PAPER ON TOUCH

Clinical, Professional & Ethical Issues

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

Introduction

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

When a child experiences touch from a loving, safe caregiver many things happen to promote healthy growth. The child develops a sense of self and the ability to relate to others; they learn to modulate affect; and develop a belief in his or her own self-worth and ability to master their environment. (Myrow, 1997, p.1). Research shows that touch is essential in forming healthy parent/child attachments, promotes physiological development, reduces the effect of stress on an infant, and promotes positive body image. (Jernberg & Booth, 1999). Touch is essential to the human experience and is a powerful form of communication. Touch, when used appropriately, can promote growth and provide healing. When misused, touch can impede healthy development and cause harm. Because touch is such a complex, powerful form of communication, the conscientious play therapist must carefully evaluate and understand their own motivations for using or not using touch, and whether or not this decision meets the needs of the client.

Touch in Play Therapy

1. Preparation – Training

Before incorporating touch into play therapy sessions, play therapists should be trained in the nature of touch as well as the related developmental, therapeutic, ethical, and pragmatic issues.

2. Preparation – Informed Consent

Play therapists should be aware that touch has become a very sensitive topic in modern American society. As such, the therapist must be prepared to manage not only the reality of any touch that occurs in session but the perception of that touch by the child and the child's caretakers. This is best accomplished by ensuring that the child's caretakers have provided informed consent before touch is introduced into the play sessions. Play therapists should do their best to give children and their caretakers examples of the types of touch that can happen during play therapy, realizing that all situations cannot be anticipated. Issues of physical safety and sexual boundaries should be discussed with parents or guardians. The play therapist may want to consider the use of a written release form for physical contact.

3. Implementation

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

4. Supervision/Consultation

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

5. Ethical Considerations

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

6. Special Considerations: Abused or Traumatized Children

The decision to use touch in play therapy with a child who has been traumatized and/or physically or sexually abused is determined on a case-by-case basis. The use of touch is not automatically excluded because a child has experienced trauma regarding *bad touch* but the therapist needs to be even more vigilant in monitoring and managing the child's perception and experience of being touched. The symptoms of trauma and the maladaptive coping strategies the child develops may be appropriately treated with touch. A conscientious play therapist is ever vigilant not to re-traumatize a child and understands that the child, in order to heal, may need to experience safe, good touch. As always, the use of touch is integrated into the treatment plan.

7. Special Considerations: Group Work

While most of this paper focuses on touch or physical contact between therapists and their child clients, the therapist must also monitor any physical contact that may occur between children in the context of a play therapy group. First and foremost, the rule not to hurt others should be stringently adhered to. Second, the therapist must, of course, set limits on any sexualized contact between members of the group. Last, the therapist needs to make the group aware that different children have different needs for physical contact and/or physical distance or space. Rules should be established whereby the children come to respect each other's boundaries. When and if inappropriate touch or contact does occur, the therapist should inform the children's respective caretakers and take precautions to ensure that the problem does not reoccur.

8. Special Considerations: Physical Restraint

Physical restraint is the most difficult form of therapeutic physical contact that can occur between a child

and a play therapist. This is because the child will almost never view the experience as positive while it is occurring. Yet, there may be occasions where the play therapist's ability to effectively and safely restrain the child is essential to maintaining the child's safety in the playroom. While this is most often the case when working with more severely disturbed children, the need for restraint may arise at any time. All play therapists should have a plan (even if it does not involve touch or restraint) for how they will manage extreme violent or self-endangering acting out on the part of a child in session. Should restraint become necessary, the event must be processed with both the child and the caretaker immediately after ending the restraint procedure. No play therapist should use restraint without training in the procedure.

Resources

Barnard, K.E. & Brazelton, T.B. (1990), *Touch: The Foundation Of Experience*. Madison, WI: International Universities Press.

Brazelton, T.B. (1990). "Touch as a Touchstone: Summary of the Round Table." In K.E. Barnard & T.B. Brazelton (Eds.), *Touch: The Foundation Of Experience.* Madison, WI: International Universities Press.

Brody, V.A. (1978), "Developmental Play: A Relationship-Focused Program For Children", *Journal Of Child Welfare*, 57(9), 591-599.

Brody, V.A. (1993), *The Dialogue Of Touch: Developmental Play Therapy*, Treasure Island, FL: Developmental Play Training Associates.

Field, T. (1995), Infant Massage Therapy, In Field T. (Ed.), *Touch In Early Development*, Mahawah, NJ.

Fuller, W.S. & Booth, P.B. (Fall 1997), "Touch With Abused Children", *The Theraplay Institute Newsletter*, p 4-7.

Gil, E. (1991), *The Healing Power Of Play: Working With Abused Children*, New York: Guilford Press.

Hunter, Mic. & Struve, Jim (1998), *The Ethical Use Of Touch In Psychotherapy*, Thousand Oaks, CA: Sage Publications, Inc.

James, B. (1989), *Treating Traumatized Children: New Insights And Creative Interventions*, Lexington, MA: Lexington Books.

Jernberg, Ann & Booth, Phyllis (1999), *Theraplay: Helping Parents and Children Build Better Relationships Through Attachment Based Play* (2nd edition), San Francisco, CA: Josey-Bass Publishers.

Montague, A. (1971), *Touching: The Human Significance Of The Skin*, New York: Columbia University Press.

Myrow, D.L. (Fall 1997), "In Touch With Theraplay", *The Theraplay Institute Newsletter*, No. 9.

Smith, Edward, Clance, P.R. & Imes, Suzanne *(Eds.)* (1998), *Touch in Psychotherapy: Theory, Research and Practice,* New York: Guilford Press.

Weiss, S.J. (1990), "Parental Touching: Correlates Of A Child's Body Concept And Body Sentiment", In K.E. Barnard and T.B. Brazalton (Eds.), *Touch: The Foundation Of Experience*, Madison, WI: International Universities Press.

Winnicott, D.W. (1958), Collected Papers; "Through Pediatrics To Psychoanalysis", London: Tavistock.

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