

ABOUT THE ETHICS OF PROFESSIONAL TOUCH

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Abstract:

Professional touch in psychotherapy, body psychotherapy and body therapy does not have a clear ethical basis and ignorance, fear and prejudice often align it with sexual contact and thus abuse. This article tries to explore some of the ethical questions and issues of such touch from professionals and how, when, why, where, who with, who not to touch, and from whom it might be appropriate? Furthermore inappropriate touch, serial abuse, institutional abuse, and supervision and training issues are looked at in an attempt to create a wider dialogue on these important matters to our profession.

Introduction:

Whilst touch is an essential aspect of our human developmental needs, and whilst there have also been many hundreds of studies to demonstrate conclusively that touch can have very beneficial and therapeutic effects, inappropriate touch can also be very disturbing, offensive and even traumatic.

As Body-Psychotherapists and Body-Therapists, we are, essentially, the main professional advocates of therapeutic touch and therefore we, ourselves, not only need to ensure that **(i)** we know what appropriate or ethical touch is, and that **(ii)** we have a very clear idea what inappropriate or unethical touch is as well, but also that **(iii)** we need to be very clear and open with those that we work with; those that we train; and with our professional colleagues, about the times and the ways that we, or they, might transgress these boundaries. It is also perhaps important to note that working in the field of Body-Psychotherapy does not necessarily require the touching of a client.

This increased clarity does not have to constrain us, as professionals, from research or experimentation in the field of touch. But it behooves us to examine carefully whatever boundaries we happen across and see whether the 'rules' that do exist are still valid for these changing times, or under different circumstances, as sometimes blanket rules can be inappropriate. In general, we do not truly learn significant things unless we make mistakes, and if we do have the urge to wander or experiment a little, then we need to be sure that we can correct our transgressions quickly, with proper controls, like adequate training, clear awareness and self-awareness, and regular supervision or professional direction.

In certain situations, if we happened to do something, involving touch, which is out of the 'normal' bounds of practice with one of our clients or trainees, we would also need to be very sure that we have the corresponding justification and rationale for stepping outside of that boundary. We would have to have a set of very good reasons, which we might also have to justify to our client, to our peers, and even in court. We would be something like a surgeon, caught up in an emergency situation, having to do extra-ordinary procedures or experimental techniques in order to save a life, because (and only because) s/he is in a situation where there is no proper equipment, operating theatre, or resuscitatory back-up, but operating clearly from within the bounds of wide knowledge, professional training, and good practice.

Without clarity, we are like sailors without a chart or compass steering blindly into unknown seas in search of legendry or fabulous continents, which may not even exist. This may be fine if we wish to take the risk and suffer the consequence for ourselves, but it not necessarily so good for any people that happen to be sailing along with us; our 'passengers' or clients, nor may it be helpful to the rest of us who may be aligned with such risky enterprises. Only with this sort of professional clarity can we begin to test the 'normal' boundaries; or do research with good parameters, proper record-keeping, and repeatably testable hypotheses.

For many years, there has been no clear "common ground" in Europe, especially in Body-Psychotherapy, as to what is appropriate touch or ethical touch within our profession. Individual schools and training centers of course vary considerably, even hugely, and some of these are excellent in this respect and have many different training sessions on the aspects of proper or ethical touch and on the theory and research behind this application of touch; but also there are others who are not so clear, and they are training people who may not really know what they are doing, they are just following. They may think they have been properly trained as Body-Psychotherapists, but I would now wish to dispute some of their training and even their classification as a Body-Psychotherapist if they do not know, or deliberately ignore, what is considered by everyone else to be ethical touch. It is time perhaps to expose our profession to a much greater degree of transparency and scrutiny.

The situation is better or worse in America as the levels of paranoia and concern about the use of touch are much, much higher.¹ This has resulted in much more explicit thought and work having been put into training, supervision and into professional standards both for psychotherapists and body workers. Even so, there is considerable room for improvement.

If the few people who do transgress only did what they had been taught, it might be all right; but then people naturally start to experiment (which can be good thing under certain circumstances) but that is when it also can become to be dangerous – and not just for them. Because we collectively in Body-Psychotherapy have no real "common ground" or clear, established, agreed and written parameters as to what is meant by appropriate or ethical touch, it is very difficult for us, as a profession, to say clearly and collectively, "*This is good; this is justified; this is ethical; and that, or that, or that is not.*"

We therefore run the considerable risk, as a professional community, of effectively being silent in such situations; silent because we don't have a common agreement of what good practice with respect to touch is; or silent because we fear perhaps even included in the collective of those being condemned; or silent because there may even be an implicit collusion with "fellow" professionals against others, with us not wanting to bring the field of Body-Psychotherapy into disrepute by exposing the potentially improper use of touch by a colleague within Body-Psychotherapy.

And these silent collusions are because of what one or two people may be doing, which may be unjustified, wrong, or unethical in one way or another. The

¹ In a survey of practicing psychotherapists about how state licensing boards should treat offenders, nine vignettes were presented to be rated for severity. Two of these vignettes involved embracing a client; one after a session to be supportive; one given in greeting a year after termination of therapy. These were described as "cases of sexual misconduct". Gottlieb, Hampton & Sell (1995)

media, who carry their own hysteria about professional misconduct, also often report situation wrongly. We may however all be tarred with the same brush, or go down with the one ship, if we do not clearly differentiate what is ethical touch and what is not. Only then can we be clear.

Hence I make this attempt to open up more of a dialogue on this topic with this article. I do not have any definitive answers. This article is not particularly 'scientific.' I trust it is professional, but I really hope, beyond any other reaction, that it encourages a more open discussion and debate about the ethics of professional touch and that this might, in due course, contribute towards the formation of some clearer answers for the whole profession of psychotherapy, maybe even rehabilitating touch back into this profession.

Proper Boundaries:

The following was written as the opening paragraph to a short article on touch, recommending a technique called Somatic Tracking as one method of identifying and assessing subjective aspects of the client's experience and the therapeutic relationship, but this actually carries a much deeper message:

The use of touch has a long history in the field of body psychotherapy, and serves as a cornerstone for many of the forms of work that are practiced today. It is a powerful intervention with the potential to heal many of the difficulties for which people seek psychological help. However, as revealed by years of cultural, theoretical and ethical controversy surrounding its use, the use of touch is relationally and ethically complex and requires skillful assessment and application. This complexity results from the fact that touch is a physical and relational experience that is generally imbued with layers of cultural and psychological meaning. The meanings invoked by touch are often unconscious or non-verbal, and they manifest somatically and/or relationally before the client is able to articulate anything about them. Boundary issues, transference, and countertransference are the most common examples of this type of response; un-addressed, these issues can wreck havoc in the therapeutic relationship and ultimately damage the client.²

We just don't have proper professional boundaries with respect to touch. This is regrettable and quite difficult to state, but I hope that the following dialogue will go some way to establishing this as a reality. The opening introductory words of the book "Touch in Psychotherapy" edited by Edward Smith et al.,³ are: "Shrouded for many in a cloak of fear, rumor, and misinformation, touch is perhaps the most controversial topic in psychotherapy today."

Smith is coming from the professional position that many therapists are afraid to touch because of fear of being misunderstood and being vulnerable to legal or ethical charges. These fears are very real, particularly in the USA. However my present concerns are a little different.

My concerns, especially as the current President of EABP, are that we do not have sufficiently clear boundaries about this topic in general Europe and within our profession of Body-Psychotherapy, and for proper therapeutic touch, and this

² Phillips: p. 63-4

³ Smith et al.

can create a very different set of problems, and a lot of confusion. We do have a number of fairly vague statements in certain ethical codes and I will discuss these shortly.

But I am also aware that, in writing this article, I am sure that I will step over, or imply, that it is not legitimate to cross what some people would consider to be a “proper” boundary in respect of certain types of touch or bodywork. I don’t apologise for this, but I do ask you to write in and tell me, so that we can enter into a debate and dialogue about these issues. Maybe my boundary was an inadvertent one and I need your clarification and precision. I may also be making some other assumptions, directly or implicitly, deliberately or inadvertently, and again, if you disagree with these, I would encourage you to write in. I can foresee already other articles, hopefully leading to a more open debate about some of these issues, and I would welcome this very much. The opening two issues of the USABP Journal started something of this debate and I refer extensively to one of these articles, the one by Kerstin White, to continue the dialogue she started. Maybe we might also create a discussion forum (‘or chat room’) on the EABP ⁴ and USABP ⁵ websites as another way of moving this dialogue further along. But the impetus for this and any further contributions need to come from you, the practitioners and the people who are touched, the clients.

Overview of Clinical and Ethical Considerations:

Various summaries have been drawn up about the wide number of issues that are involved in therapeutic touch. Jaffy, lists some of these.⁶ They are wider than might be first imagined:

- *Boundaries and Intimacy* – Touching is an intimate act and, if the client (or therapist) has poor boundaries or a poorly developed (or over-exaggerated) sense of self, then these boundaries can easily be crossed and transference and counter-transference issues then come into play. Intimacy may, however, be what is needed therapeutically and the client may benefit from the occasional physical contact which reinforces and enhances the therapeutic moments of intimacy.
- *Client Individuality* - Many clients and some therapists carry inherent contraindications about touch – male/female gender dynamics in cases involving childhood sexual abuse or rape are just two examples. There are no clear general guidelines, except those often drawn up through fear. Each client is uniquely individual and needs to be seen in this respect, with respect to touch, and with respect to touching (if appropriate) with respect.
- *Variability of Meaning* – The same kind of touch will be interpreted differently, by different clients; in different ways; depending on circumstances; because of different cultural backgrounds; different genders; different personal histories; different ‘vibes’ coming from the therapist; and the different qualities, lengths, and contexts of the different therapeutic relationships. It is – in my view – the duty of the therapist not to reinforce or reenact any negative aspects of the client’s history with regards to touch and only to use touch therapeutically and appropriately for that client, in that moment, and for that intent.

⁴ EABP – European Association for Body-Psychotherapy – www.eabp.org

⁵ USABP – United States Association for Body psychotherapy – www.usabp.org

⁶ Phillips, Jaffy: *Somatic tracking and the ethical use of touch*: USABP Journal, 1, 2, 2002: p.64

- *Ethical Protection of the Client* – Touch, as well as any other therapeutic intervention, needs the active and informed consent of the client. This should go without saying: but does a client say “Yes” when they are afraid to say “No”? As mentioned, with that particular client, there may be contraindications as regards touch, or touch may be a means to a different psychic space with a client where touch then becomes totally inappropriate. Touch and ethics need to be linked more closely, and one good moment-to-moment maxim might be “How can I justify this use of touch now to a supervisor or ethical committee?”
- *Misappropriation of Touch* - Touch can be misinterpreted as sexual contact; or touch can be misappropriated as sexual contact; or touch can be used as the gratification of other needs (like intimacy, security, contact, etc.) from either client or therapist. Since touch is so basic and fundamental a human need, it is relatively easy to sublimate other needs into this one. Again, awareness is a key issue and a transparency of method, with the client and with a supervisor, can usually overcome or avoid this.
- *Self-protection* – Given the negative cultural and professional norms about touch, it is easy to assume that touch can be negative or invasive. It is also easy to ignore these issues by “developing a therapeutic method” that involves touch. Many complementary therapies seem to use touch almost indiscriminately because they are “outside the norm” and not so open to such rigorous self-examination or such a high level of professional scrutiny. This scrutiny can prevent or bias one against the use of appropriate therapeutic touch.
- Additionally there are considerable power differentials in therapy between therapist and client, practitioner and patient, someone standing over someone lying down, between genders, and also between the toucher and the touched. So please, let us proceed with caution!

Ethical Codes:

In discussing ethics, and in particular the ethics of touch, we need to be clear that there are some common linguistic distinctions: *morals* refer to that which is considered right or wrong and sometimes contain an element of judgment; *ethics* are a code of morals or behaviour for a particular group and indicate what should be done or where transgressions can occur; and *values* reflect various individuals’ different rankings of what is good or desirable and preferred. The rationale for having an ethical code indicates that unethical practice can and does occur and is an attempt to clarify what is desired and what is not. Ideally the ethical code needs to be consensual, rather than imposed; in EABP (and most other professional associations) the ethical code has been voted on, can be changed over time, and amendments need to be accepted at a General Assembly.

Several of the functions of ethical codes are: **(i)** to bestow public acceptance and prestige upon the profession or activity; **(ii)** to provide consensual or imposed guidelines on complex issues; **(iii)** to define boundaries and responsibilities, thus **(iv)** supposedly also providing protection for all parties; **(v)** to declare the autonomy, integrity and self-regulation of the profession or organization; **(vi)** for evaluation purposes, especially connected to training & supervision; and **(vii)** for normative professional development.⁷ One could also add: **(viii)** to give those

⁷ After Austin et al: *Confronting malpractice: legal & ethical dilemmas in psychotherapy*: (Sage)

defined as or feeling abused, some objective measurement and possible means of redress. We shall touch on the effectiveness of these a little later.

When we consider proper or definite boundaries to ethical touch, we do not currently have, certainly in the EABP Code of Ethics, any definitive or absolute statements like: *"It is totally inappropriate to touch a client's genital area in all forms of body-therapy or Body-Psychotherapy."* Yet statements like this appear in the ethical codes of other organizations. Perhaps these other professions' codes are a little absolutist, but maybe this is also a failing of our own ethical code, or an indication of something deeper within our particular branch of the profession. What we currently do have (in a slightly abbreviated form) is the following:

Extracts from EABP Code of Ethics:

Respect principle: *The Body-Psychotherapist respects the client's boundaries; physical, personal, spiritual, religious and political.*

Power principle: *The Body-Psychotherapist uses his / her position as a figure of power for the client to further the client's growth and autonomy. He / she does not use it for personal enhancement.*

Sexuality principle: *The Body-Psychotherapist is centred and bounded in his / her own sexuality and uses this to aid the client in his / her psycho-sexual growth. He / she does not use sexual feelings for personal empowerment or self-gratification.*

Congruence of relationships principle: *The Body-Psychotherapist is attentive to other relationships that he / she may directly or indirectly have with the client which influence or interfere with the therapeutic relationship. He / she avoids or clarifies them.*

These do not give us, or anyone, the clear and unambiguous guidelines that we might suppose we need when we are dealing with the contentious topic of touch. Whilst the client's needs are (supposedly) respected by these principles, these statements are, in my view, for this topic, much too general. These statements are actually quite inadequate as regards this topic, which is surprising given the importance of touch in our professional work. They do not help define ethical touch and there are very many questions to be asked and pragmatic decisions to be taken, and a huge amount of work to be done before anyone knows what the *"client's boundaries"* with respect to touch really are.

As Co-chair of the Ethics Committee of the EAP,⁸ I was responsible for drafting their Statement of Ethical Principles a couple years ago and this is designed to cover all types of psychotherapy, across all countries of Europe, (but not specifically any types of Body-Psychotherapy or Body Therapy which is why perhaps the word 'touch' is not actually mentioned anywhere). It was incidentally adapted from the American Psychology Association's (APA) 1992 Code of Ethics. Anyway we now have the following: - Principle 3d is perhaps the most relevant.

PRINCIPLE 3: MORAL & LEGAL STANDARDS

General Principle: *Psychotherapists' moral and ethical standards of behaviour are a personal matter to the same degree as they are for any other citizen, except where these may compromise the fulfillment of their*

1990 outlined in Russel, J.: *Out of Bounds* (Sage) 1993: p.92

⁸ EAP – European Association for Psychotherapy – www.europsych.org

professional responsibilities or reduce the public trust in psychotherapy & psychotherapists. Regarding their own personal behaviour, psychotherapists are sensitive to prevailing community standards and to the possible impact that conformity to or deviation from these standards may have upon the quality of their performance as psychotherapists. Psychotherapists are also aware of the possible impact of their public behaviour upon the ability of colleagues to perform their professional duties.

Principle 3.a: *As professionals, psychotherapists act in accord with the principles of EAP and their National Awarding Organisation's (NAO) and their institute or association's standards and guidelines related to practice. Psychotherapists also adhere to relevant governmental laws and regulations. When European, national, provincial, organisational, or institutional laws, regulations, or practices are in conflict with EAP, the NAO, or their institution or association's standards and guidelines, psychotherapists make known their commitment to EAP, their NAO & their institute or association's standards and guidelines and, wherever possible, work toward a resolution of the conflict. As professionals, they are concerned with the development of such legal and quasi-legal regulations that best serve the public interest, and they work toward changing existing regulations that are not beneficial to the public interest.*

Principle 3.b: *As employees or employers, psychotherapists do not engage in or condone any practices that are inhumane or that result in illegal or unjustifiable actions. Such practices include, but are not limited to, those based on considerations of race, handicap, age, gender, sexual preference, religion, or national origin in practice, in hiring, promotion, or training.*

Principle 3.c: *In their professional roles, psychotherapists avoid any action that will violate or diminish the human, legal and civil rights of clients or others who may be affected.*

Principle 3.d: *As practitioners, teachers, trainers and researchers, psychotherapists are aware of the fact that their personal values may affect their communication, the use of techniques, selection and presentation of views or materials and the nature or implementation of research. When dealing with topics that may give offence, they recognise and respect the diverse attitudes and individual sensitivities that clients, students, trainees or subjects may have towards such matters.*

Again, these sorts of general statements have been fine and have served us fairly well as professional psychotherapists for many years, and they are largely in accordance with many other professional ethical codes and rules. It is sometimes a mistake in any ethical code to get too precise, as then an errant therapist might say, "Well, you said I couldn't do that, but I was doing this."

Ethical codes – even in counselling & psychotherapy – vary widely and sometimes even contradict each other: especially in areas of confidentiality, or of law, but also often in application to professional practice even if not in actual codification. They also tend to concentrate much too much on “sexuality” rather than becoming specific about actual touch. Touch, of course, extends far beyond the range of ‘sexuality’, but therapist’s physical contact with clients can be sexualised, or seen as sexualised, and if this happens frequently it may be as much

due to the wider therapeutic relationship and differential power issues within that relationship, and the touch is just a channel for this power differential. In this case you might also find differentials and unclarity about fees, timing of appointments, extent of therapy, etc.

However in these ethical codes we are also putting the responsibility very heavily, and quite deliberately, onto the individual therapist; requiring *them* to act properly and appropriately at all times, and in accordance with *their* surrounding social & professional mores. And here it is, I think, where we might be making a subtle mistake.

The accepted social conventions about touch vary considerably across different countries, cultures, professions, interest groups and social classes. As one example, one study showed that in Europe, lovers in cafés touch each other more often than lovers in cafés touch each other in Britain and much more often than in America. The social mores about nudity in (say) middle-class mid-Western America vary from those in (say) Sweden, and again these are different from the conventions in (say) working-class Scotland, or in Switzerland, or with rural villages in Croatia? Of course they vary widely. And so it is with touch, as well. Yet do we expect psychotherapists to act the same across the whole of Europe and America?

Whilst we may wish professional therapists to act within the generally accepted conventions of the society in which they operate, but, especially within Europe with the emerging distinct profession of psychotherapy, recently we have also been motivated by the desire that (professionally and politically) we do want to set some sort of standard of ethical standards across all European countries and cultures so that we can have a clear professional stance on all of these issues as well. However, since the cultures in Europe are so widely diversified and the general climate in Europe is much less paranoid about professional touch, when we drafted the EAP Statement of Ethical Principles, we decided, rightly or wrongly, not to include a separate section specifically on touch ⁹.

In the USA, in many states, psychotherapy is effectively another professional training (at the vocational level) on top of the mandatory four to seven years training in psychology (Masters degree + Ph.D.), though nominally this latter training is sufficient to qualify one for the APA (American Psychological Association). However to get licensure as a psychologist in a particular state, it can require additionally many 100s of hours of supervised practice (in California, 3000 hours), on top of (or sometimes including) what is already required to qualify as a clinical psychologist. In some other US states, there are little or no regulations.

Incidentally, there are currently three or four Masters or Doctorate programs training people in Body-Psychotherapy (or Somatic Psychology) running in the USA. (see USABP website: www.usabp.org) and we would hope that some contributions to the discussions about his topic would come from there.

It also seems that the APA is fairly limited with regards to its mentions of touch in its Code of Ethics. *Psychologists do not engage in sexual intimacies with current patients or clients*; (4.05). *Therapy with former sexual partners*; (4.06) and *Sexual intimacies with former therapy patients*; (4.07) are also discussed - but not mandated against completely.

Significantly and very interestingly, there is, in the current draft USABP Code of Ethics ¹⁰, a new section that has recently been written about “Touch”. As is

⁹ EAP AGM; Dublin 2000, Moscow 2001, Vienna 2002 when it was finally accepted.

¹⁰ Draft October 2001, available from: United States Association for Body Psychotherapy, 7831

usual and fairly obvious in any Code of Ethics, it **(a)** tries to define what one should not be doing, however it **(b)** also uses the proactive speech of the American Psychological Association (APA), which puts forward the “highest ideal” – i.e. *the Body-Psychotherapist does ‘this’ and ‘that’, rather than “the Body-Psychotherapist does not do ‘this’ and ‘that’”, or “should not do ‘this’ and ‘that.’”* And **(c)** it tries to be really positive and affirmative about professional psychotherapeutic touch.

The situation in the USA as regards professional touch, as mentioned and as we shall see, is becoming increasingly paranoid and ridiculous. There is almost a taboo about professional touch. The levels of abuse by professionals; the counter-swing of the ‘religious right’; the political correctness of the 1980’s and 90’s; and the extremely litigious culture have all contributed to such an escalation of fear about professional practice that professional insurance companies are making specific requirements and dictating the climate and some states now often require an additional “license to touch”. Yet none of the main USA professional bodies specifically mention touch in their ethical codes. John May, in his excellent booklet¹¹, identifies that the ACA, APA, NASW and AAMFT do not specifically address the issue of touch in their codes of ethics, though some contain more general ethics that could be applied¹² and nearly all such professional codes contain clauses about sexual contact, which is rarely defined.¹³

So it has been left up to the USABP to state something definitive, and to offer us some detailed guidelines on the use of touch techniques. This is what the (draft) USABP Code of Ethics says:

VIII. ETHICS OF TOUCH *The use of touch has a legitimate and valuable role as a body-oriented mode of intervention when used skillfully and with clear boundaries, sensitive application and good clinical judgement. Because use of touch may make clients especially vulnerable, body oriented therapists pay particular attention to the potential for dependent, infantile or erotic transference and seek healthy containment rather than therapeutically inappropriate accentuation of these states. Genital or other sexual touching by a therapist or client is always inappropriate.*

1. *Body psychotherapists evaluate the appropriateness of the use of touch for each client. They consider a number of factors such as the capacity of the client for genuine informed consent; the client's developmental capacity and diagnosis; the transference potential of the client's personal history in relation to touch; the client's ability to usefully integrate touch experiences; and the interaction of the practitioner's particular style of touch work with the client. They record their evaluations and consultation in the client's record.*

2. *Body psychotherapists obtain informed consent prior to using touch-related techniques in the therapeutic relationship. They make every*

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¹¹ May, John; *Explorations in Ethics for Body Psychotherapists* (April, 2002) private publication available from John May, 222 W Argonne Dr., St Louis, MO63122, USA mayway@earthlink.net

¹² Ibid: p.117-119

¹³ However, the MCPC (Missouri) Code of Ethics: § 4 CSR 95-3.020(6) defines (and forbids) “sexual intimacies” which include the “touching of the other person’s legs, stomach, chest, breasts, genitals, or buttocks.” Could be a problem for Body-Psychotherapists there !

attempt to ensure that consent for the use of touch is genuine and that the client adequately understands the nature and purposes of its use. As in all informed consent, written documentation of the consent is strongly recommended.

3. *Body psychotherapists recognize that the client's conscious verbal and even written consent for touch, while apparently genuine, may not accurately reflect objections or problems with touch of which the client is currently unaware. Knowing this, body psychotherapists strive to be sensitive to the client's spoken and unspoken cues regarding touch, taking into account the particular client's capacity for authentic and full consent.*

4. *Body psychotherapists continue to monitor for ongoing informed consent to ensure the continued appropriateness of touch-based interventions. They maintain periodic written records of on-going consent and consultation regarding any questions they or a client may have.*

5. *Body psychotherapists recognize and respect the right of the client to refuse or terminate any touch on the part of the therapist at any point, and they inform the client of this right.*

6. *Body psychotherapists recognize that, as with all aspects of the therapy, touch is only used when it can be reasonably be predicted and/or determined to benefit the client. Touch may never be utilized to gratify the personal needs of the therapist, nor because it is seen as required by the therapist's theoretical viewpoint in disregard of the client's needs or wishes.*

7. *The application of touch techniques requires a high degree of internal clarity and integration on the part of the therapist. Body psychotherapists prepare themselves for the use of therapeutic touch through thorough training and supervision in the use of touch, receiving therapy that includes touch, and appropriate supervision or consultation should any issues arise in the course of treatment.*

8. *Body psychotherapists do not engage in genital or other sexual touching nor do they knowingly use touch to sexually stimulate a client. Therapists are responsible to maintain clear sexual boundaries in terms of their own behavior and to set limits on the client's behavior towards them that prohibits any sexual touching. Information about the therapeutic value of clear sexual boundaries in the use of touch is conveyed to the client prior to and during the use of touch in a manner that is not shaming or derogatory.*

It is a brave start to a very difficult issue in a contentious environment and the USABP should be commended. Hopefully the APA will take notice and incorporate something more helpful in their Ethical Codes. We might decide in Europe, either within EABP, or within EAP to do something similar, but this is in part up to you.

A lot more work and research is also needed to overcome negative reactions to touch and some of the professional taboos: that started with Freud; that fairly fundamentalist (Puritan) attitudes and rigid social mores have fostered; and that sexual misconduct by therapists have perpetuated. In a very good book on Touch, Smith writes:

Our ethics evolve. Societal consciousness changes: the position of psychotherapy in society changes; and research informs us of false beliefs

*that have been translated into ethical pronouncements.*¹⁴

However this unfortunately is not the end of the story as there are several other complex issues involved. Smith is writing about a fairly undifferentiated culture in the USA, and the situation in Europe is very different and much more diverse. Over and above this, the least of these issues is how any ethical codes that might exist about touch, relevant, inclusive, or not, are to be actually applied in practice, and what is the effect of so doing. This is where we hit a serious problem.

Ethical Procedure:

Most ethical committees are elected from amongst the membership of the professional association, and their term of office is usually limited. There is little general experience in dealing with ethical cases and often the protocols, set down by the association, are found to be inadequate in certain difficult or complex cases. The 'accused' is sometimes someone quite prominent in the association and, because of this prominence, the association has much more difficulty in handling the ethical case than if it were about a member whom nobody really knows. This latter case can also provide it's own difficulties, because nobody knows the person 'accused' of unethical conduct. In some cases, the 'accused' can even manipulate the protocols to arrive at a result with which most people involved feel unsatisfied or incomplete.

Further into the case itself, what often needs to happen is to discover whether this is a legitimate ethical case or not. It may just be a disagreement between the practitioner and the client, or another colleague, that hasn't been properly resolved and some negotiating work by the ethical committee can bring about a reasonably satisfactory conclusion. If a case has to be "heard", then there are further protocol difficulties often about the reliability of "evidence" and "burden of proof." People often refer to the criminal court guidelines ("beyond all shadow of doubt"), which are totally inappropriate, even though someone's livelihood or reputation may be affected. These and similar dilemmas indicated levels of perspicacity and skill that usually take some considerable time to acquire. Often the association's ethical committee members are on a very steep learning curve, only to be made redundant when they have achieved such a level, or to be exhausted by the complexities that arise so that they leave voluntarily and sometimes precipitately.

When the whole issue of whether touch (itself not clearly defined) is included in this maelstrom, we have a situation that is often incredibly difficult and costly, financially & emotionally, to resolve. At this moment, there is little point in exploring these issues much further until we have reached a greater degree of clarity on the central issues of touch: what is it?; why touch?; when can it happen?; when not?; who can touch?; who don't you touch?; etc.

This, again, is not a definitive essay, but more of an exploratory or interrogative one. Again, I remind you that I would welcome feedback and I feel that we need further discussions, seminars, and symposia on this topic. I encourage your participation, however small, however negative, however positive.

¹⁴ Smith et al.

What is Touch?

So, given all these differences, I want to err a little on the side of caution, and go a little bit deeper and ask some questions about Touch, like “**What**,” “**Why**,” and “**Where**,” then “**When**,” and then “**How**”. These questions (in my view and in perhaps a somewhat Socratic method) can help us to form more legitimate questions and concepts about the proper boundaries to touch in any form of psychotherapy, Body-Psychotherapy, and in the many different body therapies.

As regards **what** we mean by touch, Smith¹⁵ proposes “a taxonomy of touch” in psychotherapy, which might initially be useful. Kerstin White nicely summarizes this in her fairly seminal article on the ethics of touch.

“He describes several kinds of touch considered acceptable or unacceptable depending on the circumstances. First, he mentions “inadvertent touch” like bumping into or brushing up against a person while moving about. Second, he refers to touch as a “conversational marker” designed to get someone’s attention by touching a hand, knee, or shoulder. The third type of touch in this taxonomy is “socially stereotyped touch,” a highly ritualized touch, such as a handshake or embrace when greeting or saying good-bye to a client. A fourth type of touch, which is particularly valuable here, is “touch as an expression of the therapeutic relationship.” This indicates a comforting gesture like putting an arm around a client’s shoulder while he or she is grieving. The therapist might also act as a parental figure in regressive work by holding, rocking or embracing the client like a child. In the fifth category, Smith describes “touch as a technique,” which is the clearly identified touch in various body-oriented therapies, designed for therapeutic purposes. In addition to these types of touch, Smith adds hostile and aggressive touch and sexual touch as being absolutely taboo.”¹⁶

This is at least a start, but maybe someone else can do better. It is obviously the fourth and fifth categories that are most significant to this particular essay. But, do we just accept these as stated? There have been therapists who have been slated (accused and verbally condemned) for being involved with the fourth kind of touch, and there are also therapists who would think of themselves as incredibly cold and rigid if they did not hug or embrace a client (especially if they were grieving) as an indication of an ‘intimate,’ on-going, long-term relationship. Objectively, it seems as if many therapists in on-going relationships may or may not touch and therefore this fourth category might need some work on it to expand it and define it more clearly. Over to you, my friends!

As regards the fifth relationship, this is (for me) the one most open to abuse. The phrase “*designed for therapeutic purposes*” hides a multitude of potential sins and abuses. I have been witness to people abusing forms of rolfing or ‘deep draining’ or ‘postural restructuring’ or whatever-you-want-to-call-it and where the client has ended up essentially psychotic as their whole personality structure and somatic identity has been systematically broken down - “therapeutically.” I regard this as unethical, short sighted and relatively incompetent: please write in and comment.

¹⁵ Smith et al.

¹⁶ White: p. 17

I have also been informed of situations where the ‘therapist’ has stimulated the client genitally, and on a regular basis, so as (in some way) to re-pattern that person “embryologically”. The fact that it has been (mostly) male therapists who have (almost exclusively) worked so on female clients may or may not be significant: again, please write in your comments and add to the debate.

This latter case was also (often) – as mentioned – male therapist to female client; both naked; also trainer to therapist; late at night; in a “research” program; with no research protocols; and was to be kept “secret”. Comments, please!

To be fair, I also know of body therapies and somatic therapists, who have some (relatively) esoteric/somatic technique and who practice it therapeutically and very ethically, as far as I am aware. There is no proper objective research and there is no evidential follow-up. But if prominent people (like (perhaps) John Cleese or Kiri Te Kanawa) wish to spend their money in this particular way, and feel that it does them considerable benefit, all the more power to their elbow (or more power to the elbow of their therapist) and I am sure that everyone is happy.

Some of these sessions have also taken place late at night and are kept relatively covert, given the public personas involved. I am also sure that there are hundreds of thousands of people in similar circumstances. I am also sure that one or two therapists in such somatic techniques might manipulate and abuse the ‘power’ they have over their clients and the ‘power’ that such techniques give to them. And this is exactly what can give “Touch” is! And so to the next question.

When to Touch and When Not to Touch:

So far, I have just touched (sic) upon various ethical codes, which might or might not indicate what we should or should not be doing in general terms, but don’t necessarily help us in any specifically defined terms, specifically with regards to touch. And also some definitions of touch.

If we consult Edward Smith’s book again, we find a useful section on “Deciding When and When Not to Touch”¹⁷ and one of his primary concerns in this area is whether we have a sound theoretical framework for touching or not.

I would like to emphasise the word ‘sound’ here as, in his terms, in the surrounding professional culture, and reluctantly in my own belief systems, this theoretical framework must be data-driven and empirically based in proper research criteria. There are wonderful, marvelous and extraordinary claims for the benefits of touch and for certain touch-based techniques, and most of them have no proper, nor ‘sound’, nor even scientific basis at all except in contemporary myth, isolated examples, and some belief systems. It is often left up to the “professional discretion” of the therapist. So there is a huge controversy on exactly this point.

Before we get further into this topic, let me reset the scales a little (in case you think I am against touch) and I would like to quote a few examples of when not to touch may, or may not, be appropriate:

1. White quotes one therapist in Malkovich’s study who said, “*Touch is therapeutically important. It is the most effective means with some clients. I think it is unethical in these cases **not** to touch the client.*”¹⁸
2. Fosshage presents a case where an analyst refused to hold a client’s hand when she asked him to do so. This was where the client was reliving a traumatic experience of being on a hospital operating table as a child and feeling a sense

¹⁷ White: pp 42-48

¹⁸ White: p. 28

of loss and abandonment when her mother fainted and their hands parted. He feels that this kind of therapeutic abstinence might lead to replicating the traumatic event, but with the therapist who is fearful of using touch in case it might contaminate the transference.¹⁹

3. Some psychotherapists say one should never touch: and I remember well a very interesting talk on “Unconscious Hope” given by Patrick Casement at an AHPP²⁰ conference back in 1987²¹ where he gave an excellent example on the psychoanalytical benefits of *not* touching a particular client, giving her instead the space and time to experience her lack of holding and needs for physical contact. Casement adopted the traditional psychoanalytical view, dating back to the late Freudian tradition, of not touching, though Freud did touch and massage his patients early on in his therapeutic career. However, interestingly in the published version of the case history, Casement illustrates an example of holding the (child) client’s wrists: *I had to control her with my holding of her until she was ready to hold herself.*²²

It is clear that psychoanalysis has remained very split about touch. Ferenczi touched; Reich touched; others didn’t. What is not so clear is where the rest of us stand: pro touch or against it, or somewhere in between and with certain “*caveats*”.

In Europe, there is a much longer tradition of legitimate body-work and body-oriented psychotherapy. Depending on the very different theoretical approaches, touch can be based on positions ranging from pure theory; through anecdotal theory; to theory guided by clinical experience; to theory allied to careful research; to touch based on “atheoretical” techniques (“those that have support from research or clinical experience, but are not understood through a larger theoretical framework”) and, in my views and from my experience, only two or three of those positions are in any way legitimate for professional practice.

My concerns about the lack of clarity in this respect are not ungrounded or paranoid: they are unfortunately based on having to deal with very difficult professional & ethical situations around psychotherapeutic touch and abuse of these parameters which is still going on. This is from both psychotherapists who don’t normally touch, and from psychotherapists who do touch, but also touch inappropriately.

In being so concerned, I am not advocating that we change towards anything closer to the psychoanalytical position (“Don’t touch: or only with great caution and restriction”), nor am I advocating something closer to the psychodynamic position (“Physical touch ... is/may be appropriate and useful under very limited circumstances”) as both these positions are much too limited, too restrictive, and are not based on any real research that I can find, but seem to be more a mixture of pragmatism, bias and fear.

Holroyd and Brodsky²³ examined whether the non-sexual touching of

¹⁹ Fosshage, J.L. *The meaning of touch in psychoanalysis: A time for reassessment*. Psychoanalytic Inquiry, 20, 1. p.13

²⁰ Association of Humanistic Psychology Practitioners; a UK-based organization and member of the United Kingdom Council for Psychotherapy (UKCP).

²¹ Later published in Casement, P. *Further Learning from the Patient* (Routledge) 1990: Cpt 7

²² Ibid: p. 114

²³ Holroyd, J.C. & Brodsky, A.M. (1980) Does touching patients lead to sexual intercourse?

patients is actually associated with therapist-client sexual involvement and found no indications that physical contact with patients made sexual contact any more likely. Pope, in *Ethics in Psychotherapy & Counseling* states in a section on 'Physical Contact with Clients' significantly in a chapter on 'Sexual Relationships with Clients':

*"If the therapist is personally comfortable engaging in physical contact with a patient, maintains a theoretical orientation for which the therapist-client contact is not antithetical, and has competence (education, training, and supervised experience) in the use of touch, then the decision of whether or not to make physical contact with a particular client must be based on a careful evaluation of the clinical needs of the client at that moment. When solidly based upon clinical needs and a clinical rationale, touch can be exceptionally caring, comforting, reassuring, or healing."*²⁴

Please note the careful qualifications! The position on "Touch" in more open and humanistic psychotherapies is inclined much more towards something like a "Yes! Touch. Of course! Why not?" position, which, whilst I might have a lot of personal sympathy for this, and it can easily and irrefutably be demonstrated that we need (and crave) much more touch in our everyday lives than we usually get,²⁵ it can also lead into horrendous professional problems if professional touch becomes totally unrestricted and unlicensed.

Why touch?

As regards the "**Why**" of touch, Nick Totton, in his recently published book on Body Psychotherapy²⁶ lists five 'levels' of touch, all of which he feels are legitimate and for which he explores the reasons, in some depth. These are: **(i)** touch as comfort; **(ii)** touch to explore contact; **(iii)** touch as amplification (of attention); **(iv)** touch as provocation (to facilitate somatic discharge); and **(v)** touch as a skilled form of therapeutic intervention. He also looks at some of the issues that are concerned with regression, re-traumatization, false memory, transference & counter-transference in body psychotherapy, and techniques to work with embodied transference, as well as language as a bodily function. And for these reasons, this is one book that I could recommend to people not fully cognoscent with the professional aspects of Body Psychotherapy.

John May looks at *Types of Touch, The Meaning of Touch, The Client's Experience of Touch, Concerns about Touch, and The Benefits of Touch*: - all within about 6 pages. He reports from two very important studies, one by Geib (1998)²⁷ which indicates that people in the study reported that touch had three types of positive meaning: **(i)** it could prevent a client becoming lost in pain by providing a link to external reality; **(ii)** it could communicate acceptance, resulting in greater self-esteem; and **(iii)** it could allow a client to experience new modes of relating.

Professional Psychology, 11, 807-811

²⁴ Pope: p. 170

²⁵ Studies on maternal deprivation & also the classic studies by Harlow & Harlow, 1962.

²⁶ Totten, Nick: *Body Psychotherapy: An introduction* (Open University Press) 2003: p.118-123

²⁷ Geib, P.: *The experience of nonerotic physical contact in traditional psychotherapy*. In Smith et al. and quoted in May, John: p.116-7

Another summarized report, this time by Horton (1998)²⁸ strongly supported the efficacy of touch and identified two primary benefits: **(a)** touch could create a feeling of a bond, a closeness, or a sense that the therapist really cared, thereby facilitating increased trust and openness between therapist and client; and **(b)** (appropriate) touch also communicated acceptance by the therapist and enhanced the client's self-esteem: both very important benefits in psychotherapy.

Hunter & Struve²⁹ identify nine reasons for using touch; **(i)** to reorient a client; **(ii)** to emphasize a point; **(iii)** to access memories and emotions; **(iv)** to communicate empathy; **(v)** to provide safety or calm a client; **(vi)** to assist in enhancing ego strength; **(vii)** to change the level of intimacy; **(viii)** as an adjunct to hypnosis; and **(ix)** to assist in working with past traumatic experience.

Fagan lists seven reasons (as a partial list) for a therapist to use touch in psychotherapy. These include: **(1)** to prevent injury to self or the patient, or to prevent destruction of property; **(2)** to solidify the therapeutic relationship; **(3)** to help overcome a patient's specific deficits in experiencing emotion or in communicating with touch; **(4)** to evoke or intensify emotional states, such as to facilitate grieving or anger; **(5)** to increase the patient's body awareness, such as awareness of tension; **(6)** to evoke past emotional states and/or trauma; **(7)** to facilitate re-parenting.³⁰

These are some of the issues around the “**Why**” of touch. But the issues around touch go much deeper than these, or trying to overcome any forms of socio-pathology or sociological inhibitions against touch; they go to the core of our biology as human animals. We actually need touch; we crave touch; and not just to be touched, we may need to touch; and we can be changed and embittered by lack of touch. Touch is almost as fundamental to us as water or food, shelter or safety. Without touch we can wither and die.³¹ As newborns, we learn primarily by touch, as well as by limited other senses. If things go “wrong” for us with respect to touch at this stage, it can affect us for the rest of our lives, and it forms a very significant part of our human interaction and socialization.

But how do we address and change such preverbal “knowledge”? Surely not by talking from our cortex to our patient's. It is done by repeatedly establishing exquisite contact with the distrustful and scared infant within the adult patient. We persist until the fragile inner baby begins to feel safe in the therapeutic setting. Only then do patients drop their socially acceptable ways of being and behaving. The affects and physical reactions of early preverbal experiences then bubble up and come to the surface.³²

If we, as therapists, are working with people, with these sick and distressed

²⁸ Horton, J. (1998) *Further research on the patient's experience of touch in psychotherapy*. In Smith, etc. and also quoted in May, John: p.117

²⁹ Hunter, M. & Struve, J. (1998) *The ethical use of touch in psychotherapy*. (Thousand Oaks, CA. Sage) Quoted in May, John: p.117

³⁰ Fagan, J. *Thought on using touch in psychotherapy*. In Smith et al.

³¹ Spitz, R.A. *A genetic field theory of ego formation*. (International Universities Press) 1957. Also with recent studies in Romanian orphanages.

³² Bar-Levav, Reuven: *A rationale for physical touching in psychotherapy*. In Smith et al.

human animals and trying to help them and heal them, then not to use touch, is to render ourselves (perhaps) mostly impotent or severely handicapped. Touch is one of the tools of self-regulation; touch is used to cope with life's stresses. We may also need to make contact with them, to demonstrate our empathy, to touch their pain, and to touch them. Think about it!

Most of the clients that we see as psychotherapists are probably suffering from handicaps in these areas: they may need 'therapeutic' help with touch. In this context, Hunter & Struve summarize the positive functions of touch: it may also help the therapist to provide real or symbolic contact and nurturance from the client; to facilitate access to, exploration of, and resolution of emotional experiences involved with 'contact'; it can help to provide containment; and it can help restore significant and healthy relationships. Other studies³³ point out the significance of touch in ego development; and in multicultural contexts can transcend language difficulties and help towards effective treatment. Touch is quintessentially fundamental to life.

In a book that I am writing currently about Psychophysiology, I start with a quote from a short story by D.H. Lawrence, where he is considering Jesus' dilemma after the crucifixion and he equates touch with life itself:

Dare I come into touch? For this is further than death. I have dared to let them lay hands on me and put me to death. But dare I come into this tender touch of life? Oh, this is much harder.....

"The Man Who Died" by D.H. Lawrence

So there are many reasons to enter into the "Why" of Touch. However it is not just "good enough" to use touch because you have been taught to use touch: the "Why" of touch and the rationales for touching this person, in this way, for this reason, at this time and at this moment in their process, have to be much more subtle. I invite you to please explore these reasons deeply within yourself and then contact me/us about these if you have new or different ones, or are unsure about the ones that you have been given.

The Meaning of Touch:

I would like to examine further the specific concept of touch and the meaning of touch: the "**Why**" of touch. There are many different aspects to the topic of the "**Why**" of touch, some lists have already been mentioned. McNeely lists a few professional and theoretical reasons³⁴:

1. *Exploration and Amplification. Most instances of enactment, positioning, assisting the patient in moving or feeling a body part, and encouragement to pay attention to some bodily state occurs here.*
2. *Mirroring. This occurs at times when the patient needs the therapist or another patient to join in a bodily experience, such as pushing or pulling against, dancing with or screaming with. Many people have never had their assertiveness mirrored or supported in any way by another. Also such an experience can be valuable in breaking out of*

³³ White: p. 22

³⁴ McNeely: p. 67-68

a pattern of alienation, especially when the alienation is largely archetypal and not part of the neurotic withholding.

- 3. De-arming. Here the therapist intends to actively move against the patient's somatic defense system (armor) through pressure that can range from light touch to deep massage.*

And in each case she gives examples. But these are not exclusive lists: and they are all very wrapped up in psychotherapeutic theory. There are many more reasons to touch, leaving aside the huge number of physiological reasons and very significant developmental reasons to touch (all mentioned and dealt with quite well in Hunter & Struve's book).

Psychotherapy is not the be-all-and-end-all of therapy: there are many legitimate sources of a referral to correct a specific need, and if this referral is done well and consciously, it can be used as an adjunct to psychotherapy, rather than a diminishment. I have often referred patients for massage, even though I am perfectly competent to massage them myself, but I have wanted in these cases to maintain the different, more psychotherapeutic, role of a "helper towards re-empowerment", rather than risk losing that in the direct application of touch. If this argument is taken much further, it could negate the psychotherapist ever touching the client at all, which could be self-defeating, so again, I would like to encourage discussion and feed-back here.

There are certain traditions of touch in psychotherapy, which can help give us an understanding or grounding in the topic, however it is worth stating here that there are considerable transatlantic differences between American and European social & cultural mores (as well as taboos) towards and about touching, which are also reflected in very different professional paradigms and American psychotherapy's basic "no-touch" attitudes can seem bizarre or alienating to Europeans and Europeans' attitudes can seem anarchic or boundary-less to Americans.

In looking at the ethics of touch and the meaning of touch, we are looking from two very different viewpoints that may even be irreconcilable in certain instances. As most of my professional work is in Europe, I tend to swing to the eastern side of this transatlantic argument; which is not to say I think that my friends and colleagues in the USABP have got it wrong: I have quoted their excellent section in their Ethical Code. They are just working in a very different environment. If I was a male doctor in Arabia or India, I might even have to examine any women patients through a hole in a sheet so as not to transgress the cultural taboos.

It was really only in the 1970's that the direct benefits of touch in psychotherapy began to be written about in mainstream American literature by a few courageous practitioners.³⁵ There is still a very significant taboo against psychotherapists touching their clients, especially in the USA, and this is not, repeat not, restricted to psychoanalysts: it is very widespread.

Most of the prevailing trends within the field of psychotherapy are toward the public denouncement of using touch, with a sizable number of clinicians tending to rate the professional environment regarding the use of touch as "unfavorable" or "very unfavorable." Within the prevailing

³⁵ Forer 1969; Perls 1969, Rogers 1970, Polster & Polster 1973, Older 1977

climate, most clinicians have resolved the cultural and professional tensions surrounding the issue of touch by adopting a one-word guideline: *Don't*.³⁶

And this is despite (a growing body of evidence) *“that some forms of touch are not only not harmful when used properly, but are indeed helpful, (and) the attitudes of psychotherapists change as slowly as the attitudes of other people.”* For me this clearly indicates the influence of a pervasive social phobia. However all considerations about ethical touch in therapy and psychotherapy need to be born with this dichotomy of conflicting views about touch in mind, and as we progress towards clarity of professional standards about touch, we need to remember who is talking, from which position, and on which side of whatever cultural division. There is a long way to go to get clarity on this topic. However Body Psychotherapy is still one of the few leading protagonists that are challenging and helping to change some of these cultural taboos, and we therefore need to be very clear about our professional “ground”. It is so easy to get confused with all the other ‘bodies’ out there: a sociological ‘turn to the body’; the ‘consumerist body’; the ‘emotional body’; the ‘libidinal body’; the ‘political body’; etc.³⁷

The impact of such a phobia is to isolate sections of the community: in the same way that a rigid class system develops an underclass, an anti-touching society develops a group of people who are not touched. If we expand the concept of not being ‘touched’ by society, then this too is an underclass: and such underclasses are very dangerous. We need to actively promote healthy touch throughout the lives of all our citizens or the health and sanity of our society.

But there is more, as mentioned, as individuals we actively need touch. Lack of touch in animals has been shown to have very profound and negative effects. We, as healers, working with human animals must be aware of touch, of its deficits; encourage touch in our clients; and even be able to provide, if appropriate, restorative touch. People get better, faster, with appropriate touch. Certain pioneers of Body Psychotherapy, such as Gerda Boyesen, Ilana Rubinfeld Charles Kelly, etc., are positive advocates of gentle touch and claim many records of psychotherapeutic insights and powerful healing through direct, gentle, specific touch. In order to deny these claims, one would have to present contrary evidence; and yet, this is not scientific proof, in itself. Research projects that focus on the benefits of touch have been undertaken, and are under way; and many show positive benefits. So, just for the record, I would like to state categorically that direct touch, done by skilled practitioners, in psychotherapy, performed appropriately is usually beneficial.

Our clients are ‘touched’ and they come back, and report well. Often Body Psychotherapists seem to be able to help people heal their presenting issues faster than many other methods in psychotherapy – and there is research that is beginning to demonstrate this. But I do not want to lose sight of the meaning of touch. Working with a powerful, non-verbal tool is effective on many different levels.

From the other end of the spectrum, it has become clear that many convicted sexual offenders also have a notorious misunderstanding of, or blatant disregard for, appropriate boundaries around physical contact and touch. There is an

³⁶ Hunter & Struve: p 67

³⁷ Totton, N.: p. 44

effective treatment program in the USA for adolescent sex offenders³⁸ that allows them to experience supervised massage sessions, six times p.a., in a highly structured setting. The purposes of the program's use of touch are: **(1)** To practice respecting another person's physical boundaries and limits on touch; **(2)** To practice clearly communicating personal limits to another person; **(3)** To facilitate an increase in awareness of emotions and physical sensations; **(4)** To increase the ability to recall past experiences of touch, whether nurturing or abusive; **(5)** To reduce homophobia; **(6)** To learn that physical contact does not have to lead to sexual arousal, and that if arousal takes place, it does not have to lead to sexual activity.

Perhaps we need to be proactive and to instigate such re-educative programs for therapists who are discovered, or reported, to touch inappropriately. Once established these could be voluntary or compulsory if professional membership is to be continued; but these will not happen without a much wider and franker debate, research and awareness about inappropriate touch and the concomitant issues of transgressions. As Hunter & Struve gently proselytize, (which is also one of the themes and points of this article):

“Open and frank discussions are needed within all mental health disciplines to determine how best to use touch, to set standards for its use, to avoid harming clients, to reduce therapists' fear of litigation, and to promote research. Bringing the issue of touch out of the closet is a more responsible way to promote quality and ethics within the healing professions than to continue promoting an environment of silence and censorship about this important issue.”³⁹

Where to touch?

And I would like now to consider the very contentious question of “**Where**” to touch or not to touch. Here I can take a very definite position based on considerable experience, and I will give a little background to this.

In my early psychotherapy training (1979-1983), I was in training at the Gerda Boyesen Centre in London where there was also an extensive and significant component of the training in various forms of psychotherapeutic massage (Biodynamic Massage, Psychoperistaltic Massage, Deep Draining, Bio-Release, etc.). However we also had to train in Swedish Massage and pass a minimal examination (I.T.E.C.) so as to be able legitimately to touch people within the London Borough of Acton & Ealing (so as to fulfill local health authority regulations).

In Germany, despite the new psychotherapy law, it is still necessary to fulfill the ‘Heilpraktiker’ requirements (1-year course as a ‘health practitioner’) before you can legitimately touch someone. In other countries there are also sometimes minimal requirements in order to be able to touch members of the public as a “health professional”. In the USA, in some states, as mentioned, training in massage (a license to touch) is almost a secondary professional training.

Nearly all of these trainings require one, as a practitioner, very specifically, never to touch certain parts of the client's body: in particular the genital areas, the pubic hair areas, nor the anal areas of the body.

³⁸ Personal/Social Awareness Program, Lutherean Social Service, Minneapolis, MA.: Described by Lutz & Willcox, 1994: *Policy on teaching appropriate touch*. (Unpublished training material)

³⁹ Hunter & Struve: p 69

Many forms of massage (legitimate therapeutic physical touch) also state (or imply delicately) that whilst it may be possible to massage certain muscles in certain areas and in certain ways for certain reasons (e.g.: the deep fascia of the pectoralis major, latissimus dorsi, teres major, teres minor, intercostals muscles, coracobrachialis, and the lateral rotators around musculartendinous cuff, etc.) – there should not be any direct contact with, massage, or stimulation of a woman’s breast, areola and nipple in the exact same area. “A rose by any other name!”

Accepted techniques to touch certain particular areas of the body do not necessarily give a license to touch these particular areas: there are very clear boundaries and limitations. One of the main reasons given is that the intention for touching these areas is often negated by the effect. It is extremely difficult, if not impossible, to touch these areas mentioned without there being a stimulation of the client’s sexuality or levels of arousal, due to their highly erogenous nature and multiplicity of nerve endings, which is not the purpose of the professional massage or of the therapeutic contact. It is thus essentially counter-productive. It may also be distressing to the client. Furthermore it takes us, as therapists, into very difficult areas, as transference and counter-transference issues with our clients rise up in clouds of potential confusion, to say nothing of being potentially erotic for ourselves.

Many people are so unaccustomed to touch that almost any form of physical contact can be experienced as erotic. In my early clinical experience above, I was massaging one man’s thigh muscles in a very matter-of-fact orthodox Swedish-style with the rest of his body well covered beneath the sheets, and by his underwear, and I happened to notice that he started to get an erection and then had a spontaneous ejaculation. This embarrassed both of us considerably and totally destroyed any of the relaxation effect that I was technically working for. He also never returned to that particular clinic.

Additionally, there are some specific forms of massage or touch for these special parts of the body: for example, of the breast; but only by a person in a certain, clear and special role, for a certain, clear and specific reason, like a midwife or post-partum attendant massaging the breast to help stimulate milk production in the first stages of maternal breast-feeding. And a specialised medical doctor like a gynaecologist is about the only person who is allowed professionally to touch a woman’s genital area and only for the purpose of a specific (and usually asked for and consented to) examination. Some sex therapists might be able to produce a rationale for some form of therapist-client genital contact, but I am not sure how well any one of these rationales would stand up in an open and honest court.

Now I am very open to correspondence on this topic; but I am also fairly convinced that any genital, public, penile, breast, or anal contact (or touch) would have to be for such clear and very specific, contractual, well-established, and well-researched (and proven) reasons. These reasons are either falling well within the generally acknowledged function of the specified and trained health professional (e.g.: midwife, obstetrician, gynaecologist etc.) or they are for a particular specified purpose, and this purpose needs to be – I say again - very clearly defined, well-researched, openly acknowledged, and previously communicated to the client, and their specific informed consent obtained. Otherwise, as we have seen, it is almost certain that *“Genital or other sexual touching by a therapist or client is always*

*inappropriate.”*⁴⁰

If I am pedantic about this point, it is because this is the area, as we have found, where a lot of the abuse of touch occurs, and where the serial abuser also is usually found to be focusing on. Whilst newspaper photos of certain minor British royalty on holiday might imply erotic touch to the toes, I have not yet heard of a body therapist so inclined. A character in the American TV series *Ally McBeal* might have got his erotic pleasure by touching elderly women's wattles (the loose skin under their chin) but this is probably just a fictional fetish.

Most male serial abusers have had inappropriate contact with their female client's breasts and/or genitals; and the only instance I have come across (read about) of serious female therapist abuse of a male client was with the client being continually regressed and infantilized, and then being encouraged to suck the therapist's breast as part of their "therapy". The client later committed suicide.

Consent, Autonomy and Touch

If we do decide to use touch in therapy, then we should only really do so when: **(i)** touch forms part of the clearly understood therapeutic contract; **(ii)** it is with the full consent of the client; and **(iii)** the client request it and the therapist can agree that it is appropriate. According to Hunter et al. the client also needs to understand the concepts of empowerment and their ability to either refuse or direct the touch according to their needs. This implies that it is crucial for the clinician to discover, by open questioning, the client's values, biases, past experiences, and expectations around the use of touch. If there are overt levels of dependency, then touch is probably contra-indicated.

*“Client autonomy becomes an ethical principle as well as a therapeutic goal. The therapeutic process presupposes that clients are considered autonomous individuals, who should be encouraged to express their preferences freely and to show active involvement in charting their treatment.”*⁴¹

If this does not happen: if this autonomy is not made paramount; then perhaps we are into a form of power politics, therapeutic exploitation, and possibly even forms of sexual abuse.

It is so incredibly difficult to talk about the ethics of touch without sliding into the dynamic of sexual contact between therapist and client. This is the "bogeyman", the 'black hole' of this whole area and probably the main reason why most non-body-oriented psychotherapists actually avoid touch.

As we have seen from the different ethical codes, physical contact is often inserted as a short section within long chapters about sexual contact with clients, and appropriate or ethical touch therefore comes across as almost the exception rather than the rule. Thus the topic of sexual contact contaminates the field of legitimate touch and doesn't allow a proper discussion of ethics of touch unless the subject of unethical sexual contact has been cleared out of the way in some fashion. This therefore is also part of the rationale for this extended essay.

However, if we do not try to differentiate something more specific in this field, we may be condoning unclarity, or even condoning implicitly, by inaction, activities

⁴⁰ USABP Draft Code of Ethics (above)

⁴¹ White: p.25

which may possibly some form of abuse, or obscured personal gratification, and which have been rationalised, justified, or even coerced upon the somewhat gullible and generally uninformed 'client' or 'victim'. There, it is said! Unfortunately these things do happen, and we have to begin to take a professional collective responsibility for them. So, again, we need your input into this debate.

Frequently, what later proves to have been serially abusive touch happens in these particular areas, where the 'sexualised' touch has somehow been rationalised on the grounds of a 'so-called' special research or 'experimental techniques', or whatever. The client has been overpowered, seduced, coerced or misinformed, or their sensibilities or predilections have been 'played upon' both intellectually and emotionally in some way so that the therapist gets to touch inappropriately, both in places and in ways that they shouldn't, and furthermore the lack of informed consent and the abuse of power is often abusive, even though the client may (in part) enjoy the actual experience of the touch and even believe it to be therapeutic. There are also quite seductive components embedded into powerful and charismatic therapeutic relationships and these can be played out on many levels: "You are my 'special' pupil, involved in this 'special' research project, which we have to keep secret"

There may also be actual secondary therapeutic gains. The client may become able to experience their sexuality in a more liberating fashion; they may overcome some of their taboos about touch; they may learn to accept pleasure from touch; etc. but I emphasise the word "secondary" as these gains may also come with a more primary cost: that of the client's disempowerment, or of a distortion in their relationship with their 'therapist'.

Who can Touch

In examining momentarily the "**Who**" of such touch, or more specifically who are the people who can touch, or should not touch, the touchers? More often than not, it is mainly male therapists who not only touch abusively, but also touch in these 'forbidden' areas of their female clients. As mentioned, I only have knowledge of one or two cases where female therapists were involved in this type of serial sexualized touch with their male clients, and one instance where a female therapist was touching female clients "inappropriately", but there may be much more to be discovered in the oblique areas of inappropriate touch.

There is also a self-selecting process about "Who can touch?" White indicates that it has been borne out in several studies that the decision about touch in psychotherapy needs to be guided essentially by the therapist's own sense of comfort about touching.⁴² It is obviously important for the therapist to maintain his or her own integrity and others have argued that physical contact that is not genuine can be perceived by the client as being insincere.⁴³

Apart from this, it is essential that therapists who do touch are those who are properly trained in touch. It is usually considered unethical to do something professionally (touch someone) if you haven't been trained properly to do so and most ethical codes have a section about lack of competence. The trainings that deal fairly comprehensively with this area, tend also to be those that are fairly selective in the type of touch or in the theory and technique behind the touch. The more generalized trainings tend to steer away from this topic.

⁴² Hunter et al, 1998; Fagan, 1998; Fosshage, 2000; Smith, 1985, 1998b.

⁴³ Smith, 1985; Hunter et al, 1998; Kertay et al., 1993.

We have also seen and will see further that the only people who ought to be touching are only the ones who have done sufficient training, supervision and therapy on themselves to ensure (as far as possible) that the touch is truly therapeutic.

The quality and extent of training and supervision in touch lamentably varies considerably and it would be wonderful to have some in-depth symposiums about what sort of training is needed, the extent of supervision and the parameters which might need to be met, and thus who can touch. However it seems that there is also a taboo about talking about touch in psychotherapy, and thus for many it is a touchy (sic) subject.⁴⁴

How to Touch

But we continually need to refer back to the **“How”** of touch. If the hand of the ‘legitimate’ (male) massage practitioner lingers a little too long on the (female) client’s inner thigh (gracilis, adductor magnus, adductor longus, pectineus, etc.), or be working in what might seem to be an overly sensuous fashion, then that massage practitioner may be on the point of abusing their role as a therapist, and also incidentally their professional status and relationship with the client. This is, in practice, a very narrow line: an extra second, a few grams of pressure, the speed of the stroke, or a difference of a centimeter or two. There can be little in the way of hard evidence of “how” a particular touch was inappropriate, except in the experience of the client; and this must always be our yardstick.

Where matters can get difficult is where or when the practitioner, body-therapist or psychotherapist propounds a theory, either internally to him/herself or externally to the client, which tries to “justify” this type of contact or that type of contact in these particular areas, and as it is also often significant that there is rarely any solid proof, or external evidence, or well-established theory & practice for this kind of touch, the arguments get really nebulous. We need, I believe, much more of a solid consensus about touch. So what I want to emphasise is that, without such proof or evidence, there is no real justification for touching in these particular risqué areas (USA proclivities aside, see above), or in such a fashion that raises questions about the professional’s ethics, and so, without that justification, they are abusing the trust of that client in themselves as a professional. They are also making it very difficult for the rest of us, as professional therapists, to continue to touch our clients legitimately and acceptably.

Ed Smith, in the article on *“A Taxonomy and Ethics of Touch”* is very clear about the **“How”** of touch and puts it in this way:

“Whenever the therapist is urged to touch by his or her need for security, for erotic stimulation or fulfillment, or for the feeling of personal power and control over the client, that touch should be eschewed (avoided). To touch for such reasons knowingly is unethical. Furthermore, it is important for the ethical therapist to look deeply and honestly into himself or herself in order to recognize and rectify any inclinations to project these needs onto the client. ... Such touch would, of course, not be in response to the client’s needs, but would be a convoluted attempt on the part of the therapist to meet his or her own need. At times, supervision or further therapy may be

⁴⁴ “Touchy” is an English idiom meaning sensitive or easily upset. This is therefore a pun, which I could not resist.

*called for, so that the therapist can recognize and bring under control any tendencies to project personal needs onto clients.”*⁴⁵

However further difficulties are raised, as much of this presupposes a level of self-awareness in the therapist: – “*to look deeply and honestly into himself or herself in order to rectify....*”. Thus an essential component of any Body-Psychotherapy training, and subsequent supervision, MUST be to try to instill this capacity of self-awareness at a very fundamental level. I suggest that we forget the specialised and many different ‘touching’ skills and all the different esoteric methods of touch, and focus more on the intention of the touch: for it is much more important. I will return to this point in a moment.

Joen Fagan who lists several kinds of touch: ritual, athletic, punishing, nurturing, intimacy-evoking, and sexual.⁴⁶ However she goes on to say: “... *especially as we move to the middle and end of this list, we find that many meanings and needs can be hidden under the obvious ones.*”

So our touch, as professionals, needs to be clear and unconfused. We, as therapists, need to be as clear, unambiguous, and sure as we possibly can be of exactly how, why, and when we touch this client. Only in this way, we can begin to be reasonably sure that any resulting confusion or unclarity lies more with the client and their perhaps long-held confusions or unclarity about touch can be examined objectively. Touch can become the medium of the analysis of the transference, rather than confusing it.

One of the traditional ways in which the “**How**” of touch has been practiced ethically is by using what is generally called “informed consent.” Informed consent is in keeping with an attitude of respect for the client; and the consideration of the needs of the client is central to good therapy. However, this consent is also capable of being manipulated by the transference aspects of the therapeutic relationship, and that is when abuse can, and does, happen. Thus I am slightly at odds with Smith here, who tries to end this section of his book on a positive note, which, in reality, is quite naïve. He says, “*When the client is regarded with profound respect, ethics surely will be served.*” This is essentially a truism, and so it does not help us determine whether any particular therapeutic touch situation is abusive or not, nor indeed how to identify or correct abusive situations. As a rule of thumb, with any hierarchical situation, if the person lower down the hierarchy (in this case the client) feels abused or disrespected, then this is the case, and their opinions about the person higher up the hierarchy need to be listened to very seriously. So we may have to look a little deeper into this topic.

We also need to consider as well as this “**How**” section, perhaps another section, “**With whom**” or “**Who not to touch.**”

Who not to touch

One of the better studies on this topic is Glickauf-Hughes & Chances’ work from object-relations therapy, which focuses on early attachment as an imprint for future relationships, and they point out that children learn to attach and relate mainly through early non-verbal communication and in particular through touch. They make suggestions, based on their classification of personality types, about which clients to touch and which clients not to touch. This article is really worth

⁴⁵ Ibid: p. 46

⁴⁶ Fagan, J: *Thoughts on using touch in psychotherapy*. In Smith et al.

reading, and it would probably be disrespectful just to offer a quick summary or list.⁴⁷

There has been mentioned already some of the power inequalities in therapy, and these are also mentioned specifically by John May. He cites one example from Hunter & Struve from a feminist perspective and there are, of course, many others writing about the issue of gender politics in therapy, but without perhaps specific reference to touch.

Babette Rothschild⁴⁸ and Lawry⁴⁹ are also very concerned with touch in connection with trauma clients, especially those who had severe or multiple traumas. This produces severe contra-indications and touch should either be restricted because of risks of traumatic acceleration, or additional questions should be asked as regarding the client's needs and the appropriateness of touch in this case. May writes:

*Is touch the only way to meet them? Does the client have sufficient ego strength? What level of dissociation is the client experiencing? Is the client seeking sexual gratification from the therapist? Is the relationship sufficiently developed and balanced to contain the potential intensity the touch may create? These seem like useful questions to address regarding the use of touch will all clients, not just ones who have been sexually abused.*⁵⁰

I echo his sentiments. May also quotes from Horton⁵¹ who postulates: "Geib's parameters for using touch in psychotherapy, though strongly supported by the present research, are far from simple guidelines. *They require astute clinical judgment, vigilant monitoring, and above all, sincerity and openness between therapist and patient.*" (my italics) Pope & Vasquez, in their disappointingly short section on Physical Contact, write: "*When not justified by clinical need and therapeutic rationale, nonsexual touch can also be experienced as intrusive, frightening, or demeaning.*"⁵² We shall return to these points a bit later on.

Inappropriate Touch

In a very good book⁵³ on this topic, though designed primarily for the American market, one of the chapters on touch for psychotherapists is primarily about self-examination and looking at one's personal attitudes. In this chapter, amongst many other questions and exercises; there is a listing of attitudes behind nine common types of relationships in psychotherapy that can lead to

⁴⁷ Glickauf-Hughes, C. & Chance, S.: *An individualized and interactive Object Relations perspective on the use of touch in psychotherapy.* In Smith et al.

⁴⁸ Rothschild, Babette; *The body remembers: The psychophysiology of trauma and trauma treatment.* (Norton) 2000

⁴⁹ Lawry, S.S. *Touch and clients who have been sexually abused.* In Smith et al.

⁵⁰ May, John: p. 116

⁵¹ Horton, J. (1998) *Further research on the patient's experience of touch in psychotherapy.* In Smith et al.: p. 138

⁵² Pope, Kenneth S., & Vasquez, Melba J.T., *Ethics in Psychotherapy & Counseling (2nd Ed.)* (Jossey-Bass) 1998: p. 170

⁵³ Hunter, Mic; Struve, Jim: *The Ethical Use of Touch in Psychotherapy* (Sage) 1998

inappropriate touch. The authors say, if you find yourself agreeing with any of these statements, “it is inadvisable for you to engage in the use of touch as an adjunct to talk therapy. Rather, participating in supervision / consultation is called for and ought to be sought immediately.”⁵⁴

However this is a little like saying to a burglar, “If you find yourself having broken into someone’s house in the middle of the night, or when they are out, please pick up the phone and call the police.” These issues really need to be discussed at much greater length and depth throughout all psychotherapy trainings: so proper training as a form of prevention is much better. In a private commentary about this article, John May writes:

Your analogy of asking the burglar to call the police is uncomfortably apt. If you want some more scholarly sources that deal with similar ideas, you might look at some of the work of the Schoener group in Minnesota, particularly the chapters on abusive therapists in their tome "Psychotherapists' Sexual Involvement With Clients." ⁵⁵ They feel that the greatest amount of damage from therapist sexual misconduct comes from narcissistic and exploitative therapists who serially abuse one client after another. Asking them to self-monitor is a joke! Also, some of the writing by Ken Pope ⁵⁶ is good on this. But really, nobody knows much of what to do with this problem.

Hunter & Struve also list many other self-examination questions, materials and training aids and I can heartily recommend every Body-Psychotherapist to look at this book, and especially every Body-Psychotherapy training school to put it onto its compulsory reading list. The authors are also concerned about non-body-oriented psychotherapists referring people to qualified and experienced body workers, (e.g. if the psychotherapist hasn’t sufficient experience to do bodywork himself or herself) and give good checklists for such circumstances. These can also help inform bodywork training schools and individuals as to what should or could be sufficient or necessary bodywork components in any such training, especially if they want to get referrals from other professionals.

Therefore the essence of what seems to lie behind “inappropriate touch” is very often a significant lack of self-awareness in the therapist. This reinforces the point made earlier about significant components in training, and hopefully, as the greater inclusion of such components in psychotherapy training courses proliferates, the instances of abuse will lessen. However the perversities of human nature probably ensure that it will not disappear altogether.

However, let us not get too fixated on therapist abuse, as we also have the situation that some forms of touch, or some ways of touching, or some occasions of therapist-client touch, whilst they may not be abusive, may still be inappropriate. John May writes:

Touch may not be abusive, but it might not be useful, either. It might not

⁵⁴ Ibid: p. 270-1

⁵⁵ Schoener, G.R., Milgrom, J.M. Gonesiorek, J.C., Luepker, E.T., & Conroe, R.M. (Eds.): *Psychotherapists' Sexual Involvement With Clients: intervention & prevention*. Minneapolis Walk-In Counseling Centre, 1989.

⁵⁶ Pope, K.S. (see refs in Hunter & Struve: p. 284)

*be relevant or helpful with the problem the client is working on. It can take the therapy into a detour, etc. It might be destructive of boundaries when boundaries are needed, yet still not be abusive.*⁵⁷

Some situations like this could not be seen as abusive objectively, but may actually be experienced as abusive **by the client** but often they are unclear or passive and the moment passes. When, as a man, I work with clients who have been sexually abused, or whom I suspect may have been so, I am extremely careful about the type and occasion of touch and probably abstain completely unless there are positive indications or even specific requests that seem appropriate. With clients who have been traumatized in other ways, especially when helping them to rebuild their boundaries, I am very careful to stay well outside of their psychic space until that type of boundary is more properly and clearly established.

There are further ramifications about therapeutic touch and inappropriate touch especially where it relates to male therapist-female client touch. Nick Totten, in his excellent new book on Body Psychotherapy⁵⁸, in a short section on the 'Ethical dimensions of touch', he quotes John Conger's observation "*In our culture, people of higher status initiate touch and touch more than people of lower status. Men touch women more than women touch men.*"⁵⁹ There are several other studies about power dynamics and gender differences that affect the use of touch, mentioned especially in Hunter & Struve (Cpt 5.).

Conger lightly explores the dichotomy between the fear of the risk of touch sexualizing the therapeutic relationship and touch as a radical and active cultural intervention breaking through the taboos and touches upon some of the male-female dynamics. Some practitioners 'medicalize' their approach and thus objectify the client's body, which works against the deeper attempt of body psychotherapy to appreciate more fully the subtleties of human embodiment. His own approach to the ethics of touch seems to acknowledge both the erotic and regressive elements. This latter aspect facilitates accessing deep emotional and physiological needs which are powerful and effective for the client yet the therapist's price of this skill is the "*enormous demands on our integrity, demands which at times will need every scrap of strength we possess.*"

What is clear is that there is a massive potential for and whole area of proper research in detail into what clients and others (the recipients) consider is appropriate touch in psychotherapy. Client's accounts are very informative and should be published more often. And I here and now invite more of this type of research and publication from Body-Psychotherapy training colleges.

I would also want much fuller discussion on the question of male-female therapist and client dynamics in relation to touch. We cannot and should not pretend that being touched by a man is the same as being touched by a woman, or, as a male therapist, touching a man is the same as touching a woman. This may not be a politically correct viewpoint, but it is a very significant dynamic, especially in the case of a female client who has been sexually abused by a man. In such a case, I personally, as a male therapist, would not enter normally or lightly into touch with such a client: it would be totally inappropriate and much too risky. It could even be seen as potentially abusive.

⁵⁷ Private e-mail from John May to author.

⁵⁸ Totten, Nick: *Body Psychotherapy: An introduction* (Open University Press) 2003: p.123-4

⁵⁹ Conger, J: *The Body in Recovery: Somatic Psychotherapy and the Self*. (Berkeley) 1994: p.13

Therapist Abuse

It is clear and axiomatic that an abusive therapist does not treat people with profound respect; because any respect that they might show to their client is either limited to very distinct areas, or is essentially manipulative. The abusive type of touch, as in the abusive therapeutic relationship, is not just self-gratifying; it is also quite demeaning to the other person, even if they don't fully realize it at the time. The client is being 'used' in some way. This 'usage' can often be unconscious, but, in a therapist, this is really a double fault.

A body therapist or Body-Psychotherapist (and I include here, trainer, or workshop leader or counsellor or supervisor – anyone who might abuse the therapeutic relationship) must, really must, be aware of all the finer points about their own sexuality, and must, really must, learn to manage their sexual energy, especially in relation to their clients. One may not touch, but one can still be very seductive: one may not actually touch, but eyes can be abusive and can strip a person naked, as any woman can tell. However, in this essay we are only dealing with the ethics of touch, and so I will try to limit the discussion to these points.

One has to be especially careful when working with the body, and when working as a Body-Psychotherapist, as one is working *with* a client's libido and sexual energy. One is possibly even trying to help them towards the proper and healthy (re-) emergence of their sexuality and the establishment of healthy future sexual relationships. But this has to be done without becoming personally involved. This is not easy, and it is done in a similar way to how a parent observes and encourages the emergence of their child's sexuality: with knowledge, experience, compassion and respect, but without personal involvement.

Janice Russel's book quotes one client, which indicates the whole topic goes way beyond just inappropriate touch or sexual relationships: "*He opened up the sexual side of me and then didn't know how to deal with it.*"⁶⁰

These energies are extremely powerful and subtle and run through our whole biology and psychology, and so there needs to be somehow instilled some sort of a therapeutic taboo or control as strong as the fear of parental incest. Yet in therapy, it must not be a fear: that would be self-defeating. The therapist could not then help the client express their sexuality in better and more positive ways if they were afraid of their own sexuality, or of any form of intimate involvement with another person: even legitimate therapy can get emotionally intimate. There needs to be a degree of self-confidence, and there also needs to be a degree of humility, as there is nothing so tacky or dangerous as a therapist who wants to show everyone the way to a better sex-life that they have found for themselves. I believe there needs to be controls (not fears) which involve a positive self-regard for a therapist; with a mature awareness and solid acknowledgement about one's own needs; and the healthy desire to express these in a personal adult relationship outside of, and well away from, the therapeutic one.

Touch that is motivated by the therapist's own need for gratification can never be justified. "*Every analyst, but especially one who engages in body therapy, must be able to experience and contain his or her own pregenital and genital impulses, both homosexual and heterosexual.*"⁶¹ This is another "should," or "should not," and so it doesn't necessarily help us very much when the therapist

⁶⁰ Russell, J.: *Out of Bounds: Sexual Exploitation in Counselling & Therapy* (Sage) 1993: p. 92

⁶¹ McNeely, Deldon Anne: *Touching: Body therapy and depth psychology* (Inner City) 1987: p.75

has to be confronted with details of their inappropriate or abusive touch. However many “should”s or “should not”s there are, someone will come along and break them, and part of this article is to try to look closer at this subject with a view to get a better understanding for preventative reasons. There is also an element of self-protection here, as one rotten apple can affect the whole barrel.

Often the therapist will deny – either to themselves or to others - that their own or the client’s sexuality has been involved. However the client might feel differently, as normally a client would reject a sexual advance from their therapist. But sometimes this is not the case and the client has been either ‘seduced’ into an unethical touch situation, or, in some way, has colluded with it. Very occasionally have they initiated such contact, and we have to assume that 99% of the clients haven’t come to expensive psychotherapy for sex.

It must also be remembered that frequently the therapist is in a much more hierarchically powerful position in many different ways and is much more able to determine and influence the nature of the relationship and interactions within the therapy session. In order to cover up or prevent the client feeling ‘used’ or ‘abused’, the therapist, whilst often seducing the client, must also usually give them some form of intellectual rationale combined for this type of inappropriate touch. This is often with considerable emotional pressure to ensure the safety of the therapist and possibly the continuation of the abuse.

The rationale itself can be an additional form of abuse: an intellectual confusion, or, in 1970’s West Coast USA parlance, a “mind fuck”. You get abused and then you get told it is good for you, or visa versa: and the order in which this happens is not particularly important as the message is probably transmitted over and over again in a number of different and subtle ways. This is the cult of the abuser and the necessary concomitant ‘brain-washing’ of the victim so that the abuser is protected. The victim therefore has to accept the rationale of the abuser, otherwise they realize they are a ‘victim’ and the other person is therefore the ‘abuser’, and the avoidance of this realization is central to the abuse being perpetrated. Traditionally the therapist also abuses the power role as well, in that they pose as the ‘knowledgeable’, the professional, or the omnipotent one; the guru; the teacher, the therapist (the-rapist); or they abuse a naturally occurring role like parent or step-parent, uncle, grandfather, elder brother, cousin, etc. There are also complex social forces sometimes present; myths - like the male sexual imperative: if a man has an erection, it must be satisfied, therefore women ask for it.

When the abused person, client or patient does try to make a complaint against a therapist to their professional association, the odds of having a completely unbiased hearing are heavily stacked against them. Firstly, the association or professional body to which the alleged abuser belongs also sees the therapist as one of its fee-paying members. There is often a feeling of collegiality and even a fear of collective exposure. This can somewhat bias the investigation by the therapist’s peers. Sometimes the accused therapist holds or has held high office or has an enviable reputation or political ‘rank’ in that association. However the accusation can also work against the therapist, giving others who make be already biased against this person within the association the opportunity and the weapon with which to pull them down.

The ethical committee that investigates the complaint is often not completely sure of its power. There may (or may not be) elements in the ethical committees proceedings that give it an investigative power over the complained-against therapist: do they have the ‘right’ to demand the therapist’s notes?; are there

requirements in the membership conditions that 'compel' the therapist to cooperate with the ethics committee on pain of dismissal of membership? Can the 'member' resign and thus avoid an investigation, or is there a clause in the membership conditions that enables the organization to refuse to accept the resignation until the investigation is completed? Can the member re-apply for membership again to the organization after a complaint? What sanctions has the ethics committee got available, other than exclusion? What resources, what budget, are available for such an investigation? What time availability do the members of the ethics committee have? What is their experience and background? These questions indicate just some of the biases or issues that can exist within a professional organization.

Finally we come to the issue of the 'burden of proof'. In criminal courts, in certain countries, there is a presumption of innocence; in other countries, the burden of proof lies with the accused. But the issues we are discussing are not (yet) criminal proceedings. So it is my view that if a therapist is complained about, the burden of proof lies clearly with them, to demonstrate their professionalism, and does not lie with the accuser. This is (perhaps) a radical position. Consider (for example) the main focus of the text of the EAP Statement of Ethical Principles. It puts the burden of professional practice fully on the shoulders of the professional: this is a service for which they are paid quite respectable amounts of money. This suggests to me that the duty to establish their professional credentials or to clear their professional reputation is much higher than any onus of proof coming from the accuser. Again, I welcome correspondence on this point.

There are a very few cases where an accusation is eventually shown to be malicious. The professional does need to be wary of such cases, and hopefully to identify them as early as possible, and make appropriate case notes, and to show their concerns to other professionals and supervisors about such a probably borderline personality. These steps should be sufficient for the therapist's protection: the whole ballgame does not have to be weighted in the other direction just because someone might

Touch being so personal; inappropriate touch is therefore extremely distressing and invasive. This point must be remembered in any such ethical investigation. So conversely the way must be made easier for complaints to be lodged and successfully investigated, otherwise we will be in the same situation as crime figures about rape were a few years ago: reported rapes were very few because the victims knew there was not much point in reporting them, and when they were reported the victim experienced even more trauma in the (often hostile) criminal investigation and trial, often ending up with an accusation of immorality herself. It is pointless to get clear about the ethics of touch if we do not also get clear about the process of investigation and the issues and biases around.

There is quite a good book, though a little dated, on therapist abuse, called "*Out of Bounds*"⁶² and one of the original classics on this topic, Rutter's book, "*Sex in the Forbidden Zone*"⁶³ is still a fairly standard text, albeit also dated, especially for going into the male power dynamics over the women in the "forbidden zone" with whom they betray their trust (as doctor, therapist, tutor, counsellor, lawyer, etc.), even though it doesn't explicitly deal with touch except in a section entitled: "*The moment of sexual touching: paralysis in the face of danger.*" There is one

⁶² Russell, Janice: *Out of Bounds: Sexual Exploitation in Counselling & Therapy* (Sage) 1993

⁶³ Rutter, P. *Sex in the Forbidden Zone* (Mandala) 1990

section that is worth quoting, which deals with the part of the woman's dynamic that doesn't or can't or won't reject the man's advances.

*At another level, a different danger looms: the threat of losing her connection with the man in whose presence she has come to feel some of the specialness she so deeply needs. Overwhelmed and confused by the contradiction between her fear of disappointing or enraging him and a deeper sense of being violated, she is unlikely to have the strength and clarity that it takes to deal effectively with the moment of sexual touching. The result is paralysis – of action, judgment, feeling, and voice. The cultural messages encouraging passivity, the personal wounds from her family that have shown her there is no protective boundary, the hope that someone will treat her differently all come together as an overwhelming flood at the moment the man touches her. This paralysis can last for minutes, hours, days, and sometimes years. In the meantime the man has proceeded with his sexual scenario.*⁶⁴

However - and this is essential - however 'person-centred' the therapy is, the client and therapist are still in some form of hierarchical relationship or collusion at the point of any abuse. Not enough about this is spoken of in the training of counsellors and therapists and little consideration has also been given to the constructive use of therapist's power. In abusive or exploitative situations, the client's boundaries are being transgressed, one-way or another, and however (nominally) willing they may be for this to happen.

Maybe both parties are deceiving themselves that this isn't abusive or sexualized behaviour. Or maybe the hierarchical relationship is being manipulated and the client / potential victim is being told that is for their own benefit. This is a lie! The therapist / potential abuser is blatantly lying to the client, and they may also be lying to themselves. There are many different situations where psychotherapists, body therapists or counsellors can unwittingly or consciously abuse this situation. There are also unclear boundaries that are often institutionalized. Often Ethical Committees or organisational superiors are more supportive of their therapist member (who may even have been a member of such a committee) or staff member than of the client or complainant.

Another frequent issue is where there is an attraction between therapist & client: and can this attraction be exercised in any way? There are many cases of therapists forming relatively successful relationships with people who have been their clients: however these are mostly male therapists and female clients; so that is an interesting dynamic. Assuming nothing untoward happens within the therapy sessions, and the relationship is not developed until after the therapy is mutually agreed to stop, has it stopped for the 'right' reasons, or because there was an attraction that was getting in the way? Another frequently debated question in bars at therapist conferences is: after how long? How long an interval should there be between the end of therapy and the start of a relationship? I have heard psychoanalysts talk of 6 weeks; I have also heard people say firmly and clearly "Never".

The betrayal of therapeutic trust is often just as abusive as direct sexual contact or inappropriate touch and it is clearly the responsibility of the therapist to

⁶⁴ Ibid: p. 132

establish very clearly what the boundaries of the relationship are at the outset of the relationship. Many therapists, trainers, tutors & supervisors are now making a definite statement at the start of the hierarchical relationship that there will not be any exploitation or intimacy; there will be no sexual contact; there will be an avoidance of other relationships that might confuse the contracted one. Clients, trainees and supervisees often report that this is very reassuring. What is helpful is a deliberate attempt to address the problem, delineate the boundaries, and engender dialogue on these topics.

Therapist abuse, when it happens or is discovered, is often repetitive and compulsive. The abuser becomes addicted to this particular form of practice, with these particular people or types (because he doesn't really see them as people). He (or she) may be an excellent therapist otherwise, can be quite renowned, and often has a lot of charisma. Abusers are often intelligent and well educated and many have written papers and given workshops & seminars. They are often involved in the hierarchies of the society or organization, as this makes them safer. There is however a lack of full integrity and often a high level of self-deception. They do not really "know" that their practice is abusive – as much as an alcoholic does not "know" that alcohol is destroying his health and his life. This is not an attempt to excuse the abusive therapist: it is an attempt to cut through some of the bullshit around therapist abuse. The therapist abuser is often very seductive, and may be very charming. They may have a high-energy field and may also be very extrovert. They are not being self-reflective at the time of the abuse and they make (self-) excuses for this lack of awareness.

Alternatively, as we shall see later, the more serious forms of abuse, the serial abusers, have a fundamental flaw in their thought processes, in their psychological structures, in their world-view, in their relationships, and also in their personal and ethical codes.

Supervision

The simplest way out of this form of self-deceit from the therapist's position is to be in regular and appropriate supervision; however this supervision needs to transparently open and sometimes brutally honest. The objectivity and the experience of the third person, supervisor, are necessary, even essential, for the therapist to be able to look at their situation and their relationship with the client more rationally, and the manner or style of their supervision needs to be in a non-judgmental neutral and explorative fashion. However, I fear that many supervisors are also constrained by the tyranny of fellow-professional niceness and their own needs to retain their supervisees, who can always exercise their option to leave. How do you tell a supervisee that they have totally fucked up?

The supervision does not have to be one-on-one; supervisor to supervisee; as it can also be peer-group supervision as long as the members of the group have a broad membership, relevant experience, and as long as there are not hierarchical situations in the peer-group that would prevent a frank and healthy discussion of these types of issues.

Earlier Smith mentioned, in the context of improper touching, the word "knowingly". The abusive therapist does not "knowingly" commit abuse, they are often lost in their own needs; often rationalising what they do as fulfilling the client's needs; their distortion is total. They probably don't think about ethics: they possibly don't know about ethics: they don't think; they don't know; and – most importantly – they don't want to know. There is frequently a level of conceit here as

well.

However, if this is true, then they shouldn't really be, or are not ready to be a therapist, and (to a certain degree) the training schools probably need to do some more rigorous checking about this.

If they are genuinely exploring out of their depth, or known area, and they have over-stepped a line that they didn't properly realize was there, or if they are prepared to admit their mistake, then effective supervision is about the only way out of this situation. If they don't want to admit their mistake, or acknowledge their fault, or are not prepared to listen and be re-educated, then we are dealing with an ego situation and issues like pride, lust, greed, or whatever are also present. These are some of the Seven Deadly Sins, and therapists are just as liable to transgress as anyone else.⁶⁵

At this point, I would like to state that I am sure that several times over the last 20 years I have transgressed professionally with regards to touch. I am also sure that I am not alone in this, but I want to sound the note for transparency and honesty here. Whether my transgressions were actual therapist abuse or not, is not properly, or possible, for me to say: that is for my client, or my supervisor to say. And sometimes they might even disagree. We, as therapists, are not and cannot be good judges of our own transgressions or abuses and anyone who thinks otherwise needs some serious re-education in professional mores and ethics.

Up to a certain point, of course, we know and can say, quite clearly, "I was not abusive." But it is when we hit our edges, those moments when there may be an abusive situation looming, and it is usually then that a little question comes to mind, however tentatively phrased. Then that is the time to ask – either the client or your supervisor – how they feel about this. And the act of asking often leads directly towards the point of resolution. We all face these moments, otherwise we would be very boring therapists. But we need to admit these moments to ourselves: and that requires self-awareness. When we do inevitably transgress, we need to be trained and to be encouraged to have the strength to ask someone else, just to ask, and as soon as possible. When we ask, we then stop being abusive, even though we might have been earlier. We have turned that particular corner, and we are open to redemption.

Training:

It almost goes without saying that many of these issues should have been comprehensively dealt with during one's professional training. Trainers should not only inform, but should also model good practice. Therapists who touch also tend to have supervisors and teachers who advocate touch as a legitimate practice.⁶⁶

This tends to point to the fact that training and supervision are extremely influential on the use of touch; and therefore some therapists who may want to use touch legitimately are influenced negatively by their professional backgrounds. It is often very difficult as a student to question the theoretical basis of the topic you are studying.

⁶⁵ An interesting series of six "Barchester" type novels by Susan Howatch examines professional & ethical transgressions (within the context of the Anglo-Catholic Church) set in the context of a cathedral town at various times between the 1930s – 1970s. The titles are: *Glittering Images*; *Glamorous Powers*; *Ultimate Prizes*; *Scandalous Risks*; *Mystical Paths* and *Absolute Truths* (Harper Collins).

⁶⁶ Milakovich, J: *Differences between therapists who touch and don't touch*: In Smith, et al.: pp 74-92

One significant aspect of training in this area is to ensure that the therapist's own needs and issues about touch have been either brought to awareness or preferably dealt with effectively. This tends to suggest that personal therapy is prerequisite, primarily as therapy is a well-known route for an individual to establish appropriate personal boundaries. Fagan suggests that a therapist who uses touch has:

*"... to be comfortable with his or her own body; to understand the differences among the different kinds of touches; to have his or her own nurturing and sexual needs met outside of therapy, and to be absolutely certain that ritual or nurturing touch is not an entrée to sexual touch and that there will never be sexual contact with patients."*⁶⁷

She probably should have mentioned "professional" as well as "ritual" or "nurturing". "Finally," she says, "the therapist needs to be very clear about limits in general and to have carefully examined possible countertransference. *Touch should meet the needs of the patient, not the therapist!*" (her italics). Where can this be ensured except through proper training?

Furthermore and unfortunately the tendentious topics of therapist abuse, inappropriate touch, breach of trust etc. are generally not dealt with very fully in psychotherapy & counselling training courses and are often noticeable by their absence.

Good or exceptional therapists are mostly empathetic; they are often charismatic; they sometimes even have healing skills. This makes them very attractive people. Unfortunately the attraction of others towards oneself can become narcissistic and therein lays the great danger, the trap. With charisma, the psychosis of 'falling in love' by the patient is all too readily apparent. With narcissism, it becomes attractive, wanted or needed. How do we train people against this?

In exactly the same way that ministers & priests need to be specially trained to deal with these issues (not always successfully), so do therapists & counsellors. Topics in the training of sexuality and power provide an important focus and discussion forum for such issues, which increases the future therapist's greater awareness when these issues rise to test us in our professional work: and they will - inevitably. Brainstorming and role-playing exercises are also very useful and the amount of potential reading on these topics is increasing.

It is also possible to challenge some of the racial, class, and gender assumptions, sexual myths, and general value systems, especially those around touch, that can also distort our responses as therapists, and these distortions can also cause our clients, trainees or supervisees to feel abused, as well as being abused by inappropriate touch. As a middle-aged man, I cannot now safely touch a child whom I do not know in a public place (especially in America) without risking an accusation of abuse, whereas a few years ago, if a child fell and hurt themselves in front of me, I could have cuddled or soothed it appropriately until the child's parent or minder was available, and this would have probably been experienced as a kindly gesture, by both the child and those around. Those days are sadly gone.

Serial or Institutional Abuse

Of course there are situations where "normal" ethics seem to have been lost

⁶⁷ Fagan, J. *Thoughts on using touch in psychotherapy*. In Smith et al: p. 150

and an “abnormal” ethic has been imposed. Certain so-called ‘therapy’ groups within the Bagwan Shree Rajneesh movement became quite physically abusive.⁶⁸ David Boadella also wrote about violence (physical and emotional) in therapy groups many years ago.⁶⁹ Emotional catharsis was then emphasized as almost being more important than respecting an individual’s (‘neurotic’) personal and culturally determined (‘repressive’) physical and sexual boundaries. There were, of course, no rules in those halcyon days and in that far-off (“far-out”) environment. That particular path on the search for enlightenment (Bagwan’s) also – by all accounts - allowed other abuses of responsibility and power, as well as financial abuses, that finally ended in criminal charges of attempted murder.

On this graduated path of abuse, inappropriate touch and the disrespecting of personal boundaries, (leading even to accounts of re-enacted rape in therapy groups) were just some of the many transgressions in that particular sect or cult. But it is interesting, and also my experience in examining individual and organizations about ethical transgressions, that the compulsive narcissism⁷⁰ that seems to allow and even justify one set of transgressions often allows and can even justify many others: the downward path is a very slippery one. There are many, many instances of transgressions of power in sexual relationships by ‘leaders’ of a sect, cult, or that happen in even more ordinary types of institution (church, company, college, etc). Even if there is no institutionalized abuse, per se, there is often a tacit condoning of abuse, or even more frequently a refusal or inability to investigate reports comprehensively, or to examine inappropriate behaviour (usually from those with rank) openly and frankly.

Some ethical codes now have specific sections that require other practitioners to report a colleague whom “*is suspected of misconduct which cannot be resolved or remedied after discussion with the practitioner involved*”, which goes one step towards breaking codes of silence, but there is still the problem of who this is reported to. If the ethics commission or whatever doesn’t take appropriate action, which nowadays usually involves an independent reviewer or impartial members, then this is also frustrating, abusive in itself, hypocritical and permits serial abuse to continue. The complainants are sometimes made to feel wrong, criminal (for slandering a “respected member” of the profession), threatened with retaliatory action, or are discriminated against if they are from within the organization.

With serial therapeutic abusers, the lack of self-awareness, or the defenses of the abuser makes “dealing” with them very difficult. From my direct experience of dealing with several difficult ethical complaints in different associations, I can assure you that this is the case. There is often quite obviously a large ego situation operating within the therapist. “Their particular method” is being questioned and therefore you, the questioner, must be ignorant or stupid or jealous or biased.

They will often try to perform every trick in the book, rather than admit that they might have been just the tiniest bit abusive. Lots of long letters full of quasi-legal sounding phrases are often a feature of trying to deal with an abusive therapist. Often the process, the investigative work, or integrity of the ethics committee will be challenged, in an attempt to undermine their ‘case’ against the

⁶⁸ Franklin, Satya Bharti: *The Promise of Paradise* (Station Hill) 1992

⁶⁹ Boadella, David: *Violence in Therapy: Energy & Character* Vol 11, No 1, Jan 1980

⁷⁰ Defined by Scott Peck as “evil” in his sequel to *The Road Less Travelled*: entitled *People of the Lie: A psychological analysis of evil* (Rider)

abuser; the best form of defense being an attack. We are therefore almost immediately into very confrontational politics; and various of the significant ethics committee people dealing with the case may well be counter-attacked or challenged themselves.

It is rare that the abuser will actually face a hearing in the non-regulated professions, nearly always preferring to resign beforehand – “out of disgust with the way in which they have been treated by their Association”. Vitriol and venom drips from their letters: the poison is being spread wider. In more regulated professions, where the abuser’s professional work is actually dependent on a successful ethics committee report, then the attack is often shifted to the accuser and various forms of denigration are posited, directly or indirectly. Some of the difficulties in making complaints, mentioned earlier, increase the more a profession is regulated as, if a colleague’s livelihood is in jeopardy, the associative & collegial support increases proportionally.

There is not, significantly, any real rational argument that this is the way the abuser professionally does things, or this is the way they were taught, and/or that they do them for this or that legitimate reason, and/or they have this or that basis of evidence to support them. Especially in the field of inappropriate touch, the arguments and rationales that they may give to the clients, trainees, their victims are rarely presented for any public scrutiny in an open fashion or for an ethical committee hearing. There is more usually the shroud of secrecy or the cloak of denial. One could extrapolate and say that this is because there is no validity for such behaviour, or there cannot be any, but this reeks a little in the form of cultural bias. We should try to stay open a little, to hear more.

The institutionalized or serial abuser’s ‘special’ methods of body therapy or touch or body-oriented psychotherapy will just be alluded to, but not explained: there will be considerable mystification. Their methods may even be kept secret, just for a privileged few, who will become first the victims and then even perhaps subsequently also perpetrators. Thus the original abuser’s work is supported and reinforced. Sometimes there are varying degrees of grandiosity about the “specialness” of their methods, and that other (untrained) people might denigrate them, or try to steal them, or change or dilute them. There may be degrees of paranoia or elevation. There is something similar to a cult-type of dynamic. Accusers can thus be denigrated and dismissed.

They really cannot and will not see that they might be or are at fault in any way whatsoever. The power they inject into this process is amazing. So maybe we just have to say to these people: *“Enough, already.” “You are wrong. Actually, you are abusive. I am not interested in your evasions or excuses. You must stop working. An extensive period of re-educational is a requirement.”* and to stop pretending that it was: (i) a single aberration; (ii) improper training; (iii) something that will be solved by chucking the person out of whatever professional association is involved; (iv) something ‘bad’ in the therapist. There **is** something ‘bad’ in the abusive therapist, and the only way forward to work with this is ultimately through proper re-education. But the serial abuser, or the institutionalized abuser, is sometimes way beyond this sort of help; it is endemic and chronic. Only very occasionally are they prepared to acknowledge their transgression and work, often very hard, towards redemption.

A lot of their defensiveness is, I believe, a desperate attempt at survival: the survival of their current personality structure. This is often quite fragile and the person may indeed have been abused himself, or herself, in their childhood or on

some earlier occasion. Degrees of compassion are certainly needed when dealing with abusive therapists if there is to be any proper redemption of that therapist, but this is often only possible after the transgression has been fully acknowledged and corrected. In the same way that the bullied often become, in turn, bullies, the abusive toucher has often been touched abusively; for we live what we learn. If touch pays a significant part in the training of a therapist, and the experience of touching and being touched is a significant part of this training, many of these issues should come out during the training, if there is good reflective, feed-back and monitoring systems installed – as there should be.

Client's charters, support groups, and networks against professional abuse⁷¹ are growing in order to help prevent therapist's abuse and institutional abuse and even though their primary purpose is to help abused individuals, their cumulative experience is a voice that is needed to be heard more widely. So, representatives of this type of grass-roots organization should be included in national professional ethical councils and, as they are often not properly funded, their representation may even need to be subsidized by the professional organizations themselves.

Conclusion

This is hopefully not the final word on this topic, as I do not have definitive answers and I am trying to encourage an on-going correspondence. I am just coming to an end to this particular contribution and to what I trust will be the forerunner of rich discussion and debate for the future. However, as with everything, the process starts within oneself.

In a recent article, Carl Goldberg explores the defects in moral development that result in shocking unethical situations (from the Holocaust to Enron) which seem to be caused more by a lack of reflective consciousness than the lack of a moral code, or superego morality. This suggests that rules and regulations about any topic, touch, in this instance, are not enough: accounting regulations did not prevent abuses like Enron or the waves of other corporate abuse that have emerged recently. Rules and regulations need to be combined with, supported and emphasized by, the development of a proper conscience, or "*a courageous reflection about oneself and others. It requires us to know our limitations, to accept ourselves as less than perfect, to live to the best of our abilities, and to come caringly together with others to heal the wounds of loneliness, shame, and self-hatred.*"⁷² Scott Peck⁷³ and other authors are writing about the need for changing attitudes within society, attitudes that demand greater respect from each other, but in very simple ways. Therapy is no different.

It is clear that any grandiose attitudes about therapy, any views about special (healing) abilities, significant charisma, secret techniques or occult methodologies, or whatsoever (however they are self-described) can impinge on the development of the necessary professional and personal humility and conscience. It is also clear that feelings of privilege, of being above the law, or feeling protected from it, or any particular attitude or social climate which denigrates or works against responsibility.

⁷¹ In the UK, the Abuse in Therapy Support Network, c/o Women's Support Project, 871 Springfield Road, Glasgow G31 4HZ and Prevention of Professional Abuse Network (POPAN) Flat 1, 20 Daleham Gardens, London NW3 5DA.

⁷² Goldberg, Carl: *The mortal storm: righteousness and compassion in moral conflict*: International Journal of Psychotherapy: Vol 7, No 3, 2002

⁷³ Peck, Scott: *A world waiting to be born: The search for civility*. (Arrow) 1993

attitudes, will almost inevitably lead to abuse – in any arena – as well as this specific area of touch.

The privilege of being able to touch another human being must be respected totally. To be allowed to touch someone is a very intimate situation; and wanting to be touched is to allow oneself to become very vulnerable to another person. Qualities such as love, compassion, empathy, care, respect, and sensitivity are all words that come to mind around such acts; and are all attitudes that are needed to be in the forefront of such acts. There is indeed almost a sacred privilege about being able to touch another person physically and a sacred communion in being touched. This use of the word 'touch' also has a spiritual component in being able to be 'touched' by someone else or to 'touch' someone else deeply. Unethical touch in this context not only becomes almost obscene but also borders on the profane.

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This manuscript was much improved after extensive commentary from John May. Any remaining vagaries or inaccuracies are entirely idiosyncratic and the author's own. The author also wishes to declare that in writing this article he is not motivated by any specific ethical or political agenda, nor is he personally under any ethical investigation. He welcomes e-mail contact about this article as long as the e-mail title includes the words "Ethics of Touch". He can be contacted by e-mail: cyoung@findhorn.org