

Paper on Touch

Clinical, Professional & Ethical Issues



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The purpose of this paper therefore is multi-faceted: 1) to provide practitioners with clinical and ethical information they may find useful in deciding whether therapeutic touch might be clinically useful in their work with a given client, 2) to promote thinking about the pros and cons of using touch in play therapy process, including sensitivity to cultural considerations and knowing when to make referrals for specific body-focused treatments, and 3) to encourage additional research related to the significance of touch as it relates to mental health, neuroscience, cultural diversity, attachment and other contributing factors that impact the client's overall wellbeing.

Introduction

When a child experiences touch from a benevolent and safe caregiver(s)/legal guardian(s), 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 a secure attachment between the caregiver(s)/legal guardian(s), and the child, fostering physiological development, reducing the effect of stress on an infant, and promoting 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 or withheld, it can impede healthy development and cause harm, as well as impact attachment. Hambrick et al. (2018) found that positive neuroscience and developmentally informed touch can even decrease restraints and critical incidents in mental health treatment. Further, touch is a complex, powerful form of communication that may occur during play therapy. Play therapists must carefully evaluate their own motivations and theoretical reasoning for using or not using touch, and whether this decision meets the therapeutic needs of the client.

In addition to considering the client's reaction to touch, other distinctions include whether the touch is initiated by the child, caregiver(s)/legal guardian(s), or the play therapist; and ultimately whether the touch is therapeutic or in some cases even harmful (Courtney, 2017). It is crucial for play therapists to be aware of their own cultural views regarding touch, as well as the cultural norms and values of their clients during this decision-making process. Furthermore, since it is feasible for touch to take place during telemental health sessions, play therapists must consider possible implications for touch while conducting both in person and virtual therapy.

Cultural considerations regarding the client are of paramount importance when considering adopting the use of therapeutic touch in play therapy sessions. The clinician will need to consider diversity and the cultural aspects of a client within their community or society. Within a larger context, multiculturalism/cultural considerations related to the client and client's system and perception of touch should be heavily considered when integrating therapeutic touch within sessions. Clinicians should have an awareness of the child's culture while considering the following:

- What are some cultural factors that need to be considered with clients before employing the use of therapeutic touch?
- How does my client's culture perceive and process therapeutic touch?
- How will therapeutic touch be beneficial in session?

In the context of this paper, *therapeutic touch is defined as:*

Any physical contact occurring between the clinician and the client. In a play therapy context, *the client* may be defined as an individual child, a caregiver/child dyad, one or more caregiver(s)/legal guardian(s), or multiple family members at once. Touch may occur during individual, dyadic, family or group play therapy session(s). At times, therapeutic touch can be perceived as nurturing or supportive and may include a simple pat or a hug. It can also be viewed neutrally, such as when a play therapist holds a young child's hand on the way to the playroom to prevent the child from wandering off. However, there are certain types of safety-focused therapeutic touch that a client may experience as unpleasant, such as taking a child's

hand to stop them from hitting a sibling in session. Cultural context, sensory issues, and trauma and abuse histories are some factors that can influence individuals' perceptions of touch. Each of these types of touch is discussed below (Courtney & Nolan, 2017).

Additional Considerations related in Play Therapy

Health Related Touch Issues. Since 2020, due to the emergence of the pandemic and COVID-19, play therapists need to recognize and maintain awareness of health related touch issues that could occur during the process of play. Play therapists should consider the impact of infection/health issues when utilizing certain materials during the process of play. Play therapists should be aware that physical touch can occur during virtual sessions and be mindful of possible health/infection issues due to COVID-19 and other contagious illnesses. Play therapists should be familiar with the guidelines regarding touch and virtual sessions presented in this paper.

Telehealth. Please be aware that clinicians that engage in telemental health using play therapy need to follow their state and/or countries licensure board's rules and laws. In addition, to following their state and/or countries rules and laws, the guidelines regarding touch, presented in this paper, should be incorporated when engaging in telemental health using play therapy

Touch in Play Therapy

1. Preparation – Education, Training, and Supervision

Play therapists should acquire the appropriate and necessary training, education and (as needed) supervision before incorporating touch into play therapy sessions and engage in continuing learning and supervision as needed to maintain such in the on-going use of touch in clinical work. Play therapists should make themselves knowledgeable regarding the general nature and varieties of touch together with touch's related developmental, cultural, ethical, legal and pragmatic aspects. Play therapists strive to understand and respect how touch is expressed and experienced within the culture of the children and families with whom they are working. This knowledge extends to and incorporates, with regard to both those being seen in counseling and the clinician themselves, consideration of the values, meanings, experience of and responses to touch. Play therapists should be aware of and actively explore their own beliefs, experiences, cultural influences and general views about touch as part of their professional development, training and supervision. Before incorporating touch into play therapy sessions, play therapists should understand the various theoretical orientations regarding the clinical use of touch. Play therapists assess and work to become conscious of their comfort level in using touch, and receive regular supervision and/or consultation when incorporating touch in treatment. Play therapists are comfortable with discussing norms, boundaries, and expectations with supervisors and guardians. Further, play therapists address initiated and inappropriate touch with their supervisors, parents or guardians, and the child as appropriate. Play therapists are trained in providing telebehavioral health services in accordance with their state and/or country licensure board with a broad skillset of incorporating touch. A skillset that assesses and directs touch in a virtual non-controlled environment, inclusive of touch with guardians, siblings, and others.

Play therapists should also be trained in the potential adverse effects of touch and should remain current on the research and/or clinical practices associated with the literature in the field of touch, including somatic, cognitive, affective experiences, and neurobiology of touch as it relates to trauma. Training should extend to obtaining trauma-focused guidance to address current, historical, and triggers of touch. Additionally, training in the therapeutic use of touch can help play therapists advance self-awareness and bring to light any potential countertransference related to touch.

2. Preparation – Informed Consent and Documentation

Play therapists must be aware that touch is an important topic of discussion at the point of intake and throughout the therapeutic process. In the play therapy setting, touch is almost inevitable whether through assisting a child, part of the play process, child frustration, or incidental. It is imperative the therapists have a consistent framework to address touch and to gain consent from the caregiver(s)/legal guardian(s), and

assent from the child, when possible. It is also imperative to have a consistent process for documenting occurrences. It is essential that therapists understand and communicate the possible usefulness of touch, the harm of withholding touch, and the possible negative consequences of touch (Courtney & Nolan, 2017; McNeil-Haber, 2004). The play 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 caregiver(s)/legal guardian(s). The play therapist should address concerns regarding touch and infectious disease. The play therapist should be aware of state and/or country COVID regulations and apply these in reference to touch.

When utilizing telemental health, the play therapist must be prepared to address and manage touch that occurs in the child's environment and the perception of that touch as well. This is accomplished through the use of a telehealth specific release (in accordance with state and/or country licensure board rules and laws), the play therapist's policy practice form, the play therapist's informed consent form, and/or in the treatment plan. In the process of formulating goals and methodology with the caregiver(s)/legal guardian(s), the play therapist can explain the purposes and process of treatment so that caregiver(s)/legal guardian(s) will understand how touch is related to the goals. Play therapists should be prepared to give children and their caregiver(s)/legal guardian(s), 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 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. By following these guidelines, the play therapist is setting professional boundaries that form the therapeutic framework to create a safe, predictable, nonexploitative and agreed upon process (McNeil-Haber, 2004; Moffatt, G. K, 2017). Play therapists recognize that the informed consent process is ongoing, and touch is discussed initially and throughout therapy.

3. Implementation

Play therapists utilize different theoretical approaches to play therapy. Play therapists should be trained and supervised in their approach to play therapy and have a clear understanding of how to conceptualize, utilize, and respond to touch in the play therapy process, from the foundation of their guiding theoretical approach.

Play therapists understand that touch can be a normative and appropriate component of children's play. Play therapists should be clear about how touch is congruent and supportive for all persons in the play therapy session (i.e., child, caregiver(s)/legal guardian(s), and sibling). When deciding to initiate, accept or allow appropriate touch in play therapy, play therapists consider child-specific factors, including treatment goals, trauma history, cultural and ethnic background, developmental level, and diagnosis. Touch should be considered when it meets the needs of a child client, has documented benefit, and is consistent with the treatment goals. Play therapists assess the purpose and need for the use of touch for children given the therapeutic contexts. The types, frequency, and duration of touch over the course of treatment commonly initiated by children or play therapists in sessions should correspond to a child client's developmental level and needs.

Play therapists inform children's legal guardians about the use and nature of touch in play therapy. Play therapists can educate children about appropriate touch and utilize therapeutic limit setting in session to avoid inappropriate touch (for example, if a child wants to kiss the play therapist on the lips, therapeutic limit setting can be utilized to acknowledge the child's intention, and communicate alternatives).

The play therapist acts in the best interest of the child and not in a manner that responds to the play therapist's own personal needs. 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 (for instance, a child initiates a hug but then the hug becomes sexualized by the child), while

also seeking out consultation or supervision on the case. Play therapists document the use of touch in clients' notes as clinically indicated.

In instances when touch is an intentional component of the therapeutic process (i.e., Theraplay), touch should be addressed with a child's legal guardians to obtain their written informed consent and the theoretical orientation should be outlined specifically in the play therapists' declaration of practice document(s). In these instances, play therapists can educate children and caregiver(s)/legal guardian(s), about the use and intention of touch in play therapy and obtain children's assent, as developmentally appropriate. When therapeutically relevant, play therapists can include caregiver(s)/legal guardian(s), in session when touch is anticipated or planned to be utilized for specific therapeutic purposes.

When utilizing telemental health and as clinically relevant, play therapists discuss with the caregiver(s)/legal guardian(s), how to implement touch and the process they will follow to discontinue the touch and set appropriate boundaries if needed.

It is the responsibility of play therapists to seek further training, consultation, supervision and guidance when questions arise regarding when to use touch therapeutically.

4. Supervision/Consultation

Touch in therapy is a complex issue. Play therapists recognize the inherent power differential between the play therapist and the 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 continuing training and supervision by a Registered Play Therapist-Supervisor™ who is knowledgeable about the play therapy model being utilized.

Play therapists having limited experience and/or training regarding the use of touch in therapy should engage in individual/group training and supervision/consultation led by clinicians experienced in the use of touch in play therapy.

Any play therapist utilizing touch in therapy must 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 play therapist's own motivations, thoughts, and feelings.

Play therapists are obligated to seek appropriate supervision/consultation whenever a potential legal and ethical conflict or question arises in the context of the use of touch in therapy.

In instances when play therapists seek supervision/consultation related to the use of touch in play therapy, play therapists maintain goals of gaining knowledge and understanding sufficient to assure the effective, moral/ethical, and legal use of therapeutic strategies. Play therapists obtain supervision/consultation to understand the potential risks and benefits of touch. Play therapists also obtain supervision/consultation and relevant training to become culturally responsive providers who can recognize the cultural relevance and meaning of touch for children in the therapeutic context. During supervision/consultation, play therapists are responsible for exploring their own feelings and concerns regarding touch in therapy.

Play therapists can utilize an ethical decision-making model to determine appropriateness of touch. An example of an ethical decision-making models is available from the American Counseling Association (Forrester-Miller & Davis, 2016), accessible at <https://www.counseling.org/knowledge-center/ethics/ethical-decision-making>.

5. Legal and Ethical Considerations

This section addresses legal and ethical considerations of touch among play therapist, client, group members, siblings, legal guardian or family members, or others involved in the treatment process. Further, this section considers client self-touch.

Due to the inherent power differential between the play therapist and child, coercion can be very subtle and this possibility should be closely monitored. There needs to be demonstration that the touch is for the client's well-being and is congruent with the clinical goals. At times, it may be beneficial to incorporate touch specifically in the client's treatment plan. In all clinical work, 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 follow an ethical decision-making model (Calmes et al., 2013), seek supervision/consultation, and/or legal aid when appropriate. Play therapists need to consider how culture and the intersectionality of the various aspects of the client's, the client's guardian, and the play therapist's cultural identities and touch histories are relevant to the client's and the guardians' perception of touch (Wright, 2020). Play therapists need to be able to discuss touch as it relates to the guardians' use of touch with their child and to, as needed, provide the guardian with education regarding appropriate touch and limit-setting based on research and recognized formats of limit setting, such as the ACT Limit Setting Model (Forrester-Miller & Davis, 2016). Additionally, it is important that play therapists gain informed consent about mandated reporting regarding violent touch as described by the state and/or country guidelines. Legal and ethical considerations about touch need to be addressed in all formats of clinical services.

A child's self-touch also needs to be considered especially if it is not developmentally or culturally appropriate or is unsafe. A play therapist may need to implement interventions, such as developmentally appropriate sex education, bibliotherapy, or limit setting (i.e., you are for loving, not for hurting.) based on the client's need and the play therapist's professional competencies and modalities. If a child sees touch in-person or through technology that is not developmentally appropriate or experiences inappropriate touch, the play therapist needs to support the client with these situations.

Sexual contact and/or erotic touch between a play therapist and child is legally, ethically, morally and professionally wrong. The inappropriate touching of a child is an egregious violation of laws and professional 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. As always, the play therapist must uphold ethical principles of autonomy, fidelity, justice, beneficence, and non-maleficence.

6. Special Considerations: Spontaneous or Unanticipated Touch

Play therapists recognize that touch comes in many forms and occurs in many contexts within the play session whether the setting is in person individual, group or family therapy or telemental health (i.e., individual, group/sibling or family). The touch that occurs is oftentimes foreseeable though not expected at other times.

Examples of foreseeable touch in a session may include:

- when a child asks for a "high five",
- when a child wants to sit on the play therapist's lap while reading a story, or
- in physically based approaches (i.e., play therapist and child thumb wrestling).

Examples of spontaneous touch may include:

- the play therapist engages in giving the child an unsolicited hug,
- the child wishes to be escorted to the bathroom, or
- the child climbs onto the play therapist's lap without warning.

Note: In a group session (whether with peers or family) or telemental health settings, the examples above also apply though the interaction may be with someone other than the play therapist.

At times, there may be unpredictable circumstances in which the play therapist or other adult present (such as caregiver(s) or legal guardian(s)) 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). There may also be incidents of incidental touch among those present in a therapy session with such touch being natural and safe/acceptable or potentially problematic/uncomfortable.

In any or all of these circumstances involving touch in session by the play therapist with a child (and/or with others present in sessions including more than a/the single child client), the play therapist should carefully monitor their touch actions as well as how the client responds to the touch, including the response of others present in any group/family setting. The play therapist should have a clear rationale that is grounded in the specific approaches/theoretical orientation being applied to the given client(s).

Related additional considerations should include: the individual's cultural/ethnic and sensory/developmental sensitivities (whether due to trauma or physical or cognitive conditions) [see later sections addressing these specific factors]. An overarching intent in all cases would be to foster and maintain an actual and sensed condition of being safe together with the provision of reasonable/acceptable boundaries for all present in the play therapy session (regardless of numbers present or format of the sessions).

When appropriate, incidents of any uncomfortable, inappropriate or questionable touch are to be documented. Such events, when clinically appropriate, should be discussed with the child's caregiver/legal guardian, –and/or the play therapist's supervisor and/or reported to necessary agencies when required (consult state and/or country statutes that would be related to the specific situation). Play therapists working in educational and/or treatment settings that have specific policies regarding touch that differ from their own and/or those of their licensing/credentialing agent must consider those policy differences and then address such with their supervisor and/or appropriate agency personnel keeping in mind that local, state, federal, and country laws and licensing professional organizations governing policies touch take precedence over administrative work environment policies. In these situations, it is the play therapist's goal to be meeting all outside expectations while maintaining in session to the greatest extent possible behavior and interactions clinically recognized as the most effective approach to providing for the treatment needs and goals of those being provided play therapy services.

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 play therapist should develop a rationale and intentionality for utilizing touch with trauma, physical or sexual abuse as the presenting issue. This rationale should be documented in the clients' progress notes and the treatment plan.

The use of touch is not automatically excluded but must demonstrate its therapeutic value. The play therapist understands that child-initiated touch may occur and will be diligent in assessing appropriateness of this interaction on a case-by-case basis. Play therapists will engage in ongoing assessments to include the caregiver(s) in order to determine history, temperament, preference and other special considerations relating to the child's response to touch.

Diverse healing traditions are central to many cultures and touch may be seen as healing in some cultures. A play therapist will be aware of cultural considerations specific to the child's needs regarding touch and exercise best practice with respect to the child's individual preferences. Needs specific to gender, gender identity, developmental and medical considerations must also be assessed and appropriately addressed. (Kim, & Nahm, (2008). Healthy, appropriate touch, in conjunction with healthy and appropriate boundaries, can be an important element in the treatment of trauma. The symptoms of trauma and maladaptive coping strategies the child develops may be treated in play therapy using appropriate therapeutic touch. When used therapeutically, touch can play an important role in co-regulation and create a safe environment in which healing can occur.

A play therapist is ever vigilant to avoid actions that retraumatize a child and understands that the child, in order to heal, may need to experience healthy, therapeutic touch. Further, the play therapist who has not been specifically trained to work with this population will require supervision from a Registered Play Therapist-Supervisor™ knowledgeable about instances of touch in the playroom. In addition to supervision, the play therapist will make every effort to utilize an ethical decision-making model as interpreted by their licensing body.

The use of touch is integrated into the play therapy treatment plan, and the play therapist always asks permission of the child before touching them 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 clients' treatment teams, consider videotaping of sessions based on treatment modality, seek supervision/consultation as appropriate, and keep caregiver(s) informed of the use and response to the use of touch related to the treatment plan.

8. Special Considerations: Children with Sensory Differences

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 differences 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 differences (inquiring about a child's background information regarding such needs and helpful interventions during the intake process). Multiple diagnoses also tend to accompany sensory differences, such as 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 differences. If deemed appropriate, a play therapist may work collaboratively and/or refer to a specialist such as an occupational therapist for further evaluation and recommendation(s).

9. Special Considerations: Multiple Clients in the Playroom

While most of this paper focuses on touch or physical contact between therapists and their child clients, the play therapist must also monitor any physical contact that may occur between children and others in the playroom (i.e., groupwork, sibling play, filial play). Play therapists must also use appropriate clinical judgement to determine a child's fit for sessions involving others and make ethical decisions about play therapist to client ratios.

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 state and/or country laws, policies on restraint in the facility in which they are working, and training in restraint. Play therapists should also include a plan for telemental health sessions involving more than one client. It may be important to include the caregiver(s)/legal guardian(s), when coming up with a plan involving sibling play.

Multiple client expectations regarding touch between clients should be introduced and enforced by play therapists on a regular basis.

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

Expectations should be established whereby children in multi-client session to respect each other's boundaries, such as using and modeling ACT limit setting and providing alternatives. When and if inappropriate touch, inappropriate contact, or disrespectful behavior (i.e., hitting or teasing) does occur, it should be addressed in constructive ways, such as a discussion on consent, as part of the process of some forms of group therapy and multi-client sessions.

Play therapist will seek consent from caregiver(s)/legal guardian(s), regarding touch in sibling, group, and multi-client sessions. Further, extraordinary events (physical injury or inappropriate contact) should be reported to the caregiver(s)/legal guardian(s), 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 their supervisor if deemed appropriate. Such documentation should note who initiated contact, how it was addressed, any consequences, and intervention(s) implemented for the individual who experienced extraordinary touch. Play therapists who plan to utilize multi-client therapy should seek out supervision from a clinician who has specific training and experience in conducting multi-client play therapy. Additionally, play therapists who engage in multi-client play therapy should have a section to this regard on their declaration of practices statement addressing the process, limit setting, and extraordinary events.

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 facility 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 aggressive/violent 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 should address a potential use of physical restraint on a child when deemed necessary with their caregiver(s)/legal guardian(s), in the beginning of treatment, especially when working with the individuals who exhibit aggressive/violent behaviors. Additionally, play therapists should provide the caregiver(s)/legal guardian(s), the option to opt out of the use of restraints. If the caregiver(s)/legal guardian(s), makes this choice, the play therapist will need to discuss an alternate plan of action with the caregiver(s)/legal guardian(s).

It might be helpful when working with this specific population to consider how the need for restraint(s) could be minimized by having a playroom inclusive of the following: soft cushions and soft furniture (no hard chairs that could be thrown, for example), soft toys, soft fabric or canvas bins for storage (so they cannot be used to harm self or others). Play therapists who specialize in working with this population or working in residential settings should be mindful of creating as low risk of an environment as possible.

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/country 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 weigh 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 caregiver(s)/legal guardian(s), 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, d) alternatives to the restraint that were attempted prior to the restraint intervention and 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, they should make arrangements with alternate personnel for doing so. According to the facilities and state and/or country guidelines on restraints, all incidents of restraint should be carefully documented. Play therapists should be mindful of the level of care that a client needs. For example, if a play therapist does not specialize in this population and lacks the support and training in restraining clients, the client should be referred to a

higher level of care. Restraint should only be used when the individual or others present are in danger of being harmed and after exhausting all other less restrictive and preventive measures.

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

- Initially crafted by a task force comprising Chair Trudy Post Sprunk (GA), LMFT, RPT-S, and members Jo Anne Mitchell (GA), MEd, LPC, RPT-S; David Myrow (NY), PhD, LP, RPT-S, and Kevin O'Connor (CA), PhD, LP, RPT-S, in 2001.
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