ABOUT THE ETHICS OF PROFESSIONAL TOUCH

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Abstract:
Professional touch in psychotherapy, body psychotherapy and body therapy does not have any single clear ethical basis. Ignorance, fear and prejudice often align touch with sexual contact and thus abuse. Limitations are variously imposed. Ignorance, fear and prejudice often align touch with sexual contact and thus abuse. Cultural & gender differences make a significant impact. The experiences and the needs of the client impose indications and contra-indications on the therapist's use of touch.

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,[1] [2] [3] and whilst there have also been many hundreds of studies to demonstrate conclusively that touch can have very beneficial and therapeutic effects,[4] inappropriate touch can also be very disturbing, offensive and even traumatic. Touch in certain cultures is also seen to be taboo between certain sets of people and for certain (assumed) reasons.[5] This is therefore a complex and contentious topic and nowadays it is being dealt with at some length: simple prohibitions or declamations are insufficient.

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 exactly 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.

Whilst most of this article refers to the use of touch in psychotherapy, I have included, when appropriate, body therapists. It is also perhaps important to note that working in the field of Body-Psychotherapy does not necessarily require psychical contact with or the touching of a client.[6]

This increased clarity does not have to constrain us, as professionals, from research or experimentation in the field of touch. But it behoves us to examine carefully whatever boundaries we happen to come across, or up against, and see whether the 'rules' or 'taboos' that exist about touch are still valid for these changing times, or, whether we are operating under sufficiently different circumstances to try to implement change, as blanket rules can sometimes be inappropriate.

As psychotherapists who touch, we need to realise that we are potentially stepping into a professional minefield: we may easily make mistakes and we might

not get support from other professionals: we might even get 'shot at'. In general, we do not truly learn any 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. If we work with this beneficial and powerful tool called 'touch', we really need to know what we are doing and whether or not we should be touching at any one moment, or with any one person.

Psychotherapists usually think about touch according to the theoretical model that they have been trained in. Often discussion is limited to an exchange of theoretical models without any of the underlying concepts ever being brought to light. Many psychotherapists and counsellors are ambivalent or anxious about touch, say that they feel uncomfortable with touch; they have not been trained in touch; and they do not touch in the therapy session. However when prompted with 'touch' examples such as handshakes, hugs, kisses on the cheek, pats on the back, etc. will often admit to such 'touch episodes' in therapy. Frequently these are seen as 'not part of the therapeutic process' or as happening in 'social space' before or after the formal therapy session, and are not treated as 'touch episodes' for supervision purposes.[7] But can clients distinguish between the two? Maybe we need to get more precise and clearer about what we mean by touch in the therapeutic context.

In certain situations, (possibly like the one quoted in footnote 7) if we happen to do something that involves 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 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 resuscitational back-up, but operating clearly from within the bounds of wide knowledge, professional training, and good practice.

There are also situations where <u>not</u> touching in psychotherapy may be considered unethical. Zur[8] suggests that:

- *Practicing risk management by rigidly avoiding touch is unethical. Therapists are not paid to protect themselves, they are hired to help, heal, support, etc.*
- *Avoiding touch in therapy on account of fear of boards or attorneys is unethical.*
- *Rigidly withholding touch from children and other clients who can benefit from it, such as those who are anxious, dissociative, grieving or terminally ill can be harming and therefore unethical.*

Without more clarity about this topic, we are like sailors without a chart or compass steering blindly into unknown seas in search of 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 or trainees, nor may it be helpful to the rest of us who may be aligned with such risky enterprises. Only with a greater professional clarity can we begin to test the 'normal' boundaries; or to do research with good parameters, proper record-keeping, and

repeatably testable hypotheses; and properly examine some of the 'grey areas' around touch in psychotherapy. One of these is to dissociate between professional touch in psychotherapy (by a Body Psychotherapist) and other therapies that use touch (Body Therapies). These latter may include various massage techniques; shiatsu acupressure; Touch for Health; physiotherapy, chiropractic, cranio-sacral work, Hellerwork; Reiki, and many others.

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 centres 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. However it also transpires that 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 and doing what they have been taught. These people may think they have been properly trained as Body-Psychotherapists, but I would now wish, through this essay, to raise this issue and dispute the quality of their training; maybe even their classification as a Body-Psychotherapist, if they do not know, or deliberately ignore, what is considered by everyone else to be the proper parameters of ethical touch. It is time perhaps to expose aspects of 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 seem to be getting much higher.[9] Touch is not a large art of the baby and child's experience and thus taboos about touch, as well as other neuroses, can perpetuate. This has resulted in more explicit thought and work now being put into training, supervision and into professional standards both for psychotherapists and for body workers. However, much of this is still fear-based and is centred essentially around what not to do, so as not to get prosecuted or sued. And whilst a number of practitioners have been prosecuted, sued or professionally condemned for unprofessional conduct or inappropriate touch, none of the Codes of Ethics of the main American professional associations actually forbid touch or see it as unethical (APA, ApA, ACA, NASW, CAMFT). [10] There are still practitioners out there restricting touch in therapy because of (perceived) fear or threat, and there is probably still considerable room for improvement in general professional attitudes.

> *The cultural taboo against touch in psychotherapy encourages therapists to perpetuate the neglect that originally caused the injury. Therapists tend to avoid touch, to neglect consideration of touch in a well thought out treatment plan and to avoid talking about this with clients. Touching clients can hurt them if done in the wrong way but touch can also heal old touch injuries. Not touching can cause injury to certain clients in certain situations. The silence about this in our education and training programs of therapists, in supervision, or in actual therapy with clients often results in less effective therapy.*[11]

Some of the therapists who seriously transgress 'touch' boundaries do it from their own unresolved needs: this is a form of counter-transference. It is also potentially abusive and can break the therapeutic relationship and ethical boundaries. If the few people (that we know about) who do transgress only did

what they had been taught, it might be all right. But, like many things, touch and bodies have become sexualised and attitudes towards touch, skin, and bodies are considerably distorted. So I am writing this essay to try to raise some of these points for discussion: I am not pointing the finger and neither am I wanting to say 'this' is right or 'that' is wrong.

I know of at least two instances where a certain type of deep touch was being taught and practiced, as an adjunct to a particular form of psychotherapy, without what I would now consider as 'proper' safeguards. In both these specific instances, so much 'body energy' was released by the touch that the client could not cope and went into something very like a psychotic episode involving eventual admission to a psychiatric hospital. I know of several other instances where quite deep and invasive touch has been applied, almost as a matter of course in this particular type of therapy; furthermore, in these cases, no proper psychodynamic 'history' was taken and no proper 'risk assessment' was made as to the suitability of this treatment for this person. With some clients, this type of touch would be clearly contra-indicated, but the trainee therapists were taught (then) that this method 'had been developed by the founder' (of the method); 'had been practiced for many years', 'was well proven' (it was not), and 'was effective for nearly all types of person', etc. This is arrogance and it is dangerous.

Because we collectively in Body-Psychotherapy have no real "common ground" or clearly 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."* Even though we are beginning to establish parameters, we are still not able to criticise our colleagues and say: *"Sorry! What you are doing is* <u>not</u> *OK; for these reasons ..."*

In an EABP Internet discussion chat-room on the subject of touch[12]: Maarten Aalberse writes:

> *One thing I would like to mention ... about the "arguments against touch". I'd like to reformulate these as "dangers" of the therapist touching the client. Touch can be too intrusive, by introducing a physical closeness for which the client is not ready yet, by pushing the client's body to respond in a way that conflicts with patterns of responding that the client still needs, etc. Touch can be too seductive. It may "touch" desires of the client that have been deeply buried and that the client isn't yet able to deal with. The client may feel "seduced" to go deeper than he is ready to go, and will then become very dependent on the support of the therapist to survive the deep waters that he is seduced into. The touch may be experienced as "magical": the healing that the client experiences as a result of therapeutic touch is experienced as provided by the therapist. This may feed the grandiosity of the therapist and the idealization dependency of the client. The basis of a dangerously regressive and even exploitative relationship is set up.*
> *Note that all these three patterns have to do with the therapist bypassing resistances of the client. So we could say that one major pre-condition for a good use of therapeutic touch is that the therapist acknowledges and respects and knows how to explore the client's resistances. Or to look at it from a slightly different angle: - that the therapist is able to recognize signs of negative transference, knows how to bring this negative transference on the table and is able to help the client elaborate without resorting too soon to*

cheap interventions that mostly serve to protect the therapist, such as "To whom else did you feel this way?" "By whom else you feel intruded, (seduced, abandoned)?" - related to the above, that the therapist is willing and able to explore his needs (his therapeutic and personal needs) for touching, is willing and able to acknowledge, at least to himself, that he has made an error, and is able to restore a more authentic and respectful communication. Largely this means that the therapist is willing to be challenged (and to challenge himself!) his own narcissism.

This sort of analytical clarity is unfortunately quite rare in Body-Psychotherapy. There is an implied professional and personal problem whereby we can easily remain silent in such cases, because we dare not challenge the 'magical' component that possibly attracted us into training, or because we realize that we have hit upon a serious potential defect in our training – and don't feel able to ask about this, or because we discover a deeper and unresolved aspect of our self. Either way, individually we do not wish to expose either of these problems to any form of peer criticism or supervision, so that we can learn from it effectively. One of the reasons that several of us are writing about touch in this way are that, all to often, we have come across aspects of these forms of distortions of therapeutic touch. We want to speak out to protect the community of Body-Psychotherapists and their clients. However we are often met with further collective silences. However this discussion is gradually becoming more mainstream.

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

And most of 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 media, which carry their own hysteria about professional misconduct, also often report a situation wrongly or inaccurately or with bias and exaggeration. Many of us may thus be 'tarred with the same brush' by their association of us with such an 'erring' colleague, especially if we do not and cannot clearly and quickly differentiate what is ethical touch and what is not.

Hence I make this attempt to open up more of a dialogue on this topic with this particular form of extended essay. I do not have any definitive answers. This article is not particularly 'scientific'. I trust that it is reasonably 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 something towards the formation of some clearer answers for Body-Psychotherapy – and even for the whole profession of psychotherapy.

I can also dream that at some point we may even be able to rehabilitate the professional touch in psychotherapy and a proper and full awareness of the body back into this profession. I have spoken and written about this on several different occasions recently[13] and here I do not want to digress further from the

ethics of touch into this wider professional 'political' debate or campaign.

Professional Services:

The essential starting point is that the therapist, psychotherapist, or Body-Psychotherapist, is a professional is providing a contractual service, a therapy. The professional is paid for this service. The client decides to go to, or the patient is referred to, that professional for that service and for that service only. Once the service is performed, hopefully satisfactorily, the contract is concluded, and the two parties should have no need to contact each other further.

There is an inherent hierarchical situation built into the therapeutic relationship: the therapist has more power and influence based on their knowledge, training, techniques, and experience and the therapeutic situation implies that a degree of trust is needed from the recipient towards the therapist.

There is therefore an ethical position that the therapist / practitioner should not exploit that hierarchical position in any way whatsoever: and should not jeopardize that trust.

The '*primum mobile,*' the driving force behind any set of ethics is the protection of the client and an acknowledgment of this situation of therapeutic influence and trust.

Proper Boundaries:

The following extract 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 extract actually carries a much deeper message as well as some false arguments and assumptions:

> *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.* [14]

We just don't have proper professional boundaries with respect to touch: and most of do not know what we are doing: and very few of us can stand outside of the culture we grew up in and see what some of the taboos and distortions are doing to us. This is regrettable and quite difficult to state, but I hope that the following dialogue will go some way to establishing this more as a reality, and hopefully as the beginnings of an understanding. The opening introductory words of the book *"Touch in Psychotherapy"* edited by Edward Smith et al.,[15] 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, as already mentioned. 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 in Europe; and within our profession of Body-Psychotherapy, and for proper therapeutic touch. This can create a very different set of problems and a lot of confusions. We are trying to establish Body-Psychotherapy as a coherent and 'scientifically valid psychotherapy and to have it become politically and professionally accepted in Europe. These potentials confusions do not help and there is very little condensed material that does.

We do have a number of fairly vague statements made in certain ethical codes and I will discuss these shortly. We also have a whole raft of somewhat conflicting values and uses within the different modalities and methods within Body-Psychotherapy, which causes further confusion and dissent. There is finally the deep rift between Body-Psychotherapy and other psychotherapies about the professional use of touch in psychotherapy.

But I am also aware that, in writing this article, that 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. Some people believe that <u>all</u> touch is good and healthy - as long as it is done properly. I disagree with the first part of that statement (*<u>all</u> touch is good and healthy*) and I think the second part of the statement is very poorly defined (*as long as it is done properly*). I don't apologise for this view, but I do ask you to write in and tell me if you disagree, 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 (I was culturally conditioned too), and again, if you disagree with these, I would encourage you to write in.

I can foresee already several other articles, hopefully leading to a more open debate about some of these issues, and I welcome this very much: a number have appeared recently.[16],[17],[18]. The opening two issues of the USABP Journal[19] also started something of this debate and I refer to these articles, especially the one by Kerstin White, to try to continue the dialogue that she started. Recently a different attempt was made to create an e-mail discussion circle in the USABP Membership called 'The Pulse': unfortunately (or fortunately) an open question on touch got 'high-jacked' by a couple of non-members and diverted into a very heated discussion about 'genital touching' (which they advocated, but is clearly contrary to the USABP Code of Ethics). Maybe a different kind of discussion forum ('or chat room') is needed on the EABP [20] and USABP [21] websites, which can be used as another way of moving this dialogue further along. But the impetus for this development and for any further contributions really need to come from you, the practitioners, and from the people who are being 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 Phillips lists some of these, and I have expounded on them a little.[22] 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 transferential and counter-transferential issues then come into play. Maarten Aalberse mentioned this earlier. 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, and can also 'ground' the client-therapist contact.
- *Client Individuality* - Many clients and some therapists carry inherent contra-indications 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 different circumstances; because of different cultural backgrounds; different genders; different personal histories; different 'vibes' coming from the therapist; different emotional states in the client; 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.
- *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.] and should be embedded a the core of all psychotherapy training. But does a client sometimes say "Yes" when they are afraid to say "No"? As mentioned, with any particular client, there may be contra-indications 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.

- *Power differentials* - 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!
- *Restoration of Touch Deficiency* - I now add another point. It is fairly safe to say that many people coming into therapy have had a disturbed childhood, and one of the disturbances is often to do with touch or lack of touch,[23] whether this is acknowledged or not. It is possible, and often legitimate, to use the therapeutic space to help restore some of the deficiencies of childhood, and this can be part of the therapeutic content. Some Body-Psychotherapists think that this is what they are doing when they touch, or when they use touch in the normal course of their work: and this may well be true, and healing, and legitimate, and done very appropriately. They can, and maybe are, "restoring" touch to its natural place. My question to them is: *Is this an explicit part of the therapeutic contract?* Or are they assuming that this is why a client has come to them, or are they just practicing this method because this is the only way in which they have been trained. This actually happens in many other therapies, as in (say) the presumption in psychoanalysis that the client wishes to (or resists to) look at the transference of earlier emotional states on to the therapist.

So we have a number of very different ethical and professional issues already wrapped up in a very complex situation when we consider something as simple as touch in a therapeutic setting.[24] No wonder that we sometimes try to avoid the subject by <u>not</u> looking at some of these issues.

Ethical Codes:

In discussing ethics, and in particular the ethics of touch, we need to be clear that there are some common linguistic distinctions, especially as Europe is linguistically quite diverse: *'morals'* refer to that which is considered right or wrong and sometimes contain an element of judgment; *'ethics'* are a set 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 usual rationale for having an ethical *'code'* or enforceable rules of behaviour is that unethical practice can sometimes and does occur and the 'code' is an attempt to clarify or 'codify' what is desired behavior 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, and it can be changed over time, though amendments need to be accepted at a General Assembly.

Several of the functions of ethical professional 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.[25] One could also add: **(viii)** to give those defined as or feeling abused, some objective measurement and possible grounds for redress. We shall touch on the effectiveness of these a

little later on in this essay.

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 (for example): *"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, including the USABP's Ethical Code, as we shall see shortly. Perhaps these other professions' codes are a little absolutist, but maybe this is also a failing of our own professional association's ethical code, or an indication of something deeper going on within our particular branch of the profession. What we currently do have (in a slightly abbreviated form) is the following: ......

Extracts from current 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 clearly do not give us, or anyone, the clear and unambiguous guidelines that we might suppose we could need when we are dealing with the contentious topic of professional 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 probably 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, 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 in any clear manner.

As Co-chair of the Ethics Committee of the EAP,[26] 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 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 serious mistake in any ethical code to get too precise, as then an errant therapist might say (and sometimes does say), *"Well, you said I couldn't do that, but I was doing this."* One of the reasons that I liked the EAP / APA ethical formulation was that it does not constrict actions to this, or not to that, but it effectively states a level of aspiration of professional practice. This is harder to argue against, but does not lead us to further clarity about ethical touch, except in important general statements: the *"use of techniques"* and *"recognise and respect diverse attitudes and individual sensitivities"* are the important phrases above.

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', and to see all touch as being sexual is, of course, one of the huge distortions that is around. But the 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 being used as a channel for this power differential. In this case, you would also find similar differentials and unclarities 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 it is here, I think, where we might be making a subtle mistake.

The accepted social conventions, and thus 'moralities' about touch, vary considerably across different countries, cultures, professions, interest groups, and social classes. Using one or two examples to illustrate this point, 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 lovers in cafés touch each other in America. Secondly, the social mores about nudity in (say) middle-class mid-Western America vary considerably from those in (say) Sweden or Finland, and again these are probably very different from the conventions in (say) working-class Scotland, or in Switzerland, or in rural villages in Croatia. The normal common greeting in France is not a formal handshake, as in Scotland, but a two-handed contact to the arms or hands, and giving an 'air' kiss on either side of the cheek, irrespective of the genders. This approach might be seen as a homosexual assault in another country. Of course countries vary widely! Different groupings also vary widely: when living in the "New Age" Findhorn Foundation community in North-East Scotland, community members and guests would have contact with each other socially and publicly, fairly freely, using arms around shoulder, hugs, arm in arm contact, etc, which was fine within the environment of the Foundation, and was also capable of causing offence to prurient neighbours 500 metres away in the local village.

And so it is with touch, as well. Yet, as we consider this issue professionally, do we somehow expect psychotherapists to act in respect to touch in exactly the same way across the whole of Europe and America? We do! How surprising, and somehow how confusing this is as well.

Whilst we may wish professional therapists to act within the generally accepted conventions of the society in which they operate, especially within Europe with the emerging distinct profession of psychotherapy, recently we have also been motivated by the desire that (professionally and politically) we actually 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 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.[27] This was partly practical and partly political.

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 clinical psychology (Masters degree + Ph.D.), though nominally this latter training is sufficient to qualify one for the APA (American Psychological Association). There are also different degrees of professional licensure, some of which may make it possible to touch clients socially [28] and some which may be necessary in order to touch client professionally.[29] However to get licensure as a psychologist in any particular state, it can require additionally many 100s of hours of supervised practice (in California, 3,000 hours), on top of (or sometimes including) what is already required to qualify as a clinical psychologist. In some other US states, there seem to be less or little regulations on this point, though therapists can quite easily get into trouble (see Appendix 2). State licensure, archaic & un-repealed laws, and state-based ethical codes vary considerably as well, all within the same country.

Incidentally, there are currently 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 this topic will come from these.

It also appears that the APA is fairly limited with regards to its mentions of sex (which is different from touch, please remember) 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, so – interestingly – the USABP have recently developed stricter and much clearer codes about touch than the American Psychological Association (APA),

In the current USABP Code of Ethics [30], a new section has recently been written about "Touch". As is 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 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. These are my personal views and not any declared intent.

The situation in the USA, as regards professional touch, as mentioned and as we shall see, is becoming increasingly paranoid and ridiculous – this according to the views of people (and Body-Psychotherapists) in the USA.[31] There is almost a taboo about professional touch in the USA. 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 increasingly making considerable extra specific requirements and dictating the climate about touch, 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 booklet[32], identifies that some of these professional bodies, 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 applied[33] as we have already seen and nearly all such professional codes contain clauses about sexual contact, which is however rarely defined.[34]

No matter how thorough or lax their education, every psychotherapist in

practice today should surely know this: sex between therapist and patient is ethically wrong, whatever the scenario. Always. Every professional psychotherapy organization--the American Psychological Association, the American Psychiatric Association, the National Assocation of Social Workers, the American Association for Marriage and Family Therapy--is in unambiguous agreement on that point.
But why, if the patient is willing? Because the feelings unleashed in therapy are so strong, "consent" may have no more meaning than it would with an underaged sex partner. Even when the patient initiates sex--as happens in an estimated 14-25 percent of cases--it is still the therapist who is ethically, and increasingly legally, obligated to make sure it doesn't happen. [35]

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: a challenge they have risen to superbly. This is what the 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 transferential 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 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, in due course, the APA will take notice and incorporate something more helpful in to their Ethical Codes, which are something of an 'industry standard'. We might decide in Europe, either within EABP, or within EAP, to adopt something similar. [36]

Taboos about Touch

There are definitely taboos about touch and these are not confined to America, but are also fairly prevalent in many cultures and societies, particularly between touch between men and women who are not married. In some Muslim countries, it was/is forbidden for a male doctor to examine a female patient without the patient being completely covered by a sheet with a hole in: interestingly the doctor was allowed to touch (palpate), but not to see! There are similar barriers throughout history in cultures, especially where patriarchy reigned and women were in many ways denigrated; with harems, with Victorian attitudes, with chaperones, during female menstruation, the 'value' put on virginity, and so forth. These still have prevalent echoes in our present culture, even after the1960s. Some of these taboos to touch and how they affect therapy are now being explored.[37]

A lot more work, writing and research will be needed to overcome negative reactions to touch in general and some of the professional taboos against touch in psychotherapy. These latter seem to have started with Freud and his aversion to considering the body as a legitimate part of the client in psychotherapy. This may have been a personal predilection, or a reaction to social mores in Victorian Vienna, as his predecessor, Pierre Janet, was writing extensively about the body in psychotherapy in 1885 (albeit in Paris) and was not so restrictive as he discusses "channels of contact" and the need to work with the body of the traumatized patient.

There are also fairly fundamentalist attitudes and fairly rigid social mores that have often fostered puritanical attitudes towards touch. These are very difficult to change. Such attitudes have been reinforced by the occasional transgressions into sexual misconduct by therapists. As touch and inappropriate sexual conduct are seem almost synonymously so the debate is increasingly confused as to the difference between these two aspects, and our attitudes towards touch tend to suffer and be aligned with inappropriate sexual conduct, which is not the case. Our contention is clearly that appropriate professional touch can be totally legitimate and does not imply any sort of sexual transgression by the professional towards their client.

I can heartily recommend Tiffany Field writing very positively about touch, in general (not just in psychotherapy), and her work is very clear and well researched: she is also doing something practical.[38] It is important to remember that the social climate and attitudes do change. In a good book on touch in psychotherapy, referring to professional attitudes, 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.*[39]

However much we might show up beliefs to be false, by solid research, by newspaper articles, by new laws, social attitudes and taboos usually persist for several generations further on – just consider the modern attitudes towards female circumcision and the impact of sexuality, and the extent that clitorectomies are still practiced, quite barbarically, in many African villages even today. There are huge difficulties in changing attitudes towards some of these fundamental issues.

There are several other complex issues involved. Smith (above) is writing about the reasonably undifferentiated professional culture in the USA, even though social attitudes to touch can differ radically from California or New York to the more conservative mid-west, or especially in specific enclaves like the Amish or Hassidic Jews. Whereas the situation of psychotherapy and counselling in Europe is, as mentioned, very different and much more diverse in a number of different ways – especially as the European Union have now expanded to 25 different countries, and the EAP acknowledges 41 different countries. This is a huge divergence and we are only just beginning to form a European-wide association, let alone a solid professional culture.

Taboo or no taboo, code or no code, and differentiations apart, we should also be concerned to try to discover what might be actual proper ethical procedure if there is a complaint with respect to touch. To a certain extent it is up to us, as professionals, to determine what the parameters of this topic are in the field of professional practice and how these parameters would be applied. So, in this context, the least of these issues is perhaps how any taboos, social attitudes, ethical codes, or whatever, that might exist out there about touch, relevant, inclusive, or not, are to be actually applied in professional psychotherapeutic practice, in a complaints procedure about what happened 'behind the closed door' of the therapy room, and what the effect of this application might be.

Ethical Procedure:

A few general points first. Most ethical committees are elected from amongst the membership of the professional association, and their term of office is

usually quite limited. There is therefore little general experience in dealing with ethical cases and often the protocols, set down by the association, are found to be inadequate in certain very difficult or complex cases.

Professional associations are often quite small. There is sometimes a noticeable difference of treatment if the 'accused' or complained-about person is someone quite prominent or long-standing in the association and, because of this prominence, their colleagues in the association have much more difficulty in handling this ethical case than if it were about a member whom nobody really knows. In some cases, the 'accused' can even manipulate the protocols (or even get the case rejected). If the 'accused' is virtually unknown, this can also provide it's own difficulties, just because nobody knows them. There may even be an unconsciously harsh treatment of such a person, to compensate for the above situation.

Further, when going into the complaint itself, what often needs to happen first is to discover whether this is a legitimate ethical case or not. It may just be a disagreement between the practitioner and their client or another colleague that has not been properly resolved. Some negotiating work by a skilled mediator or the ethical committee can often bring about a reasonably satisfactory conclusion. There is then the separate issue of whether mediation was properly tried and genuinely failed, or whether the complainant or 'aggrieved party' had a separate agenda to ensure the failure of such mediation: i.e. whether there is now a degree of malice that has

If an ethical case has to be "heard", then there are further protocol difficulties often about the reliability of "evidence" and the "burden of proof." People often unconsciously refer to the criminal court guidelines ("beyond all shadow of doubt"), which are totally inappropriate, even though they may have been serious aggrieved, a crime has not been committed. More appropriate or suitable criteria for a case where someone's livelihood or reputation may genuinely be affected are: "Is this is reasonably likely?" or "What is the balance of probability?"

These and similar dilemmas indicate 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.

There are then additional complications of the 'professional litigant', who does unfortunately sometimes exist: the person who will never really be satisfied unless they are proved 'correct' and the other person 'punished'. The other 'nightmare' scenario is the borderline personality (again quite rare) who will feel aggrieved or abandoned (say) if the therapist is moving away. In such a situation, the complainant's personal process becomes intricately involved in the complaint.

All of these seen or unforeseen elements can affect the ethical procedure of a case, and thus its outcome. This, over time, begins to determine the build-up of a set of 'case law' or precedents. So, we might need to ask ourselves, who does the ethics committee of the professional association really serve in such cases: the complainant or the member of the association, or both. Accusations often fly both ways.

Since the whole issue of whether "touch" itself has often not been clearly defined (as we have seen) and when this is included in the complex maelstrom of an actual ethical case, we have a situation that is often incredibly difficult and

costly, financially & emotionally, - if not impossible - to resolve satisfactorily.

However the reality is that if, and I repeat this word very clearly, **if** the practitioner or therapist has been involved in forms of unethical touch, then this may be a part of their own psychological process that has not been properly worked out: there may be a pattern, or more than one case. To discover this is difficult, as there are strict confidentiality rules and no way of asking that practitioner's other clients or trainees about similar instances of inappropriate touch.

It is highly likely that this sort of person will probably eventually resign from the more usual voluntary professional association before the case comes anywhere near to a conclusion. Severe dissatisfaction will probably be expressed, often very forcefully, about the process of handling the complaint. Attack and obfuscation[40] are sometimes the best form of defence, and so the ethics committee people involved may be subjected to long letters, multi-issue confusions and even counter-charges or personal nastiness. I mention these points from bitter experience.

Clarity of process is therefore as essential as clarity of definition and it is highly unlikely that a successful case that can establish a precedent (case law) will be concluded. If this does not happen, then the outcome of the case potentially benefits only one party, and can destroy the other. It is essential for the members of the ethics committee to have, as remedies, a series of possible measures. These might include a reprimand, the requirement to make an apology, additional supervision, a process of re-education, a suspension of practice as well as the ultimate and irrevocable exclusion from the professional association.

As most professional associations do not carry the power of licensure, then there may be a subsequent hearing (even with a contradictory finding) with the licensing authority. It may be very important for the practitioner to have had a complaint against them heard by their peers before progressing onto a more formal and external licence hearing, but sometimes events are overtaken by outside forces.

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 suggestions and I feel that we need much more further discussions, seminars, and symposia on this topic. So I encourage your participation, however small, however negative, hopefully positive, and especially welcome if coming from different countries or from people with direct experience of these issues.

What is Touch?

This seems a simple question: one that we all know the answer to – *to come or be in (physical) contact with.* One initially perspective on this comes from the work of Rene Weber.[41] She defines three views, which can conveniently give three different 'lenses' for usefully discussing touch in therapy. These are:[42] (i) the physio-sensory model; (ii) the psychological – humanistic model; and (iii) the 'field' model: briefly:

… the physio-sensual model fits with reductionism and a mechanistic world view". "The source of the touch is not relevant." "discussion on touch as a technique or intervention fits here." Whereas the psychological – humanistic model: *"… is closest to phenomenology and existentialism. "Sympathy and empathy are seen as being most perfectly expressed by touch." "Touch here is always reciprocal.*
The field model harmonises with Eastern philosophy and it can incorporate the other two models. This model postulates energies not yet embraced by science. Field theory sees everything connected.
Westland writes: *"Informed discussion on the use of touch in psychotherapy requires that the discussants have had some* experiential *training in the use of touch for psychotherapeutic purposes. If touch is to be considered psychotherapeutically then the psychotherapist needs to have a theoretical basis for the touch, a means of evaluating the touch and the possibility of discussing it in the* process *of the consulting room. Otherwise how do you know what your touch has communicated?"* She concludes the article by saying: *Contactful touch is embodied relationship manifested in touch. The key elements of contactful touch are presence, intention and the ongoing relationship between client and psychotherapist. This is supported by technique. This includes method, pressure, speed, rhythm, pacing, monitoring, autonomic nervous system reactions, etc."*

The issue of being the recipient is a very important one in the therapeutic setting, and given all these issues, there is going to be no easy description of what constitutes "touch in psychotherapy". So I want to err a little on the side of caution, and go into the subject a little bit deeper and ask some more 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 statements and concepts about the definition and the proper boundaries to touch in any form of psychotherapy, Body-Psychotherapy, and in the many different body therapies.

As regards **what** we might mean by touch, Smith[43] 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.[44]

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 (fourth type) especially if they were grieving, as an indication of an 'intimate,' on-going, long-term relationship, albeit a therapeutic one. I am slightly more concerned about the juxture-position of acting *as a parental figure in regressive work by holding, rocking or embracing the client like a child* as that might indicate more of touch as a technique (fifth type) and some of our psychoanalytical colleagues would probably have a problem with this use or abuse of the transferential position.

Objectively, it seems as if many therapists in on-going relationships may nowadays not touch as an expression of the therapeutic relationship, either because of psychoanalytical impositions, or because of (fear of) litigation and the possible removal of professional licensure, and therefore this fourth category might need some much more detailed work on it to expand it and define it more clearly. Over to you!

As regards the fifth relationship, this is (for me) the one most open to confusion, misunderstanding and abuse. The phrase *"designed for therapeutic purposes"* hides a multitude of potential purposes, 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 in a psychotic episode as their whole personality structure and somatic identity has been systematically broken down at the same time as their deep muscular structures have been broken down - "therapeutically" you understand, "to help their rigidities." Whilst it is possible and often therapeutic to work in these ways on the deep structural and postural muscles, the therapist 'should' have made a suitable assessment of the client's ego-strength as the possibility of such a 'break-down' is relatively well-known. In occupational health and safety, it is now a legal requirement for an employer or contractor to make a "risk assessment" and to take reasonable and appropriate steps to reduce all identified risks: the world of therapy should apply the same criterion. I regard this type of misuse of a therapeutic situation as unethical, short sighted and relatively incompetent: please write in and comment.

I have also been informed of situations where the 'therapist' has stimulated the client genitally, and on a regular basis, and makes various claims for this: perhaps (in some way) to re-pattern that person "embryologically" or to "heal" their wounded sexuality. The fact that it has been (mostly) male therapists who have (almost exclusively) worked in such ways on female clients may or may not be significant. One recent case was – as mentioned – often a male therapist to female client; both naked; sometimes trainer to therapist; late at night; in a "research" program; with no research protocols; and it was to be kept "secret". What was even more difficult to comprehend was that this "technique" had been "taught" to several others who were now using it. Comments, please!

This sort of 'technique' seems to be given (only by those who practice it) a number of different rationales: "age-old", "healing", "ritual", etc. I think there are

pagan rituals that used to use this sort of touch in a form of initiation: there may be aspects of Shamanism involved: several cults or sects have also had similar rituals. I should not have to state that whatever the rationale, whatever we may be missing out in possible healing potentials, this type of touch is definitely not acceptable in any way whatsoever within the European or American concept of mainstream psychotherapy and is does not form any part of Body-Psychotherapy.

Any body therapy that might use this type of genital touch had better start doing some very well substantiated research to be able to support whatever claims they put forward, otherwise they will probably find themselves condemned, ostracized and even persecuted. The same applies, by the way, to anybody putting forward any claims about any technique. There is a general move to bring these 'therapies" more under professional regulatory bodies and all such claims will be investigated, in due course. Of course, the "therapies" that cannot produce such evidence will probably decry the relatory process and re-label themselves as a form of spiritual practice. Again, please write in your comments and add to the debate. See also the addenda (page 44)

To be fair, I also know of several body therapies and somatic therapists who have some (relatively) esoteric techniques and who practice these therapeutically and very ethically, as far as I am aware. But there is no proper objective research yet and there is no evidential follow-up. So if prominent people (like (perhaps) John Cleese or Kiri Te Kanawa or whatever film star of the moment) wish to spend their money in this particular way on this particular therapy and then, feeling that it does them considerable benefit, wishes to promote it or get someone else to write about it, all the more power to their elbow (or more power to the elbow of their therapist) and to the sales of such magazines. I am sure that almost everyone involved is fairly happy, for the moment. I just hope that they stay that way. But this sort of 'populist' fad is also nothing to do with proper Body-Psychotherapy.

Some of these type of populist sessions have also taken place late at night and are kept relatively covert, given the public personalities involved. I am sure that there are hundreds of thousands of people who find themselves 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" a bad name and confuse the definition of what "Touch" is! And so we have to progress 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 the beginning of 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"* [45] 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. On the one hand, there are wonderful, marvelous and extraordinary claims for the benefits of touch and for certain touch-based

techniques, and these may have some truth in them. On the other hand, most of these techniques have no proper, nor 'sound', nor even scientific basis at all except in contemporary myth, isolated examples, and in 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."*[46]
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 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.[47]
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 AHPP[48] conference back in 1987[49] 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.* [50]

It is clear that psychoanalysis has remained very split about touch. See Mintz (1969). 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, with several confusions or exemptions, and with certain accepted *"caveats"*.

In Europe, there has been a much longer tradition of legitimate and professional bodywork and a long established experiential practice and development of body-oriented psychotherapies. Depending on the very different theoretical approaches, protocols or rationales for professional 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"). In my view and from my personal experience, only two or three of those positions are in any way legitimate for the basis of professional practice. Again, I need your comments, especially those from other cultures.

My concerns about the lack of clarity in this respect are not ungrounded nor are they paranoid: they are unfortunately based on having to deal with several very difficult professional & ethical situations around psychotherapeutic touch and several types of abuse of these parameters, which are still going on (see

Addenda). These situations derive 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 basis that I can find, but they seem to be more a mixture of pragmatism, bias and fear.

I am advocating that we take a long, hard look at ourselves and our justifications for ethical, professional and appropriate touch and seriously try to re-evaluate what stands up and can be condoned, according to some of the criteria that come from these 'other' critical positions, and what does not stand up, and therefore cannot be excused or condoned. This is the "acid test" for the profession of Body-Psychotherapy and we might either stand or fall by this sort of test eventually. We desperately need many more well thought-out research programs, scientifically based essays and articles, and professional education to 'tease out' some of these issues.

Holroyd and Brodsky[51] examined whether the non-sexual touching of 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 included 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 rational, touch can be exceptionally caring, comforting, reassuring, or healing."* [52]

Please note the very careful qualifications! The position on "When to Touch" or whether to touch in the more open and humanistic psychotherapies is inclined much more towards something like the *"Yes! Touch. Of course! Why not? It's wonderful!"* position, which, whilst I might have a lot of personal sympathy for this position, and it can easily and irrefutably be demonstrated that as a race and a culture we need (and crave) much more touch in our everyday lives than we usually get,[53] it can also lead into horrendous professional problems if professional touch becomes totally unrestricted and unlicensed. It is this sort of 'liberal' situation where professional touch can also become systematically abused.

To touch me on any part of the body, (say) the shoulder, if you have previously been informed that I am sore or 'wounded' there, is essentially unethical: you are causing me pain though your inattention or clumsiness. I do not care whether you are a "spiritual healer" or not: neither do I want to hear that I am experiencing my own pain, or the pain of past transgressions and this is necessary to the "healing". You need my informed consent to cause me pain or do

anything manipulative or invasive.

To abuse the inherent power relationship of a therapist to their client by touching in a particular way because of (say) your own theories about the benefits of a certain type of touch is also unethical: you are imposing your theories and touch) onto a person in a vulnerable position. It may also be immoral. And if that person happens to be under the arbitrary age of (say) 16 and if you have touched them in a way or place that someone has arbitrarily defined as sexual, then this may further be criminal. It is possible to be professionally unethical, without being criminal. It is possible to be highly moral (by your own lights) and also be unethical. If you are very ethical, it is unlikely that you are being immoral. There are some laws, which are archaic and, whilst technically one is criminal, society (in general) needs to repeal that particular law.

There is one male practitioner (a long-standing and qualified physiotherapist) that I know of who works independently, aged 70, in a rural community. He will not accept a female client unless her partner, or a member of her family, accompanies her and is present throughout the session. Fear of moral, social or criminal persecution often affects our view of what professional ethics should or should not be. As moralities about touch wax and wane, and as these eventually influence the laws and professional codes of practice, where lies now a solid ground for professional ethics?

Why touch?

Touch is considered as highly significant for all mammals and thus also human beings, and it seems, developmentally, essential for health and social integration. There have been many studies and writings, almost too numerous to mention, that affirm this position. [54] Early infant attachment, for which touch is central if not crucial, is a complex combination of biological, physiological, psychological, and emotional interactions between mother (parent, sibling, etc.) and child. [55] Since much of our work in psychotherapy is to 'heal' some of the early material and dysfunctionalities, the 'why' of touch is (perhaps too often) sometimes seen as all too self-evident. This is also a form of distortion. There is all too often a presumption that 'correct touch' will 'heal' the early experiences of 'incorrect touch': this is a form of magical thinking and is frequently found in certain sects, cults, pagan rituals, or being used by inappropriate therapists. We need much better reasons for the "why" of touch.

As regards the "**Why**" of touch, Nick Totton, in his recently published book on Body Psychotherapy [56] 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 [57] 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) [58] 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.

Another summarized report, this time by Horton (1998) [59] 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 & Struve [60] 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.[61]

These are some of the issues around the "**Why**" of touch. But the issues around why we touch go much deeper than these, whether these are trying to overcome any forms of socio-pathology or sociological inhibitions against touch; or whether they go to the core of our biology as human animals is difficult to say.

We actually need touch; we crave touch; and not just to be touched, we may need **to** touch; and we surely can be changed and embittered by lack of touch. Touch is almost as fundamental to us, as human animals, as water or food, shelter or safety. Without touch we can whither and die.[62] 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 touch forms a very significant part of our human interaction and socialization. So the "why" of touch in psychotherapy cores to the core of our human identity.

> *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.*[63]

If we, as therapists, are working with people, with these sick and distressed 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 perhaps is one of the essential tools of self-regulation; touch is used to cope with life's stresses. We may also need, as therapists, to make contact with our clients,

to demonstrate our empathy, to touch their pain, and even to touch them – to contact them in order to justify ourselves. 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. Touch 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'. Touch can help to provide containment; and it can help restore significant and healthy relationships. Other studies [64] point out the significance of touch in ego development; and in multicultural contexts touch can transcend language difficulties and help towards effective treatment. Touch is quintessentially fundamental to human 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*

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 examined much more subtly. It is not just to heal old wounds: nor is it to bring 'new life' or 'new experience' into being. So I invite you to please explore some of these reasons for the 'why' of touch, deeply within yourself, and then to contact me, or talk to your colleagues or supervisor, about these issues if you have new or different reasons, or if you are unsure about the reasons that you have been given. We must start to examine our fundamental reasons and rationales a little bit more.

The Meaning of Touch:

I would now like to try to examine further the specific concept of touch and the meaning of touch: not just the "why" of touch, but the meaning of touch. There are many different aspects to the topic of the "why" of touch, some lists have already been mentioned. McNeely also lists a few more professional and theoretical reasons [65]:

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 a pattern of alienation, especially when the*

alienation is largely archetypal and not part of the neurotic withholding.

3. *De-armoring. 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 significant reasons to touch, leaving aside the huge number of physiological reasons and very important developmental reasons to touch (all mentioned and dealt with quite well in Hunter & Struve's book). There is another, almost existential level: what does "touch" mean to us.

I was recently watching a documentary on Harold Shipman, the UK doctor who killed about 280 of his patients over a 25 year period. It transpires that his mother, to whom he was very close, suffered terminally from lung cancer and he watched the local GP inject her regularly every afternoon with diamorphine. Later he used this drug exclusively, often in the afternoon, to kill his elderly patients. I fantasis that maybe, as a teenager, he longed for the doctor to kindly kill his mother: later in life, as a doctor, he performed this function over and over again. So, why do we touch, and what does it do for us? And why do some people serially abuse touch? Questions like these need an answer. Please help to provide one.

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 being a "helper towards re-empowerment", rather than risk losing that in the direct application of touch, where the 'power' lies more in the hands of the therapist. 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 from their Ethical Code. They are just working in a very different environment. If I was a male doctor in Arabia or India, I would have to examine any women patients through a hole in a sheet so as not to transgress the cultural taboos of those countries: unthinkable in the USA or UK & Europe, perhaps..

It was really only in the1970's that the direct benefits of touch in psychotherapy began to be written about in mainstream American literature by a few courageous practitioners. [66] 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 across many disciplines.

> *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 climate, most clinicians have resolved the cultural and professional tensions surrounding the issue of touch by adopting a one-word guideline:* Don't. [67]

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 as well as a professional prediliction.

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 a degree of clarity about professional standards towards touch, we always need to remember who is talking, from which position, and on which side of whatever cultural division. There is still a long way to go to get clarity on this topic.

Body Psychotherapy is one of the few leading protagonists that are challenging and (hopefully) helping to change some of these cultural taboos, and we therefore need to be very (if not incredibly) 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'; [68] as well as the 'disgusting' body, seen by Victorian moralists as full of original sin and unnatural impulses; the 'desirable' body used in advertising; the 'disempowered' body, incapable of having a child without medical intervention; the 'expendable' body in acceptable casualties; and the 'political' body used as a weapon of mass destruction by suicide bombers, etc.

The impact of such a attitudes about the body, body taboos, phobias about contact or touch' with such bodies 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 just not touched. If we expand the concept of not being 'touched' by society, then this too is an underclass: and such under-classes are very dangerous. They become the rigid pariahs. We need to actively promote healthy touch throughout the lives of all our citizens or the health and sanity of our society is in jeopardy.

But there is more, as mentioned, as individuals and as human animals we actively need touch. Lack of touch in animals has been shown to have very profound and negative effects.[69] We, as healers, working with human animals, must be aware of touch, of its deficits, and encourage touch in our clients; and even be able to provide, if appropriate, restorative touch to them. People get better, faster, with appropriate touch.

Certain pioneers of Body Psychotherapy, such as Gerda Boyesen, Ilana

Rubenfeld Charles Kelly, & Eva Reich etc., are positive advocates of gentle touch and claim many records of psychotherapeutic insights and powerful healing through direct, specific, and gentle touch. In order to deny these claims, one would have to present significant contrary evidence; and yet, none of this is scientific proof, in itself. Research projects that focus on the benefits of touch have been undertaken, and are under way; and many show significantly 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. It also affects us, as practitioners, significantly. We cannot lose sight of this, and we need to analyse why **we** touch: what does it mean to us?

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 effective treatment program in the USA for adolescent sex offenders [70] 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. Maybe, like the addictive serial abuser, the meaning of touch has some undisclosed gratification. Once established these programs 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."* [71]

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 'Heilpractiker' requirements (1-year course as a 'health practitioner') before you can legitimately touch someone as a health professional. 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; sometimes also the nipples of the breast in female clients. For a variety of reasons, there are 'verboten' (forbidden). (See: the discussion in the Addenda)

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 muscular tendinous cuff, etc.) – there should not be any direct contact with, massage of, or stimulation of, a woman's breast, areola and nipple in the exact same area. This is "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 the highly erogenous nature and multiplicity of nerve endings in these areas. This is not the purpose of the professional massage, nor of the therapeutic contact. It is thus essentially counter-productive.

Since this type of touch may also produce disturbing transferential and even counter-tranferential issues, it is also contra-indicated. The risks outweigh the benefits. It may be distressing or confusing to the client. Furthermore it takes us, as therapists, into very difficult areas, as transferential and counter-transferential issues with our clients rise up in clouds of potential confusion, to say nothing of being potentially erotic for them, and even 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 inner thigh muscles in a very matter-of-fact orthodox Swedish-style with the rest of his body well covered beneath the sheets: he was also wearing underwear. I happened to notice that he started to get an erection

and then had a spontaneous ejaculation. This was considerably embarrassing for both of us and totally destroyed any of the relaxation effect that I was technically working for therapeutically. 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 gaenocologist is about the only person who is professionally allowed to touch a woman's genital area and only for the purpose of a specific (and usually asked for (and consented to) gynecological or sexual 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. There are also, as mentioned, some (quite subversive) new age, cultist, shamanistic or pagan philosophies and practices that promote this type of genital contact. These could destroy the profession of Body Psychotherapy.

Now I am very open to correspondence on all aspects of 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, gynecologist 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."* [72]

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 the area where the serial abuser also is usually found to be focusing on: very few therapists are fixated on their clients' elbow, toes, or wattles. Whilst newspaper photos of certain minor British royalty whilst 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 possibly just a fictional fetish.

Most male therapist serial abusers have had inappropriate contact with several of their female client's breasts and/or genital areas. There is usually some sort of 'rationale' identified to 'justify' this type of touch (viz: experimental research; 'womb healing'; freedom from taboos, etc). This is rubbish! This is abuse! They may have had (some would say "almost certainly") inappropriate contact with someone in a power or hierarchical relationship in their childhood.

There may well be early shamanistic or pagan rituals where this type of touch is considered 'initiatory', or 'healing', but this should be clearly stated as such and not 'disguised' as a form of body therapy.

The only instance that I have come across (I read about it) of serious female therapist abuse of a male client was where the client was being continually regressed and infantilized, and was encouraged to suck the therapist's breast as part of their "therapy". The client became increasingly confused and later committed suicide. The therapist was not in any form of proper supervision.

There are many other recorded instances of male sexual abuse.[73] The phenomenon of general therapist-client abuse seems to be running at a figure of between 7-12%; statistics of doctor-patient are comparable. What has changed is the incidence of reporting this type of abuse.

Consent, Autonomy and Touch

If we do decide, legitimately and professionally, 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 requests it and the therapist can agree (perhaps after consultation or understanding with their supervisor) 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 and 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."*[74]

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. Our Western cultures often carry a taboo about certain types of touch which have encroached into the accepted set of professional values.

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 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.[75] 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.[76]

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.

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)[77] subject.

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 is felt to 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. As in all hierarchical situations, the person higher up in the hierarchy (in this case the therapist) is incapable of saying whether their action was, or was not, oppressive or abusive. The only person who directly experiences the oppression or abuse, and can therefore comment reliably on it, is the person lower down in that particular hierarchy, the recipient. Their voice must be heard! If they experience the 'quality' of touch as being abusive or unethical, then it probably was.

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 called for, so that the therapist can recognize and bring under control any tendencies to project personal needs onto clients."* [78]

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….*".

It becomes clear that 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 put aside some of the specialised and many different 'touching' skills, and all the different esoteric methods of touch, and focus more on the basic intention behind 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.[79] 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."*

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. Touch must not be taken for granted as a 'normal' and inevitable part of the therapy: it is here that some of our confusion lies. It is in some of our biases, and only when we are clearer about these, can we begin to be reasonably sure that any residual confusion or unclarity lies more with the client and then their (perhaps long-held) attitudes about touch and their need for it, or rejection of it, can be examined more objectively. Touch can thus 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 transferential aspects of the therapeutic relationship, and that is when abuse can, and does, sometimes 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 to determine whether any particular therapeutic touch situation is abusive or not, nor indeed how to identify or correct any abusive situations.

Again I say, 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 probably 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 [80] is really worth reading, and it would probably be somewhat disrespectful just to offer a quick summary or list. Since it is readily available in this book, which is now something of a 'necessary reading' for all Body-Psychotherapists in training, I will leave it that way.

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, often with reference to sexual abuse, but without perhaps specific reference to touch. 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.* [81]

I echo his sentiments. May also quotes from Horton[82] 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."* [83] We shall return to these points a bit later on.

Babette Rothschild [84] and Lawry [85] are also very concerned, and rightly so, with touch in connection with trauma clients, especially those who have had severe or multiple traumas. This type of experience produces severe contra-indications and touch should either be restricted here because of increased risks of traumatic acceleration, or additional questions should be asked as regarding the client's needs and the appropriateness of touch in this case.

Other categories of clients for whom touch may be contra-indicated or for whom very specialist types of touch are required are children and adolescents. Children who are hyperactive and children with certain disorders (autism) tend not to like touch. Some studies show that children who tend to be very aggressive, violent or antisocial may well have had early childhood touch deprivation.[86] Another category to touch-deprived people is our elders, especially those in care.

Furthermore, *"Touch is usually contraindicated for clients who are highly paranoid, actively hostile or aggressive, highly sexualized or who implicitly or explicitly demand touch."*[87] If touch is potentially so provocative, or such an issue for such people, then it is probably wiser to avoid touching them in any routine way: therefore any touch entered into with such people would have to be very clearly negotiated, explicitly part of the therapeutic 'contract', have clear intentions, boundaries and limits, and proceeded with very cautiously.

Gender differences often determine whether a child is touched more than another; and men tend to perceive touch less affectionately, more sexualised, or experience the effect of touch as quite regressive. Several studies affirm this.[88] If women therapists are touching male clients in therapy, there may be a tendency to sexualise the touch or to get into transferential issues more easily. If men are touching male clients, issues around homosexuality, aggression, homophobia or

transferential issues to the father may be paramount. None of these factors are contraindicative of touch in themselves, but need to be seen in the context of the whole therapeutic relationship and the client's needs and process.

I will add another category into the above list: clients with poor boundary issues: either psychological 'boundaries' (which might include becoming easily over-involved or with a borderline personality disorder) or emotional 'boundaries' (which can include people who have had their boundaries abused or who have suffered trauma), or physical boundaries: over-sensitive or under-sensitive. In the last category I would include people who are very armoured, and personally I would prefer to work with them in other ways first to 'soften' their armour, before working with them involving touch. If one spends months massaging rock-like muscles, or one tries 'digging' into places to cause a (pain) reaction, then I question whether this is effective therapy. Work hard to get to the place in therapy where they start talking about their need for touch, softness or gentleness, and then refer them to a professional massage therapist, and continue working with them on their reactions.

Inappropriate Touch

In a very good book[89] on this topic, though designed primarily for the American market, one of the chapters on touch for psychotherapists emphasizes 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 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."*[90]

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 or your probation officer."* These issues really need to be discussed at much greater length and depth throughout all of that person's psychotherapy training. It becomes increasingly evident that proper training as a form of prevention is much better than later controls. 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."* [91] *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* [92] *is good on this. But really, nobody knows much of what to do with this problem.*

I might make a further suggestion here. Many of the trainings in Body-Psychotherapy were based around one gifted person's particular way of working with touch: Reich's Character Analytic Vegetotherapy; Boyesen's Biodynamic Massage; Rubenfeld's 'Listening Hand'; Marcher's 'Bodynamic Analysis'; and so

forth. Rather than train people for several years in 'how' to touch in these particular ways, maybe we should have been training people in 'how not' to touch in other self-centred ways. Maybe we should, as a profession, be much more selective about who we enter into the training. I trained in a very touch-based psychotherapy with some people who seemed to fit almost exactly into the above criterion, but I have no idea how they turned out as therapists: so it might be better to 'weed out' such people before the training starts.

Hunter & Struve 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 they 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 and touch components in any such training, especially if they want to get referrals from other professionals.

Therefore we can perhaps conclude that 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 in the trainee's required personal psychotherapy, and hopefully, as the greater inclusion of such components in psychotherapy training courses proliferates, the instances of such abuse will lessen.

The need on the part of the therapist to touch people seductively or abusively is like an addiction, and trainees must be warned, just as if they were working in a drug factory, about some of the dangers involved and how to monitor the early signs of 'addiction' to inappropriate touch. However the complexities and perversities of human nature will probably ensure that this type of abuse will never totally disappear.

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 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.* [93]

Some situations like this could not be seen objectively as abusive, but they may actually be experienced as abusive or disquieting **by the client**; often they will initially be unclear or passive, and then the moment passes. Perhaps it is important to recognize that, at this moment, the therapy has stopped. The therapeutic relationship has switched from the needs of the client being met properly, to a lack of awareness or insensitivity on the part of the therapist. I believe that there is a noticeable change in the atmosphere or relationship between the client and therapist at this point. The therapist needs to be aware of this noticeable but subtle change, and then be clear enough, or brave enough, or wise enough, to ask the relevant questions and elicit the cause of the change. It only takes a few moments initially and the therapeutic relationship can usually be

restored. If it is ignored and passed over, then sooner or later the client will almost inevitably leave the therapy.

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 not only the type and occasion of touch but will probably abstain completely unless there are very positive indications or even specific requests for touch that seems to be appropriate to their process at that moment. We may need to discuss this further so that I can be reassured that a 'touch intervention' really is 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 much more properly and clearly established. Then we can negotiate much more as equals.

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 book on Body Psychotherapy[94], in a short section on the 'Ethical dimensions of touch', 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."* [95] There are several other studies about power dynamics and gender differences that affect this type of use of touch, mentioned especially in Hunter & Struve (Cpt 5.). Please remember that the person who is higher up in the power relationship can never determine what is appropriate or not. Only by taking this sort of stance is the power relationship potentially rebalanced.

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 attempts within Body Psychotherapy to appreciate more fully the subtleties and dynamics 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 for them in psychotherapy. Client's accounts are very informative and should be published much more often. We need to adopt a much more questioning approach on a minute-by-minute basis when we touch: *"Is this right?" "How about this?"* And I here and now invite more discussion of these points, and more of this type of research and publication from Body-Psychotherapy training colleges.

I would also like a 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 cases, 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. I would need to explore all the issues of the abuse first and reassure myself that the client's sense of herself, her boundaries, and her empowerment had been restored before I would consider touching her. A referral to a female touch therapist or massage specialist could be much more appropriate.

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 well away from the area of abuse, 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, or objectivized, or not seen fully as a person, because of the lack of awareness of the therapist about their own abuse issues. There are many very gentle and loving people who, when they have had too much to drink, lose their gentleness and become quite abusive: talking to them about this when they are sober, they will often (seemingly rightly to them at that moment) deny their abusive behaviour. Even if they can acknowledge that they did this (the evidence is staring them in the face) they will see it as an aberration and be genuinely sorry. They cannot take the next step and see is as a much deeper problem. This for of 'use' or 'abuse' of touch 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, their own sense of power and their own sense of themselves and must, really must, learn to manage these aspects of their 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 you. A person's presence can be dominating, or relaxed. Subtle body language conveys much more than words: estimates of 90-95% of all aspects of communication are not unreasonable. 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: yet they set a context.

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. Perhaps the client's body should be seen, not as an arena of therapeutic interactions, but more as a sacred temple, easily profaned. One is possibly even trying to help the client towards the proper and healthy (re-) emergence of their sexuality, their sense of themselves and the establishment of healthy balanced future sexual relationships. But this has to be done without becoming personally involved in any way whatsoever. 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 any personal involvement. Almost as soon as the therapist becomes involved, in any way whatsoever, then the therapy stops.

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."* [96]

These energies can be 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 almost 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 or their power in better and more positive ways if they were afraid of their own sexuality, their own power, 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. Then and only then can the client feel that their own issues are paramount.

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."* [97] This is another "should," or "should not," and so it doesn't necessarily help us very much when the therapist 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 or compromised. 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 just for sexual gratification.

It must always be remembered that 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 an abusive relationship, in order to cover up or prevent the client feeling 'used' or 'abused' and making a complaint, the therapist, whilst often effectively seducing the client, must also usually give them some form of intellectual rationale for this type of inappropriate touch. This is often combined with considerable emotional pressure to ensure the safety of the therapist and possibly the continuation of the abuse. There is also the distortion of roles, as the client is still paying the therapist, yet it is the therapist who is receiving gratification.

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 must have asked for it.

One way of overcoming many of these problems is to create a form of 'worship' of the therapist, through charisma, through the hierarchy in a sect, through 'being such a wonderful therapist or trainer'. Putting someone on this sort of pedestal creates a hierarchical situation, which is of course totally against any form of healthy therapy.

Investigating a Complaint

When the abused person, client or patient does try to make a complaint against a therapist, to their professional association, to their family or peers, to the police, to the press or whatever, 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 essential fee-paying members. There is often a feeling of collegiality and even a fear of collective exposure. This can 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.

In more of a non-professional or peer setting, the accusation against another member of the 'family', or training, or group somehow breaks a taboo of collective support. There are further genuine fears about going to the press, or the courts, as the situation can get easily 'out of control' and the abused persons' dynamics are often exposed, as many victims of rape have discovered when being questioned in court about their sexuality. In a sect, the person on the pedestal, often the abuser, is the 'leader' or the 'guru' and is therefore inviolate in some way: they are the person who determines what is right or not, which means the accuser is inevitably in the wrong. They are often excluded, or punished in some way, well before a complaint will be listened to.

The ethical committee that might investigate 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 has been made against

them? What sanctions has the ethics committee got available, other than exclusion? What resources, what budgets, 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 that is supposed to be able to investigate such complaints.

Finally we come again 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 that 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 have made already 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 ball-game does not have to be weighted in the other direction just because someone might accuse. That is living in fear, which is also not therapy.

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 somehow be made easier for complaints to be lodged and successfully investigated, otherwise we will be in the same situation as crime figures about rape: reported rapes are very few because the victims know there is not much point in reporting them, because the incidence of it getting to court or them getting satisfaction is very low and when rapes are reported the victim experiences even more trauma in the (often hostile or biased) criminal investigation and trial, occasionally ending up with an accusation of immorality against 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 this.

There is quite a good book, though a little dated, on therapist abuse, called *"Out of Bounds"* [98] and one of the original classics on this topic, Rutter's book, *"Sex in the Forbidden Zone"* [99] 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 section that is worth quoting though, 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. [100]

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 Body-Psychotherapists and little consideration has also been given to the constructive use of therapist's power of self-awareness. 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, it is still abusive.

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: the known versus the unknown.

Attraction and abuse

Another frequent issue is where there is an attraction between therapist & client: and can this attraction be exercised in any way whatsoever in therapy? 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 well after the therapy has been 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 the bar at therapists' conferences) is: *"How long after … should one wait?"* How long an interval should there be between the end of therapy and the start of a relationship? I have heard some psycho-analysists talk of 6 weeks; I have also heard people say firmly and clearly "Never". Both are probably unrealistic.

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 establish very clearly what the boundaries of the relationship are at the outset of the relationship, or even long before they start to see clients. It is unreasonable to suppose that: *"it cannot happen to me?"* Being thrown into an intimate relationship with many members of the opposite sex can try the limitations of a saint. It is not so much a question of *"Will it happen?"*, as a question of *"When will it happen?"*

Many therapists, trainers, tutors & supervisors are now making a definite statement at the start of any hierarchical relationship that there will not be any exploitation or intimacy; there will be no sexual contact; there will be an avoidance of other types of relationships with that person 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 identify and 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 (perhaps 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, and 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 or 'persona' 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 and self-deception 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 much more rigorous checking about this. Often training schools are quite small and dependent (fees, status, reputation) on their students. There need to be well-thought out methods throughout the duration of the training to elicit some of these issues and to create opportunities for self-awareness and non-judgmental examination around this subject area.

If the trainee therapists are genuinely exploring out of their depth, or known areas, and if 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, arrogance, 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.[101]

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, power reelationships and ethics.

Up to a certain point, of course, we all know and can say, quite clearly, *"I was not abusive."* But it is when we hit our own 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 type of touch. 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 semi-constant self-awareness. When we do inevitably transgress - for at some point we will and this is how we learn through our mistakes - we need to be trained to have 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 correction and 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.[102]

This tends to point to the fact that training and supervision are extremely influential on the use of touch and on the views about touch; and therefore some therapists who may want to use touch legitimately are influenced negatively by their professional background and attitudes within their training courses. It is often very difficult as a student to question the theoretical basis of the topic you are studying. The converse situation (in some Body-Psychotherapy trainings) is to assume that (this type of) touch is totally legitimate and never to question the issue properly, especially as that might mean questioning the course leader or 'founder' of the 'method': a form of sacrilege.

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 pre-requisite, 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."*[103]

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 more noticeable by their absence. Tis perpetuates the situation when touch is psychotherapy is almost taboo and not talked about.

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, and celibacy is not a solution), so do therapists & counsellors need to be trained particularly. 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 distort our responses as therapists as well, and these distortions

can cause our clients, trainees or supervisees to feel just as abused, as well as possibly 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 picked it up, 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 and an "abnormal" ethic has been imposed. Certain so-called 'therapy' groups within the Bagwan Shree Rajneesh movement became quite physically abusive.[104]

David Boadella wrote about violence (physical and emotional) in therapy groups many years ago.[105] 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. One of the recent correspondents to The Pulse (see Appendix) advocating the 'beauty' of genital touch turns out to be a supporter of Bagwan.

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. I am sure many similar things happen in similar sects: I don't have a particular prejudice against that one, I just used it as a well-known example.

But it is interesting, and also my experience in examining individual and organizations about ethical transgressions, that the compulsive narcissism[106] 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 / often 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. This can happen in smallish communities as well as in professional bodies. The abuse by the "laird", the vicar or priest, the doctor is

often not believed at first and the accuser is condemned or 'shunned' into silence. The community perpetuates the abuse by its inability to self-examine some of its value systems and institutions.

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 abuser; the best form of defense being an attack. We are therefore almost immediately into obfuscation, very confrontational internal 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. With a personality disorder, the abuser is incapable of really understanding that what they are doing is wrong and might harm someone else. In the same way that the bullied often become, in turn, bullies, the abusive toucher has often been touched abusively; for we live by 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 have 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 abuse [107] 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 ideally 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. *Quis custodiet ipsos custodes?* [108]

Conclusion

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

I have discussed a lot of the negative implications and must re-address the balance. Most therapeutic touch is beneficial. Often it is unconscious: a pat on the shoulder as the client leaves; a handshake before and after the therapy; the occasional hug when the client is in obvious distress. Even some psychodynamic psychotherapists confess to doing this.

Here are some fairly simplistic, standard guidelines for clinical and ethical touch in psychotherapy (personally I think the bits about 'written contracts' are overstating the case and are part of the 'fear' reaction, but then this list did originate in California):

- *Touch should be employed in therapy if it is likely to be helpful and clinically effective.*
- *Avoiding touch due to fear of boards and attorneys is unethical and a betrayal of our clinical commitment to aid clients.*
- *Touch in therapy must always be employed with full consideration to the context of therapy and clients' factors, such as presenting problems and symptoms, personal touch and sexual history, ability to differentiate types of touch, the clients level of ability to assertively identify and protect his or her boundaries as well as the gender, and cultural influences of both the client and the therapist.*
- *Touch should be used according to the therapists training and competence.*
- *Extensive touch should be incorporated into the written treatment planning.*
- *The decision to touch should include a thorough deliberation of the clients' potential perception and interpretation of touch.*
- *Therapists must be particularly careful to structure a foundation of client safety and empowerment before using touch.*
- *Factors that are associated with congruence are; clarity regarding boundaries, patients' perception of being in control of the physical contact, the patient's perception that the touch is for his/her benefit rather than the therapists.*
- *The therapist should state clearly that there will be no sexual contact and to be clear about the process and type of touch that will be used.*
- *Permission to touch should be obtained from clients if the form involves more than a handshake. Extensive use of touch, as utilized in some forms of body psychotherapy, is likely to require a written consent.*
- *Touch is usually contraindicated for clients who are highly paranoid, actively hostile or aggressive, highly sexualized or who implicitly or explicitly demand touch.*
- *Special care should be taken in the use of touch with people who have experienced assault, neglect, attachment difficulties, rape, molestation, sexual addictions, eating disorders, and intimacy issues.*
- *Therapists should not avoid touch out of fear of boards, attorneys or dread of litigation. Therapists are paid to provide the best care for their clients not to practice risk management.*
- *Consultation is recommended in complex cases.*
- *Therapists have a responsibility to explore their personal issues regarding touch and to seek education and consultation regarding the appropriate use of touch in psychotherapy.*[109]

In a recent newspaper 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 succession of other corporate abuses 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." [110]

Scott Peck[111] and other authors are increasingly 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, occult methodologies, or whatsoever (however they are self-described) can impinge on the development of this necessary professional self-examination and personal humility and conscience. It is also clear that feelings of privilege, of being above the law (because of spiritual guidance), or feeling protected from it (because of special positions), or any particular attitude or social climate which denigrates or works against responsible attitudes, will almost inevitably lead to abuse – in any arena – as well as in this special 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 is 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.

APPENDIX 1:

As an addendum: there has been a recent (2004) e-mail discussion within the USABP that highlights some of these issues. I quote a few paragraphs here, admittedly out of context:

Correspondent 1:

"I am an interloper here. I was declined membership in USABP due to my lack of commitment to the ethical guidelines of no genital touch. I strongly feel that not to touch people's genitals when appropriate and necessary is further instilling shame about our totally natural, wonderful & pleasurable bodies. …"

Correspondent 2:

"… The quality of depth, of intimacy, of safe and reverent heart-to-heart sharing between people – these experiences can be experienced in non-sexual contexts – and they could also be experienced where sexuality is consciously called upon for healing purposes. I have had to ask myself, could there not be situations where including the genitals might be an essential part of healing and integration? Are there not people who have been wounded around their sexuality who could most effectively heal by experiencing the kind of reverent, sacred environment I am describing in relationship to their genitals, to their sexuality, to their bodies as whole systems?"

Correspondent 3:

"… In my practice and experience, I have never found it necessary to directly touch the genitals of my clients in order to "heal" them. … Yes, perhaps in a very free society where sexuality and touch are valued and accepted and utilized in a responsible and loving way, perhaps in such a society, direct touch of the sexual organs would assist to heal a deep sexual wound.

But we are currently living in the United States of America, in a climate of much more repression than in past few decades. Sexual research has been squelched! Sexual education has been limited to be focused on 'Abstinence before Marriage'. I am often disturbed when I hear body-psychotherapists claiming to work with sexual issues when they have not, to my knowledge, been involved in any of the organizations doing the accreditation or research in the field of sexuality.

… Many very needy people with real sexual problems that can be helped by a qualified sex therapist are reluctant to go for such therapy because of what I believe is the somewhat irresponsible exploitation of sexuality by people with a minimal training in the field. This causes many potential clients to be afraid to go for therapy because they fear that their sexual organs will be touched, they will have to perform sexually in front of the therapist, (or) they will be expected to become something sexually that they do not feel is natural to them. Others want a quick fix, to work with a surrogate who will touch them sexually and make them all better – without having to do the inner psychological work."

Thus we can see that there is a very important distinction that must be made here between what is "unethical," what is immoral, and has been criminalized in some way, or is illegal.

Correspondent No 1 (above) is trying to create a moral argument by elevating his own *"healing practices"* of genital touch and his belief systems about the *"totally natural, wonderful & pleasurable body"* whilst opposing these with comments about *"shameful"* constraints and inappropriately severe professional ethics. Whilst many of us might agree that puritan morality and draconian restrictions are inappropriate, it does not follow that unrestrained methods of practice are, de facto, more appropriate. Neither does any of this say anything

pertinent about professional ethics. Correspondent Number 3 also mentions (not quoted) many years of experience as a Sex Therapist. Her final comments quoted, about the *"quick fix"* or the 'magic touch' of a healer, are very apt. Many of the so-called 'therapies' that utilize this form of genital touch (and there are many, it appears) draw more on somewhat ancient esoteric or shamanistic practices, or even pagan rituals of initiation. However relevant they might have been 6,000 years ago, and however effective they might be to some people even now, they do not form part of the repertoire of a modern day professional therapist or psychotherapist working in a Western culture. So let us separate professional ethics, prevailing morality and legitimate practice well away from shamanism, healing or religious sects.

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This manuscript was much improved after extensive commentary from John May and some other colleagues. Thanks are given to David Tune for an advanced look at his article on a similar topic. Thanks are given to Dr Ofur Zur and colleagues for communications about similar articles. Any remaining vagaries or inaccuracies are entirely idiosyncratic and the author's own. It was written originally in 2003 and revised extensively in 2005. It is available as a PDF file.
The author wishes to declare that in writing this article he is not motivated by any specific ethical or political agenda, other than as stated – to promote greater consideration of professional ethical touch in psychotherapy: nor is he personally currently under any ethical investigation.
Courtenay welcomes e-mail contact about this article as long as the e-mail subject title includes the words "Ethics of Touch". He can be contacted by e-mail: courtenay@courtenay-young.com

Endnotes:

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[2] Harlow, H. (1971): *Learning to Love.* New York: Albion.
[3] Montagu, A. (1971): *Touching; The Human Significance of the Skin.* New York: Columbia University Press.
[4] Field, T. (1998): Massage Therapy Effects. *American Psychologist,* 53, 12, 1270-1281 and other writings.
[5] Zur, O. & Nordmarken, N. (2004): *To Touch Or Not To Touch: Rethinking The Prohibition On Touch In Psychotherapy And Counseling*: http://www.drzur.com/touchintherapy.html
[6] Young, C. (2005) "To Touch or Not to Touch: That is the Question" Doing effective Body-Psychotherapy without touch: Article awaiting publication in *USA Journal of Body-Psychotherapy*.
[7] Survey results: Counselling and Psychotherapy Research, Vol 1, No 3, (2001): p. 167-171
[8] Zur, O. & Nordmarken, N. (2004): op. cit
[9] In a US 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 both described as "cases of sexual misconduct". Gottlieb, Hampton & Sell (1995)
[10] Zur,O.(2005): Ethical and Legal Aspects of Touch in Psychotherapy: www.drzur.com/ethicsoftouch.html
[11] Zur, O. & Nordmarken, N. (2004): op. cit.
[12] http://www.eabp.org/phpBB2/viewtopic.php?t=17
[13] UKCP Conference, Cambridge, UK, Sept. 2004; EABP Conference, Marathon, Greece, Oct., 2004; Group Analytic Symposium, Budapest, Hungary, Jan 2005; Proceedings, USABP Conference Tuscon AZ, June 2005.
[14] Phillips: (see Reading List) p. 63-4
[15] Smith et al. (see Reading List)
[16] Westland, G.: *An Exploration of How Touch can be Contactful in Psychotherapy*: Biodynamic Massage: The Journal of the Association of Holistic Biodynamic Massage Therapists: Vol. 8, No 1, 2004/5 ISSN 1461-3743: p. 10-14
[17] Tune, D. (2006): Dilemmas around the ethical use of touch in psychotherapy: Chapter in Totton, N. (ed)(2005):*New Dimensions in Body Psychotherapy*: Open University Press
[18] Zur, O. (2005, 2005): op. cit.
[19] White, Kerstin: A Study of Ethical and Clinical Implications for the Appropriate Use of Touch in Psychotherapy , *USA Journal of Body Psychotherapy*: Vol. 1, No. 1, 2002: and Phillips, Jaffy: Somatic Tracking and the Ethical Use of Touch, *USA Journal of Body Psychotherapy*: Vol. 1, No. 2, 2002. Available from www.usabp.org
[20] EABP – European Association for Body-Psychotherapy – www.eabp.org
[21] USABP – United States Association for Body psychotherapy – www.usabp.org
[22] Phillips, Jaffy: 2002: op. cit. p.64
[23] Field: (see Reading List)
[24] Zur, O. & Nordmarken, N.: op. cit.: describe 16 different types of frequently found touch in therapy: 1.Ritualistic or socially accepted gesture for greeting and departure: 2. Conversational Marker: 3. Consolation touch: 4. Reassuring touch: 5. Playful touch: 6. Grounding or reorienting

touch: 7. Task-Oriented touch: 8. Corrective experience: 9. Instructional or modeling touch: 10. Celebratory or congratulatory touch: 11. Experiential Touch: 12. Referential touch: 13. Inadvertent touch: 14. Touch intended to prevent a client from hurting his/her self: 15. Touch intended to prevent someone from hurting another: 16. Self-defense. Then: 17. Touch as a Therapeutic Intervention. And finally 3 (unacceptable) forms of touch: 18. Sexual Touch: 19. Hostile-Violent touch: 20.Punishing touch

[25] After Austin et al: (1990) Confronting malpractice: legal & ethical dilemmas in psychotherapy: (Sage) outlined in Russel, J.(1993): *Out of Bounds* Sage: p.92

[26] EAP – European Association for Psychotherapy. The full statement can be found on the EAP website: www.europsych.org in the "Guidelines" section.

[27] EAP AGM; Dublin 2000, Moscow 2001, Vienna 2002 when the Ethical Statement was accepted.

[28] Licensed Family & Marital Therapist.

[29] Licensed Massage Therapist.

[30] Draft October 2001, accepted 2004, available from: United States Association for Body Psychotherapy, 7831 Woodmont Avenue, PMB 294, Bethesda, MD 20814 Phone: 202-466-1619 Email: usabp@usabp.org

[31] See also "Uniquely Male Ethics in Massage Therapy: The Response" By Charles W. Wiltsie: www.dayspaassociation.com

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

[33] Ibid: p.117-119

[34] 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!

[35] Psychology Today website: cms.psychologytoday.com: Sherman, Carl: *Behind Closed Doors: Sex Therapists*: originally published May/June 1993

[36] Recently the EABP Ethics Committee decided not to adopt this text, but to write its own version.

[37] Zur, O. & Nordmarken, N. (2004): op. cit

[38] Field, Tiffany: (see Reading List)

[39] Smith et al.: op. cit.

[40] Obfuscate: to make something obscure or unclear, especially by making it unnecessarily complicated

[41] Weber, R.: *A philosophical perspective on touch:* in Barnard, W.E. et al. (1990): *The Foundation of Experience:* International Universities Press, Madison

[42] Described in Westland G. "An exploration of how touch can be contactful in therapy".J. in *Ass. Of Holistic Biodynamic Massage Therapists*: Vol. 8, No. 1 (2004/5)

[43] Smith et al.: op. cit.

[44] White: (see Reading List) p. 17

[45] Ibid: pp 42-48

[46] Ibid: p. 28

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

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

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

[50] Ibid: p. 114

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

Professional Psychology, 11, 807-811

[52] Pope: p. 170

[53] Studies on maternal deprivation & also the classic primate studies by Harlow & Harlow (1962). See also Field (2003)

[54] Field, Tiffany: *Touch*: (Bradford Book, MIT Press) 2003

[55] See: Schore, A. (1994): *Affect Regulation and the Origin of the Self* : Lawrence Erbaum; Brazelton, Berry & Cramer (1991): *The earliest relationship: parents, infant and the drama of early attachment:* Karnac, London; Stern, D. (1985): *The Impersonal World of the Infant:* Basic Books, NY; Trevarthen , C. & Aitkin, K.J.: Infant Intersubjectivity: research, Theory & Clinical Appllications: *J. Child Psychol.* Vol. 42, No 1, 3-48, 2001; Montague, A. (1971, 1986.): *Touching: the Human Significance of the Skin:* Perennial Books

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

[57] May, John: see Reading List.

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

[59] 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

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

[61] Fagan, J. Thought on using touch in psychotherapy. In Smith et al.

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

[63] Bar-Levav, Reuven: A rationale for physical touching in psychotherapy. In Smith et al.

[64] White: op. cit.: p. 22

[65] McNeely: p. 67-68

[66] Forer 1969; Perls 1969, Rogers 1970, Polster & Polster 1973, Older 1977

[67] Hunter & Struve: op. cit.: p 67

[68] Totton, N. (2003): p. 44

[69] Harlow & Harlow: and other studies.

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

[71] Hunter & Struve: p 69

[72] USABP Draft Code of Ethics (above)

[73] See www.jimhunter.com; www.ipt-forensics.com and other similar sites.

[74] White: op. cit.: p.25

[75] Hunter et al,m 1998; Fagan, 1998; Fosshage, 2000; Smith, 1985, 1998b.

[76] Smith, 1985; Hunter et al, 1998; Kertay et al., 1993.

[77] "Touchy" is an English idiom meaning sensitive or easily upset. This is therefore a pun, which I could not resist.

[78] Smith (1985): op. cit.: p. 46

[79] Fagan, J: Thoughts on using touch in psychotherapy. In Smith et al.

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[81] May, John: op. cit.: p. 116

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[99] Rutter (1990), P. *Sex in the Forbidden Zone*: Mandala

[100] Ibid: p. 132

[101] 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 mythical cathedral town, Starchester, and 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).

[102] Milakovich, J: Differences between therapists who touch and don’t touch: In Smith, et al.: pp 74-92

[103] Fagan, J. Thoughts on using touch in psychotherapy. In Smith et al: p. 150

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

[106] 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

[107] 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.

[108] “Who will guard the guardians themselves?” Juvenal.

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