictions, consensus among professionals is hard to come by. Thus, it follows that consensus among professionals is a rather vague aspect of the standard of care. It is primarily derived from a wide range of diverse professional publications (Younggren & Gottlieb, 2004), as well as professional association guidelines and presentations at professional conferences. An additional complexity of this part of the standard is what has been called the “respectable minority.” This doctrine may apply when there is significant support for a certain type of treatment of a certain disorder, or if the scientific or research support of the technique is not well established (Reid, 1998; Simon, 2001).

6. Consensus in the community: While some scholars emphasize the general, unified, or global aspects of the standard of care across settings, others emphasize the importance of community, local culture, and setting in determining the standard. Following the latter line of thought highlights that different settings and communities which abide by different cultural customs and values have different standards. For example, the exchange of gifts and

attending ceremonies and rituals are normal and expected in Hispanic or American Indian communities, but not necessarily in an upper class suburban clinic (Lazarus & Zur, 2002; Zur, 2001). Complex dual relationships between therapists and clients are inherent, and, in fact, mandated by law in the military and are common in rural areas, but are infrequent in urban areas (Zur, 2007).

What the Standard of Care is Not

The standard of care has often been viewed in several inaccurate ways, some of which have had a direct implication in understanding the relationship between touch and the standard of care. Following is a non-exhaustive list of what the standard of care is not:

1. It is not a standard of perfection. It is the standard based on the average practitioner and on reasonable or “good enough” actions. Caudill (2004) described it as a ‘C’ student’s standard. Simply making a common or ordinary mistake or common error in judgment does not automatically put a therapist’s actions below the standard of care (Simon, 2001).

2. It is not an either/or standard. Compliance or non-compliance with the standard of care has gradations or shades of deviation from the standard. Most commonly, three terms have been used to describe the range of practices: gross negligence, simple departure from the standard of care, and mistakes or errors in judgment. Gross negligence has often been defined as an extreme departure from the ordinary standard of practice in the community. Gross negligence often involves a pattern of systematic and/or extreme departure from the minimum and reasonable standard of practice. Gross negligence is almost always one of the key components of malpractice suits and licensing board hearings. The next level, a simple departure from the standard of practice, has been called “ordinary negligence.” The third level, the most common one, is a simple mistake or error in judgment, which is an unavoidable part of human nature and of the practice of psychotherapy and does not constitute departure from the standard of practice.

3. It is not guided by risk management principles. One of the most significant errors by expert witnesses, attorneys, courts, and licensing boards has been confusing the standard of care with risk management principles (Lazarus & Zur, 2002; Williams, 1997). While the standard is based on legal-professional-communal principles, risk management guidelines are primarily enforced to reduce the risk of malpractice accusations for therapists (Gutheil & Gabbard, 1993; Williams, 2003; Zur, 2007). While the standard of care focuses on what is good for the patient, risk management guidelines have too often come to focus on preemptive protection of therapists and reducing insurance companies’ financial liability.

4. It does not follow any particular therapeutic modality or theoretical orientation. The standard of care is theoretically blind and philosophically neutral. It is not based on psychiatric, biological, analytic, or any other therapeutic modality or theoretical orientation. Attorneys and experts have often presented the psychoanalytic guidelines as the basis for the standard of care (Williams, 1997). Gutheil (1989) accurately pointed out: “It seems that professionals who belong to a school of thought that rejects the idea of transference, behaviorists, or psychiatrists who provide only drug treatment, are being held to a standard of care they do not acknowledge” (p. 31).

5. It is not determined by outcome. Interventions by therapists who do not violate the law or board regulations and use “good enough” decision-making processes are most likely to fall within the standard of care, even if the outcome is negative. An unfortunate outcome, such as suicide, divorce or depression, does not necessarily translate to substandard care (Baerger, 2001; Simon, 2001).

6. It is not permanent or fixed. The standard of care is a dynamic standard that continues to evolve over time. Obviously, new statutes and new case laws change the standard. Then, as more practitioners practice in new or modified ways, the standard changes, too. HIPAA law is an example of how new regulations significantly impact the standard of care (Zur, 2005). The continuously revised professional ethics codes, publication of new research findings, new practice guidelines, or new theoretical breakthroughs all can affect the standard.

Touch in Psychotherapy

The importance of touch for human development, communicating, bonding, and healing has been scientifically studied and documented for the last half century by culturally iconic figures, such as Bowlby (1952), Harlow (1971), and Montagu (1986), and more recently by Tiffany Field (1998, 2003). Ample research has demonstrated that tactile stimulation is extremely important for development and maintenance of physiological and psychological regulation in infants, children, and adults (Field, 1998, 2003; Heller, 1997; LaPierre, 2006). Touch has been an essential part of ancient healing practices and is reported to have been an integral part of health care practices and medicine since the beginning of time (Levitan & Johnson, 1986; Smith, et al., 1998). In his seminal work, *Touching: The Human Significance of the Skin*, Ashley Montagu brings together a vast array of studies shedding light on the role of skin and physical touch in human development. He illuminates how the sensory system, the skin, is the most important organ system of the body. “Among all the senses,” Montagu states, “touch stands paramount” (1986, p. 17). He concludes: “When the need for touch remains

unsatisfied, abnormal behavior will result” (1986, p. 46). Indeed, touch deprivation has been consistently linked to aggression, delinquency, social isolation, and depression in children and adults (Field, 2003).

Recent research has demonstrated that touch triggers a cascade of chemical responses including a decrease in urinary stress hormones (i.e., cortisol, catecholamines, norepinephrine, epinephrine) and an increase in serotonin and dopamine levels (LaPierre, 2006). The shift in these bio-chemicals has been proven to decrease depression (Field, 2003). Touch is, obviously, good medicine. It also enhances the immune system by increasing natural killer cells and killer cell activity, balancing the ratio of cd4 cells and cd4/cd8 cells. The immune system's cytotoxic capacity increases with touch, thus helping the body maintain its defense against pathogens (Field, 1998).

The utility of psychotherapeutic touch has been extensively documented. Generally, touch has been reported to effectively reduce stress, anxiety, dissociation, and depression, and can be very effective in the treatment of Post Traumatic Stress Disorder. It has also been repeatedly reported that touch in therapy positively influences bonding between therapists and clients and increases the therapeutic alliance, the best predictor of positive therapeutic outcome. At this point we must differentiate between “therapy” and “psychotherapy.” While there are many therapies that legitimately involve touch, like physiotherapy and massage, they are not considered psychotherapy. Accordingly, the focus of this paper is on psychotherapy or counseling. Obviously, psychotherapy per se does not necessarily involve touch, even though most therapists (85%) hug their clients rarely or sometimes (Pope et al., 1987), and almost all shake hands with their clients (Smith et al., 1998). Body psychotherapy defines itself as involving the potential for appropriate professional touch (Young, 2005) and, accordingly, most body psychotherapists are specifically trained to employ touch as part of psychotherapy.

While review of the literature of the effectiveness of touch in mental health services is beyond the scope of this paper, extensive reviews of the research on touch can be found in the works of Durana (1998), Field (2003), Heler (1997), Hunter and Struve (1998), Marten (2006), May (2005), McNeil-Haber (2004), Nordmarken and Zur (2004), Smith, et al., (1998), and Young (2005).

In this article, touch refers to any physical contact occurring between a psychotherapist and a client or patient in the context of psychotherapy. Generally, there are three types of touch in psychotherapy: touch that is used as an adjunct to verbal psychotherapy, systematic touch that is used by specially trained body psychotherapists, and inappropriate touch. Following are detailed descriptions of the three types of touch in therapy.

The first type of touch includes touch employed as an adjunct to verbal psychotherapy. These forms of touch are intentionally and strategically used to enhance a sense of connection with the client and to soothe, greet, relax or reassure the client. Their use is also intended to reduce anxiety, slow heartbeat, physically and emotionally calm the client, or assist the client in moving out of a dissociative state. It also includes culturally appropriate touch. Therapeutic touch in this context most often includes a hug, light touch, handholding, or rubbing. The places of contact are usually on a client's back, shoulder, or arm. Based partly on formulations by Downey (2001), Nordmarken and Zur (2004), Smith, et al., (1998), and Zur (2007), these forms of touch may fall under the following categories:

- **Ritualistic or socially accepted gestures for greeting and goodbye upon arrival and departure:** These gestures figure significantly among most cultures and include handshakes, a greeting or farewell embrace, and other culturally accepted gestures.
- **Conversational marker:** This form of light touch on the arm, hand, back, or shoulder is intended to make or highlight a point and can also take place at times of stillness, with the purpose of accentuating the therapist's presence and conveying attention.
- **Consolatory touch:** This important form of touch, holding the hands or shoulders of a client, or providing a comforting hug, is most likely to enhance therapeutic alliance.
- **Reassuring touch:** This form of touch is geared to encouraging and reassuring clients and usually involves a pat on the back or shoulder.
- **Playful touch:** This form of touch, mostly of hand, shoulders, or head, may take place while playing a game with a child or adolescent client.
- **Grounding or reorienting touch:** This form of touch is intended to help clients reduce anxiety or dissociation by using touch to the hand or arm, or by leading them to touch their own hand or arm.
- **Task-oriented touch:** This involves touch that is merely ancillary to the task at hand, such as offering a hand to help someone stand up or bracing an arm around a client's shoulders to keep the client from falling.
- **Corrective experience:** This form of touch may involve the holding of an adult or rocking of a child by a therapist who practices forms of therapy that emphasize the importance of corrective experiences.
- **Instructional or modeling touch:** Therapists may model how to touch or respond to touch by demonstrating a firm handshake, holding an agitated child, or responding to unwanted touch.
- **Celebratory or congratulatory touch:** The therapist may give a pat on the back or a

congratulatory hug to a client who has achieved a goal.

- **Experiential touch:** This form of touch usually takes place when the therapist conducts an experiential exercise. For example, when teaching gestures during assertiveness training; or in family sculpturing in which family members are asked to assume certain positions in relationship to each other.
- **Referential touch:** This is often done in group or family therapy when the therapist lightly taps the arm or shoulder of a client, indicating that he or she can take a turn or be silent.
- **Inadvertent touch:** This is unintentional, involuntary, and unpremeditated touch, such as an inadvertent brush against a client by the therapist.
- **Touch intended to prevent a client from hurting him- or herself:** This type of touch is intended to stop self-harming behaviors, such as head banging, self-hitting, or self-cutting.
- **Touch intended to prevent someone from hurting another:** This form of touch is intended to stop or restrain someone from hurting another person, as sometimes happens in family, couple, or group therapy, or when working with extremely volatile clients.
- **Touch in therapist's self-defense:** This form of touch is used by a therapist to physically defend him- or herself from the assault of a violent client by using self-defense techniques that restrain clients with minimum force.

(Zur, 2007, p. 173-174)

The second type of touch in therapy includes therapeutic touch by body psychotherapists. This is different than the use of touch as an adjunct to verbal psychotherapy. Most somatic and body psychotherapists who are specially trained in these modalities regularly use touch as part of their theoretically prescribed clinical interventions. These psychotherapies can include Reichian (LaTorre, 2005; Reich, 1972), Bioenergetics (Lowen, 1958), Somatic Experiencing (Levine & Frederick, 1997), Rubinfeld Synergy, Hakomi, Biodynamic Psychotherapy, Biosynthesis, among the many other modalities described by Barshop (2005), Aposhyan (2004), and others. Young (1997) reviewed the history of body psychotherapy and the definition articulated by the United States Association of Body Psychotherapy (USABP, 2006) and the European Association of Body-Psychotherapy (EABP, 2006).

The third type of touch includes inappropriate forms of touch, and is in contrast to the aforementioned forms of touch. The following three forms of touch in psychotherapy are unethical, considered as boundary violations, and, depending on the state, are often illegal (Smith, et al., 1998; Zur, 2007). They are counter-clinical and should always be

avoided. They include:

- **Sexual touch**
- **Hostile or violent touch**
- **Punishing touch**

While this paper focuses on touch that is initiated by the therapist, it is quite usual for clients to initiate touch. The most common client-initiated touch is a handshake. McNeil-Harber (2004) discussed touch that is initiated by child-patients usually differentiates between aggressive, oversexualized, inappropriate, and appropriate touch. When a client initiates or requests touch, the therapist must use his or her clinical judgment to ascertain whether providing or withholding touch is ethical, and if it is clinically advantageous in each therapeutic situation.

In summary, touch has been indisputably important for human development, bonding, and healing. Touch is being extensively employed in a variety of ways as an adjunct to verbal psychotherapy and in many long-established and well-researched body psychotherapy modalities.

Therapeutic Touch and the Standard of Care

With the demystification of the standard of care and the summary of the general issues involved in psychotherapy, it is now appropriate for a discussion of the specific application of the elements that comprise the standard of care to non-sexual touch in psychotherapy. As sexual touch between therapists and current clients is always unethical and illegal in most states, the discussion below, like the focus of this paper, is about non-sexual touch.

When it comes to the standard of care, it is very clear that there are no statutes, licensing board regulations, or ethics codes of any major professional association that prohibit non-sexual, clinically appropriate touch. State and federal laws, licensing board regulations, and professional organization codes of ethics do not even mention, regulate, or prohibit non-sexual, ethical therapeutic touch. As was noted above, state and federal laws, board regulations, and codes of ethics are all modality neutral. Therefore, the applications of touch as an adjunct to verbal psychotherapy (e.g., supportive touch at times of distress, an appropriate hug at the end of a session) are treated by federal and state laws, licensing boards, or codes of ethics no differently than any other appropriate boundary crossing (e.g., self-disclosure, gifts). Similarly, somatic and body psychotherapy interventions (e.g., Bioenergetics, Orgonomy, Somatic Experiencing) are treated by federal and state laws, licensing boards, and codes of ethics no differently than any other therapeutic technique (e.g., Cognitive-behavioral, Gestalt).

Evaluating the issue of case law is highly complicated when it comes to touch in therapy. The main reason for this is that experts testifying for plaintiffs have often erroneously argued that non-sexual touch is likely to lead to sexual touch, and therefore is below the standard of care (Zur, 2007). Another common erroneous argument has been the fact that patients who have reported they were aroused by a therapist's touch meant that the touch-intervention was below the standard of care (Williams, 2000). While the former argument is based on the fallacious slippery slope argument; the latter erroneously claims that therapists are to be judged by the outcome of treatment rather than by the process of decision-making and adherence to laws and regulations. To my knowledge there has not been any case law that mandated the avoidance of all non-sexual touch in therapy.

The standard of care element that refers to consensus among professionals is highly relevant to therapeutic touch. As was cited above, there is a vast body of literature that supports the importance of touch as an adjunct to verbal psychotherapy (see summaries in Fields, 2003; Hunter & Struve, 1998; Smith, et al., 1998) and as a discipline of its own, as embodied in body psychotherapy. The "respectable minority" provision discussed above is also highly relevant to touch in therapy as it establishes that the many less-established and less-researched varieties of body psychotherapy, and the many forms of ethical touch employed as an adjunct to verbal psychotherapy, do not necessarily fall below the standard of care.

The part of the standard of care that states that it is bound by community norms is also applicable to touch in psychotherapy. Practicing in certain Latin, African American, French, or Jewish communities or rehabilitation centers often involves culturally or community-appropriate touch between therapists and clients. A full-body hug, or a peck on both cheeks ("European kiss") is often the culturally appropriate greeting ritual within these communities or settings. This element of the standard of care clearly establishes that different settings and communities which abide by different cultural customs and values often have different standards, including different therapeutic standards of care in regard to touch. For example, extensive physical touch may be employed in adventure therapy or sport psychology. The community standard is also applied where therapists are working in certain settings that focus on somatic or body psychotherapy. For example, therapists who practice in training institutions that focus on Reichian therapy or somatic experiencing are likely to use these touch-based techniques extensively. To comply with these professional standards, clients may be asked to sign special informed consent forms in regard to touch.

As was discussed above, the standard is neither guided by risk management principles of avoiding touching a client beyond a handshake, nor by the physically distanced approach of the psychoanalytically based modalities. Therefore, risk management and analytic yardsticks are not applicable to appropriate, ethical, and clinically driven therapeutic touch.

Highly relevant to the issue of touch is the fact that the standard of care is not determined by outcome. As in a previous example in which a client's suicide does not necessarily mean that the therapist operated below the standard of care, a client's sexual feelings in response to a therapist's touch does not necessarily mean that the therapist was engaged in sexual touch. What is relevant to the standard of care is the therapist's clinical rationale for the touch, the client's consent, as well as the clinically appropriate evaluation of the impact of the touch, and the therapist's appropriate follow-up. Also relevant is the therapist's ethical decision-making process that led to the touch and understanding how the touch fit within the original treatment plan. In other words, the sheer fact that a client felt sexually aroused does not mean that the therapist operated below the standard of care. As with any other intervention, it is the responsibility of the therapist to conduct a competent evaluation of the effect of the touch by observing the client, asking the client for feedback, or by other means. If a therapist realizes that the touch resulted in unintended sexual arousal, it is his or her responsibility to attend to that in a clinically appropriate manner. This may include discussing it with the client, stopping or changing the touch, or other clinically appropriate responses.

Ethics of Touch

The question of the ethics of touch has often been raised in relation to therapeutic touch. The APA Ethics Code (APA, 2002), as is true for the ethics codes of all major psychotherapy professional associations—the AAMFT (2001), the ACA (2005), and the NASW (1999)—neither specifically mentions nor prohibits the use of appropriate, non-sexual touch in therapy. All psychotherapy professional codes of ethics view sexual touch with a current client as unethical. The answer to whether touch is ethical is simple and clear: clinically appropriate touch in psychotherapy is neither unethical nor below the standard of care.

Historically, unethical sexual touch in therapy received extensive attention (i.e., Pope, 1990; Pope, Sonne, & Holroyd, 1993; Rutter, 1989; Simon, 1994), and increased numbers of publications have attended to the ethics of touch in more recent years (i.e., Durana, 1998; Herlihy & Corey, 2006; Hunter & Struve, 1998; Marten, 2006; McNeil-Haber, 2004; Nordmarken & Zur, 2004; Smith, et al., 1998; White, 2002; Young, 2005; Zur, 2007). These authors discussed

the importance of taking into consideration client factors, such as history of abuse, gender, culture, attitude towards touch, presenting problem, as well as the setting of therapy, therapeutic modality employed, nature of the therapeutic relationship and therapist's training, culture, gender, and attitude towards touch. Appropriate use of consultation and client consent was also emphasized.

Obviously, the ethics of touch has received the most extensive coverage from the USABP (2001). Their guidelines clearly articulate the ethical use of touch in therapy, the importance of informed consent, and concerns regarding respect, diversity, consultation, record keeping, treatment plans, and many other pertinent issues. Most body psychotherapists use actual touch as their primary tool in psychotherapy, therefore an extra focus on the ethics of touch is called for in their therapist's training (Caldwell, 1997; Durana, 1998; LaPierre, 2003; Phillips, 2002; Smith, et al., 1998; Young, 1997).

Partly in respond to testimonies by psychoanalytically oriented and risk management expert witnesses against boundary crossing in general including testimonies disparaging clinically appropriate and ethical touch, a much-needed clarification of "reasonable" was added to the APA Ethics Code of 2002, as shown in this excerpt from the Introduction and Applicability section:

The modifiers used in some of the standards of this Ethics Code (e.g., *reasonably*, *appropriate*, *potentially*) are included in the standards when they would (1) allow professional judgment on the part of psychologists, (2) eliminate injustice or inequality that would occur without the modifier, (3) ensure applicability across the broad range of activities conducted by psychologists, or (4) guard against a set of rigid rules that might be quickly outdated. As used in this Ethics Code, the term *reasonable* means the prevailing professional judgment of psychologists engaged in similar activities in similar circumstances, given the knowledge the psychologist had or should have had at the time. (p. 162)

Clearly, one of the intentions of this statement is this: No longer will courts and licensing boards that define the standard of care use any one particular modality or orientation as the yard stick to measure interventions that are rooted in other disciplines. This means analytic or risk management principles legitimately may not apply to a body psychotherapy situation. The APA statement acknowledges that some clinical situation boundary crossings, such as gifts, bartering, or dual relationships, may be appropriate, clinically beneficial, and unavoidable. This statement is relevant to touch in psychotherapy and clearly implies that the evaluation of the appropriateness of touch in therapy must be according to the "... prevailing professional

judgment of psychologists engaged in similar activities in similar circumstances . . .," which means the "prevailing professional judgment" of other psychologists who use touch with similar client populations and in similar settings. For the first time this paragraph actually makes it unethical for a testifying psychologist-expert to use psychoanalytic, psycho-pharmacological, or other therapeutic orientations to determine that clinically appropriate and ethical touch supported by other established orientations is below the standard of care.

Risk Management Practices, Slippery Slope Claims, Sexualization of Touch, and Risk-Benefits Analysis

At the core of the risk management injunction against touch in psychotherapy is an assumption about a slippery slope. This refers to the idea that failure to adhere to hands-off, rigid standards will most likely lead to therapist-client sexual relationships. This process is described by Gabbard (1994) as follows: "... the crossing of one boundary without obvious catastrophic results (making) it easier to cross the next boundary" (p. 284). This fear-based view has been most dominant in the discussion of employing or incorporating touch in psychotherapy as it asserts that a pat on the back, hand-holding, non-sexual supportive or a greeting hug are all just the first downhill steps towards inevitable deterioration of ethical conduct and towards sexual relationships.

Pope (1990), whose endorsement of the slippery slope idea has significantly contributed to its popularity, stated: "... non-sexual dual relationships, while not unethical and harmful per se, foster sexual dual relationships" (p. 688). Similarly, Strasburger, Jorgenson, and Sutherland (1992) concluded, "Obviously, the best advice to therapists is not to start (down) the slippery slope, and to avoid boundary violations or dual relationships with patients" (p. 547-548). Also in agreement was Simon (1991), who decreed: "The boundary violation precursors of therapist-patient sex can be as psychologically damaging as the actual sexual involvement itself" (p. 614). These poignant restrictive statements summarize the slippery slope idea and its derivative risk management stance that the chance of exploitation and harm is significantly reduced or nullified by simply refraining from engaging in any boundary crossing, including any form of non-sexual touch, regardless of its clinical effectiveness. This is a false argument and contains an unproven non-sequitur.

A careful review of the slippery slope argument reveals that it is founded primarily on the (somewhat paranoid) assumption that any boundary crossing, however trivial, inevitably leads to boundary violations and sex (Lazarus &

Zur, 2002; Zur, 2007). The slippery slope argument claims to get support from the fact that most sexual exploitations of clients have started with non-sexual or ethical boundary crossing. While it may be true that abusive therapists might have introduced themselves with a handshake, it does not follow that this leads to sexual relationships; a vastly significant number of therapists have also introduced themselves with a handshake to no ill effect.

Furthermore, to assert that self-disclosure is likely to lead to social relationships, that an appropriate hug is most likely to end with intercourse, or accepting a gift is the first step towards inevitable inappropriate business relationships, is irrational and illogical. Sonne (1994) discussed how a therapist and client who were sport teammates might easily move their relationship to encompass activities such as carpooling or drinking. She concluded that, "With the blurring of the expected functions and responsibilities of the therapist and client comes the breakdown of the boundaries of the professional relationship itself" (p. 338). Along these lines Woody (1998) asserted, "In order to minimize the risk of sexual conduct, policies must prohibit a practitioner from having any contact with the client outside the treatment context and must preclude any type of dual relationships" (p. 188). The risk management literature is saturated with articles and books describing therapists' behaviors (e.g., self-disclosure, hugs, home visits, socializing, longer sessions, lunching, exchanging gifts, walks, playing in recreational leagues) that the authors contended were precursors to or on the slippery slope to sexual or other harmful dual relationships (Borys & Pope, 1989; Craig, 1991; Koocher & Keith-Spiegel 1998; Lakin, 1991; Pope, 1990; Pope & Vasquez, 2007; Rutter, 1989; St. Germaine, 1996).

The belief in the slippery slope is a part of the more widespread cultural and professional problem, which includes risk management experts' tendency to sexualize boundaries in general and touch in particular (Dineen, 1996; Zur, 2007). This so-called "prudence" is akin to prudery, where the sin lies more in the eye of the beholder than in the mind of the enactor. It must be challenged wherever it tries to circumscribe. But there is also a wider issue: why do touch taboos exist and why is there such touch illiteracy. Field (2003) notes that social attitudes to touch have changed, from the "laying-on" of hands (common in the Bible, Middle Ages, and still found in some religions), to touch becoming sexual in the 19th century (as everything was, even the sight of a woman's ankle), to touch being now "more associated with criminality in increasingly frequent court cases on sexual harassment, sexual abuse, child-care hysteria, and kindergarten and lower grade teachers' avoidance of any form of touch beyond a handshake"

When it comes to touch in therapy, the slippery slope idea basically claims that there is no meaningful differentiation

between non-sexual touch and sexual touch because one inevitably or very likely leads to the other. Again, there is little real evidence put forward for this claim. In a critical examination of the slippery slope argument, Zur (2000) reflected that to assert, as most proponents of the slippery slope idea do, that self-disclosure, a home visit, a hug, or accepting a gift were actions likely to lead to sex was like saying that doctors' visits cause death because most people see a doctor before they die. Lazarus called this thinking "an extreme form of syllogistic reasoning" (1994, p. 257). We learn in school that sequential statistical relationships (correlations) cannot simply be translated into causal ones. Despite the popularity of the term, the slippery slope is a paranoid, baseless and illogical construct claiming that any deviation from risk management or rigid analytic guidelines is likely to lead to harm, exploitation, and sex.

While all risk management and most ethics texts appropriately emphasize the important risk-benefits analysis for touch or any other clinical intervention, very few address the risk-benefits analysis of "in-action" or the avoidance of certain interventions (Zur, 2007). While risk-management focus is, obviously, on risk avoidance, and most ethical decision-making processes emphasize the risk-benefits analysis of touching, rarely mentioned is the equally important risk-benefits analysis of avoiding touch at all cost. Along these lines the author has reflected on his experience of avoidance of touch at all cost:

For example, I have been working with a woman who, 10 years prior to our first session, lost her infant son in an automobile accident. In an emergency appointment with a psychiatrist right after the death of her son, as she sobbed uncontrollably, she begged him to hold her. He refused, citing something about professional boundaries. Instead, he prescribed Valium. Eight years later, addicted to Valium and alcohol, she began therapy with me. After an intense few months of therapy, we visited her son's grave. It was the first time she had visited the grave. There we stood, holding each other and both weeping as she finally started facing her baby's death and grieving for him and for her years lost in drugged denial. While the psychiatrist followed risk management guidelines to perfection, he also may have inflicted immense harm. Did he sacrifice his humanity and the core of his professional being, to heartless protocol? (Nordmarken & Zur, 2004)

Risk-benefits analysis of actions or inactions brings to the forefront the contexts of therapy (i.e., client factors, setting, therapy, and therapist factors). Such risk-benefits must be included in treatment planning for the use of touch or any other interventions. The rarely acknowledged fact is that all clinical interventions also contain risk. As a matter of fact,

any human action as well as any human inaction is associated with some level of risk. Therefore, a thorough risk-benefits analysis does not simply reject boundary crossings, such as touch, because it involves risk; instead therapists are invited to ask the question, “Do these risks outweigh the benefits?” or “Are these risks justified?” Therapists must always take into consideration that they can actually *do* harm through inaction and the avoidance of touch in the attempt to avoid harm (Fay, 2002; Lazarus & Zur, 2002).

When it comes to risk management in regard to touch, the question then becomes, “*what can be done to reduce any inherent risks to a reasonable and appropriate level?*” The “solution” to the “problem” (which exists in a very small minority of therapists, and thus the risk is very small) is not to restrict all therapists by penalizing codes, but simply to ensure they are educated better and aware of appropriate boundaries, and perhaps even supervise them a little more regularly.

There is an additional sociological question, “*Why are behaviors and interventions, such as touch, that are known to be clinically helpful, as well as very natural elements of human interaction, being looked at as suspicious and driven underground?*” The answer lies partially in the concept, practice, and teaching of defensive medicine or risk management. Reflecting on the analytic touch taboo, Lapierre asserts, “From this perspective, the touch taboo and the resulting touch illiteracy limit our psychotherapeutic horizons and rob us of effective, perhaps critical, forms of clinical reparation interventions and interactive couple and caregiver education” (2003, p. 5). This paper demonstrates that from a standard of care point of view, ethical touch, which is based on a thorough risk-benefits analysis and is the result of a sound ethical decision-making process, inevitably falls within the standard of care.

Touch in Context

The clinical application of touch in psychotherapy can only be understood within the context of the therapy. Accordingly, whether therapeutic touch falls within the standard of care or not can also be understood within the context that it is employed. Touch, when viewed through the prism of client factors, therapeutic setting, therapeutic orientation, therapeutic relationship, and therapist factors, can have radically different contextual meanings (Hedges, et al., 1997; Koocher & Keith-Spiegel, 1998; Phillips, 2002; Smith, et al., 1998; Young, 2005; Zur, 2007).

Former APA president and leading ethicist Gerry Koocher provides a vivid example of how professionals tend prematurely to judge touch and other boundary crossings without taking the context into consideration.

On occasion I tell my students and professional audiences that I once spent an entire psychotherapy session holding hands with a 26-year-old woman together in a quiet darkened room. That disclosure usually elicits more than a few gasps and grimaces. When I add that I could not bring myself to end the session after 50 minutes and stayed with the young woman holding hands for another half hour, and when I add the fact that I never billed for the extra time, eyes roll.

Then, I explain that the young woman had cystic fibrosis with severe pulmonary disease and panic-inducing air hunger. She had to struggle through three breaths on an oxygen line before she could speak a sentence. I had come into her room, sat down by her bedside, and asked how I might help her. She grabbed my hand and said, “Don’t let go.” When the time came for another appointment, I called a nurse to take my place. By this point in my story most listeners, who had felt critical of or offended by the “hand holding,” have moved from an assumption of sexualized impropriety to one of empathy and compassion. (2006, p. xxii)

Following are descriptions of the five factors that can help to define the relationship to touch in the context of therapy.

Client Factors

This factor includes the client’s age, gender, presenting problem, diagnosis, personality, personal touch history, culture, and class. These are all highly relevant to the meaning and potential healing effect of touch in therapy. What is particularly appropriate and effective with one client may be clinically inappropriate and even damaging with another. Letting a young child jump into the therapist’s lap in the midst of family therapy may be very appropriate, but it is generally not permissible with an adult client. Reaching out gently and respectfully to hold the hand of a grieving mother may not have the intended positive effect if the same is done in early stages of therapy with a survivor of sexual abuse. The client’s past experiences with touch are important and so are their present attitudes towards touch. Elements of personal space are defined within a culture and affect the interpretation of therapeutic touch. In this context a therapist’s touch or lack of touch may be seen as distant, respectful, or invasive depending on the socialization, culture, and experience of the individual client (Aponte & Wohl, 2000; Smith, et al., 1998; Sue & Sue, 2003).

Gender issues are also extremely important in understanding the context of touch. Touch in psychotherapy occurs between therapists of both sexes and their female and male clients as well as same-sex therapist-client dyads (Brodsky, 1985). Research has confirmed that women responded more

positively to touch than did men (Hunter & Struve, 1998). From birth, American females received more affectionate touch from males and females and were given greater permission to touch either gender and be touched by either gender. They were more likely to have and expect a broader repertoire of touch, and were less likely than men to perceive sexual intent in men when touched by them (Downey, 2001; Smith, et al., 1998).

The use of touch with survivors of childhood trauma has been much debated. Whereas some authors asserted that touch in any form should never be used with this population, many others agreed that the clinically appropriate and ethical use of touch with survivors of childhood abuse, when applied cautiously, could be invaluable in helping them heal and recover from their traumatic experiences. The concern was the possibility that touch used with these clients may have recreated, evoked, or re-traumatized previous client-experienced dynamics of victimization (Lawry, 1998). Cornell (1997) stated that once a strong therapeutic alliance had been formed, “the use of touch will evoke, address and hopefully help correct such historical experiences and distortion” (p. 33). What seemed to be of the highest importance was that the client wanted to be touched and understood the concepts of choice and personal empowerment before it was clinically or ethically appropriate to begin the use of touch in session. Research has also found that sexually abused clients were more likely to attribute a corrective or educative role to touch in therapy than were non-abused clients. Of these clients, 71% reported that appropriate touch repaired self-esteem, trust, and a sense of their own power or agency, especially in setting limits and asking for what they needed (Smith, et al., 1998).

Consistent with the pattern in the general culture, therapists tend to touch young clients more often than they do their adult clients, and female therapists touch child clients more often than do male therapists (Hunter & Struve, 1998). Research has demonstrated that when the staff of an adolescent treatment program modeled nonsexual, nonviolent touch and incorporated physical contact as an acceptable aspect of the milieu, the adolescents demonstrated a marked decrease in violent and sexual behaviors (Dunne, Bruggen, & O’Brien, 1982). Touch is usually contraindicated for clients who are actively paranoid, hostile and aggressive, or who implicitly or explicitly demand touch (Durana, 1998). Most people experience some diminution in physical faculties and perceptual skills as they age, but the sense of touch generally remains intact and is valued as increasingly important as a source of contact and communication. The soothing, affirming experience of touch is most important at the beginning and end of one’s life and generous, nurturing touch can gently facilitate the process of aging and dying with dignity (Hollinger, 1986).

Setting Factor

The setting of therapy is profoundly important in evaluating the efficacy and meaning of touch. Some settings, such as prisons, are likely to restrict touch, whereas clinics for children or hospice are likely to encourage it. Obviously, sport psychology, adventure therapy—such as rope courses or flying trapeze—and adolescent programs that involve sports and camping, often involve extensive forms of touch (Zur, 2007). Practicing in different cultural milieus is likely to result in different attitudes and use of touch. Latino or Middle Eastern clients are likely to endorse and expect physical touch more than Northern European, Japanese, or North American clients (Smith, et al., 1998). With levels of class and authority, it often moves from higher to lower; that is, a higher ranking individual may initiate touch of a subordinate but not vice versa. The same is true of male-to-female interaction in some societies (Halbrook & Duplechin, 1994). Touch as an aspect of group therapy or in a therapeutic community is probably more accepted and more often found than in one-to-one therapy.

Therapeutic Relationship (Therapeutic Alliance) Factors

The therapeutic relationship between therapists and clients, or the nature and quality of the therapeutic alliance, are among the most important factors determining the potential efficacy of the use of touch in therapy. A therapist-client relationship of trust and of long duration is more likely to create a familiar and safe context for effective use of touch in therapy. In contrast, a shorter or conflictual or confrontational relationship is less likely to be conducive to it. The relationship between touch and the therapeutic alliance seems to be bidirectional; as appropriate and “in-tune” touch significantly enhances a positive therapeutic alliance (Horton, et al., 1995; Smith, et al., 1998) and, in return, creates a further atmosphere of trust and the possibility of the further use of clinically appropriate touch. Given that most research studies indicate that the therapeutic alliance is one of the most significant factors in respect of efficacy, one can then argue that, where appropriate and enhancing, touch can be seen as a significant factor in promoting the alliance and thus the efficacy of the therapy. It may even follow that “lack of touch” might diminish efficacy and thus standard of care.

Therapeutic Orientation

As with any boundary consideration, therapeutic orientation or modality is exceptionally relevant in the clinical usefulness of touch in therapy. Body psychotherapists with clinical orientation, such as Reichian (Reich, 1972) or Bioenergetics (Lowen, 1976), often use touch as their primary tool in psychotherapy. In contrast, most traditional psychoanalysts are generally opposed to any form of touch in therapy (Menninger, 1958; Smith, et al., 1988; Wolberg, 1967). Generally, humanistically oriented therapies are

more likely to endorse appropriate, non-erotic touch as they view it as an enhancement of the therapist-client connection (Hunter & Struve, 1998; Williams 1997). Rogers (1970) discussed the value of touch and specifically described how he soothed clients by holding, embracing, and kissing them. Gestalt therapy incorporates numerous forms of touch as an integral part of therapy (Perls, 1973). Gestalt practitioners place a special importance on nonverbal communication and nonverbal intervention. Unfortunately, gestalt practices in the 1960s and early 1970s, under Perls's leadership, went too far and at times included unethical sexual touch in conjunction with therapy (Hunter & Struve, 1998). Family therapists, including Satir (1972), often used touch as an element of engaging clients in therapy (Holub & Lee, 1990). Behavioral and cognitive-behavioral therapists were likely to incorporate touch or any boundary crossing into therapy if it fit with their interventions, such as modeling or reinforcement (Zur, 2007). Orientations, such as feminist and group therapy, supported the clinically appropriate use of touch (Milakovitch, 1993; Williams, 1997). A few modern analysts, such as Fosshage (2000), have differed with mainstream analytic doctrine and advocated the incorporation of clinically responsible use of touch in psychoanalytical and psychodynamically oriented therapies.

Consistent with the theoretical literature, Holroyd and Brodsky (1977) found that humanistic psychologists were more likely to engage in non-erotic touch than those of other orientations. Similarly, Pope, et al., (1987) reported that therapists of differing theoretical orientations have very different beliefs about the effect and practice of touching clients. They reported that 30% of humanistic therapists indicated that non-erotic hugging, kissing, and affectionate touching might frequently benefit clients in psychotherapy. In contrast, only 6% of psychodynamic therapists indicated the same. Whereas most psychodynamic therapists thought touch could be easily misunderstood, humanistic therapists did not share this view. Similarly, Milakovitch (1993) compared therapists who use or did not use touch and reported that therapists who used touch were likely to subscribe to a humanistic theoretical orientation, whereas therapists who did not use touch usually subscribed to a psychodynamic orientation. Clients who chose those therapists might have similar differences.

Therapist Factors

Therapists' culture, age, and professional socializations are likely to affect their use of clinical touch. Older therapists were professionally socialized to practice with less fear of boundary crossing, were not trained in risk management practices, and were more likely to use touch more casually than younger ones whose training included much more focus on risk management and defensive medicine (Williams, 1977). Therapists' own cultural background was very likely to affect their personal comfort with touch and,

therefore, its use in the clinical settings. Milakovitch (1993) compared therapists who touched and those who did not touch and found that besides the therapeutic orientation factor, therapists who touched obviously valued touch in therapy and believed that gratifying the need to be touched was important. Therapists who did not touch believed that gratifying the need to be touched was detrimental to therapy and the client. Unlike therapists who did not touch, therapists who touched were more likely to be touched by their own therapists and had supervisors and professors who believed in the legitimacy of touch as a therapeutic tool. Therapists who touched were more likely to experience body psychotherapies as clients than therapists who did not touch.

Gender of therapists (and clients) seemed to impact the use of non-erotic touch. Stake and Oliver (1991) found that female psychologists reported more touching of female than male clients. Male psychologists, on the other hand, reported more touching of male clients on the shoulders, arm, hand, or knee, but more touching of female clients in ways such as hugging, holding hands, or touching face, hair or neck. These findings seemed consistent with Holroyd and Brodsky's (1977) finding that non-erotic touching occurred more frequently in female dyads than male dyads.

Demonstrating Compliance with the Standard of Care

Compliance with the standard of care, in general, as well as with touch issues means that therapists have acted in a professionally reasonable manner and followed community and professional standards as have others of the same profession or discipline with comparable qualifications in similar situations. Due to the professional and public concern with therapeutic touch, demonstrating compliance is very important. One of the primary ways for therapists to demonstrate compliance with the standard of care is accomplished primarily by means of documentation in clinical records (Caudill, 2004; Hedges, 2000; Gutheil, 1998). Good records go hand-in-hand with quality care.

At the minimum, records for each client, couple, or family should include: Diagnosis impression (does not need to be a DSM diagnosis; it can be developmental, familial, or other impressions); initial assessment of mental status; details of the presenting problem; relevant biographical background information, treatment planning, including rationale for treatment and revised treatment plans; and as necessary, progress notes and termination notes. When therapists choose not to use widely used, mainstream, or standard interventions, they must articulate their clinical rationale for their choice of treatment and demonstrate their awareness and consideration of different treatment options. Extra

documentation is often required in cases of emergencies, crisis intervention, violence and abuse situations, mandated reporting, extensive touch, dual relationships, and abrupt termination. Signed informed consents might be considered as more important when it comes to body psychotherapy practices and other therapies that employ touch extensively. Finally, consultations on relevant clinical, legal, and ethical cases should be used when necessary and documented as part of the records (Younggren & Gottlieb, 2004). Consultation with experts is one of the best ways to establish that the standard of care is met (Younggren & Gottlieb, 2004). Such consultations with experts or regular supervision allows the psychotherapist to demonstrate that the clinical intervention he or she is engaged in is reported to be similar to what other reasonable psychotherapists would do under similar circumstances.

One way for psychotherapists to evaluate if their conduct is within the standard of care is to ask themselves several questions, such as: Does my conduct violate state or federal law or licensing board regulations? Does my conduct breach an ethical principle? Is there a court ruling that imposes a duty on me that is relevant to my conduct? What is the best way to help this particular client, taking into consideration the context of the professional relationship? What should I do to help? What should I not do to help? What are the ramifications of not doing certain things? And what would an average peer, who uses a similar theoretical orientation, working with a similar type of client, with a similar diagnosis or problem, in a comparable type of community, say about my conduct? When appropriate, the records should reflect therapist's responses or contemplation of these questions. Many of these questions will also get asked in regular supervision, which in some settings is seen as a useful and necessary adjunct to the therapy.

Ethical decision-making in psychotherapy has received much attention because a thorough decision-making process is the important phase in the development of a treatment plan and essential for demonstrating compliance with the standard of care. Many texts have focused on the principles of ethics in psychology (e.g., Beauchamp & Childress, 2001). As with the general principles of the APA (2002) Ethics Code, many ethicists view the following five moral principles as the foundation of ethical decision-making: autonomy, nonmaleficence (i.e., do no harm), beneficence (commitment to benefit the client), justice, and fidelity. Several texts outlined ethical decision-making for psychotherapists as being broad and inclusive (e.g., Canter, Bennett, Jones, & Nagy, 1996; Corey, Corey, & Callahan, 2003; Herlihy & Corey, 2006; Knapp & VandeCreek, 2006). Other texts focused on ethical decision-making and guidelines with regard to boundary crossings (i.e., Corey, et al., 2003; Gutheil & Gabbard, 1993; Herlihy & Corey, 2006; Knapp & VandeCreek, 2006; Koocher & Keith-Spiegel, 1998; Reamer, 2001; Welfel, 2002). Still others

have provided more specific guidelines, such as those for handling nonsexual touch (Durana, 1998; Hunter & Struve, 1998; McNeil-Haber, 2004; Nordmarken & Zur, 2004; Smith, et al., 1998; Zur, 2007), and some explore the whole issue of ethical touch in psychotherapy (Young, 2005; Zur, 2007).

Demonstrating compliance with the standard of care around touch issues is essentially no different than any other intervention. What may be more relevant to the employment of touch is the issue of consent. Consent to minor and intermittent touch, such as a pat on the back or a hug at the end of the session, can be implied or achieved verbally or non-verbally if the client initiates it or seems to respond positively. Any consistent touch beyond a handshake, such as greeting and departing hugs, or hand holding that is repeated in each or most sessions, may be documented in the record with a brief note of explanation for its clinical rationale. Systematic employment of body psychotherapy methods requires both signed written consent by clients and clear documentation of the methods employed in the clinical records.

Summary

The standard of care is a legal term and has been defined as the customary professional practice in the community. It describes the qualities and conditions that prevail, or should prevail, in a particular mental health service that a reasonable or average practitioner follows. Most commonly, the standard is defined in legal terms as "that degree of care which a reasonably prudent person would exercise in the same or similar circumstances" (Black, 1990, p. 1405, in Baerger, 2001). It is very important to understand that the standard of care is a minimum and reasonable standard, not a standard of perfection. The standard of care is neither determined by the outcome of therapy, nor is it based on analytic or risk management principles. It calls on practitioners to act in a reasonable, average, or "good enough" manner rather than in ideal or perfect ways. The standard of care is derived from the following six elements: state law, licensing board regulations, professional organization codes of ethics, case laws, consensus of the professionals, and consensus in the community.

Touch in psychotherapy is a boundary issue. While sexual touch with current clients is a boundary violation and always below the standard of care, non-sexual, clinically appropriate touch is boundary crossing and has wide utility in the treatment of anxiety, depression, trauma, and many other mental ailments. Clinically appropriate and ethical touch clearly falls within the standard of care. Clinicians who employ touch in therapy must make sure it is clinically appropriate given the client's history, age, gender, sexual

orientation, culture, and presenting problem. They also must take into consideration the type of setting, the quality of the therapeutic relationship, their own comfort and attitudes towards touch and, of course, their training and scope of practice. Consulting with experts can be very beneficial and obtaining some form of consent from their clients is important. When using techniques that involve touch, it is essential to ensure that appropriate training and supervision has been received. Extensive and systematic use of touch may require signed written informed consent and a rationale given in the clinical records.

In summary, when touch in psychotherapy is employed in clinically and ethically appropriate ways, it clearly falls within the standard of care and has high clinical utility for healing a wide range of ailments and mental disorders.

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Ofer Zur

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