CLINICAL PRACTICE

Teodor Huzij, DO, FACN

The Touch Taboo: Origins for the Prohibition of Touch in Psychiatry and a Rational Osteopathic Approach

Abstract

The prohibition of touch in psychiatry has multiple origins. The most prominent advocate for an interdiction on touch has been Sigmund Freud and the legacy of psychoanalysis. Scientism, dualism, and medicolegal concerns have also promoted a touch taboo in psychiatry. However, it is evident that non-sexual physical touch is vital for human health; studies of touch in children and adults have shown numerous health benefits physically and psychologically. A discussion of ethical principles in light of the use of touch in psychiatry is provided. Several theoretical paradigms do utilize touch in treating patients and are reviewed including the medical model, body-psychotherapies, and osteopathic medicine. The osteopathic philosophy provides a lens through which the osteopathic physician both assesses and provides rational treatment to the patient. In addition to this philosophy, osteopathic physicians are extensively trained in osteopathic manipulative treatment (OMT). Osteopathic physicians have treated patients with psychiatric disorders with OMT and other treatments for nearly 150 years. The unique osteopathic model of care contrasts with the long-standing prohibition of touch with psychiatric patients and thereby provides a rational approach to the use of touch in psychiatry. The reasoned recommendations for osteopathic psychiatrists using touch clinically include consent, context, and competency considerations.

Introduction

The nature of touch in psychiatry has a variable history. In medicine, touch represents an essential assessment tool of the physician. Appropriately, the prohibition of sexual contact between healers and patients emerged during ancient Greece in the writings of Hippocrates.[1] However, the prohibition of touch between psychotherapists and patients is relatively recent. Prior to the advent of psychoanalysis in the 1880s, efforts to help mentally troubled individuals frequently involved application of various physical interventions from restraints to the laying on of hands.[2] People are inherently physical and the natural expressions of the species are therefore physical. Touch is physiological with multiple purposes and benefits as will be explored in the physiology of touch section of this article.

The origins of touch in medicine and especially psychiatric disorders derive from religious and magical practices, and range from shamanic ceremonies, to the laying on of hands by spiritual elders, to animal and human sacrifices on

Submitted March 9, 2022. Accepted for publication August 30, 2022.

Corresponding Author

Teodor Huzij, DO, FACN
Trinity Institute
14960 Woodcarver Road, Suite 101
Colorado Springs, CO 80921

719-694-2542

thuzij@thetrinityinstitute.com

Disclosures

None reported.

Keywords

Touch, Psychiatry, Osteopathy, Osteopathic Medicine, Taboo, Freud, Psychoanalysis, Psychotherapy, Ethics, Consent, Physiology

behalf of the mentally ill.[2,3] The etiology of mental illness in ancient cultures was thought to be supernatural in origin, yet the interventions routinely involved the physical world and the body of the afflicted. There was an inherent understanding of the unity of the body, mind, and spirit of each person.[4] Medicine grew out of these roots and became its own practice as early as ancient Mesopotamia, India, Greece, and Rome.[4] The person was approached as a whole by the physician, both physically and spiritually, in understanding the disease as well as in treatment.[4] Psychiatric patients, however, were often ignored by medicine as a whole. When these patients were accepted for treatment, it often involved imprisonment, restraint with chains and regular beatings by facility staff in addition to the cutting-edge medicine of the day of blistering and blood letting.[5] With more contemporary evidence for the vital benefits of healthy touch, we can only imagine the suffering and harm experienced by these psychiatric patients at that time.

Eventually, humane treatment movements led to reform in the care of patients with psychiatric conditions and the age of asylums was born in the 1880s. Treatment now involved nutrition, exercise, time outside as well as work activities to help address the psychiatric conditions through physical means.[6,7] How did the field of psychiatry come from this long standing history of touch, both non-therapeutic and therapeutic, to an absolute a-physical approach? Additionally, what rationale response could provide a clinically-ethical approach regarding the use of touch within psychiatry?

Origins of the Prohibition of Touch in Psychiatry

Freud and Psychoanalysis

The abandonment of touch within the field of mental health has its clearest roots in the paradigm of psychoanalysis.[8] Interestingly, this was not always the case. In his original work developing psychoanalysis, Sigmund Freud, MD used physical contact to facilitate verbal therapy. His touch included stroking the head and neck of patients as well as allowing his patients to touch him. Freud provided the following description of his early treatment approach:

> I proceeded as follows. I placed my hand on the patient's forehead or took her head between my hands and said: "You will think of it under the pressure of my hands. At the moment at which I relax my pressure, you will see something in front of you or something will come into your head. Catch hold of it."[8]

The very particular physical placement of the analyst in respect to the analysand appears to have its roots in hypnosis. Like many contemporaries of his time, Freud explored the use of hypnotism, ultimately concluding, "So I abandoned hypnotism, only retaining my practice of requiring the patient to lie upon a sofa while I sat behind him, seeing him, but not seen myself."[9]

There are several factors that may have influenced Freud to change his approach using touch in psychoanalysis. The first involves his own neuroses. During his early 40s, Freud experienced various physical (cardiac ailments and oral cancer) and psychological conditions (anxiety, mood and psychosomatic symptoms).[10,11,12] It was during this time that he embarked on the challenging task of self-analysis of his own dreams and childhood memories, which became the raw material for his seminal work on dream interpretation.[13] Freud also took interest in the clinical uses of cocaine which included self-experimentation with the substance.[14] The use of cocaine would continue to be a regular part of his life, possibly an effort to address chronic depressive symptoms.[10,11,12] It also seems quite possible that Freud coped with his own anxiety symptoms in his sessions by utilizing the hypnosis-influenced physical placement of analyst behind and out of view of a reclined analysand. Such positioning would allow him to avoid the anxious discomfort of eye-to-eye encounters with another and be able to more fully attend to and analyze the patient's presenting issues. Whether psychological symptoms of his own neuroses, the physical limitations of medical conditions, the long-term sequela of ongoing cocaine use, or the interplay of all of these conditions, Freud possibly coped with these issues through an altered clinical perspective and role of touch.

The fundamental conceptualization of the body in psychoanalysis, as developed by Freud and subsequent psychoanalysts, reveals clear origins of the prohibition of touch in psychotherapy. Freud writes:

> The ego is first and foremost a bodily ego; it is not merely a surface entity, but is itself the projection of a surface. The ego is ultimately derived from bodily sensations, chiefly those springing from the surface of the body. It may thus be regarded as a mental projection of the surface of the body.[15]

Freud also described touch between mother and infant as essentially erotic.[16] This was thought to be validated with patients who had pre-Oedipal problems, by the effectiveness of using techniques that allowed patients to

regress. Smith notes, "This approach gave rise to holding, rocking or even bottle feeding." An essential element of this process involved the analyst assuming the conceptual role of a blank screen, endeavoring to remain impersonal, objective and nonjudgmental, making effort to avoid interactions that may contaminate the transference process. The analyst's goal, according to Fosshage, is to "prevent or remove any possible contribution from the analyst to the patient's experience in order to illuminate the patient's intrapsychically generated projections and displacements."[17] Analysts increasingly viewed touch as a response that gratified a patient's desires, which interfered with development of the transference neurosis. This was considered the energizing force in analysis and its absence led to stagnation in therapy. Freud argued that the transferential reliving of early attachments underscored the importance of the unconscious meanings of body contact.[8] The recognition of the important difference between "drive" needs and developmental needs led to modifications in the traditional psychoanalytic model.[3]

> The dual motivational model of sex and aggression within classical theory renders touch as either sexual or aggressive. Other types of touch and, therefore, other meanings are excluded from consideration.[17]

This model reinterpreted touch as now serving seductive wish fulfillment, which was detrimental to therapeutic success, as any physical contact colluded in avoiding painful experiences rather than working through them without touch instead. This also contributed to the physical orientation in an analyst's office, with the patient lying on a couch without seeing or being touched by the analyst. As psychoanalysis grew in renown, theoretical rationales supporting strict prohibitions against touch were commonly accepted, which evolved into an institutionalized taboo against touch in psychoanalysis.[8] Sandor Ferenczi, in contrast, continued to use physical contact in psychoanalysis just as Freud once did.[18] Freud initially supported Ferenczi's experiments with touch and psychoanalysis, as nurturing touch was proposed to "facilitate the analysis by helping a patient to tolerate pain that was characterologically defended against."[19] However, later Freud withdrew support upon learning that Ferenczi was romantically and sexually involved with at least two of his patients. To Freud's credit, he had warned Ferenczi in an earlier letter that "this sort of behavior would inevitably lead to a downward spiral to full sexual engagement."[20] Ferenczi refused to discontinue the use of touch in his use of psychoanalysis and was subsequently expelled from his prominent position within the ranks of early psychoanalysts. Interestingly, Ferenczi several years later discontinued all forms of touch within his therapy and advocated that not only should analysts avoid physical contact with patients but also patients should not touch themselves, especially by masturbating.[8] This prohibition of all touch in psychoanalysis arose out of theoretical origins; however, it could also be interpreted as a reactionary overcorrection in an attempt to align with the medical ethic prohibiting sexual interactions between patients and their healers, as first articulated by Hippocrates.[1] It appears overly simplistic to prohibit all touch when the primary concern is prohibiting sexual contact between the patient and their physician. The prohibition of touch in psychoanalysis became dogma nonetheless. Menninger clearly affirms this in his text on psychoanalytic technique, "transgressions of the rule against physical contact constitute evidence of the incompetence or criminal ruthlessness of the analyst,"[21] as does Wolberg in his psychotherapy text, "It goes without saying that physical contact with the patients is absolutely taboo."[22] Freud's interdiction on touch has influenced most schools of psychotherapy, with the exception of body oriented paradigms.[17] However, in recent decades, research in the fields of neuroscience, trauma and development have supported the necessity of touch which has prompted psychoanalysts to reconsider the touch taboo.[23,24] The current practice of psychiatry has abandoned many of the precepts of psychoanalysis, with the exception of the prohibition of touch. With very few psychiatrists being trained in or practicing psychoanalysis, it is unclear why the interdiction on touch persists.

Scientism, Dualism and Medicolegal Concerns

As psychoanalysis gained favor at the turn of the century, Freud was allegedly "hypervigilant in seeking scientific respectability and avoiding negative stigma" regarding his new talking cure.[18] His efforts to use physical science to validate the psychological is an example of scientism, specifically an "exaggerated trust in the efficacy of the methods of natural science applied to all areas of investigation," in this case the mind.[25] The sociopolitical influences are rather complex as Freud formulated his psychoanalytic theories during the Victorian era, which one author describes as "a period that was characterized by unyielding sexual prudishness and a strong emphasis on the products of the mind."[26] This Victorian Viennese medical society had already expressed concerns with Freud's original psychoanalytic practices using manual techniques including stroking and massage as proof

that analysts were clearly sexual perverts.[8,18] Certainly the sexual encounters of Ferenczi and his patients validated such concerns to some extent. Wolberg underscores this concern, writing that:

> Physical contact with the patient is absolutely a taboo [since it may] mobilize sexual feelings in the patient and the therapist, or bring forth violent outbursts of anger.[22]

The influence of scientism, and the often-included concept of materialism, represents a disregard for historical metaphysical traditions of religion and ritual and their use of physical contact, such as "the laying on of hands."[26] The roots of this perspective can be found in mind-body dualism, which has origins in ancient Greece but may have been most clearly stated by Descartes. Dualism divides human experience into separate physical and mental components exclusively, suggesting that either component can be reductionistically focused on while ignoring the other entirely.[3] In the case of psychoanalysis, the mental component became the exclusive focus of therapy, rendering the body and touch as taboo. However, this dualistic approach does not reflect the wholistic experience of being human.[27] Some authors have suggested that the touch taboo in psychoanalysis and psychotherapy on the whole may have been influenced by Judaism and Christianity in promotion of dichotomization or dualism which replaced the Hellinistic glorification of the body.[2,28] This proposition suffers from ignorance of history and possible revisionist perspectives. Regarding Judaism, the physical world and the human body were created by God and declared good, as noted in sacred texts, predating any dualism origins of Plato in ancient Greece[29,30] While Freud was raised in a Jewish home, he rejected the faith of his family and subsequently identified expressly with atheism, ultimately discounting all religion as devoid of a deity and merely serving to avoid fulfilling sexual impulses.[31] Therefore, the spiritual precepts of Judaism likely did not significantly influence or pressure Freud. Similarly, Christianity draws from many spiritual texts shared with Judaism and the New Testament scriptures provide a high regard for the physical world as well as the body. This is clearly expressed in the understanding of the body as the "temple of the Holy Spirit."[32] As an atheist, Freud was again not likely influenced by Christianity. The allegations of either Judaism or Christianity as the source of dualism are invalid historically and are not supported by their own religious texts.

The modern era has brought an additional factor influencing the use of touch in psychotherapy and psychiatry, specifically, medico-legal risk management. This introduces concern for any contact by the clinician being misunderstood, resulting in subsequent malpractice allegations and an accompanying burgeoning litigious culture.[33] In this context, limiting all physical context would seem to optimize risk management. As stated previously, the practice of medicine has long held an interdiction against sexual contact between a patient and physician, however, this has not been held in universal practice.[34] Some of these inappropriate contacts resulted in legitimate and warranted legal action against offending physicians, while at the same time avoiding any absolute prohibition of physical contact, in stark contrast to what has occurred in psychoanalysis and many paradigms of psychotherapy.[35] While sexual encounters in the clinical setting are a clear example of inappropriate, unhealthy touch, there is also a place for appropriate, healthy touch.

Physiology of Touch

Touch has been called "the mother of the senses" as it is the earliest sense to develop in the human embryo.[36] The skin is the largest organ of the body and is highly developed. Before the 2.5cm embryo even has eyes or ears, the ability to respond to touch has already developed during the 8th week of gestation. The skin and nervous systems are both derived from ectoderm embryologically, which creates a critical link between these systems[36,37] The neonate exhibits numerous skin reflexes, including rooting and grasp, which serve vital functions as well as reveal a growing sensitivity to touch.[36] In life, children as well as adults use touch to corroborate information obtained by the other senses, interact with the environment and provide grounding of themselves.[8,36] General stimulation of the skin in childhood has been associated with increased resistance to infections and other diseases in adulthood, while deficiency of touch in childhood has been associated with immune system dysfunction, social isolation, and propensity towards violence.[8,36-37] Research has demonstrated that clinically significant physiological changes in hemoglobin levels, blood pressure, heart rate, pulse, respiratory rate and body weight can occur when medical staff simply touch a patient by holding their hand or providing a massage.[38-41]

Non-sexual affirming physical touch is a vital need of all human beings, not only integral for development, but for sustaining life in general.[8,17,36,42-45] Orphanage data from the late 1800s to 1915 in both Germany and the United States, during which touch was discouraged for infants

in these settings, reports mortality rates ranging from 32-90% before the end of their second year of life.[46,47] In the 1930s, some US hospitals began to incorporate routine physical contact in child care protocols, including picking up, holding, and physically nurturing each hospitalized baby multiple times a day. In these hospitals, the pediatric ward mortality rate dropped dramatically from over 30% to less than 10%.[48] Infants that experience little to no physical touch have been shown to develop high rates of failure to thrive and overall mortality, while touch is associated with general thriving even for medically at risk neonates.[33,40,49-51] A deconditioning effect in those that have had a history of physical abuse has been noted with the use of touch clinically.[52] Touch is not only vital to human development during infancy and childhood, but also provides benefits in geriatric adults, including increasing weight gain and behavioral management in patients with dementia.[53-54] Despite the vital need, surveys on the use of touch by health care professionals found that older patients received the least amount of touch in hospitalized settings, with the majority of the clinicians reporting feeling uncomfortable and having some degree of anxiety when touching older patients.[55-56] In recent years, it has been proposed that a decreased availability of non-sexual affirming physical touch within most cultures has contributed to touch starved people expressing a perception of "skin hunger," or a profound need for physical contact with others.[57] Non-sexual physical touch is clearly vital to human health throughout the life span.

Medical model of touch

The basic model of disease is founded on the framework of touch. The word disease, derived from Latin, has roots of *dis* meaning "not" and *ease* meaning "adjacent" or "touching." Therefore, the fundamental meaning of disease is separate or not touching.[58] Touch remains the primary element involved in the physician's physical exam skills and results in the commonly accepted process of physicians touching patients.[8] The role of touch in a physician's physical exam is not exclusive to the practice of medicine; however, compared to non-physician mental health clinician training and practice, it is a unique and essential component of medical care. Modern medicine technology has started to replace the physician's skilled touch, resulting in a loss of the physician's reassuring touch and attention that previously accompanied assessment and treatment of all conditions, including psychiatric.[8] Various documented medical benefits of touch include improving mood, anxiety, pain, tension, blood pressure, immune function, sleep, coping with sexual abuse, and weight gain.[59-61]

Review of Touch in Psychotherapy and Psychiatry

Theoretical Approaches

Despite the formative influence of psychoanalysis upon most forms of psychotherapy and psychiatry, there have been psychotherapy paradigms utilizing touch since the time of Freud. Some of Freud's students continued to utilize touch during treatment, including Ferenczi as discussed previously, as well as Wilhelm Reich, who is often referred to as the father of body-psychotherapy.[8] Reich, a student of Ferenczi, contributed significant efforts in reducing the barriers toward touch imposed by psychoanalytic influences, including the addition of:

> the dimension of the body to Freud's model of ego and internal conflict, in that he saw the ego as controlling impulses and emotions through physiological patterns, e.g. a holding jaw, a tight belly etc.[62]

These physical holding patterns or "blocking" functioned to protect the person against painful emotional experiences.[63] Treatment for the physical holding patterns involved Reich pressing certain muscle groups to dissolve muscle tension and free inhibited energy. This direct physical contact with patients represented a diversion from psychoanalytic dogma prohibiting touch, for which Reich was ultimately rejected from the psychoanalytic community.[64] Alexander Lowen, a student of Reich, proposed the concept of bioenergetics as a singular fundamental energy in the human body regardless of its manifestation as psychological or physical phenomena.[65-66] Lowen similarly used muscle pressure as well as expressive exercises and breathing techniques to release physical tensions and therefore free blocked emotions or bioenergy.[65] The humanistic movement of the 1960s offered different approaches to touch in psychotherapy, including endorsing appropriate, non-sexual touch as enhancing the therapist-patient relationship.[8] Interpersonal therapist Carl Rogers supported the validity of touch in psychotherapy with examples of soothing patients by holding, embracing and even kissing them.[8] Gestalt therapy also advocated multiple forms of touch in psychotherapy.[67] However, some Gestalt therapists in the 1960s transgressed ethical boundaries by engaging in sexual touch with patients under the false pretense of psychotherapy, resulting in appropriate criticism and concern for such touch in therapeutic relationships.[8] Body-centered psychotherapy, developed

in the 1990s, is founded on the theoretical proposition of the extant functional unity shared between the psyche (mind) and soma (body).[68-69] The field has expanded over the years to be both influenced by and include a diverse set of perspectives and approaches, which broadly involve somatic awareness, breath, movement and touch during therapy sessions. Touch examples include deep manipulation, hugs and holding.[68-69] Physical touch has also been understood as not only appropriate but necessary in working with patients experiencing deep regression, delusional transference, and psychotic anxieties, as well as severe schizophrenia.[70-76]

A small study by Geib of 8 female patients who had male psychotherapists were interviewed regarding touch experiences during psychotherapy.[77] Several factors were identified that helped make touch therapeutic and included: discussion with the therapist of the touch itself, the boundaries of the relationship, and sexual feelings; feeling in control of initiating and/or sustaining the contact; feeling that the contact was not a demand or need of the therapist; feeling that expectations of therapy were congruent with the reality the client experienced; feeling that emotional and physical intimacy proceeded congruently.[77] The identification of these factors is of great value in validating a beneficial role that touch may play in psychiatry.

A later study sought to test and extend the Geib study. A substantially larger sample size of 231 male and female adults were surveyed regarding experiences of physical contact with their therapist. Geib's factors supporting therapeutic touch were confirmed with the exception of "feeling that emotional and physical intimacy proceeded congruently." A majority of subjects (69%) reported that touch "fostered a feeling of a stronger bond, closeness, and a sense that the therapist really cares, thereby facilitating increased trust and openness." Additionally, 47% of the subjects reported touch "communicated acceptance and enhanced their self-esteem." Of special note, those subjects with a history of sexual abuse reported touch in session contributed to feeling more touchable, lovable, and better about themselves. Ten subjects (4%) endorsed negative experiences with touch in their sessions.[76] A role for touch in psychiatry is supported by the identification of psychotherapeutic factors including promoting patient trust and openness in therapy.

Osteopathy

Osteopathy was founded by A.T. Still, MD, DO in 1874 who emphasized total health physically, mentally and spiritually while addressing physical and mental diseases through normalization of body structures and functions by palpatory assessment and manipulative treatments.[27] Still proposed a dynamic interrelationship of body and mind;

> All mental orders are based upon the favorable or unfavorable report of one or more of the five sensory sets of nerves. So, we see at once that mentality or the mind of man, in all its action has as its foundation for its conclusions the report or reports of one or more of the five senses. If the mind is normal then wise conclusions and judicious orders are issued for the support and comfort of the human body.[78]He was committed to understanding and treating mental illness as he asserts, "Since the birth of Osteopathy in 1874, I have sought and hunted faithfully to find the cause, or friction, that produces such abnormal conditions as are seen in the raving maniac."[78]

Still described osteopathic manipulative treatment (OMT) for any mental disorders should at least seek:

> to adjust all bony variations, all mechanical or obstructing causes of any kind that would prohibit the easy transit of blood to and from the heart, also nerve fluid and force to and from the brain. It is his business to keep up perpetual harmony both in blood and nerve supply.[78]

The founding school of osteopathic medicine, the American School of Osteopathy, opened in 1892 in Kirksville, MO and offered psychiatric coursework such as Dr. Littlejohn's Psycho-Physiology lectures. The course presented a perspective of mental illness through an osteopathic model and a rational treatment approach including osteopathic manipulative treatment.[79]

In 1914, the Still-Hildreth Sanatorium, the first osteopathic psychiatric hospital, was opened in Macon, MO with the audacious mission to cure patients of psychiatric disorders rather than simply managing them. Treatment included a healthy diet, exercise, occupational therapy, and at least three sessions of OMT per week.[80] The OMT primarily addressed the autonomic nervous system as well as more gross somatic dysfunctions that may have arose following physical trauma.[81] The use of OMT within osteopathic psychiatry continued in varying degrees, even after the closing of Still-Hildreth Sanatorium in 1968.[80]

With the fall of psychoanalysis from preeminence and dominance of psychiatry in the United States, extending through the early 1990s, biological psychiatry and reductionistic medicine became the primary paradigm.[82] The

rebranding of mainstream psychiatric practice as "primary care psychiatry" has further opened the door for more comprehensive treatment options for psychiatric patients, including osteopathic manipulative medicine (OMM) to address chronic pain, hypothalamic-pituitary-adrenal axis dysregulation, and chronic stress as some proposed targets.[83] A comprehensive review is beyond the scope of this article, yet various studies have shown possible roles for OMM in helping patients with psychiatric conditions. Regarding assessment, osteopathic structural exam findings may be associated with certain psychiatric conditions.[84-86] Several studies have been published regarding the use of OMM in variety of patient populations as well as psychiatric conditions including both pediatric and adult patients with anxiety, depressive, ADHD, dementia, and trauma disorders, as well as shorter inpatient psychiatric hospitalization duration.[87-100]

Sexual Encounters

Non-sexual touch within psychiatry may be appropriately utilized by various psychotherapy, medical and osteopathic paradigms, but what about the concerning reality of sexual encounters between mental health clinicians and their patients? In the 1960s and 70s, there are examples of intentional sexual experiences during a psychotherapeutic process that have been experimented with, including "Nude Sensitivity Training Workshops" and groups seeking "peak experiences."[101-103] However, these have received near universal criticism as clearly violating professional ethical boundaries and have faded from the clinical landscape.

Self-report studies have found that 10% and 2% of male and female psychotherapists, respectively, have had some form of sexual contact with their own patients.[104] Interestingly, the number of sexual encounters did not differ based on theoretical paradigm (humanistic, psychodynamic or cognitive behavioral therapists).[104] Similar studies of physicians have found any form of erotic contact with patients was endorsed by 10.9% and 1.9% of male and female physicians, respectively.[1,105]

Additionally, research has shown that those psychotherapists who use non-sexual touch are no more likely to act unethically compared to those who do not use touch at all.[106] This challenges the clinical myth that any clinical use of touch will ultimately progress to acting out sexually.[20]

Ethics of touch

Ethics have held a guiding role in medicine at least since the time of Hippocrates, when the principle of "First, do no harm" was espoused.[107] One of the harms enumerated included sexual contact between the patient and physician.[1] Touch as a universal prohibition has never been promoted in the practice of medicine, primarily due to the role of touch in the form of physical exam skills. Indeed, the root of the word physician is ultimately derived from Latin *physica* meaning "of the natural" as well as Greek *physikos* meaning "natural or nature."[108] This etymology then clearly grounds medicine in the physical world including the physical body and its senses, specifically touch.

The four principles of bioethics most relevant to medical care classically include: beneficence, nonmaleficence, autonomy and justice.[109] It is valuable to consider touch, in this case specifically clinically appropriate touch, from each of these ethical principles. Beneficence involves the physician's duty to "do good."[109] In order for touch to meet the ethical principle of beneficence, the touch should be clinically appropriate physical contact that "does good" for the patient. Examples may include relevant physical examination of body regions and systems, such as an abdominal or osteopathic structural exams, which provide the physician valuable assessment data in arriving at an accurate diagnosis and subsequent treatment, including osteopathic manipulative medicine, for the patient's benefit.

Nonmaleficence includes the physician's duty to "not harm."[109] Examples may include avoiding interventions that irreparably harm the patient, such as amputating a healthy limb. Many medical interventions cause some degree of harm, including the systemic ravages occurring with chemotherapy or the collateral damage with routine abdominal and orthopedic surgeries. However, theoretically, in these cases the benefit of removing the pathology outweighs the harm caused by the process of removing the pathology. This is reasonable largely in light of the body's innate self-healing mechanisms that typically recover from these harms. The role of consent for an intervention, such as osteopathic manipulative medicine, helps avoids harm to the patient as well.

Autonomy includes the physician's duty to honor the patient's right of self-determination and self-agency. Examples may include obtaining informed consent regarding the risks and benefits of a particular intervention as well

as the risks of not performing the intervention, such as the clinical purpose of a specific physical exam, a medication, a surgical procedure, a psychotherapy, or an osteopathic manipulative technique. Respecting a patient's preference for a specific osteopathic manipulative medicine modality is also an example of honoring autonomy.

Finally, justice includes the physician's duty to reasonably provide the same quality, competent care for each patient.[109] Examples may include providing the same level of respective physical exam for each comparative patient presentation or similar treatment options, such as all patients presenting with abdominal pain will receive the same thorough abdominal physical exam or similar patients with low back pain will be offered comparable treatment options of osteopathic manipulative treatment, non-opioid pain medication, and physical therapy. Clinically-appropriate touch in medical care honors the ethical principles of beneficence, nonmaleficence, autonomy and justice.

More recent efforts to provide a systematic approach to clinical-ethical decisions have proposed prioritized categories into which clinical case considerations can be distributed. These categories included:

1. The medical indications in a case;
2. The patient's preferences;
3. Quality of life factors; and
4. Factors external to the immediate physician-patient encounter.[110]

The first category is medical indication, and in psychiatry, touch has numerous medical indications. Medical indications correlate an action or intervention as warranted based on medical utility, purpose, and/or benefit.

As discussed previously, non-sexual affirming touch is essential to human health throughout a person's lifespan. The practice of medicine necessitates a relevant physical exam assessment, which is a form of touch. Both of these examples support the clinical-ethical decision category of medical indication. The second category is patient preference, which can range widely from preferences for a psychiatrist's gender, ethnicity, worldview, training, specialty, or practice to the type of assessment methods, diagnoses given, and treatments offered. One patient may prefer that only a female physician perform certain types of physical exams while another patient has no gender bias but prefers specific physical treatments be provided, such as osteopathic manipulative medicine. Each physician can strive to meet each patient's preference, while balancing the limitations of available physicians with appropriate skills and training for the conditions to be addressed. If the preferences cannot be fully met, the patient should be informed of the inability to meet those and offered to see physicians available without these preferences met or referral to another practice that may be able to meet specific preferences of the patient.

The clinical-ethical decision categories are prioritized by importance with primary concern given to medical indication. Thus, a patient's preference would not supersede the absence of a legitimate medical indication. People are entitled to have wants, but it is impossible to meet every want of every person. Therefore, for those patients who prefer to have certain physical medical interventions provided by their psychiatrist, such as osteopathic manipulative medicine, may as long as there is a legitimate medical indication. A psychiatrist providing such treatment would fulfill the patient's preference and meet this clinical-ethical decision category.

The third category considers quality of life factors which are quite relevant in psychiatric care. As many psychiatric conditions are chronic with some level of symptomatology present long term, cure is not always possible. Therefore, the focus of care moves from cure to management of ongoing symptom impact and ultimately quality of life factors in these cases. A patient who has multiple medical comorbidities such as chronic pain or migraines in addition to major depressive disorder would have less frequent medical appointments if the patient's psychiatrist also was trained and skilled in providing osteopathic manipulative medicine that benefitted the pain and migraines while simultaneously managing the major depressive disorder through psychotherapy, psychopharmacologic management, and osteopathic manipulative medicine. This would meet the clinical-ethical decision category of quality of life.

The fourth category is any external factor to the physician-patient encounter. This could be social, cultural, or economic factors influencing access and adherence of medical care. If an elderly widowed patient who lived alone had few social or physical contacts with other people, the physician's handshake, physical exam, and osteopathic manipulative treatment may be the only healthy affirming physical encounter the patient receives. This would not only meet the clinical-ethical decision category of other factors, but it also provides vitally-needed touch to a vulnerable patient population.

Medical ethical principles are independent and not validated by the adherence of a certain number of people. For example, some physicians may not adhere to principles of trust and honesty in that they file fraudulent insurance claims. This does not make the principles less valid or important. Conversely, if many psychiatrists and other mental health clinicians avoid touch with their patients, it does not validate a touch prohibition as correct.

> The mere fact that almost everyone says that something is proper, or that almost everyone acts in a certain way, does not make it proper to act that way. The appeal to popular opinion can sometimes amount to an example of the informal logical fallacy of the argumentum ad populum.[111]

A Rational Osteopathic Approach to Psychiatry

Education and training regarding appropriate non-sexual touch in psychotherapy is largely missing from the curriculum of most therapists (excluding physicians), and therefore inadvertently promoting a touch taboo.[33,112] Additionally, rigidly-applied rules either prohibiting touch or enforcing ritualized touch will ignore both valuable clinical and ethical elements.[76] As this article primarily focuses on the field of psychiatry, a medical practice paradigm can provide the most relevant guidance. In seeking a uniquely osteopathic approach to psychiatry, the osteopathic philosophy serves as valuable guidance.

Osteopathic Philosophy

The osteopathic philosophy has been refined over the years from the days when Dr. Still first articulated his unique approach. Per the Glossary of Osteopathic Terminology,[113] the current definition of the osteopathic philosophy states it is,

> A concept of health care supported by expanding scientific knowledge that embraces the concept of the unity of the living organism's structure (anatomy) and function (physiology). Emphasizes the following principles. (1) The human being is a dynamic unit of function; (2) The body possesses self-regulatory mechanisms that are self-healing in nature; (3) Structure and function are interrelated at all levels; (4) Rational treatment is based on these principles. This wholistic approach understands that each person is a dynamic unit of function comprised of a body, mind, and spirit elements, which dwells within and influences as well is influenced by a myriad of biopsychosocial environmental systems.[27] The osteopathic philosophy can be seen as a lens through which the patient is both perceived in assessment as well as through which rational treatment is determined and provided.

The first tenet, "the human being is a dynamic unit of function" acknowledges the triune (body, mind, spirit) existence of people and challenges both the biological reductionism paradigm of medicine and the interdiction on touch in psychiatry. With this tenet, mental disorders are not understood as purely "brain diseases" that can solely be addressed through psychopharmacology and psychotherapy, but instead require a comprehensive treatment plan to address all body unit elements within their biopsychosocial environments.[114] The dynamic unity elements of body, mind and spirit are reciprocally interrelated as well. What happens in one element effects the remaining other elements in kind. This also means that healing resources can be recruited from any of the elements in support of fighting disease and restoring health in any of the remaining elements. Some examples include hypothalamic-pituitary-adrenal axis modulation in response to physical and psychological stressors,[115] increased risk of developing depression following myocardial infarction,[116] meditation improving mood and immune system functioning,[117] and reduced suicides among religious patients with schizophrenia.[118]

The second tenet, "the body possesses self-regulatory mechanisms that are self-healing in nature" is echoed in the words of Irvin Korr, PhD: "Health and healing come from within. It is the patient who gets well not the physician or treatment that makes them well."[115] Relevant psychiatric self-regulatory examples include the up and down regulation of receptors in response to neurotransmitter levels and emotions serving as signals for internal states in response to external stimuli.[119-120] Self-healing examples relevant to psychiatric practice include the regeneration of certain neurons following injury and macrophages reclaiming resources from waste products and dying neurons to be used as building blocks in neuronal cell construction.[121-122]

The third tenet, "structure and function are interrelated at all levels" is manifested in each person from the micro to macro systems with the structure of an entity mandating its function and the functioning of an entity determining its structure. The interrelated nature of structure and function are evident in psychiatry with examples of thyroid hormone's structure determining its specific production, storage, transport, and sites of action, or even pathologic processes such as a patient with bulimia who purges via vomiting causing dental enamel and esophageal erosions.[115,123]

The fourth tenet, "rational treatment is based on these

principles," in the specialty of psychiatry results in an individualized treatment approach for each patient's body unit within the unique biopsychosocial systems in which they exist.[27] Still grounded osteopathy in this rational approach, when he stated "An osteopath reasons from his knowledge of anatomy."[78] This was further elucidated by later osteopaths, "Principles of osteopathy follow the logic of an applied knowledge of anatomy-the science of structure, physiology-the science of function, and pathology-the science of disease."[124]

Recommendations for Touch in Psychiatry

The fundamental need for non-sexual physical touch in human health is well evident. Additionally, the long-standing osteopathic philosophy and its application within osteopathic psychiatry can provide a clinical paradigm for guiding the appropriate use of touch in psychiatry. Informed by the preceding review of the physiology of human touch, ethics, the use of touch within the medical model and the osteopathic philosophy, several recommendations for the inclusion of touch in psychiatry are proposed.

1. Consent

The medical pillar of informed consent should be paramount in any clinical encounter. A written informed consent document detailing indications, risks, benefits, and alternative options can be provided to and reviewed with the patient prior to initiating care. Verbal informed consent can then be obtained at subsequent clinical encounters. Both the written and verbal consent will address physical examination, including the osteopathic structural exam, as well as treatment offered, including osteopathic manipulative treatment.[8] It is important that consent be revisited throughout the course of treatment and a patient is made aware that they may revoke consent at any time. Approaching the use of touch in psychiatric care, including an osteopathic structural examination and osteopathic manipulative treatment, like any other medical procedure, will prompt obtaining informed consent and help ensure the use of touch is clinically relevant.

2. Context

Sociocultural norms will influence touch in a clinical setting to some degree. In Europe, a kiss on each cheek may be standard greeting custom, while in the United States a handshake is customary, and in Japan, a bow without physical interaction is commonplace. The cultural location of the clinical setting as well as the patient's cultural background should be assessed, considered, and honored by the psychiatrist. Even with this level of awareness, it remains prudent and preferred for the psychiatrist to initially obtain permission before offering or engaging in physical social interactions, such as a handshake, hug or kiss. This shows respect for cultural norms as well as unique preferences of the patient, while also allowing the psychiatrist to be experienced as a real human being. Other aspects of context include both the issues being addressed in treatment and the status of the patient at the time touch is utilized. If, for example, the patient is working on issues related to physical or sexual abuse it would be prudent for the psychiatrist to openly and repeatedly inquire of the patient's experience of touch during the treatment session. Similarly, if a patient becomes agitated during an encounter or has a history of violence the psychiatrist should inquire of the patient's current ability and willingness to receive touch during the treatment session. Both examples could include an offer by the psychiatrist to modify or cease the use of touch during the treatment session.

3. Competency

In order for the use of touch in medicine and specifically in psychiatry to be ethical and competent, it must be grounded in a concrete philosophical and/or theoretical paradigm. The unethical misuse of any technique (whether touch generally or osteopathic manipulative treatment specifically) ought to be the cause for the indictment, not of the technique, but rather of the clinician who misused it.[8] Physicians receive extensive training in physical examination skills for assessment and osteopathic physicians obtain extensive training in the application of osteopathic manipulative treatment. Likely due to the touch taboo, psychiatry residencies do not typically offer further training in the clinical use of touch with patients. However, as all psychiatrists complete medical school training and those that are Doctors of Osteopathic Medicine have also completed training in osteopathic structural examination and osteopathic manipulative treatment, these foundational touch skills can be reasonably applied in the practice of psychiatry. Some authors have proposed providing touch clinically by having a psychiatrist or other mental health clinician refer the patient to another professional who would provide manual medicine (such as massage, chiropractic, or osteopathic manipulative treatment). This is certainly an option to consider, with awareness

that splitting off touch from the psychotherapeutic relationship may reinforce the touch taboo and provide a disjointed clinical experience for the patient.[125]

Despite a long-standing history of utilizing touch in the care for the mentally ill, multiple influences contributed to a change in this approach. The fear of contamination led to physical distancing and avoidance of touching the mentally ill. Freud's experiences as well as the paradigm of psychoanalysis categorized touch as sexual or hostile leaving no place for healthy physical contact. Scientism, dualism, and medicolegal management theoretically and practically devalued the human body and a healthy role for touch. These influences are contrasted with the evidence for various health benefits of touch physically and psychologically across the human life span. The medical indications for touch range from physical examination to treatment interventions. Additionally, the osteopathic medical profession has the longest history successfully utilizing touch in the care of the mentally ill. Appropriate non-sexual touch is a vital human need and its inclusion in psychiatry supports ethical principles. By obtaining routine consent both medical ethical principles and patient rights are respected. An awareness and honoring of sociocultural context respects each unique patient as a human being, reducing stigma, and allows the psychiatrist to be seen as a real person, thereby promoting a therapeutic relationship. The competent use of touch in psychiatry should be founded on a proven philosophical paradigm, such as the osteopathic philosophy, which has been utilized by osteopathic physicians, including osteopathic manipulative medicine, in treating patients with psychiatric disorders for nearly 150 years. These concepts can help guide the appropriate use of touch in psychiatry.

References

1. Perry J. Physicians' erotic and nonerotic physical involvement with patients. *Am J Psychiatry*. 1976;133:838-848.
2. Levitan A, Johnson J. The role of touch in healing and hypnotherapy. *Am J Clin Hypn*. 1986;28(4):218-223.
3. Smith E, Clance P, Imes S, eds. *Touch in psychotherapy: Theory, research and practice*. New York:Guilford Press; 1998.
4. History of medicine. Encyclopedia Brittanica. https://www.britannica.com/science/history-of-medicine. Accessed December 10, 2021.
5. Deutsch A. The Mentally Ill in America. 3rd ed. New York: Columbia University Press; 1937. https://archive.org/details/mentallyilliname029063mbp/page/n9/mode/2up. Accessed December 10, 2021.
6. Shorter E. *A History of Psychiatry From the Age of the Asylum To the Age of Prozac*. Hoboken: John Wiley & Sons, Inc; 1997.
7. History of psychiatry. ScienceDirect. https://www.sciencedirect.com/topics/medicine-and-dentistry/history-of-psychiatry. Accessed December 10, 2021.
8. Hunter M, Struve J. *The Ethical Use of Touch in Psychotherapy*. Thousand Oaks, CA: SAGE Publications, Inc; 1998.
9. Gay P. *The Freud Reader*. New York: W. W. Norton & Company;1989. https://books.google.com/books?hl=en&lr=&id=3QtZ6gC7QC4C&oi=fnd&pg=PR11&dq=sigmund+freud%27s+life+freud+exhibit&ots=E82lKzX5rj&sig=tU6EGMVVG-Wlv8-GeSoHrz3H-b_Q#v=onepage&q&f=false). Accessed December 10, 2021.
10. Corey G. *Theory and Practice of Counseling and Psychotherapy*. 9th ed. New York: Cengage Learning; 2013. https://archive.org/details/theorypracticeof0000core/page/n1/mode/2up. Accessed December 10, 2021.
11. Haynal A. Freud His Illness and Ourselves. *Am J Psychoanal*. 2008;68:103-116. https://link.springer.com/article/10.1057/ajp.2008.2#citeas. June 2, 2008. Accessed December 10, 2021.
12. Fromm E. *Sigmund Freud's Mission: An Analysis Of His Personality and Influence*. New York: Open Road; 2013.
13. Freud S. *The Intepretation of Dreams*. 3rd ed. Vienna: 1911.
14. Freud S. Uber Coca. *Therapie*. 1884;2:289-314.
15. Freud S. *The Ego and the Id*. New York: Norton; 1960.
16. Freud S. *The standard edition of the complete psychological works of Sigmund Freud*. London: Hogarth; 1955.
17. Fosshage J. The Meanings of Touch in Psychoanalysis: A Time for Reassessment. *Psychoanal Inq*. 2000;20(1):21-43.
18. Jones E. *The life and work of Sigmund Freud: Vol 2. Years of maturity.* New York: Basic Books; 1955.
19. Ferenczi S. *First contributions to psychoanalysis*. New York: Brunner/Mazel; 1952.
20. Masson J. *Against therapy: Emotional tyranny and the myth of psychological healing*. New York: Atheneum; 1988.
21. Menninger K. *Theory of psychoanalytic technique*. New York: Basic Books; 1958.
22. Wolberg L. *The technique of psychotherapy*. 2nd ed. New York: Grune & Stratton; 1954.
23. Carroll R. A new era for psychotherapy. In: Corrigall, Payne, Wilkinson, eds. *About a body: Working with the embodied mind in psychotherapy*. New York: Routledge; 2006:50-62.
24. Orback S, Carroll R. Contemporary approaches to the body in psychotherapy: Two psychotherapists in dialogue. In: Corrigall, Payne, Wilkinson, eds. *About a body: Working with the embodied mind in psychotherapy*. New York: Routledge; 2006:63-82.
25. Scientism. Merriam-Webster Dictionary. https://www.merriam-webster.com/dictionary/scientism. Accessed December 10, 2021.

26. Mintz E. Touch and the psychoanalytic tradition. *Psychoanal Rev*. 1969;56:365-376.

27. Seffinger M, et al. Philosophy of Osteopathic Medicine. In: Seffinger M, ed. Foundations of Osteopathic Medicine. 4th ed. Philadelphia: Lippincott Williams & Wilkins; 2018. https://oce-ovid-com.proxy.rvu.edu/book?SerialCode=02014365. Accessed December 10, 2021.

28. Burton A, Heller L. The touching of the body. *Psychoanal Rev*. 1964;51:122-134.

29. Genesis 1:1-31.

30. Robinson H. Dualism. The Stanford Encyclopedia of Philosophy. https://plato.stanford.edu/entries/dualism/. Published August 19, 2003. Updated September 11, 2020. Accessed December 10, 2021.

31. Freud S. *Totem and Taboo*. New York: Routledge; 2004.

32. 1 Corinthians 6:19.

33. Phelan J. Exploring The Use Of Touch In The Psychotherapeutic Setting: A Phenomenological Review. *Psychotherapy*. 2009;46(1):97.111.

34. Levinson E. Larry Nassar sentenced to up to 175 years in prison for decades of sexual abuse. CNN. https://www.cnn.com/2018/01/24/us/larry-nassar-sentencing/index.html. Accessed December 10, 2021.

35. Graveland B. Calgary psychiatrist found guilty of sexually assaulting patients. The Glove and Mail. https://www.theglobeandmail.com/news/national/calgary-psychiatrist-found-guilty-of-sexually-assaulting-patients/article7936263/. Accessed December 10, 2021.

36. Montagu A. *Touching: The human significance of the skin*. New York: Columbia University; 1971.

37. Swann J. The skin is the Body's Largest Organ. *Vis Commun Med*. 2010;Dec;33(4):148-9. DOI: 10.3109/17453054.2010.525439.

38. Krieger D. Therapeutic touch: The imprimatur of nursing. *Am J Nurs*. 1975;75(5):784-787.

39. Lynch J, Thomas S, Mills M, Malinow K, Katcher A. The effect of human contact on cardiac arrhythmia in coronary care patients. *J Nerv Ment Dis*.1974;158(2):88-99.

40. Field T, Schanberg S, Scafidi F, Bauer C, Vega-Lahr N. Garcis R, Nystrom J, Kuhn C. Tactile/kinesthetic stimulation effects on preterm neonates. *Pediatrics*. 1986;77:654-658.

41. Hainline L, Krinsky-McHale S. Hurting While Helping? The Paradox of the Neonatal Intensive Care Unit. *Children's Environments*. 1994;11(2):27-65.

42. Bowlby J. *Attachment and loss: Vol 1 attachment*. New York: Basic Books; 1969.

43. Bowlby J. A Two Year Old Goes to Hospital. *Psychoanal Stud Child*. 1952;7(1):82-94.

44. Harlow H, Harlow M, Soumi S. From thought to therapy: Lessons from a primate laboratory. *Am Sci*.1971;59(5):538–549.

45. Harlow H, Harlow M, Hansen E, Rheingold H. *Maternal behavior in mammals*. New York: John; 1963.

46. Spitz R. An Inquiry Into the Genesis of Psychiatric Conditions In Early Childhood. *Psychoanal Stud Child*, 1945;I: 53-74.

47. Older J. Four Taboos That May Limit the Success of Psychotherapy. *Psychiatry*. 1977;40:197-204.

48. Cowen E, Weissberg R, Lotyczeuski B. Physical Contact in Interactions Between Clinicians and Young Children. *J Consult Clin Psychol*, 1983;51:132-138.

49. Spitz R. *A Genetic Field Theory of Ego Formation*. New York: International Universities Press; 1957.

50. Spitz R. *The First Year of Life*. New York: International Universities Press; 1965.

51. Deangelis T. Mwakalyelye N. The Power of Touch Helps Vulnerable Babies Thrive. *APA Monitor*. 1995;October:25.

52. Woodmansey A. Are Psychotherapists Out of Touch? Br J Psychother. 1988;5:57-65.

53. Friedman E. The effect of touch on nutritional intake of chronic organic brain syndrome patients. *J Gerontol*. 1986;41:611-616.

54. Hansen N. Massage and touch for dementia (Review). *Cochrane Library*. 2010. DOI: 10.1002/14651858.CD004989.pub2.

55. Barnett K. A theoretical construct of the concepts of touch as they relate to nursing. *Nurs Res*. 1972;21(2):106-107.

56. Huss A. Touch with care or a caring touch? *Am J Occup Ther*. 1977;31(1):11-18.

57. Jourard S. *Disclosing Man to Himself*. Princeton: Van Nostrand; 1968.

58. Ford C. *Where healing waters meet: Touching mind and emotion through the body.* Barrytown: Station Hill Press; 1989.

59. Field T. *Touch*. London: Bradford Book, MIT Press; 2003.

60. Westland G. Massage as a therapeutic tool, Part I. *Br J Occup Ther*. 1993;56(4):129-134.

61. Westland G. Massage as a Therapeutic Tool, Part 2. *Br J Occup Ther*. 1993;56(5):177-180.

62. Eiden B. The Use of Touch in Psychotherapy. *Self & Society*. 1998;26(2):3-8.

63. Reich W. *Character Analysis*. New York: Simon & Schuster; 1972.

64. Older J. Touching is Healing. New York: Stein & Day; 1982.

65. Lowen A. Bioenergetics. New York: Penguin Books; 1976.

66. What is Bioenergetic Analysis? The Alexander Lowen Foundation. https://www.lowenfoundation.org/what-is-bioenergetics. Accessed December 10, 2021.

67. Perls F. *The Gestalt approach and eye witness to therapy.* Palo Alto: Science and Behavior Books; 1973.

68. Caldwell C. *Getting in Touch: The guide to New Body-Centered Therapies*. Wheaton: Quest Books; 1997.

69. Definition of Body Psychotherapy. United States Association for Body Psychotherapy. https://usabp.org/Definition-of-Body-Psychotherapy.

Accessed December 10, 2021.

70. Balint M. *Primary Love and Psycho-Analytic Technique*. London: Tavistock; 1952.

71. Balint M. *Basic Fault*. London: Tavistock Publications; 1968.

72. Winnicott D. The theory of parent-infant relationship. *Internat J Psycho-Anal*. 1958;41:585-595.

73. Winnicott D. *Through Pediatrics to Psychoanalysis*. New York: Basic Books; 1975.

74. Little M. Transference in borderline states. *Internat J Psycho-Anal*. 1966;47:135-154.

75. Mintz E. On the rationale of touch in psychotherapy. *Psychother Theory Res & Pract*. 1969;6:232-234.

76. Horton J, Clance P, Sterk-Elifson E. Touch psychotherapy: A survey of patients' experiences. *Psychotherapy*. 1995;32:443-457.

77. Geib P. *The Experience of Nonerotic Physical Contact in Traditional Psychotherapy: A Critical Investigation of the Taboo Against Touch*. Boston University School of Education. ProQuest Dissertations Publishing. https://www.proquest.com/openview/85796e753e113d071407080712e925dc/1?pq-origsite=gscholar&cbl=18750&diss=y. Accessed December 10, 2021.

78. Still A. *Osteopathy Research and Practice*. Kirksville: A.T. Still; 1910.

79. Littlejohn J. Lectures on Psycho-Physiology. Kirksville: American School of Osteopathy; 1899.

80. Ching L. The Still-Hildreth Sanatorium: A History and Chart Review. AAO Journal. 2014;24(4):12-34.

81. Hildreth A. Still F. *Schizophrenia. J Am Osteopath Assoc*. 1939;38(9):422-426.

82. Samuel L. *Shrink: A Cultural History of Psychoanalysis in America*. Lincoln: University of Nebraska Press; 2013. https://books.google.com/books?hl=en&lr=&id=0W8pDwAAQBAJ&oi=fnd&pg=PR9&dq=psychoanalysis+popularity+wanes&ots=jqMyQxIeBw&sig=otcetR_liyg3jjCs827rijLHpOg#v=onepage&q=psychoanalysis%20popularity%20wanes&f=false. Accessed December 10, 2021.

83. Blumer T. Osteopathic Considerations in Psychiatry. In: Seffinger M, ed. Foundations of Osteopathic Medicine. 4th ed. Philadelphia: Lippincott Williams & Wilkins; 2018. https://oce-ovid-com.proxy.rvu.edu/book?SerialCode=02014365. Accessed December 10, 2021.

84. Dunn F. Osteopathic Concepts in Psychiatry. *J Am Osteopath Assoc*. 1950;March:354-357.

85. Woods J, Woods R. A physical finding related to psychiatric disorders. *J Am Osteopath Assoc*. 1961;60:988-993.

86. Huzij T. The Cranial Rhythmic Impulse as a Measure in Patients with Bipolar Disorder: A Case Report. *AAO Journal*. 2019;29(4):31-33.

87. Cantieri M. Inpatient Osteopathic Manipulative Treatment: Impact on Length of Stay. *Policy Research Reports*. 1996:1.

88. Miranda E. Giza J. Feketeova E, Castro-Nunez C, Vieux U, Huynh M. Osteopathic Manipulative Treatment in Patients with Anxiety and Depression: A Pilot Study. *AAO Journal*. 2021;31(3):9-16.

89. Chinsky R, Chan T. The Osteopathic Approach to Treating Depression in Children and Adolescents. *Osteopathic Family Physician*. 2021;13(3):19-26.

90. Blumer T, Blumer J. Osteopathic Approach to Anxiety. *Osteopathic Family Physician*. 2017;9(4):26-34.

91. Dixon L, et al. Effect of Osteopathic Manipulative Therapy on Generalized Anxiety Disorder. *J Am Osteopath Assoc.* 2020;120(3):133-143.

92. D'Ippolito M, Tramontano M, Buzzi M. Effects of Osteopathic Manipulative Therapy on Pain and Mood Disorders in Patients with High-Frequency Migraine. *J Am Osteopath Assoc*. 2017;117(6):365-369.

93. Collebrusco L, et al. Osteopathy and Emergency: A Model of Osteopathic Treatment Aimed at Managing the Post-Traumatic Stress-Part 1. *Health*. 2018;10:998-1005.

94. Tait J. *The Osteopathic Treatment of Adults who Experienced War as Children*. Thesis submission to international jury at Collège D'études Ostéopathiques De Montreal. May 2012.

95. Bradford S. Role of osteopathic manipulative therapy in emotional disorders: A physiologic hypothesis. *J Am Osteopath Assoc*. 1965;64:484-493.

96. Davis L, Hanson B, Gilliam S. Pilot study of the effects of mixed light touch manual therapies on active duty soldiers with chronic post-traumatic stress disorder and injury to the head. *J Bodyw Mov Ther.* 2016;20:42-51.

97. Sampath K, Roy D. Management of mood disorders by osteopaths in New Zealand: A survey of current clinical practice. *Int J Osteopath Med*. 2015;18(3):161-170. https://doi.org/10.1016/j.ijosm.2015.01.003.

98. Plotkin B, et al. Adjunctive osteopathic manipulative treatment in women with depression: a pilot study. *J Am Osteopath Assoc*. 2001;101(9):517-523.

99. Merrill E. Osteopathic and "Old School" Results in Mental Diseases. *J Am Osteopath Assoc.* 1934;33(8):327-328.

100. Still F. Comparison of Osteopathic and Allopathic Results in Dementia Praecox. *J Am Osteopath Assoc.* 1933;33(2):57-58.

101. Howard J. *Please touch: A guided tour of the human potential movement.* New York: McGraw-Hill Book Company; 1970.

102. Perls F. *In and out of the garbage pail*. New York: Bantam Books; 1969.

103. Shepard M. *A psychiatrist's head*. New York: Peter H Syden; 1972.

104. Holroyd C, Brodsky A. Does touching patients lead to sexual intercourse? *Prof Psychol*. 1977;11:807-811.

105. Kardner S, et al. A survey of physicians' attitudes and practices regarding erotic and nonerotic contact with patients. *Am J Psychiatry*. 1973;130:1077-1081.

106. Milakovich J. Touching is psychotherapy: The differences between therapists who touch and those who do not. *Dissertation Abstracts International*. 1993;54(6-B):3347.

107. Frezza E. *Medical Ethics A Reference Guide for Guaranteeing Principled Care and Quality*. New York: Taylor & Francis Group; 2019. https://www.google.com/books/edition/Medical_Ethics/H_Z1DwAAQBAJ?hl=en&gbpv=0. Accessed December 10, 2021.

108. Mosby's Medical Dictionary. 10th ed. Mosby; 2017. https://ebookcentral.proquest.com/lib/rvucom-ebooks/detail.action?docID=4747147. Accessed December 10, 2021.

109. Jonsen A, Siegler M, Winslade W. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*. 9th ed. United States of America: McGraw Hill; 2022. https://accessmedicine-mhmedical-com.proxy.rvu.edu/book.aspx?bookid=3130. Accessed December 10, 2021.

110. Siegler M. Decision making strategy for clinical ethical problems in medicine. Arch Intern Med. 1982;142:2178-9.

111. Sugarman J, Sulmasy D, eds. *Methods in Medical Ethics*. 2nd ed. Washington D.C.: Georgetown University Press; 2010. https://www.google.com/books/edition/Methods_in_Medical_Ethics/QPvoTjDn0B4C?hl=en&gbpv=1&dq=medical+ethics&printsec=frontcover. Accessed December 10, 2021.

112. Caldwell C. Using touch in psychotherapy. Paper presented at: USA Body Psychotherapy Conference; June 2002; Baltimore, MD.

113. Giusti R, ed. *Glossary of Osteopathic Terminology*. 3rd ed. Chevy Chase: American Association of Colleges of Osteopathic Medicine; 2017.

114. McLaren N. Toward an Osteopathic Psychiatry: The Biocognitive Model of Mind. *J Am Osteopath Assoc.* 2010;110(12):725-732.

115. Ward R, ed. *Foundations for Osteopathic Medicine*. 2nd ed. Philadelphia: Lippincott Williams & Wilkins; 2003.

116. Mallik S. Depressive symptoms after acute myocardial infarction. *Arch Intern Med*. 2006;166(8):876-883.

117. Sitcher F. A randomized double-blind study of the effect of distant healing in a population with advanced AIDS. Report of a small scale study. *West J Med*. 1998;169(6):356-363.

118. Mohr S. Toward an integration of spirituality and religiousness into the psychosocial demention of schizophrenia. *Am J Psychiatry*. 2006;163(11):1952-1959.

119. Landen M. A model to explain the therapeutic effects of selective serotonin reuptake inhibitors: The role of 5HT-3 receptors. *Psychopharmacology Bulletin*. 2006;39(1):147–166.

120. Krystal H. Trauma and affects. *Psychoanal Study Child*. 1978;33:81–116.

121. Kidd P. Integrated brain restoration after ischemic stroke--medical management, risk factors, nutrients, and other interventions for managing inflammation and enhancing brain plasticity. *Altern Med Rev*. 2009 Mar;14(1):14-35.

122. Sawada, M. Neuroprotective and toxic changes in microglia in neurodegenerative disease. *Parkinsonism Relat Disord*. 2009;15.

123. Mitchell J, et al. Medical Complications and Medical Management of Bulimia. *Ann Intern Med*. 1987;107(1):71-77.

124. Webster G. *Sage Sayings of Still*. Los Angeles: Wetzel Publishing; 1935.

125. Westland G. Physical touch in psychotherapy: Why are we not touching more? *Body Mov Dance Psychother*. 2011:6(1):17-29. ■