Paper on Touch

Clinical, Professional & Ethical Issues

"Touch functions on many levels of adaptation, first to make survival possible and then to make life meaningful" (Brazelton, 1990, p. 561).

Introduction

In the context of this paper, *touch* refers to any physical contact occurring between persons in the course of the play therapy session. In its most positive form, touch is nurturing and supportive and may include a pat or a hug. There is also fairly neutral touch, such as holding a young child's hand on the way to the playroom to prevent the child wandering off. There is touch that the child may experience as unpleasant, such as taking a child's hand to stop him or her from hitting a sibling in session. Each of these types of touch is discussed below. The purpose of this paper is threefold: 1) to provide practitioners with information they may find useful in deciding whether touch might prove clinically useful in their work with a given child, 2) to stimulate thinking about the pros and cons of using touch in play therapy, and 3) to encourage additional research on this topic.

When a child experiences touch from a loving, safe caregiver many things happen to promote healthy growth. Children develop a sense of self and the ability to relate to others; they learn to modulate affect; and develop a belief in his or her own self-worth and ability to master their environment. Research indicates that touch is essential in forming healthy parent/child attachments, promotes physiological development, reduces the effect of stress on an infant, and promotes positive body image (Jernberg & Booth, 1999). Touch is considered essential to the human experience and is a powerful form of communication. Touch, when used appropriately, can promote growth and provide healing. When misused, touch can impede healthy development and cause harm. Because touch is such a complex, powerful form of communication, the play therapist must carefully evaluate and understand their own motivations for using or not using touch, and whether or not this decision meets the needs of the child.

Touch in Play Therapy

1. Preparation – Training

Before incorporating touch into play therapy sessions, play therapists should be trained in the nature of touch as well as the related developmental, therapeutic, ethical, and pragmatic issues. Play therapists are aware that different cultures place different values and meaning on touch and therefore strive to understand how touch is expressed within the culture of the children they are working with. Further, before incorporating touch into play therapy sessions, play therapists should understand the various theoretical orientations to the clinical use of touch. Finally, play therapists should maintain an ongoing relationship with the literature in the field of touch.

2. Preparation – Informed Consent and Documentation

Play therapists should be aware that touch has become a very sensitive topic in contemporary society. As such, the therapist must be prepared to manage not only the reality of any touch that occurs in session but the perception of that touch by the child and the child's caretakers. This is best accomplished by ensuring that the child's caretakers have provided informed consent before touch is introduced into the play sessions. Play therapists should do their best to give children and their caretakers examples of the types of touch that can happen during play therapy (see sections 6-8 below), realizing that all situations cannot be anticipated. Issues of physical safety and sexual boundaries should be discussed with parents or guardians, as should any relevant documents that the supporting agency maintains. The play therapist should consider the use of a separate written release form regarding physical contact. The play therapist

should also document any/all forms of touch that transpire in session, noting who initiated it, how it was addressed/implemented and the consequence/reaction.

3. Implementation

Touch should only be considered when it BOTH meets the needs of the child and is consistent with the treatment goals. The types of touch, its frequency and duration over the course of treatment, should correspond to the child's developmental level and needs

4. Supervision/Consultation

Due to the complexity of the issue of touch and the inherent power differential between the play therapist and child, the play therapist should consider individual or group training, supervision and/or consultation with other professionals who are experienced in the use of touch in play therapy. The play therapist must be willing to give careful thought and consideration to the decision to use or not use touch in relationship to the child's needs as well as the therapist's own motivations, thoughts, and feelings. In the event that a potential ethical conflict occurs in the context of touch, the play therapist seeks appropriate supervision/consultation.

5. Ethical Considerations

Sexual contact and/or erotic touch between play therapist and child is ethically, morally and professionally wrong. Touch should also be avoided when there exists the potential for exploitation due to power differential. Since there is an inherent power differential between play therapist and child and coercion can be very subtle, this possibility should be closely monitored by the play therapist. The play therapist should not touch the client when the play therapist is uncomfortable with the touch, sexually aroused, or angry. Extreme caution should be exercised in situations where the child might construe the touch as either aggressive, punitive or seductive.

6. Special Considerations: Non-Erotic Touch

Play therapists recognize that touch comes in many forms and occurs in many contexts within the play session. Oftentimes, the use of touch is foreseeable, such as when a child asks for a 'high five' or wants to sit on the therapists lap while reading a story. Other times, the child may spontaneously touch the therapist such as in giving an unsolicited hug, wishing to be escorted to the bathroom, or climbing onto the therapists lap without warning. Still other times, unpredictable circumstances may arise in which the therapist may need to touch the child for reasons related but not limited to physically guiding the child in a play activity such as climbing, climbing unsafely in the playroom or playground, locking him/herself in an unsafe space in the facility, or bolting from the playroom in the absence of a waiting caretaker. In any or all of these circumstances, the play therapist carefully monitors his/her touch response, utilizes touch with a clear rationale and appropriate intensity and acts in the most judicious manner in order to maintain safe conditions for the child and/or comfortable/acceptable boundaries for him/herself. All incidents of any of these examples of touch are to be documented and discussed with the child's guardian. Play therapists working in educational and/or treatment settings that have specific policies regarding touch that differ from their own, consider those policies, address such with their supervisor and guide themselves accordingly.

7. Special Considerations: Abused or Traumatized Children

The decision to use touch in play therapy with a child who has been traumatized and/or physically or sexually abused is determined on a case-by-case basis. The use of touch is not automatically excluded because a child has experienced trauma regarding *bad touch* but the therapist needs to be even more vigilant in monitoring and managing the child's perception and experience of being touched. The symptoms of trauma and the maladaptive coping strategies the child develops may be appropriately treated with touch. A play therapist is ever vigilant not to retraumatize a child and understands that the child, in order to heal, may need to experience safe, good touch. Further, the play therapist that has not been specifically trained to work with this population, will require supervision from a clinician who is

competent to do so. As always, the use of touch is integrated into the treatment plan, and the play therapist always asks permission of the child before touching in this context.

8. Special Considerations: Group Work

While most of this paper focuses on touch or physical contact between therapists and their child clients, the therapist must also monitor any physical contact that may occur between children in the context of a play therapy group. All play therapists should have a plan (even if it does not involve touch or restraint) for how they will manage extreme violent or self-endangering acting out on the part of a child in session. This plan should be consistent with their training in restraint and the policies on restraint in the facility in which they are working.

- The rule not to hurt others should be stringently observed.
- The therapist must set limits on all physical, and, in particular, any sexualized contact between members of the group.
- The therapist needs to make the group aware that different children have different needs for physical contact and/or physical distance or space.

Rules should be established whereby the children respect each other's boundaries. When and if inappropriate touch or contact does occur, the therapist should inform the children's respective caretakers and take precautions to ensure that the problem does not reoccur. Play therapists who plan to utilize group therapy should seek out supervision from a clinician who has been trained, and when possible, certified in group therapy.

9. Special Considerations: Physical Restraint

Physical restraint is the most challenging and often times difficult form of therapeutic physical contact that can occur between a child and a play therapist. This is because the child will almost never view the experience as positive while it is occurring. Yet, there may be occasions, particularly when a child is being seen in a residential treatment center or hospital, where the play therapist's ability to effectively and safely restrain the child is essential to maintaining the child's safety in the playroom. While this is most often the case when working with more severely disturbed children, the need for restraint may arise at any time and in any treatment setting, after less restrictive means have been attempted.

Play therapists working in a setting in which restraint is commonplace make sure that they receive the necessary training and become thoroughly familiar with any laws in their state regarding the use of physical restraint. All play therapists should have a plan (even if it does not involve touch or restraint) for how they will manage extreme violent or self-endangering acting out on the part of a child in session, and this plan should be consistent with their training in restraint and the policies on restraint in the facility in which they are working. Should restraint become necessary, the event must be processed with both the child and the caretaker immediately after ending the restraint procedure. In the event that the play therapist is not comfortable, for any reason, in utilizing restraint, he/she should make arrangements with alternate personnel for doing so. All incidents of restraint should be carefully documented.

10. Disclaimer

The information contained herein are guidelines only to be used as a reference for play therapists. This information does not replace and is not, and should not be used as a substitute for any standards, guidelines or other rules and regulations by which play therapists are bound, including ethical standards of their parent licensing body. Play therapists are entirely responsible for their own professional activity. In no event shall APT or any branch be liable for any reason to any member, client or other individual for any decision made, action taken, omission, misdiagnosis or malpractice that may occur as a result of treatment provided by any play therapist. APT and the branches have no control over the services provided by any play therapist and disclaim any and all liability for any loss or injury to any member, client or other individual caused by any play therapist. The data and statements in the materials provided herein are the sole responsibility of the authors. APT shall not be responsible or liable for the consequences of

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11. Revisions

- Initially crafted by a task force comprising Chair Trudy Post Sprunk (GA), LMFT, RPT-S, and members Jo Anne Mitchell (GA), MEd, LPC, RPT-S; David Myrow (NY), PhD, LP, RPT-S, and Kevin O'Connor (CA), PhD, LP, RPT-S, in 2001.
- Reviewed but not revised by Chair Jeff Ashby (GA), PhD, and the Ethics & Practices Committee in 2006.
- Reviewed and revised by Chair Lawrence Rubin (FL), PhD, LMHC, RPT-S, and a special Ethics & Practices Task Force in 2009.
- Next review 2012.

Resources

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