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

When a child experiences touch from a caring and safe caregiver, many things happen to promote healthy growth. Children develop a sense of self and the ability to relate to others; they learn to modulate affect, regulate their behavior, and develop a belief in their own self-worth and ability to master their environment.

Research indicates that touch is essential in forming secure attachment between the parent and the child, fosters physiological development, reduces the effect of stress on an infant, and promotes positive body image (Booth & Jernberg, 2010; Field, 2014). Touch is considered essential to the human experience and when used appropriately, can promote growth and provide healing. When misused, it can impede healthy development and cause harm. In addition to the child's reaction to touch, other distinctions include whether the touch is initiated by the child or the therapist, and ultimately whether the touch is therapeutic or in some cases even harmful (Courtney, 2017). Because touch is a complex, powerful form of communication, play therapists must carefully evaluate and understand their own motivations for using or not using touch, and whether or not this decision meets the needs of the child.

In the context of this paper, *touch* refers to any physical contact occurring between children and/or adolescents and clinicians. In its most positive form, touch is nurturing and supportive and may include a simple 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. However, 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 therefore is (1) to provide practitioners with clinical and ethical 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, which includes knowing when to make referrals for specific body focused treatments, and lastly, 3) to encourage additional research related to the significance of touch as it relates to mental health, neuroscience and other contributing factors that impact the child's overall wellbeing.

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 related developmental, therapeutic, legal, ethical, and pragmatic issues. Play therapists are aware that different cultures attach different values and meaning to touch and therefore strive to understand how touch is expressed within the culture of the children with whom they are working. Before incorporating touch into play therapy sessions, play therapists should understand the various theoretical orientations regarding the clinical use of touch and assess their comfort level using touch, and receive regular supervision and/or consultation when incorporating touch in treatment. Play therapists should also be trained in the potential adverse effects of touch misapplied and should remain current on the research and/or clinical practices associated with the literature in the field of touch, including the neurobiology of touch as it relates to trauma. Additionally, training in the therapeutic use of touch can help play therapists to advance self-awareness and bring to light any potential countertransferences related to touch.

2. Preparation – Informed Consent and Documentation

Play therapists should be aware that touch has become a very sensitive topic in contemporary society and organizations may have policies and procedures in place addressing the use of touch. 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. When touch is inherent in play activities, this can be accomplished by including the parents or caregivers in assessment and treatment planning. In the process of formulating goals and methodology, the therapist can explain the purposes and process of treatment so that the parents or caregivers will understand how touch is related to the goals. Play therapists should be prepared to give children and their caretakers specific examples of the types of touch which can occur during play therapy (see sections 6-8 below), while realizing that not all situations can be anticipated. When circumstances make issues of physical safety and sexual boundaries particularly germane to play therapy, provisions to protect the child should be reviewed as well as any relevant documents that the supporting agency maintains. The play therapist may consider the use of a separate written release form regarding physical contact. The play therapist should also document any/all unanticipated touch that transpires in a session, noting who initiated it, how it was addressed/implemented and the consequence/reaction. Play therapists also document a clear rationale and justification for the use of touch, linking it to theories or clients' goals. Play therapists recognize that the informed consent process is ongoing, and touch is discussed with guardians initially, as well as throughout therapy.

3. Implementation

Touch should only be considered when it only meets the needs of the child, has documented benefit, and is consistent with the treatment goals. The types, frequency, and duration of touch over the course of treatment commonly initiated by children or play therapist in sessions should correspond to the child's developmental level and needs and should be addressed with a child's legal guardian in order to obtain his or her written informed consent.

In cases where touch initially appears to be therapeutically indicated, but later becomes problematic or harmful, the play therapist discontinues the touch and sets appropriate boundaries (e.g., a child initiates a hug but then the hug becomes sexualized by the child).

4. Supervision/Consultation

Touch in therapy is a complex issue and the inherent power differential between the play therapist and child. Any play therapist who will be utilizing touch in therapy – particularly when touch will be an essential and inherent aspect of the treatment – should have advanced professional training and/or receives supervision.

Any play therapist utilizing touch in therapy 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. Further, the play therapist is obligated to seek appropriate supervision/consultation whenever a potential legal and ethical conflict or question arises in the context of their use of touch in therapy.

Play therapists having limited experience and/or training regarding the use of touch in therapy should engage in individual or group training, supervision and/or consultation with clinicians experienced in the use of touch in play therapy with the goal of gaining knowledge and understanding sufficient to assure the effective, moral/ethical and legal use of such strategies.

5. Legal and Ethical Considerations

Sexual contact and/or erotic touch between a play therapist and child is legally, ethically, morally and professionally wrong.

Due to the inherent power differential between play therapist and child in that coercion can be very subtle, this possibility should be closely monitored. There needs to be demonstration that the touch is for the clients' benefit and not something for the therapist. The play therapist should not touch or allow themselves to be touched by the child when the play therapist is uncomfortable with the touch, angry, or sexually aroused. Play therapists need to be vigilant to how touch is perceived by the child and seek supervision/consultation when appropriate.

The inappropriate touching of a child is an egregious violation of laws and ethics constituting a felony that puts the practitioner at severe legal risk including incarceration. Moreover, when working with children, the "slippery slope" argument as addressed in the literature related to adults is not the primary dynamic between the practitioner and child, nor are the actions against them the same.

6. Special Considerations: Non-Clinical or Unanticipated Touch

Play therapists recognize that touch comes in many forms and occurs in many contexts within the play session. Oftentimes, the use of touch is foreseeable, such as when a child asks for a 'high five' or wants to sit on the therapist's lap while reading a story, or in physically based approaches (i.e. therapist and child thumb wrestling). Other times, the child may spontaneously touch the therapist when giving an unsolicited hug, wishing to be escorted to the bathroom, or climbing onto the therapists' lap without warning.

Unpredictable circumstances may arise in which the therapist may need to touch the child to provide supportive guidance in physical activities, provide nurturing touch in emotional situations or to otherwise tend to the emotional and physical safety of the child (i.e. when a child bolts from the playroom, climbs up shelves or locks themselves into various spaces).

In any or all of these circumstances, the play therapist carefully monitors his/her touch response, utilizes touch with a clear rationale and appropriate intensity and acts in the most judicious manner in order to maintain safe conditions for the child and/or comfortable/acceptable boundaries for him/herself.

When appropriate incidents of any of these examples of touch are to be documented and discussed with the child's guardian and/or the therapist's supervisor. Play therapists working in educational and/or treatment settings that have specific policies regarding touch that differ from their own must consider those policies, address such with their supervisor and guide themselves accordingly. Play therapists are mindful that local, state, and federal laws and licensing professional organizations governing touch take precedence over administrative work environment policies.

7. Special Considerations: Children Who Have Experienced Trauma or Abuse

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 if or when a child has experienced trauma regarding inappropriate touch but the therapist needs to be extremely vigilant in monitoring and managing the child's perception and experience of being touched.

Research has indicated that healthy, appropriate touch can be an important element in the treatment of touch as it relates to trauma. The symptoms of trauma and the maladaptive coping strategies the child develops may be appropriately treated with touch.

A play therapist is ever vigilant not to retraumatize a child and understands that the child, in order to heal, may need to experience safe, good touch. Further, the play therapist who has not been specifically trained to work with this population will require supervision from a clinician who is competent to do so. As always, the use of touch is integrated into the treatment plan, and the play therapist always asks permission of the child before touching him or her in this context. When working with children who have experienced abuse or trauma, play therapists take additional precautions to closely follow documentation procedures, collaborate with client treatment teams, consider videotaping of sessions based on treatment modality, seek supervision/consultation as appropriate, and keep caregivers/guardians informed of the use and response to the use of touch related to the treatment plan.

8. Special Considerations: Children with Sensory Issues

Sensory processing disorder refers to the way the nervous system receives messages from the senses and turns them into appropriate motor and behavioral responses. Children with sensory issues may exhibit tactile or touch sensory integration challenges. Children who are hypersensitive and have an unusual or increased sensitivity to touch, also called tactile defensiveness or tactile over-sensitivity. For these children, touch can feel uncomfortable, strange, overwhelming, painful, and often lead to avoiding touch when possible. Children may also be hyposensitive, meaning they have tactile under-sensitivity, also called tactile under-responsiveness. Those who are hyposensitive to tactile input are underwhelmed and seek out additional sensory information to feel content. They may touch many things or have difficulty noticing touch (even hard or painful touch). They also may not be able to communicate when a touch is unpleasant or causing pain.

The play therapist should be mindful of sensory processing issues (inquiring about a child's background information regarding such challenges during the intake process). Multiple diagnoses also tend to accompany sensory problems including autism spectrum disorder, attention-deficit/hyperactivity disorder, and developmental disorders. However, children with sensory processing challenges may be able to participate in touch related interventions and such interventions may be part of treatment to address sensory issues.

9. 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 a play therapy group.

All play therapists should have a plan (even if it does not involve touch or restraint) for how they will manage extreme violent or self-endangering acting out on the part of a child in session. This plan should be consistent with their training in restraint and the policies on restraint in the facility in which they are working.

Group rules regarding touch between group participants should be introduced and enforced by play therapists on a regular basis.

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

Rules should be established whereby children in group play therapy/therapy respect each other's boundaries. When and if inappropriate touch, inappropriate contact or disrespectful behavior (i.e. hitting or teasing) does occur, it should be addressed in constructive ways as part of the process of some forms of group therapy.

Extraordinary events (physical injury or inappropriate contact) should be reported to caregivers, reaffirming the safety measures and precautions that are in place. Play therapists should always document the extraordinary touch or contact and/or discuss the incident with his or her supervisor if deemed appropriately. Such documentation should note who initiated contact, how it was addressed, and any consequences. Play therapists who plan to utilize group therapy should seek out supervision from a clinician who has specific training and experience in conducting play therapy groups.

10. Special Considerations: Physical Restraint

Physical restraint is the most challenging and often times difficult form of therapeutic physical contact that can occur between a child and a play therapist. A child will almost never view the experience of physical restraint as positive while it is occurring, and the restraint may have negative impacts on the therapeutic relationship. There may be occasions, particularly when a child is in a residential treatment center or

hospital, where the play therapist's ability to effectively and safely restrain the child is essential to maintaining the child's safety in the playroom. While this is most often the case when working with more severely disturbed children, the need for restraint may arise at any time and in any treatment setting, after less restrictive means have been attempted unsuccessfully. Restraint should only be used after exhausting all other preventative measures.

Play therapists working in a setting in which restraint is commonplace should receive the necessary training and become thoroughly familiar with any laws in their state and legal and ethical code in their parent licensing body regarding the use of physical restraint. All play therapists should have a plan (even if it does not involve touch or restraint) for how they will manage extreme violent or self-endangering acting out on the part of a child in session, and this plan should be consistent with their training in restraint and the policies on restraint in the facility in which they are working.

As part of their plan to address these behaviors, a play therapist needs to weight the potential impacts of restraint on the child with the immediate need for safety. Should restraint become necessary, the event must be thoroughly documented and processed with both the child and the caretaker immediately after ending the restraint procedure. The notification to the parent or guardian should include: a) description of the activity in which the client was engaged immediately preceding the restraint b) the behavior that prompted the restraint c) the efforts made to de-escalate the situation and d) alternatives to the restraint that were attempted prior to the restraint intervention e) discussed with a play therapist's supervisor if needed.

In the event that the play therapist is not comfortable or not appropriately trained in utilizing restraint, he/she should make arrangements with alternate personnel for doing so. All incidents of restraint should be carefully documented.

11. Disclaimer

The information contained herein are guidelines which serve as a reference for play therapists. This information does not replace and is not, and should not be used as a substitute for any standards, guidelines or other rules and regulations by which play therapists are bound, including legal and ethical standards of their parent licensing body or applicable laws.

Play therapists, as licensed mental health professionals are entirely responsible for their own professional activity, as evidenced by each discipline's code of ethics including, but not limited to: *American Counseling Association, American Association for Marriage and Family Therapy, Association for Play Therapy, National Association of Social Workers*, and the *American Psychological Association*. In no event shall APT or any branch be liable for any reason to any member, client or other individual for any decision made, action taken, omission, misdiagnosis or malpractice that may occur as a result of treatment provided by any play therapist.

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12. Revisions

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