Ethical Considerations in the Use of Nonerotic Touch in Psychotherapy With Children

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Although touch frequently occurs in psychotherapy with children, there is little written on the ethical considerations of therapeutic touch. Because physical contact does occur, therapists must consider if, how, and when it is used, for both their clients' safety and their own. In this review, I further develop the issues suggested by Aquino and Lee (2000) in the use of nurturing touch in therapy by considering many types of touch that occur in psychotherapy with children; the possible positive role of touch; clients' perception of touch in therapy; considerations related to the therapist, the child's safety, and any history of abuse in the child's and family's background; and other practical considerations. I list guidelines.

Keywords: child psychotherapy, touch, ethics

Clinicians must address several unique ethical issues when working with children. An important area is the issue of boundaries in psychotherapy. Boundaries have been described as the therapeutic frame of psychotherapy and the therapeutic relationship (Gutheil & Gabbard, 1993; D. Smith & Fitzpatrick, 1995). This frame helps to create a safe, nonexploitative, predictable, and agreed on environment for the child–patient, the parent, and the therapeutic process. There are many elements that help to create a therapeutic frame, including structural boundaries such as time, length, place, and cost of sessions and process components such as orientation of the therapy, exchanging of gifts, and self-disclosure (D. Smith & Fitzpatrick, 1995). Although the question of appropriate boundaries occurs with adults as well, there are questions that routinely arise with children that usually do not arise with adults.

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Boundaries related specifically to therapy with children include when the therapist should discuss information received from the child with the parent and who attends sessions. One important and complex area is the issue of physical contact between therapists and young children.

Both legally and developmentally, children are thought to be less able to make reasonable judgments about where boundaries lie in psychotherapy. This includes the ability to make an informed consent to the treatment plan and the establishment and maintenance of the therapeutic frame. Children can only assent to therapy. Consequently, others, namely, parents and psychotherapists, decide with them and for them throughout psychotherapy (Koocher & Keith-Spiegel, 1990). Thus, child psychotherapists must have tools to decide where boundaries lie and what behaviors are appropriate. Although rarely discussed in the literature, the issue of physical boundaries frequently comes up in child therapy.

Whereas the field of adult psychology has struggled with the issue of physical boundaries in psychotherapy (Durana, 1998; Gutheil & Gabbard, 1993; Hunter & Struve, 1998; Kertay & Reviere, 1993; Lazarus, 1998; Lazarus & Zur, 2002), little has been written on the topic in the area of child therapy. Even overviews of ethical issues with children seldom go into detail about touch. Two chapters in different volumes focusing on ethical issues involved in working with children and families have each spent at most a paragraph addressing touch in therapy and have suggested that context be taken into account (Rae & Fournier, 1999; Yanagida, 1998). Yet, when working with young children, touching and being touched is normative and almost inevitably occurs. A child who is climbing up an office table to get something off a shelf may need to be quickly and physically removed from the situation to ensure the child’s safety. Most counselors attempting to help a child understand a fatal disease would likely physically comfort a child who began to sob uncontrollably. After an intense session with a psychotherapist, a child may impulsively hug the clinician as a way to show appreciation for the clinician’s help.

It is important for practitioners to have a way to think about touch with young children that considers the child’s needs, boundaries, developmental level, and ability to communicate yet does not confuse the child with inconsistent responses or shame the child. Additionally, psychotherapists need to protect themselves from suit in a litigious society. When thinking about ethical considerations in touch, it is essential for professionals to have some understanding of the possible usefulness of touch, the harm of withholding touch, and the possible negative consequences of touch.

I found only one article that discussed the ethical considerations of touch in working with children in psychotherapy (Aquino & Lee, 2000). Aquino and Lee focused on the use of nurturing touch in psychotherapy including hugging, cuddling, and so forth. In this article, I expand on many of the areas discussed by Aquino and Lee as well as address other important considerations in ethical touch with children. First, I discuss child-initiated touch. Next, I examine therapist-initi-
CHILD-INITIATED TOUCH

Child-initiated touch can be separated into two categories: inappropriate touch, which would include oversexualized and physically aggressive behaviors, and more appropriate forms of touch used to communicate and express emotion. Inappropriate touch by children may include hitting, kicking, grabbing, or suggestive behaviors. Aggressive and sexualized touch should be addressed immediately with limit setting and nonshaming explanations to the child as to why such touch is inappropriate. There may be times that a child’s physically aggressive behaviors may be dangerous to the therapist, the child, or others around the child. Physically attacking a client is unacceptable; yet, there are times when self-defense against a client’s aggression may be necessary (E. W. L. Smith, 1998). Children with emotional and behavioral difficulties are more likely than adults to act out physically and aggressively (e.g., kicking, spitting). On these occasions, the therapist may need to physically stop the child’s behavior by using force. E. W. L. Smith (1998) recommended (a) making every effort not to provoke an attack by the client and (b) “using only the force necessary to neutralize the attack” (p. 38). In inpatient settings, workshops are conducted to teach staff the best way to neutralize an aggressive child. These workshops are less likely to occur in outpatient settings. On these occasions, therapists should initially take cues from the child’s parents. One example might be that of a small child spitting at a therapist during a discussion with the child’s mother. The mother may initially attempt to verbally discipline the child, followed by picking up the child and covering the child’s mouth to prevent her from spitting on the therapist. Waiting for the parent’s reaction can prevent the therapist from having to intervene physically to stop the child. However, if the parent is not there or is unable to stop the child, the therapist may need to physically remove a child’s body part from the therapist (e.g., with pinching or sexually suggestive behaviors), use restraint, or as a last resort physically defend oneself. For example, a small child might try to get a therapist’s attention by smacking the therapist’s behind. Although the child may not mean anything suggestive by this action, it is clearly inappropriate. Before the child smacks again, the therapist might hold the child’s hands gently, telling the child in an age-appropriate manner why the behavior is unacceptable, give suggestions on better ways to get the therapist’s attention, and explain the future consequences of such behavior (e.g., a timeout).

Inappropriate touch should be further explored with the child and parent to assess its prevalence and extensiveness outside the therapy session. If inappropriate forms of physical contact are a problem in the child’s life, in the therapy session, or
both, the therapist should work with the family to create a treatment plan to address the behaviors. In the treatment of destructive and abusive behavior with traumatized children, James (1996) recommended cognitive behavioral therapy to work on containing and decreasing the inappropriate behavior coupled with addressing the underlying motivations behind the behaviors. This can be useful with inappropriate touch in general. With the previously mentioned child who used hitting to get the therapist’s attention, a treatment plan focused on reducing the inappropriate hitting as well as one addressing attention seeking in the family might be useful.

More appropriate types of touch between adults and children may pose ethical dilemmas for professionals who need to weigh (a) the harm of rejecting the child’s touch, (b) the possible therapeutic effects of allowing the child to participate in appropriate touch, and (c) the harmful messages possibly communicated through always allowing the child’s touch. This falls under the rubric of General Principle A: Beneficence and Nonmaleficence, “psychologists strive to benefit those with whom they work and take care to do no harm” (American Psychological Association, 2002, p. 1062). However, very little is written on such circumstances of touch in psychotherapy with children.

E. W. L. Smith (1998) listed five forms of touch in psychotherapy: inadvertent touch (e.g., child brushes a female clinician’s chest), conversational markers (e.g., a touch used to get a therapist’s attention), socially stereotyped touch (e.g., handshake), touch as an expression of the therapeutic relationship (e.g., hugging), and touch as a technique (e.g., touch used in touch and massage therapies). I add four forms of touch that specifically happen between therapists and children related to helping the child (e.g., holding a child’s hand to lead a child somewhere), protecting the child (e.g., removing a child who has climbed on the window sill), playful touch (e.g., tickling), and normative touching initiated by children (e.g., child leaning on an adult).

It is hard to conduct therapy with young children without some form of normative or inadvertent touching by the child. However, inadvertent touch may also create dilemmas in therapy. In the example of the child brushing a female clinician’s chest, depending on the age of the child, the clinician may decide to just say “whoops,” drawing attention to the ill-timed touch and choose to watch for patterns of such “accidental” behaviors. The clinician may alternatively choose to open a discussion with the child about the touch.

Touch is such a pervasive part of children’s play and thus the way children play with others that this issue inevitably arises in play therapy. In fact, touching is so natural for children, one might question why a particular child may be wary of touching the therapist (e.g., the child is not feeling connected, the child does not like touching, the lack of touching is diagnostically related, etc.). Furthermore, it would be inappropriate in many circumstances to withdraw from a young child’s hug. However, the therapist should carefully consider seemingly appropriate touch with a child who frequently displays overly sexualized behaviors. Whereas norma-
tive touching by the child need not be overemphasized, the therapist should be cognizant of how and when it occurs. If certain touching makes the therapist feel uncomfortable, this may be an opportunity to talk with the child about personal boundaries, emphasizing how everybody has different ways that they like or do not like to be touched. Furthermore, a therapist must also be careful not to convey to a child that touch is the only way for them to gain the therapist's attention or warmth.

**THERAPIST-INITIATED TOUCH**

Many of the types of touch listed earlier, including inadvertent touch (e.g., a therapist accidentally stepping on a child's foot), conversational markers, socially stereotyped touch, touch as an expression of the therapeutic relationship, touch as a technique, protective touch, playful touch, and touch related to helping the child, are ways therapists initiate touch with children. Protective touch is used to provide a sense of safety (Hunter & Struve, 1998). Naturally if an adult senses danger, he or she would draw a child near. For example, a therapist walking with a child client might pull the young child close if walking past an unleashed dog. Additionally, a fearful child will tend to move closer to the adult whose care they are in. Playful touch may be used to diffuse a tense situation (Hunter & Struve, 1998). For example, a child testing limits in a playful manner may be best responded to in a playful manner with a gentle tickling of the knee or foot.

It is not surprising that therapists do touch children in therapy. Indeed, Rae and Worchel (1991) surveyed a group of pediatric psychologists about their behaviors and ethical beliefs in touching their child clients. The behaviors were rated on a scale ranging from 1 (never) to 5 (very often). Hugging and kissing were the only forms of touch measured. Forty-two percent of respondents endorsed that they sometimes hug a child, with 21.9% endorsing rarely, and 13% endorsing fairly often. Ninety-two percent of respondents endorsed never or rarely kissing a child, with no one endorsing fairly often or very often. Respondents were also asked to report their own ethical beliefs about the use of hugging and kissing a child in therapy. The Likert scale was rated ranging from 1 (unquestionably not) to 5 (unquestionably yes). For kissing with children, respondents consistently held a more conservative belief, as was reflected in their behaviors. Eighty-one percent of respondents endorsed unquestionably not or under rare circumstances for kissing children. However, for hugging a child, professionals were more split in their beliefs with 21% endorsing under rare circumstances and 73.4% endorsing under many circumstances or unquestionably yes.

In another study exploring a broader range of touching, Cowen, Weissberg, and Lotyczewski (1983) surveyed a group of 51 clinicians comprised of 40 psychologists, six social workers, and five psychiatrists about the use of touch in psychotherapy with children. There were 363 children, ages 5 to 10 years, included in the
study. The survey found that clinicians participated in touch in 89% of the cases, hand holding in 49%, having the child sit on their lap in 22%, and hugging in 45% of the cases. In neither study were the respondents’ reasons for their choices or beliefs explored.

Because therapists do touch children, it is important to explore the decision-making strategies that should be used in considering touch in psychotherapy. Therapists must be able to determine when touching is or is not appropriate and be able to consider the risks and benefits of touch. There are seven broad areas to bear in mind:

1. Possible positive role of touch.
2. The child’s perceptions of touch.
3. Considerations related to the therapist.
4. The child’s safety.
5. A child’s history of abuse.
6. The child and family’s background.
7. Practical considerations.

Positive Role of Touch

For the consideration of touch to create an ethical dilemma, there must be some compelling reasons why therapists would use touch in therapy as well as important reasons why it should not be used. The use of touch in therapy can have numerous beneficial effects. Touch is an integral part of human physiological and psychological development. As babies, touching, handling, and cuddling is critical to survival and growth. Touch has been shown to have positive effects in the development of premature babies (Field, 2001; Montagu, 1978). Touch deprivation has been associated with physical violence, sleep disturbances, suppressed immune response, and growth deprivation (Field, 2001). Furthermore, massage therapies have been related to decreases in depression and anxiety in traumatized children, psychiatric child patients, and bulimic and anorexic adolescent girls (Field, 2001). Indeed, touch can be healing, nurturing, and calming.

Few studies have looked at the possible positive role of nonerotic touch as therapeutic in psychotherapy and even fewer in a child sample. One study (Clements & Tracy, 1977) that looked at tactile and verbal reinforcement for 10 emotionally disturbed 9- to 11-year-old boys compared tactile only (firm grasp of the shoulders), verbal only (e.g., “good job”), tactile and verbal reinforcements, and no reinforcements for each of the boys during an attention task and an arithmetic task. The tactile reinforcements had a significant effect on children’s behaviors. For the attention task, tactile only and tactile plus verbal reinforcements led to significantly greater levels of attention than the verbal only and no reinforcement conditions. For the arithmetic task, verbal and tactile reinforcements together were signifi-
cantly greater than tactile or verbal reinforcements alone, which were both significantly more effective than no reinforcement. In a similar study (Triplett & Arnesson, 1979), verbal only comforting (e.g., singing, talking) versus verbal and tactile comforting (e.g., stroking, rocking) was compared in pediatric patients ages 3 days to 44 months when they showed signs of distress. Tactile-verbal comforting was significantly more effective in relieving distress within 5 min than the use of verbal comforting only. Eighty-eight percent of the time, children in the verbal and tactile group were comforted compared with 17.5% of the time in the verbal only group. Touch is both a powerful reinforcer for children and an effective means of comfort.

Touch can be a useful tool in psychotherapy as reinforcement for a job well done as well as a means to calm and soothe a distressed child. A genuine touch can add additional validity to verbal communication. The importance of touch as a means of communication, expressing acceptance with a self-loathing patient, restoring contact with reality, having a controlled exploration of aggressive feelings (e.g., arm wrestling), and focusing a patient's attention have all been cited as times when physical contact with a patient may be beneficial (Durana, 1998; Mintz, 1969). It is expected that touch in child therapy would also have these benefits.

In addition, appropriate touch can be used to educate children about the expression of positive emotion (Aquino & Lee, 2000). Often children who come to therapy have a great deal of difficulty communicating both negative and positive feelings. Whereas therapists spend a great deal of time helping children not to express negative emotions with inappropriate behavioral reactions, it is also important to address how to communicate positive emotions. Touch can be combined with other forms of positive emotion expression to establish multiple ways a child can communicate connection and pleasure with important people in his or her life.

Client Perceptions of Touch in Therapy

Just because touch with children is normative and natural does not mean children cannot have a variety of reactions to being touched. No published studies to date have looked at children's perceptions of touch in therapy. There are some data that adult clients find touch meaningful in therapy that can be informative to thinking about touch with children. Indeed, adults have endorsed perceiving touch as positive in therapy. In narratives taken from adult patients (Horton, Clance, Stork-Eifson, & Emshoff, 1995), the four most highly endorsed themes were that touch created feelings of closeness and caring from the therapist (69%); "communicated acceptance" (p. 451) and enhanced self-esteem (47%); helped to "create a new mode of relating" (21%; p. 451); and/or gave the patient feelings of strength, assurance, comfort, and healing (p. 451). Another study (Geib, 1998) conducted in-depth interviews with 10 adult women who experienced touch in psychotherapy. Women who found touch in counseling therapeutic reported feeling that touch
helped them feel connected to reality, that they experienced a new way of relating, and that the touch communicated acceptance or increased their self-esteem. Similar to adults, children most likely experience touch in these positive ways.

Furthermore, positive touch in these studies has been related to several factors including “congruence of touch with the patient’s issues” (Horton et al., 1995, p. 449); “patient’s perception of therapist’s sensitivity to patient’s reaction” (p. 449); “patient’s ability to communicate with therapist about feelings toward therapist” (p. 449); and the therapeutic alliance, particularly the degree of the bond between the therapist and the patient. Geib (1998) found similar factors that were related to the client’s experience of touch as positive (six clients) or negative (four clients). These factors included whether the clients felt in control of the touch, whether they felt like the touch was for them or the therapist, how openly the touch was discussed, and congruence of the physical touch and the emotional intimacy. Indeed, positive touch with children is also related to these factors. Touch in therapy with children should be congruent with a patient’s diagnosis, mood, and affect as well as the level of closeness and bond between the therapist and child.

There were four themes among those women who found touch countertherapeutic (Geib, 1998). First, the experience was so gratifying that it made exposing negative feelings impossible. Second, the women felt anger about the resulting difficulty in discussing negative feelings, the lack of discussion of boundaries, and guilt related to feeling angry. Third, they felt that their therapists were vulnerable and needed protecting from their negative feelings. Finally, the women experienced the touch as repeating problematic dynamics they had experienced in their family of origin. It is difficult to extrapolate exactly how this may relate to children who are at different developmental levels than adults. However, one might expect that children would have similar experiences with touch in therapy.

Both of these studies (Horton et al., 1995, and Geib, 1998) have illustrated that it is extremely important for therapists to consider the message that their child-patients may be receiving. Children should not infer that they have no control over when they are touched or that they must participate in touch to take care of the clinician. Duran (1998) warned therapists to be careful of replaying power dynamics, which are pervasive in the culture. Although there is naturally a power dynamic between adults and children in society, the therapist should be wary of increasing the power differential or causing the child to feel exploited or coerced due to feelings of powerlessness. Furthermore, the therapist-client relationship also creates a power imbalance. The therapist’s role is specifically to help the child and the child’s family with a problem they have not otherwise been able to handle. Moreover, the relationship is one in which the child and family share intimate details of their life and that openness is not reciprocated. Whereas this is a very important part of the therapeutic relationship, it puts the family in a vulnerable position. Therapists should work to empower the family and the child. Touching can increase the power differential if only the therapist is allowed to initiate or termi-
nate touch (Willison & Masson, 1986). Therapists should work to give younger children who may initiate touch naturally and older children who have a clearer understanding of touch and its implications equal say in how touch transpires.

Moreover, the therapist will only begin to understand the child’s experience if she discusses touch with the child. The ability and opportunity to discuss touch with the psychotherapist appears to be vital in adults’ positive experience of touch and in therapists’ ability to adjust the therapy to the client’s needs (Geib, 1998). This is also important because touch can be easily misinterpreted, and thus, it is important to make intentions explicit. Therapists can casually ask children their experience of the physical interaction, phrasing questions as “Some children do not mind being hugged in therapy and others do, what was it like for you?” This can help make it easier for children to know that both liking and disliking a touch are normal responses. Whereas therapists should encourage discussion of touch with young clients, children may have more difficulty articulating their feelings and in turn be more likely to act them out behaviorally. Therapists should be vigilant to behavioral reactions to touch in therapy. It can be helpful to anticipate possible reactions by children and help them to verbalize the experience.

This leads to the point Aquino and Lee (2000) made about teaching children the boundaries of therapist/counselor touch. A therapist may wish to process the first few instances of touch and the client’s response as well as any other significant touches that arise later (Durana, 1998). Therapists need to be careful of the line between asking a child if he or she would like a touch and having the child construe the question as a request they cannot deny (Koocher & Keith-Spiegel, 1990). Additionally, it can be useful to practice with children how to say no to touch, showing them that it is both acceptable to say no and that saying no will not harm their relationship with the therapist. Whenever a child does say no to touch in therapy, it should be taken seriously, processed, and precautions should be taken by the psychotherapist in future use of touch with the child.

Not only should touch be discussed with children, it should also be discussed with parents. The child should know that touch should never be a secret. Having the child tell the parent about the session and the type of touch that occurred not only gives the child another chance to verbalize feelings about touch but also empowers the child because he or she is then the leader of the interaction and this teaches the child the importance of sharing information about touch with his or her parent.

Another consideration is the message being sent to a child by never using touch. One may be communicating that touch is indeed bad and needs to be avoided or that the child is not worthy of touch (Aquino & Lee, 2000). Further consideration should be taken related to the therapeutic setting. In group therapy or a residential setting, a therapist should beware of using touch with some children and not others and in turn sending a message of who is worthy of touch and who is not.
Considerations Related to the Therapist

First and foremost, a clinician participating in touch in therapy must ask himself or herself whose needs are being met (Holub & Lee, 1990). Above all, psychotherapists should always act with regard to their understanding of each child’s best interest and not respond to their own personal needs. For example, a clinician feeling anxious about a child’s upset feelings may offer the child a hug; however, this clinician must be sure that the hug is not an attempt to avoid dealing with the feeling due to the clinician’s own anxiety. Furthermore, child therapists may feel a great need or pull from the child to be the child’s protector, rescuer, or ideal parent (Koocher & Keith-Spiegel, 1990). A therapist may wish to provide a child with the affection the therapist did not receive as a child or receive affection from a child when they are having personal problems with their own children. This may interfere with the clinician’s role as the child’s psychotherapist and cloud the therapist’s judgment about appropriate boundaries. Additionally, clinicians do experience distress related to personal and/or professional problems, and at times, this distress can lead to the impairment of their clinical work in or outside of their conscious awareness (Sherman, 1996). It is important for psychotherapists to be attentive to their experiences of distress and work to ensure that the distress does not result in improper decisions regarding boundaries with clients. Goals about touch should be clear and countertransference reactions avoided in the use of touch with both adults (Durana, 1998) and children. Although touch should have a therapeutic purpose, this is not to imply that touch as a genuine emotional expression from the therapist to the child is never allowed. However, the therapist must consider how that expression will be received and understood by the patient, and if there is the possibility of confusion, touch may not be the best form of expression.

Aquino and Lee (2000) suggested that psychotherapists be clear about their institution’s policies on touch in therapy. Some institutions implement a “no-touch” policy. A possible benefit to such a stance is a clear, universal, and objective guideline for employees and patients. However, no-touch policies with young children may be impractical if not impossible. If a child crawls onto a therapist’s desk to reach a shelf, the therapist therapeutically and ethically must make every effort to make sure the child is safe and does not incidentally hurt himself or herself while in the therapist’s care. No-touch policies could have a detrimental effect on the therapeutic process. Durana (1998) suggested that when working with adults, if the therapist works in an institution with a no-touch policy, the therapist should make it clear that the no-touch policy is a clinical stance. Children, however, may have difficulty understanding that a no-touch policy is not about their personal relationship with the therapist. Furthermore, children are likely to forget the no-touch policy. Having to frequently address inadvertent and appropriate touch may distract from the therapeutic process.
Clinicians also should be aware of their own views of touch. Some clinicians may be more uncomfortable with touch, whereas others may use more touch and be more physically affectionate in general. Kertay and Reviere (1993) pointed out that if a therapist is uncomfortable with the use of touch or unsure about its benefit to the therapy, this most likely will come across to the client. Such attitudes may send subtle messages to the client about the meaning of touch and the therapist's own feelings about touching them. In addition, touch that is not genuine probably will be communicated to the client as disingenuous and engender detachment in the relationship (Kertay & Reviere, 1993). When working with a child who frequently touches, the therapist should find the most appropriate, comfortable, and natural interaction with the child rather than forcing artificial exchanges.

Other therapists may spend more time touching children both in and outside of their practice. Whereas this can be a very natural adult–child interaction promoting connection and caring, it may not work well with all children. More affectionate therapists will need to be particularly cognizant of issues related to touching children in the therapeutic process. Specifically, they need to be very aware of the patient's background, the degree of the therapeutic bond, and the patient's reaction and ability to communicate it. This is critical with children with sexualized behaviors in which touch may need to be limited. This is also very important with aggressive children who may have difficulty gauging a neutral touch versus an aggressive touch or who may have difficulty returning touch in a gentle, nonhurtful way.

Child's Safety

Another important question for child clinicians to contemplate is whether touch is needed to keep the child safe. What if a frustrated client is hitting his or her head against the wall during the therapy session? The therapist must quickly assess the chances the child will actually hurt himself or herself. Usually the first response to the child would be verbal limit setting; however, children test limits. At what point do therapists physically put their hand between the child's head and the wall? Clearly, therapists must use their clinical judgment and the minimum interference in the children's right to autonomy with their own body. The clinician must also consider the child's possible reaction. Clinicians must ask themselves if becoming physically involved might escalate the situation. The therapist should also consider precautions that can be taken to keep any safety issues to a minimum. For example, when going on a walk with an impulsive child it may be more advantageous to walk with the child inside the building as opposed to outside where the therapist might be forced to hold the child's hand to prevent the child from running into the street.

Child's History of Abuse

Although not often discussed, sexual exploitation of children does occur in therapy and therapeutic settings. Sexual contact with children is not only prohibited by the
American Psychological Association (2002) Code of Ethics, Standards 3.04, "avoiding harm" (p. 1065); 3.08, "do not exploit clients" (p. 1065); and 10.05, "do not engage in sexual intimacies with current therapy clients/patients" (p. 1073); it is also illegal. Bajt and Pope (1989) surveyed members of the American Psychological Association's Division 37 (Child, Youth, and Family Services) with fellow or diplomate status and psychologists who have published in the area of therapist–client sexual intimacies to investigate this phenomenon. The survey asked for reports of "any instances of sexual intimacy between a therapist and a minor client" (Bajt & Pope, 1989, p. 455) encountered by the respondent. Ninety out of 100 individuals responded to the survey; 22 persons reported having encountered a situation of therapist–child client sexual intimacies. Because many participants of the study were surveyed specifically because they had published in the area of therapist–client sexual intimacies, the sample of psychologists collected were more likely to have been exposed to child clients who have experienced sexual exploitation. Bajt and Pope did not suggest that they were making precise estimates of sexual encounters that occur between children and child therapists. What is illustrated in that article is that such events do occur and the need for consideration of these occurrences when thinking about touch in child therapy. Bajt and Pope suggested that therapists be alert to clients' previous therapeutic experiences. Indeed, negative therapeutic experiences would most certainly impact a client's view of touch in therapy.

The fact that sexual touch in therapy happens has serious implications for therapists working with children. At times, children may have difficulty differentiating between fact and fantasy. Children who have been abused may have particular difficulty separating a scary feeling from actually being in an abusive situation. Ironside (1995) described a 4-year-old boy with a history of sexual abuse who made an allegation of sexual abuse by his therapist. Although Ironside did not specifically discuss touch, he talked about how the child would remove his clothing in session or at times wet them with urine or water. The allegation was unsubstantiated, and therapy continued; however, both the child and the psychotherapist were affected.

Furthermore, children who have experienced any kind of history of physical or sexual abuse may have a much stronger reaction to touch by adults. In one study (Horton et al., 1995), adult patients who endorsed having sexual problems, a history of sexual assault, or phobias reported experiencing touch as significantly more positive than those who endorsed other concerns. Such patients may have a more distorted view of touch, seeing it as more positive than other patients may, or the touch may have had a greater restorative impact for these patients. One might suspect that appropriate use of touch could have therapeutic effects with abused children also. Indeed, touch may be a very important topic in therapy with an abused child to help the child to develop a healthy understanding of touch. However, clinicians should be especially attentive to the decisions related to touch because these children may be especially vulnerable to the detrimental effects of insufficiently
considered touch. In addition, abused children many times have a heightened sense of perceived threat and may more easily misinterpret touch.

Similarly, a family’s past history can impact the way the child and the child’s parents perceive touch in therapy. For example, a family who are refugees from a war-torn country may have a greater mistrust of authority figures or may have experiences with torture or abuse, and this could impact their perceptions of a psychotherapist’s physical contact with their child.

Child Background: Culture and Gender

Culture is based on many personal and historical characteristics, including race, ethnicity, nationality, religion, sexual orientation, and gender. Each of these variables may interact to impact a client or parent’s notion of touching. Therapists need to be aware of their clients’ cultural background and how the use of touch may differ in that culture. Indeed, touch as conversational markers, socially stereotyped touch, and touch as an emotional expression vary cross-culturally. In some cultures, touch is used more freely than in others (Remland, Jones, & Brinkman, 1995). For example, French, Italian, and African cultures touch more freely and spend more time touching their children (Field, 2001). Touching is also related to socialization strategies. Japanese mothers have been found to touch children more, whereas American mothers tended to emphasize verbal interactions more (Montagu, 1978). This was suggested to be consistent with cultural interaction preferences, with Americans preferring self-assertive behaviors and Japanese preferring interdependent and passive interactions. Furthermore, in American culture there is a pervasive stigma against touching children for fear touch will be equated with child sexual abuse (Field, 2001; Ward, 1990). In turn, touching can be dangerous in its implications for abuse yet powerful due to its developmental significance (Field, 2001).

Touch in America also appears to differ by ethnicity and gender. One study (Ford & Graves, 1977) that investigated prosocial touch in 16 Mexican American and 16 White elementary school children found that Mexican American girls engaged in more episodes of long duration touching (e.g., handholding, arm around shoulder or waist) than Mexican American boys or either White gender. Another study (S. J. Williams & Willis, 1978) that examined touch in 3- to 5-year-old Black and White children found a higher frequency of touch between same-sex Black children than same-sex White children or opposite-sex touch.

Indeed, gender can have a large influence on what is deemed appropriate touch in a particular culture. Based on therapists’ ratings, Cowen et al.’s (1983) survey of physical touch used with children revealed that girls were hugged more often, and younger children in general were touched more often. Female clinicians reported touching, hugging, and allowing the child to sit on their lap more often than male clinicians. This study emphasizes the importance of considering gender of the
child and therapist in touch in psychotherapy. Gender-related cultural expectancies may include a greater mistrust of men in relation to physical or sexual abuse and/or a greater societal pressure for women to nurture through touch. Moreover, there is a stigma against male-to-male touch in Western cultures related to perceptions of masculinity and homophobia (Hunter & Struve, 1998). Because touch in American culture is so complicated by sexual implications (Hunter & Struve, 1998), male therapists may be less comfortable touching clients of either gender. Furthermore, male children may also have a more complicated response to touch in therapy.

Moreover, therapists must keep in mind how the child’s parents will perceive the touching due to their own background and culture. Aquino and Lee (2000) suggested the use of informed parental consent and children’s assent around touch. Indeed, this may be a good opportunity to discuss with parents their culture, their personal ideas of types of touch between children and adults, and what types of touch are likely to occur in therapy. In addition, having a cotherapist in the room at times when touch may be used could reduce feelings of anxiety on the part of the child and/or the therapist (Aquino & Lee, 2000). Another option is to include the parent at times when more intimate touching may occur, for example, having sessions arranged so that the parent is in the room at the end of the session, when goodbye hugs occur.

Practical Considerations

Clinicians should think carefully before using touch in psychotherapy due to the risks involved in using touch in the therapeutic setting. Concern lies in the American Psychological Association (2002) Ethics Code, Standards 3.04, “avoiding harm” (p. 1065); and 3.08, “do not exploit clients” (p. 1065), as well as the therapist’s own fears that nonerotic touch in therapy could be seen as evidence of wrongdoing if the therapist were accused of exploitation. Concern lies not only in whether touch may have been inappropriately used but also in whether nonerotic touch suggests the possibility of erotic touch because unfortunately, some therapists do exploit children (Bajt & Pope, 1989). There is no evidence that nonerotic touch leads to erotic touch in the exploitation of children or adults (Holroyd & Brodsky, 1980); however, sexual involvement with adult patients is typically preceded by other less invasive forms of boundary crossings and boundary violations (Gutheil & Gabbard, 1993). This raises the question of whether minor boundary crossings, such as touching, compromise the therapist’s objectivity and eventually lead to boundary violations and client exploitations. Several authors have suggested that this is not universally or even typically the case and that well chosen physical touch can be helpful to patients (Kertay & Reviere, 1993; E. W. L. Smith, 1998). Because minor boundary crossings do typically precede boundary violations (Gutheil & Gabbard, 1993), such minor boundary crossings have been used
in court as evidence of a growing inappropriate therapist–client relationship despite not being boundary violations in and of themselves (M. H. Williams, 2003). Thus, practitioners need to carefully document touch in therapy and why touch was important for the child. This can provide protection for the clinicians in case the therapist's behaviors come under scrutiny or litigation. In addition, documentation provides another opportunity for practitioners to review and examine the event and their own responses and behaviors (D. Smith & Fitzpatrick, 1995).

Finally, clinicians should consult about any ambiguous situations or uncertainty (Aquino & Lee, 2000). The importance of consultation cannot be overemphasized. One study (Gooch & Sells, 1996), which looked at counselors' evaluations of videotaped vignettes on the counselors' expertness, attractiveness, or trustworthiness, found that the use of touch did not have an impact on the evaluation. Unfortunately, the counselors were not asked to assess how ethical they believed each counselor was. Therapists may be nervous about discussing touch with other practitioners to get their outlook because of their fears of how using touch may be viewed by the other professionals. This study (Gooch & Sells, 1996) suggested that touch per se will not discount one's expertness or trustworthiness in the eyes of other therapists.

GUIDELINES IN THE USE OF TOUCH IN THERAPY

Touch may not only be inevitable in therapy (e.g., child-induced touch, responses to acting out) but may at times provide a very therapeutic experience for the child. Ethical considerations of the use of appropriate touch lie in the ethical principle that above all, therapists should do no harm and avoid exploitation. In addition, psychotherapists must consider what is in the best interests of the patient. The use of touch can have powerful meaning to patients and possibly further the growth of the client and therapeutic relationship (Horton et al., 1995). To avoid harm and use touch as a means to promote growth, psychotherapists should consider several guidelines and ask themselves a number of important questions before deciding to engage in touch with a child.

1. Whose needs are being met by the touch, the child’s or the clinician’s? Touch should always be considered in the interest of the child.
2. Is touch needed and necessary to keep the child safe? Are there any precautions that can be taken to avoid an unsafe situation?
3. Is touch needed to keep the therapist safe? If touch is needed, (a) follow the parent’s lead if the parent is available and (b) use the minimum force needed to neutralize a child’s attack (E. W. L. Smith, 1998).
4. Be clear about personal views and institutional policies on touch in therapy.
5. Take into account the child's culture and gender when deciding how touch will be perceived by the child and the child's parents.
6. Consider the child's diagnosis, abuse history, and the family's history of abuse.
7. Be careful not to replay power dynamics pervasive in the culture.
8. Discuss with the child his or her experiences of touch in the therapy. Be aware of behavioral communications about touch in therapy.
9. Discuss touch with parents.
10. Practice having the child say no to touch and tell his or her parents about touch.
11. Use informed consent procedures with parents and obtain children's assent.
12. Consider having another person, such as a cotherapist or parent, in the room during times touching typically occurs.
13. Consult with other professionals about touch used in therapy.
14. Document touching in therapy. Use this as an opportunity to review and examine touch that occurs in the patient’s therapy.

FUTURE DIRECTIONS

Future directions in the area of nonerotic touch with children include increased training and research. Training in the ethical use of touch in child therapy should be integrated into programs in three ways: in child psychotherapy classes, ethics classes, and supervision with interns doing child therapy. Focus groups and narrative interviews with professionals in child therapy could be used to gather information about the frequency and types of touch used with children, how professionals make decisions about using touch, and how their child patients have reacted to touch. Surveys attempting to capture how often touch is occurring should be expanded to include the many types of touch in addition to hugs and kisses. Furthermore, research recording therapy sessions with children would be helpful in gaining a more objective view of what is happening with touch in child psychotherapy. In addition, there may be several factors related to the frequency and type of touch in psychotherapy with children including type of treatment (play therapy vs. family therapy), clinician's gender, child's gender, age, diagnosis, and history of abuse. Exploring child and parent perceptions of touch in therapy would provide a greater understanding of how it may be helpful and how it might be harmful to child clients. Important questions to answer include what do therapists do that makes touch positive or problematic for children and what improves or impedes children's ability to articulate their experiences of touch to their therapists because this appears to be vital in the positive experience of touch. In addition, research
should focus on what variables are related to children's perception of touch (e.g., child's gender, diagnosis, age, history of abuse, culture, and therapist's gender).

CONCLUSION

There are many types of touch that can occur between therapists and child clients during the course of psychotherapy. Focusing on nurturing touch, Aquino and Lee (2000) examined the potential benefits and risks of its use in therapy with children and developed guidelines for practitioners to consider. In this review, I expanded both on the types of touch between therapists and child clients that were examined (e.g., touch to keep the child safe, child-initiated touch) and considerations and guidelines that need to be regarded. Overall, the practice of touch in therapy with children can be a powerful tool with some children if carefully thought out by psychotherapists. Practitioners need to make decisions about the use of touch in their practice, with a particular client, and in a particular moment. Precautions should be taken toward preventing the misunderstanding of touch in therapy by including the use of informed consent and assent; discussions between the psychotherapist, the child, and the child's parents about events that could or have already occurred in therapy; having another adult in the session; and thorough documentation of these events. Clinicians should be clear about the purpose of the use of physical contact and incorporate helping the child understand appropriate adult–child touch. Finally, counselors should not shy away from seeking consultation about the use of touch in therapy pertaining to past or future experiences.

REFERENCES


