THE UNPREDICTABLE IMPROVISATIONAL MOMENT AND TOUCH: WHAT INFLUENCES THE THERAPIST?

Linda Kay Waters

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By

LINDA KAY WATERS

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CERTIFICATE OF APPROVAL

I certify that I have read THE UNPREDICTABLE IMPROVISATIONAL MOMENT AND TOUCH: WHAT INFLUENCENCES THE THERAPIST? by Linda Kay Waters and that in my opinion this work meets the criteria for approving a dissertation submitted in partial fulfillment of the requirements for the Doctor of Philosophy in Clinical Social Work at The Sanville Institute.

Alexis Selwood, PhD 12/17/09
Alexis Selwood, PhD, Chair, Date

Samoan Barish PhD 12/14/09
Samoan Barish, PhD, Faculty, Date

Paul Carlo, PhD. 12-18-09
Paul Carlo, PhD, Date
Associate Professor & Program Director, Center on Child Welfare,
University of Southern California

Whitney van Nouhuys, PhD 2-28-10
Whitney van Nouhuys, PhD, Academic Dean, Date

ABSTRACT

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Results from six semi-structured interviews with experienced female therapists found that even therapists who said they did not touch, did touch. Findings indicated that therapists' decision-making process was primarily shaped by a dynamic interplay of multilayered factors that formed their overall attitude toward touch. This interplay enhanced or constricted levels and areas of flexibility in therapists at any given time. Decisions about touching were also influenced by the emotional tenor of a session, the therapist's relationship with the particular client, and whether a distinction was made between the formal session and the leaving process. This research demonstrated the need for and the effectiveness of open, nonjudgmental dialogue about touch.

DEDICATION

This dissertation is dedicated to:

- My parents for their view of learning as a life-long process and to my sisters for their ability to laugh;
- The six participants who so openly shared their experiences;
- Eleanor Belser for her guidance in finding the field of clinical social work;
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CHAPTER 1: INTRODUCTION

Intent of Project

This research project seeks to gain an understanding of what influences a therapist's process when deciding if and when to physically touch a client. Touch is herein understood to be nonsexual physical touch that is not meant to sexually stimulate or gratify either the therapist or the client. This research attempts to better understand what goes on within therapists, both consciously and unconsciously, when they move toward or away from touching a specific client at a specific moment in time. A qualitative approach is used to understand the variability and complexity of participants' experience and the interrelationships among conditions, meaning, and action.

Problem Description

I grew up in a culture and family where love and caring were expressed physically through touch and hugs. A different rule applied to strangers or to business or school relationships, but hugging relatives and friends was the natural and expected method of greeting and parting. Growing up in this environment left me with an unconscious and deeply internalized assumption that benign, nonsexual physical touch was as comfortable for others as it was for my family and me. Attending graduate school did nothing to alter this assumption. As I remember it, the issue of physical touch between therapist and client, except the prohibition against sexual touch, was never discussed during my early

training or supervision. Touch, such as putting a hand on a client's shoulder for calming or in empathy, or sharing a hug with a client, was left up to the discretion of the therapist.

My direct experiences with clients brought my unconscious assumption into conscious awareness. Clients taught me that the same touch can have many different meanings for them and trigger a variety of reactions in them. As a new therapist, I had too little awareness of the power and impact of touch and too few questions. Now, as an experienced therapist, I am filled with curiosity about our relationship to touch.

Questions about touch are not new. The debate about the use of physical touch within the context of therapy dates back to the early days of psychoanalytic work. This ongoing debate regarding the use and abuse of nonsexual physical touch has most often been bifurcated into "right – wrong" positions. On one hand, the classic psychoanalytic fear of gratifying clients' needs, together with the resultant prohibition against nonsexual touch, seems to have created a doctrine against responsiveness to any client need for supportive touch. The strength of this proscription can be seen in what some consider to be a classic textbook on psychoanalytic technique by Robert Langs written in 1982. Langs described therapists as divided into "those who adhere to Freud's legacy and the ground rules providing the ideal therapeutic relationship and setting . . . [and those] therapists who modify one or another of the basic ground rules, and therefore create a treatment setting that is basically deviant" (p. 325). This clearly

illustrated why therapists may have been hesitant to talk about touch. If they did, they were considered deviant.

On the other hand, those therapists who have held that nonsexual touch can be helpful or is necessary to facilitate the treatment of certain clients often view classic analysts as withholding, cold, or unaware of their own issues with touch. For example, Breckenridge (2000) stated that "not to touch proscriptively" communicates a message from the therapist of "unavailable rigidity, or even worse" (p. 10). Pizer (2000) was stronger and more direct in her language than Breckenridge's implication of something "even worse" when she shared thoughts from her 1994 presentation "that a prevailing analytic attitude of deprivation or nonengagement creates the very climate in which mavericks and exploiters thrive" (p. 104). Pizer went on to point out the iatrogenic nature of retraumatization by therapists who are unenlightened by current research. From this position, therapists who choose not to touch might be judged as having a lack of awareness, being overly rigid, and possibly contributing to a climate in which the taboo on the discussion of touch supports exploitive therapists.

These bifurcated "right—wrong" positions have often resulted in judgmental attitudes, which have made therapists feel awkward and embarrassed when talking about use of touch of clients – as if making a confession of wrongdoing. These judgmental positions have shut down open, healthy dialogue and discussion by therapists about their own questions and experiences with the use of touch. This in turn has restricted therapists' ability to broaden and deepen their understanding of the therapeutic relationship and of

themselves as therapists. Therapists need to be able to safely explore their thinking in order to reach a heightened awareness of their own reasoning and motivations. In consultation with their peers, they need to be able to reflect on the pros and cons of possible interventions such as touch, as well as the anticipated and unanticipated results of their actions and inactions. It is the sharing of case experiences that increases our understanding and informs and strengthens our ability to make clinical decisions especially about controversial issues such as touch. Therefore, this study sought to understand what influenced the therapists' decision-making process.

Research Question and Design Overview

Therapists must make many decisions related to touching clients. Some decisions, such as the legal and ethical taboo against sexual touch, are clear-cut. Other decisions, such as whether or not to respond to a client who verbally or nonverbally seems to be reaching for physical contact, can be much less clear-cut. Ideally, therapists' movement toward or away from touching a client would be guided by the consideration of what could best facilitate an individual client's treatment. However, there are many contradictory theories and conflicting opinions about the use of touch as a clinical intervention. So how do therapists decide when touching or not touching facilitates the client's treatment? The overarching question addressed by this research is: What influences a therapist to touch or not touch a client when a client, explicitly or implicitly, asked to be

touched or in those moments when the therapist experienced an inner urge to touch the client?

Findings in prior research indicated that professional training, theoretical orientation, personal and professional experiences, and client characteristics including gender influence the frequency and use of touch by therapists. Therefore, it was assumed that these variables would influence the participants in this study. The researcher presupposed that therapists were influenced by their life and professional stage, ability for self-reflection, and their assessment of and relationship with the particular client in question. The researcher was also interested in exploring the participants' awareness of and incorporation of findings from current infant and trauma research and neuropsychobiology. Additionally, the researcher wondered if the issue of risk management in today's litigious society would be an influencing factor.

One of the limitations of this study was the discussion centered on touch occurring within a dyad without interviewing both the person touching and the person being touched. However, the experiences recounted by the participants during the interviews included their thoughts about their clients' experiences.

This research is a qualitative study using grounded theory inquiry. Grounded theory, as described by Glaser and Strauss (1967) and Strauss and Corbin (1998), is a process of developing theory from data. Grounded theory research was developed by Glaser and Strauss. Its utilization of phenomenological inquiry has been found very useful in discovering participants' subjective experience, making it ideal for this study. A systematic set of

procedures was applied to the data gathered from participants' narratives to create theory. In grounded theory research, the study itself is a live entity, which can, and likely will, change during the course of the study, thus calling for flexibility. Therefore, the interview guide (Appendix A) was modified to accommodate new data and to allow the participant material to guide the study. This design sought to illuminate the influencing factors that shaped participants' processes as they responded to an implicit or explicit request from a client or an urge to touch a client. It was the overall experience as perceived and lived by the participant that was explored and studied rather than whether the therapist did or did not use touch in the moment. The researcher sought to gain an understanding of the participants' thoughts and feelings about their action or nonaction in retrospect and to determine *if* and *how* the participants processed the action or nonaction after the fact. The study attempted to gain an understanding of the phenomenon itself without predicting, quantifying, or controlling the phenomenon.

This study used open-ended guided interview questions in a conversational style, asking participants to share an example from their own experiences. This type of interview and self-report allowed the participants to express themselves more fully when sharing their subjective experience of the moment and gave rise to new phenomena not anticipated by the researcher. Polkinghorne (2005) pointed out several limitations of self-reports by participants. Self-reports are dependent on the participants' ability to reflectively discern and to effectively communicate aspects of their own experience through language.

The lived experience of the participant is altered by time, by the re-telling, by the process of the transcribing of the data, by the memory of the speaker and the perspective of the listener. Taking into account such limitations, the research questions were designed to capture as much of the fullness and variety of the therapists' experiences as possible. A qualitative, rather than quantitative research design was best suited for this study because the primary focus was the process rather than the outcome.

Theoretical Framework and Definition of Concepts

Creswell (1994) pointed out that in "qualitative study, one does not begin with a theory to test or verify" (p. 94). While there are theories of psychotherapy that incorporate ideas about the use or nonuse of touch, this research project adopted no particular theoretical framework from which to study this phenomenon. In keeping with grounded research, the researcher was interested in finding out to what extent and in what ways the therapist's own theoretical framework functioned as an influence in the process. Theoretical framework was looked at as only one of many factors.

Touch, as used herein, referred to nonsexual physical touch, which was intended by the therapist to further the treatment plan. It was not meant to sexually stimulate or gratify either the therapist or the client. The touch was used by the therapist with the intent of being respectful and supportive of the client's particular needs.

This study used Smith's (1998b) definition of touch "as an expression of the therapeutic relationship" (p. 39). In the current study, examples of this type of touch included but were not limited to the therapist putting an arm around the client's shoulder for comfort or the therapist holding the client when the client was distraught or grieving, hugging the client, placing a hand on the client's shoulder, or holding a client's hand. Inherent in Smith's definition of touch as an expression of the therapeutic relationship are the moments when the client asks, verbally or non-verbally, for physical contact, or the emotional tone of the session or a deep sense of attunement with a client might move the therapist to want to offer a hand clasp or an embrace. These moments by their very nature were not predictable and the therapist was faced with making an immediate in-the-moment response to the client's implicit or explicit appeal, to the situation, or to her own interpersonal intrapsychic urges. Smith discussed this only in terms of the touch that might occur at these moments, but equally important was the touch that did not occur in these moments when the therapist was forced to respond either by touching or not touching the client. What was important was that the unpredictable improvisational moment happened – that is the nature of therapy.

Project Significance

Historically, the issue of therapists' use of nonsexual physical touch has most often been polarized into "right – wrong" positions with each side categorizing the *other* as too rigid or too loose in some manner. This polarization and categorizing has, with few exceptions, shut down open discourse and

theorizing about touch. In the researcher's experience, therapists have tended to find it safer to stay quiet about those unpredictable moments in the therapy that call for a creative, and sometimes instantaneous, response. Therapists need to be aware of the influences that guide them in these moments in order to better understand the impact on clients of their actions or non-actions. If therapists are to make thoughtful decisions about the use or nonuse of touch as a therapeutic technique, they need an open, nonjudgmental discussion that helps them understand their own processes when faced with the dilemmas involved with the question of touch. Research, especially grounded research utilizing phenomenological inquiry, with therapists and the influences that shape their in-the-moment decision to touch or not touch has been limited. This study adds to the body of knowledge about the decision-making processes of therapists and the phenomena that shape those processes. It is the researcher's hope that this study will encourage dialogue about touch, keeping open the discussion that gives this topic the serious inquiry that it deserves. It will help therapists think about and be more conversant with the meaning and impact of touch from their point of view. It will add to the *safety* of discussing touch, which will help all mental health professionals, especially interns and new therapists, to be more open to asking questions and more thoughtful about touch.

CHAPTER 2: REVIEW OF THE LITERATURE

This chapter reviews selected literature relevant to the use of nonsexual touch within the psychotherapy session. The first section looks at the history of the controversy surrounding the use of physical touch in the psychoanalytical community. The impact of the split between early psychoanalysts who came to view any use of touch as anti-therapeutic and psychoanalysts who took a different perspective is also addressed in this section. The next section traces the ongoing struggle for a dialogue regarding the use of nonsexual touch in literature from the original split to today. The final section focuses on the research that relates to this study.

Physical Touch in Psychotherapy

The roots of the use of physical touch in the psychological and medical healing arts date back to various ancient religious and cultural practices (Smith, 1998a; Hunter & Struve, 1998). Hunter and Struve discussed historical examples of the belief in the magical healing powers of faith-based leaders' touch such as the yogis and shamans of Eastern cultures, Jesus in the Christian belief system, and medicine men in Native American cultures. The use of touch as a sanctioned part of healing rituals has ranged from beating evil spirits out of those who were thought possessed by the devil to the laying on of hands for healing of diseases (Smith).

Freud and the Establishment of the Prohibition Against Touch

In his early work with psychiatric clients, Freud used touch in conjunction with verbal interventions. He used touch when hypnotizing clients (Hunter & Struve, 1998) and he held the heads of hysterical patients when applying his *pressure technique* (Clark, 1982, p.119; Rothgeb, 1973, p.164). Initially, Freud was a physician who touched his clients in the course of regular physical examinations. He became what was known in those days as a neuropathologist, a specialist in the nervous system. This in turn became the basis for his intense interest in the mind-body connection of the hysterical patient. Freud understood the power of touch to influence and, in fact, wrote of the ego as rooted in the individual's early experience with touch. In 1960, he stated:

> The body is first and foremost a bodily ego. . . . 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. (as cited in Hunter & Struve, pp. 52-53)

Freud's ideas about the use of touch as an intervention in psychoanalytic treatment changed, and they appear to have been influenced by more than one factor. Freud was developing his psychosexual theories during the sexual prudery of the Victorian era, and gaining acceptance from the scientific community was critical for him. Therefore, he was very concerned that his ideas not be rejected due to any misperceptions of sexual misconduct on the part of those practicing his techniques (Mintz, 1969; Smith, 1998a). Freud's lack of success with hypnosis moved him toward the use of free association and the talking cure, which centered on clients in the post-oedipal phases of psychosexual development (Roazen, 1974). Freud's focus was on those clients

who could respond to the talking cure, not on those whose problems were rooted in the pre-oedipal and infant developmental stages of development where touch rather than language was the basis of healthy development.

However, it was Freud's conceptualization of transference and the accompanying development of the belief that the therapist should maintain a neutral stance that has had the most profound and lasting influence on the use of touch in psychotherapy (Hunter & Struve, 1998). In this context, touch was seen as having the potential, even the probability, for arousing sexual feelings in both the analyst and the client. Frustration of need rather than responsiveness to need was seen as the principal means of forcing the unconscious into active play. Therefore, if therapists were to be effective they needed to maintain a non-responsive therapeutic stance in relationship to clients. Although Freud did not always maintain strict therapeutic neutrality (Clark, 1982; Roazen, 1974, 1995) and did not write any definitive guidelines regarding touch, an articulated prohibition against touch developed that continues to exist (Casement, 1992; Langs, 1982).

The Prohibition Against Dialogue About Touch

Despite Freud's prohibition against touch some of his followers argued that touch and responsiveness were actually necessary in helping certain clients. Two of these were Sandor Ferenczi and Wilhelm Reich. Ferenczi studied and trained under Freud and is credited with being a key person in helping psychoanalysis become a branch of science (Aron & Harris, 1993; Mishne,

1993). Ferenczi's work with patients who suffered severe early traumatization led him to disagree with Freud regarding the clinical benefit of the therapist's neutrality and/or the frustration of the client's needs and wishes (Hunter & Struve, 1998). Ferenczi's and Freud's differences involved both theory and technique. Based on the highly traumatized clients he treated, Ferenczi came to believe that regression, rather than being undesirable, was actually necessary for psychological healing to occur. Ferenczi conceptualized touch as nurturing and parental rather than sexual. He believed it would be experienced as calming and soothing by the client and experimented with using it as an intervention when treating a client in regression. Ferenczi focused on psychoanalysis as a process in which the therapist played an active role using his/her self awareness to modify his/her techniques in response to the client's needs and to overcome therapeutic stalemates. Ferenczi viewed touch as having the potential for providing the reparative experience necessary during regression. He made the argument that touch held the potential for being therapeutic and therefore needed to be considered as an intervention for clients with early and severe traumatization (Aron & Harris, 1993; Roazen, 1974).

Wilhelm Reich, a student of Freud's and Ferenczi's, carried Ferenczi's ideas even further in exploring the mind-body connection. Reich developed the concept of *muscular armor* which described the resistances he observed in patients' physical presentation (Wilhelm Reich Museum, 2004-2010). Reich utilized touch for diagnosis and for treatment. Smith (1998a) pointed out that Reich held a position much like Freud had earlier, i.e. that "remembrances, in

order to be curative, must be accompanied by appropriate affect" (p. 11). Reich took a very active role in working with patients in order to soften and break down their body armor. He touched them to rearrange their physical positioning, to locate points of muscular tension, and to teach them breathing techniques. Reich has come to be considered the founder of somatic psychology because so many who trained under Reich either incorporated his approach or developed techniques of their own involving the formal use of touch, including Fritz Perls, a co-founder of Gestalt therapy (Daniels, 2008).

Ferenczi and Reich, each in his own way, brought the idea of touch as a legitimate psychotherapeutic technique back to the table for discussion. However, Freud was not ready to hold this discussion. Ferenczi and Reich's concept of touch as nonsexual was in direct conflict with Freud's view of touch as fraught with sexual desire. Their idea that touch held the potential for being an important, sometimes necessary, element in the treatment of certain clients clashed with Freud's treatment doctrine that neutrality and non-responsiveness were necessary for successful treatment. As a result of their lack of adherence to the accepted structure of Freud's classic teachings, Ferenczi and Reich were ostracized by the analytic community. Although Ferenczi considered himself to be a member of the analytic society until his death, he and his ideas were marginalized (Haynal, 1989). According to Older (as cited in Hunter & Struve, 1998), Reich was eventually forced to resign from the analytic society, which disassociated itself from him and his work.

The nature and strength of the splits between Freud and Ferenczi and between Freud and Reich appeared to have had a lasting impact (Aron & Harris, 1993; Haynal, 1989; Hunter & Struve, 1998; Mishne, 1993). First, it intensified and strengthened the analytical community's adherence to Freud's treatment concepts of touch as sexual and of effective therapy as neutral and non-responsive. It also had a second and perhaps more crucial impact: open dialogue regarding the use of nonsexual touch was effectively shut down. Freud's legacy now included an interdiction against classical therapists exploring their thoughts about the possible use of touch as an intervention.

Some of the Object Relations and Relational psychotherapists came to believe that the judicious and carefully thought out use of touch with certain types of clients was helpful and furthered the client's treatment (Smith, 1998a). Psychoanalysts such as Winnicott (1965) and Balint (1968) later reintroduced the idea of the value of touch as an intervention with certain types of clients. Both Winnicott and Balint believed that verbal interpretations were insufficient for some psychotic clients and some clients with pre-oedipal traumas. Winnicott stated, "there are times when a psychotic patient needs physical holding" (p. 240). Winnicott's use of physical touch, including holding, with his patient Margaret Little has continued to be debated as a creatively innovative intervention on the one hand and a major boundary violation on the other (Kahr, 2006; McWilliams, 2004). This controversy has persisted despite Little's (1981) description of Winnicott's use of physical touch as fostering her psychological growth and facilitating her treatment. Balint argued that when working with clients

in an extremely regressed state some form of touching such as holding the therapist's hand was often required because words were unreliable and insufficient. However, as with Ferenczi and Reich, the therapists who raised the issue of touch seem to have been seen as individual voices and no generalized open dialogue within the psychotherapeutic community appeared to have taken hold. The general taboo against the use of touch prevailed.

The rise of the humanistic and experiential psychological approaches in the 1960s and 1970s brought a general easing of the taboo against touch in psychotherapy. Gestalt therapy and encounter groups actively integrated physical contact into the therapist-client relationship. Arguments for a broader view of how touch might be useful with psychotherapy clients were again being made by some therapists, including Mintz and Fuchs. Mintz (1969) thought that touch communicated acceptance, nurturance, and support and helped to *ground* patients. Fuchs (1975) pointed out how the neutral antiseptic analytic model could reinforce a client's sense of isolation. Perhaps the most important point these therapists made centered on the idea of therapists being flexible enough to consider that individual clients might need different approaches at differing junctures in their treatment. Kupfermann and Smaldino (1987) discussed the complexity of managing the therapeutic relational issues, writing that therapists who consider the use and nonuse of touch, "must have the capacity and stamina to be disciplined in the aftermath of flexibility" so that they "may be free to learn whether the use of touch is in fact helpful" (p. 233). Throughout these discussions, there was agreement that therapists needed an increased level of

awareness surrounding the issue of touch. Therefore, a more open nonjudgmental atmosphere for professional discussion and exploration of the issue was needed.

However, open dialogue remained a struggle as illustrated by these analytical textbooks, which spelled out Freud's prohibition against touch in the guidelines provided to new therapists. For example, Karl Menninger wrote in his *Theory of Psychoanalytic Technique* (1958):

> For reasons that will become increasingly clear as we go on, the psychoanalyst must try (and it is not easy) to remain neutral and "aseptic." This means that one doesn't chat with patients, touch them (e.g., shake hands) unnecessarily, ask favors of them or accept favors or gifts from them.* (p. 40)

The asterisk (*) denoted the comments by a European associate of Menninger's pointing out that all the European analysts he knew shook hands with their patients at the beginning and the end of the hour. It was interesting to note that shaking a client's hand was considered so controversial that differences between classic analysts in the United States and in Europe needed to be clarified.

A later example was in what some consider a classic textbook on technique, Langs' *Psychotherapy: A Basic Text* (1982). In describing what he termed the ground rules of conducting therapy, Langs stated, "The listening process is essentially visual and auditory, although it may involve touch, either inadvertently or with a rare but appropriate handshake, such as at the time of the first meeting with the patient" (p. 73). He called this an Implicit Ground Rule "seldom explicitly" stated. Langs saw therapists as "polarized into two groups" in respect to the type of ground rules to which they adhere. In one group were those who adhered to

Freud's legacy and the ground rules providing "the ideal therapeutic relationship and setting." In the other group were "therapists who modify one or another of the basic ground rules, and therefore create a treatment setting that is basically deviant" (p. 325).

These are illustrations of the attitude that made dialogue and exploration of nonsexual touch as a therapeutic intervention almost unthinkable – to do so meant to risk censure. By this standard any therapist who had the impulse to touch or did touch in support or empathy would be labeled as deviant; any client who touched or wanted touch was breaking boundaries and was possibly sexually pathological. This type of mindset squelched the opportunity for exploration of the meaning of touch for the client and for the therapist. It encouraged a lack of self-awareness because therapists must never allow themselves to explore touch-related questions. It encouraged secret keeping. While doing her 1981 research on touch and psychotherapy, Geib (1998) found herself being "ambushed in corridors and dragged off to offices" (p. 111). Other staff members "confessed" to her "that there had been many instances in which therapists had been moved to touch clients, but had been afraid to discuss, and therefore unable to evaluate, this contact" (p. 111).

Current Views and the Need for Dialogue

The literature written over the last twenty-five years led the researcher to the following perspective: that the need for on-going, open, and in-depth dialogue to increase our knowledge and understanding of the controversial subject of

therapeutic touch only grows increasingly more important. This was based on the discussion of touch in three areas of literature: infant and trauma research and neuropsychobiology, psychotherapy, and risk management for therapists. The combination of new information and psychosocial, cultural, and legal shifts has set up confusing, sometimes conflicting, dilemmas for therapists, adding another layer to the already existing theoretical split.

Infant and Trauma Research and Neuropsychobiology

Conclusions from infant and trauma research and neuropsychobiology research have added impetus to earlier ideas that the use of nonsexual therapeutic touch has implications as a healing intervention that can go beyond that of a verbal intervention, especially in the treatment of certain clients who suffer from developmental attachment disorders or sexual abuse or other types of trauma (Geib, 1998; Harper & Steadman, 2003; Hughes, 1997; Lawry, 1998; Schore, 1994, 2003; Siegel, 1999; Solomon & Siegel, 2003). Indeed, Schore's (1994) work indicates that sensory contact, including touch, actually can transmute shame into a manageable affect in what he termed the "positive socialization of shame" (p. 243). These findings have emphasized that mutual attunement in emotionally significant relationships, such as between therapist and client, plays a significant role in helping clients to develop internal emotional self-regulatory functions (Schore, 1994, 2003; Siegel). The attunement and regulatory influence of the therapist is communicated through the senses, including touch, during what Stern (1998) termed unpremeditated *now moments*.

Stern stated that the "vast majority of therapeutic change is found to occur in this domain . . . [in] the improvised, largely unpredictable, nonlinear movements toward mutual goals that characterize the processes of parent-infant and therapist-patient interactions" (p. 300). The use or nonuse of touch in Stern's *now moment* fits with Smith's (1998b) definition of touch as "an expression of the therapeutic relationship" (p. 39) and is the focus of this study.

Therapeutic Complexity

Knowledge gained from infant and trauma research, and neuropsychobiology research coincided with two major paradigm shifts in analytic thinking, which forced a rethinking of the treatment doctrine of neutrality and nonresponsiveness. These were the shift from a positivistic to a relativistic perspective in scientific thinking and the change in the conceptualization of the therapeutic relationship from an intrapsychic to an intersubjective model. Fosshage (2000) attributed therapists' consideration of the question of touch in therapy to the coming together of these two changes. He pointed out that from this new perspective a nonaction became as important as an action and the concept of the neutral therapist no longer existed. From this intersubjective relativistic model a prescriptive approach simply would not fit with *best clinical practice*.

Thus, the controversial issue of touch seemed to get only more controversial. The clinical issues with the use and the nonuse of touch were no longer so easily bi-furcated into "right—wrong" positions. Now therapists needed

to consider with whom, when, under what circumstances, as well as how to assess and process the impact of the therapist's action or nonaction. Touch was being discussed in a much more nuanced way. Definitions of touch that addressed the gray areas between a *hello handshake* and a *good-bye hug*, including the unplanned moments of potential touch faced by therapists during sessions, were now being described (Downey, 2001; Fagan, 1998; Smith, 1998a; Zur & Nordmarken, 2007). Certain themes were consistently emphasized throughout the literature (Downey; Durana, 1998; Ruderman, E. Shane, & M. Shane, 2000; Smith, Clance, & Imes, 1998; Strozier, Krizek, & Sale, 2003; Toronto, 2002; Zur & Nordmarken). These themes were: the complexity involved in the consideration of the use of nonsexual touch in therapy; the need for therapists to be self-aware and open to exploring their motivations for the use of touch; the use of touch must be for the therapeutic benefit of the client, not the therapist; the use of touch should be introduced only in an established and on-going therapeutic relationship; any use of touch should be contextually appropriate and undertaken thoughtfully and with great care; both the client and the therapist should feel comfortable with the touch; therapists must be certain to stress both to the client and themselves that the touch is nonsexual; the importance of the client's sense of empowerment in controlling the situation; and the need for supervision and touch-related training for therapists, especially those just beginning their careers.

Nonsexual touch as an issue of power was discussed by several authors (Geib, 1998; Hetherington, 1998, 1999; Horton, 1994, 1998; Hunter & Struve,

1998; Kertay & Reviere, 1993). Significantly, an in-depth consideration of erotic issues related to the use of touch, including the emergence of erotic transference, was discussed as an area of intense complexity by authors, but not with the *slippery slope* classical analytic prohibition (Hunter & Struve; Lawry, 1998; M. Shane, E. Shane, & Gales, 2000). Ethics and boundary issues related to the consideration of the positive use of nonsexual touch were being discussed rather than the single focus on avoidance of touch (Durana, 1998; Hetherington, 1998, 1999; Kertay & Reviere; Smith, Clance, & Imes, 1998; Zur & Nordmarken, 2007). Case examples and guidelines for assessing the use or nonuse of touch in relationship to the client's dynamics began appearing in the literature (Durana; Halbrook & Duplechin, 1994; Hunter & Struve; Kertay & Reviere; McLaughlin, 2000; Ruderman, 2000; Smith et al.; Toronto, 2002). Authors were now making the point that touch in psychotherapy could be beneficial to some clients at some times and contraindicated with those same clients at other times, and for other clients touch was completely inappropriate at any time (Kertay, & Reviere; Kupfermann & Smaldino, 1987; Pinson, 2002; Ruderman, E. Shane, & M. Shane, 2000; Smith et al.; Toronto; Zur & Nordmarken).

In spite of the infant research and the paradigm shifts, the power of the analytic censor did not disappear. The literature reflected many examples of therapists' concerns of being judged as nonprofessional by their colleagues. For example, in Volume 20 of the 2000 *Psychoanalytic Inquiry*, which was probably the first focused dialogue on the issue of touch in analytic therapy, Breckenridge wrote that she was aware that she took the risk of having her work judged as

"unanalytical" by some other analysts (p. 3). In this same volume on the use of touch, Schlesinger and Appelbaum (2000) discussed analysts who had learned that strict compliance with the rules of neutrality, abstinence, and anonymity was ineffective for many of their clients and who had "learned how to make the modifications of technique required to meet the needs of their patients, doing what they found necessary, but for the most part, they did so quietly" (p. 133). The implication of that comment, from this researcher's point of view, was that they did so quietly because they feared the negative judgment of their peers. Indeed, in an article in the same journal, a retrospective overview discussing his 1985 case study used as the supporting argument for the classical stance of no physical contact, Patrick Casement (2000) described himself as one of Schlesinger and Appelbaum's quiet analysts. This concern of *negative judgment* was noted by two different researchers in relationship to therapists who had been asked to be participants in their studies on touch (Cronise, 1993; Jones, 1999). Eight analysts refused to discuss touch with Cronise after they were told they might be quoted even though they were assured they would not be cited and their anonymity and confidentiality would be protected. Jones observed that a noticeable number of psychologists exhibited extreme caution in responding to her surveys, returning the surveys in their own envelopes with no return address and therefore no respondent identification code. Therapists have tended to keep quiet about their use of nonsexual touch for good reason: there is evidence that other professionals easily and frequently misconstrue nonsexual touch. A study by Gottlieb, Hampton, and Sell (1995) showed that many psychologists rated a

vignette of a supportive hug at termination and one of an affectionate embrace given in greeting a year after a client's termination as sexual misconduct.

The Fear Factor - Risk Management

Touch was also discussed in the literature as a *risk management* issue. Many authors wrote of the fear of lawsuits or of the litigious culture in which therapists currently practice (Cronise, 1993; Fagan, 1998; Glickauf-Hughes & Chance, 1998; Imes, 1998; Mandelbaum, 1998; Zur & Nordmarken, 2007). For example, some malpractice insurance carriers view therapists who consider using touch as an intervention as a higher risk than those who do not (Fagan; Imes; Jones, 1999; Mandelbaum). An oft-quoted article by Gutheil and Gabbard (1993) on risk management stated that "From the viewpoint of current risk-management principles, a handshake is about the limit of social physical contact at this time" (p. 195). Based on the possible appearance of wrong-doing or crossing boundaries, Williams (1997) recommended the avoidance of touch even when inherently justified and consistent with treatment. Therapists were and are constantly reminded that one false move – one misinterpreted touch – could cost them their license.

Summary of Therapeutic Complexity

On the one hand, evolving knowledge and paradigm shifts in analytic thinking has pushed therapists toward the consideration of the healing power of touch. On the other hand risk management has instructed against touch. This

dichotomy has added an additional layer of confusion and fear to the earlier theoretical splits. A 1987 article by Kupfermann and Smaldino raised some interesting questions that seem equally relevant and unanswered today: Is the rule prohibiting touch used by some therapists as a wall affording the safety of emotional and legal distance? Do some therapists at the other extreme misuse the concept of supportive touch to collude with a client to maintain positive transference? Certainly, risk management practices, fueled by fear of a lawsuit, are the defining forces behind defensive therapy practices. Equally as certain, therapists who use rigid theoretical assumptions to never or always include touch save themselves the considerable struggle of making individual decisions with each client, thereby avoiding the necessity of self awareness and open dialogue which this decision making requires.

Research Relating to This Study

Despite the long history of debate regarding the use of touch in psychotherapy, there has been relatively little qualitative research seeking to gain an understanding of the therapist's process when deciding to use or not use touch with a client. Much of the research conducted in the seventies and eighties utilized simulated situations and/or planned touch rather than actual therapist-client situations in ongoing therapy (Alagna, Whitcher, Fisher, & Wicas, 1979; Anderson, 1984; Dye, 1983; Hubble, 1980; Kukal, 1984; Shirley, 1980; Wheaton, 1984). Therefore, factors such as the therapeutic relationship and the intent of the touch were missed. Some of the research focused solely on the impact of

touch on the client (Donnelly, 1992; Geib, 1998; Horton, 1994; Imes, 1998; Kunkle, 2000). This review discusses only the research relevant to the current study of therapists' use or nonuse of touch within the therapy session.

There was limited qualitative data about the influences that move a therapist to touch or not touch a client under the circumstances as outlined in this study. This researcher found a total of sixteen research studies focused on therapists' use or nonuse of touch, nine of which were quantitative and conducted via mailed questionnaires (Cassatly, 2003; Clance & Petras, 1998; Holroyd & Brodsky, 1977; Jones, 1999; Pope, Tabacnick, & Keith-Spiegel, 1987; Stenzel, 2002; Strozier et al., 2003; Weisberg, Cowen, & Lotyczeuski, 1983; Zand, 1997). One study utilized structured questionnaires sent to participants beforehand in order to conduct telephone interviews (Milakovich, 1992). Two research interviewers studied the therapists' theoretical orientation in relationship to their use of touch (Moy, 1980; Raab, 1996). Four researchers utilized phenomenological inquiry to explore therapists' use of touch with clients (Cronise, 1993; Dworsky, 2001; Pinson, 2002; Taylor, 2002).

Findings in the above studies indicate that frequency and use of touch by therapists differed based upon a number of variables including gender, training and theoretical orientation, personal and professional experiences, and client characteristics.

Gender

Gender of both the therapist and the client was found to influence when, with whom, and how often touch was used. Female therapists reported using

touch more frequently than their male counterparts (Holroyd & Brodsky, 1977; Milakovich, 1992; Weisberg et al., 1983). Supportive touch during the psychotherapy session was offered by both male and female therapists significantly more often to female clients than to male clients (Holroyd & Brodsky; Stenzel, 2002; Zand, 1997). Female therapists were more likely to use touch as an expression of the relationship while males tended to use touch in socially stereotyped ways (Stenzel). Female therapists were found to be significantly more likely to be approached for touch than males (Stenzel). Male therapists were significantly more likely to refuse to touch clients who requested or expected touch than were female therapists (Milakovich).

Training and Theoretical Orientation

Therapists' training and theoretical orientation, especially humanistic and psychodynamic, have been found to be influential in shaping the way they approached and practiced the use or nonuse of touch with clients. Humanistic therapists reported using touch during a psychotherapy session significantly more often than psychodynamic psychologists (Milakovich, 1992; Moy, 1980; Pope et al., 1987; Raab, 1996; Stenzel, 2002). Non-touching psychodynamic therapists were significantly more likely to view touch as a wish, and gratification of that wish as harmful, while therapists who touched viewed touch as a need, and gratification of need as beneficial (Clance & Petras, 1998; Milakovich; Pinson, 2002).

A seven-year study conducted across a variety of settings found that psychiatrists reported using less physical contact than psychologists and social workers, and therapists with doctoral-level training indicated less frequent use of touch than therapists without this level of training (Weisberg et al., 1983). Social workers who claimed a theoretical orientation were less likely to use touch than those who identified themselves as eclectic (Strozier et al., 2003).

Personal and Professional Experiences

Research indicated that therapists' personal and professional experiences and their family or cultural backgrounds had more influence on their decision to touch or not to touch than did their theoretical orientation (Cronise, 1993; Milakovich, 1992, 1998; Pinson, 2002; Taylor, 2002). A strong self-perception of having been well nurtured as a child was strongly associated with a level of comfort in reaching out to others and the use of touch by therapists (Moy, 1980). Those therapists whose personal therapy had included touching experiences were significantly more likely to use touch than those therapists whose personal therapy had not (Milakovich).

Professional experience with clients was found to play a role in therapists' reporting that, due to their years in practice, intuition regarding each client's needs was their main guide in their decision-making, rather than any theoretical prohibitions (Dworsky, 2001; Strozier et al., 2003; Taylor, 2002). In these studies, therapists appeared to feel that their experience allowed them to trust their reading of their clients' cues and nonverbal messages in deciding when and with

whom to use touch. On the other hand, therapists who had had negative experiences related to their use of touch with clients were more hesitant to utilize touch or had stopped utilizing it as an intervention (Cronise, 1993).

Client Characteristics

Therapists' decisions to use or not use touch have been shown to be influenced by the clients' gender and age (Cassatly, 2003; Strozier et al., 2003; Weisberg et al., 1983). Therapists tended to use touch significantly more often with children than with adults (Strozier et al.; Weisberg et al.). As noted above, touch was utilized with female clients by both male and female therapists significantly more often than with male clients (Holroyd & Brodsky, 1977; Stenzel, 2002; Zand, 1997).

Client diagnosis or dysfunction has also been shown to be a major influence in therapists' decision to use or not use touch (Cassatly, 2003; Clance & Petras, 1998; Dworsky, 2001; Strozier et al., 2003; Taylor; 2002). Therapists reported touch as contraindicated with certain clients: clients who need clear and firm boundaries because they demand touch in a manipulative way or have personality disorders (Cassatly; Dworsky; Strozier et al.; Taylor); who have a lack of tolerance for physical contact or who might possibly misinterpret the contact as sexual or disrespectful (Clance & Petras); who are experiencing a strong sexual transference (Dworsky); who are actively dissociative (Horton, 1994) or psychotic (Cassatly); or who are potentially dangerous (Cassatly; Strozier et al.; Taylor).

Whether to use or not to use touch depended on whether it was assessed to be clinically beneficial for the client, which in turn was dependent upon ascertaining the meaning of touch to the individual client (Dworsky, 2001; Moy, 1980; Taylor, 2002). Therapists viewed touch as beneficial for clients who were assessed to have enough ego strengths to discuss and process its meaning for them, and for clients who had a history of touch deprivation (Clance & Petras, 1998). Although some clients with a history of childhood sexual abuse reported that touch was helpful (Horton, 1994; Kunkle, 2000), therapists reported avoiding offering touch to this population (Stenzel, 2002).

CHAPTER 3: METHODS AND PROCEDURES

This chapter will discuss the research design and methodology, including a description of the sampling methods, data collection and analysis, presentation of findings and the limitations of the study. It will also address the issue of reliability and validity.

Research Design and Methodology

The approach to this research on touch within the therapy session is qualitative, using grounded theory as originated by Glaser and Strauss (Strauss & Corbin, 1990). They used field research in order to understand the variability and complexity of an experience and the interrelationships among its conditions, meaning, and action. Grounded theory refers to qualitative research that utilizes data organized into "a set of well-developed categories (e.g., themes, concepts) that are systematically interrelated through statements of relationship to form a theoretical framework that explains some relevant social, psychological . . . or other phenomenon" (Strauss & Corbin, 1998, p. 22). Grounded theory is appropriate for analyzing data derived from participants' experiences because it allows for the personal quality of individual experiences to be retained in the analysis and interpretation. This study looks at therapists' subjective lived experience as reported in open-ended conversational interviews. The focus is on the process rather than any particular outcome. This inquiry sought to get a picture of the structure and the essence of the experience of this phenomenon for these therapists. From their point of view, what was their experience, how did

they experience what they experienced, what was its meaning for them and how did each participant structure the experience into her professional reality. This approach is particularly appropriate for looking at this subject matter because it provides the freedom for the participants and the researcher to explore the variables that might not be accessed by a survey. This model also allows for the depth and detail of the experience to be illuminated by the therapists who had lived it.

Grounded theory goes beyond the description of the phenomena through the organization and categorization of the data into increasingly complex conceptualization and levels of abstraction. The grounded theory researcher allows the theory to emerge from the data rather than beginning the study with a preconceived theory in mind. The methodology of grounded theory combines well with the semi-structured interview style described by Elliot Mishler (1986), to provide an overall approach where findings and theoretical conclusions stay close to the phenomenological data from which they are derived.

Participants and Sample

In keeping with the nature of the research question and the study's qualitative grounded research design, the sampling was purposeful and focused on a small number of participants who were most likely to provide information-rich data. The researcher could learn the greatest amount of information from participants who fit Patton's description of "exemplars of the phenomenon" and "whose study will illuminate the question" (1990, p. 169). Therefore, to be

included in the project, participants had to be *experienced* psychotherapists. *Experienced* was defined as having at least twenty years of private clinical practice experience, a period of time during which participants could be expected to have developed a style of practice and to be able to reflect on their own clinical work. Participants self-selected by expressing interest in the research subject. This study did not control for age, gender or other demographic variables.

After interviewing six licensed professional therapists who worked with adult clients, the researcher, determined that "the point of redundancy" (Lincoln & Guba, 1985 as cited in Patton, 1990, p. 185) had been reached. That is, sufficient information had been gathered to do justice to the subject in question. As Strauss and Corbin (1990) pointed out, there is a dynamic relationship between data collection and analysis in grounded theory. Analysis of the data from early interviews influenced the form of all subsequent interviews and resulted in the need for one additional interview.

The researcher recruited participants by telephoning professional colleagues to ask for referrals. After the telephone conversation, the researcher sent a follow-up letter describing the research (see Appendix B) to those colleagues who knew possible participants for the study. Potentially interested therapists either contacted the researcher directly or were contacted by the researcher using their information provided through the professional colleague. The researcher then sent prospective participants a letter (see Appendix C), which included a description of the research project and its methodology, and the consent form (see Appendix D). The consent form acknowledged that reflecting

on and examining one's practice might lead to self-questioning. Participants were advised that they could stop the interview or drop out of the study at any time should they feel discomfited. In the course of interviewing, discomfiting subjective experiences may come to light; therefore, participants were advised that if they experienced study related distress and needed to speak with a therapist or consultant and did not have one of their own, the researcher would help locate one. Sending this information in advance allowed the participants to consider the nature of the interview and to be focused on the subject matter.

The researcher telephoned the selected participants and made arrangements for the interview at the convenience of each participant. Notes were sent to therapists who were not chosen to participate, thanking them for their interest (see Appendix E).

Data Collection

The sample data consisted of audio taped participant interviews. Interviews were semi-structured, open-ended, and conversational in style to maximize an atmosphere in which subjective experiences could be explored. All data was stored in a separate, locked, confidential file so that the confidentiality of participants was protected (see the section on Confidentiality).

An interview schedule (see Appendix A) consisting of relevant areas and probe questions was used to ensure that no significant areas of research were missed. The interview schedule was only for the researcher's use as a guide and was not used to direct or shape the interview. Participants were interviewed one

time in face-to-face interviews of ninety minutes in a location that was acceptable to both the researcher and the participant. At the time of the interview, the researcher received permission for a follow-up phone call or interview if needed for clarification.

Prior to beginning the interview, the researcher reviewed the purpose of the study, discussed issues of confidentiality, obtained the participant's signature on the informed consent form and provided a copy to the participant. Next the researcher answered any questions the participant had about the project. The researcher completed a personal information form on each participant (see Appendix F). Once the participant was ready to begin, the researcher provided an introductory statement about the research question. The introductory statement focused the interview on those moments in a session when a client, explicitly or implicitly, asked to be touched or on those moments when the therapist experienced an inner impulse to touch the client. It was carefully explained that there were no right or wrong answers or correct responses to the situation, and that this study sought to understand, not judge, the situation. Next the participants were invited to describe one or two particular instances when they decided to touch or not touch a client. The researcher encouraged the participants to share their thoughts and feelings about their experience and their process in dealing with it. Although the interview schedule followed a logical order, the actual order of the topics was dependent on how the interview proceeded. After the interview, a note was sent to each participant thanking her for her participation in the study (see Appendix G).

After each interview was completed, an interview summary was written detailing factors relevant to the study that could not be captured on audio tape. Examples of areas covered in the summary notes are the emotional tone of the interview, the participant's manner, presentation, and nonverbal language and cues, and the researcher's impressions and reactions.

Data Analysis

The data was analyzed utilizing Glaser & Strauss' "constant comparative method of analysis" which characterizes grounded theory research (Strauss & Corbin, 1990, p. 62). The researcher made comparisons and asked questions beginning with the initial interview and continuing throughout the process of data collection and beyond. The researcher scrutinized the data, examining the details for nuance and meaning in order to deepen and broaden her understanding of the research subject. This questioning and comparing and contrasting of data as it was compiled influenced the on-going process of collecting further data. This method called for the researcher to identify themes and categories as they appeared and to be sensitive to the saturation of categories as the study proceeded. Saturation occurred when no new data was emerging; the category development was dense; and the "relationships between categories was well established and validated" (Strauss & Corbin, p. 188).

Grounded theory analysis methodology involved a series of coding procedures – open, axial, and selective. Open coding was the first and basic analytical step in which the data was closely examined and broken down into

discrete parts. Each audiotaped interview was listened to carefully by the researcher and then transcribed. The researcher paid close attention to what the participants said and did not say, to the participants' emotional tone, and to phrasing. The transcripts were read carefully by the researcher to elicit the depth of participant responses and to understand, as closely as possible, their meanings. The researcher analyzed each interview, coordinating transcribed data, audio data and data from the researcher's notes written immediately after the interview. According to Strauss & Corbin (1990) it is "Through this process, [that] one's own and others' assumptions about phenomena are questioned or explored, leading to new discoveries" (p. 62). Emergent themes were identified and broken down into conceptual categories characterized by defining properties and dimensions.

Axial coding is the process of reassembling data broken down in the open coding process, "making connections between a category and its sub-categories" (Strauss & Corbin, 1990, p. 97). Axial coding links subcategories to categories in order to arrive at relational explanations about phenomena adding depth and structure to categories. Though open and axial coding are distinct processes, they did not occur in a linear, sequential manner. The researcher actually alternated between the two methods as she engaged in the analytic process. Axial coding developed the basis for selective coding.

Selective coding refers to the process through which the researcher refined the data, seeking a unifying concept or core category. The researcher systematically studied and validated the relationships of the core category to

other categories. This central category became the focus for the construction of a statement that offered a theoretical explanation of the data.

The analysis of data in grounded theory research is closely associated with the concept of *theoretical sensitivity.*

> Theoretical sensitivity refers to the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from that which isn't. . . . It is theoretical sensitivity that allows one to develop a theory that is grounded, conceptually dense, and well integrated – and to do this more quickly than if this sensitivity were lacking. (Strauss & Corbin, 1990, p. 42)

Theoretical sensitivity comes from the researcher's review of the literature, and professional and personal experience.

Grounded theory implies that a researcher's subjective experience with the data is valid and this creative latitude lends credence to the identification of themes and meanings as data is reviewed. For example, through years of professional experience, the researcher has acquired a certain level of understanding of what constitutes the standards of good clinical practice and what might occur under certain conditions and why. On the one hand, this knowledge can help the researcher to better understand events and actions described by the participants. Similarities hold the possibility for stimulating the generation of potentially relevant concepts and their relationships. On the other hand, it was extremely important that the researcher be aware that prior professional experience can be a block and prevent the researcher from seeing things that have become routine to her. It was important that the researcher be careful to avoid making assumptions about the participants' experience being similar to hers.

Presentation of the Data

The data is presented in Chapters 4 and 5. Chapter 4 describes the findings and data analysis. The thematic categories are described with illustrations from the data. The participants' privacy and anonymity are carefully safeguarded. Only common features and variations are noted with enough information to illustrate categories and themes found by the study.

Chapter 5 discusses how the findings relate to and illuminate the original research questions. It looks at the meaning, implications, and significance of the findings. A discussion of the central themes, grounded in the data and its analysis, suggests a theoretical explanation of the phenomenon studied. Limitations of the study are addressed. Recommendations for future research are offered.

Confidentiality

Completed forms, tapes and transcribed interviews were stored in a separate, locked, confidential file so that the confidentiality of participants was preserved. No data will be used outside of the realm of the current study.

Validity and Reliability

Polkinghorne (1988) pointed out that in narrative-based, qualitative research, the terms *validity* and *reliability* retain their ordinary meanings related to the groundedness of the data collected and conclusions drawn. "Reliability in narrative study usually refers to the dependability of the data, and validity to the strength of the analysis of the data" (p. 176). The narrative interview is a reliable

means of collecting data according to Mishler (1986) and Strauss and Corbin (1998). Mishler believes that the narrative interview elicits reliable data that is richer than that elicited by traditional methods of data collection because the process does not alienate the interviewee. The point is that in this type of research, the researcher is both the interviewer in the data collection process and interpreter of the data in the analysis process. These facts make it essential that the theoretical perspective, personal values, assumptions, and biases of the researcher be identified and articulated at the outset of the study. According to Mishler, the validity of interpretations of the data depends upon the care and rigor with which the researcher applies analytical coding processes of categorization and comparison.

Strauss and Corbin (1990, 1998) addressed two main canons of reliability and validity – reproducibility and generalizability. They argued that grounded research findings are capable of being replicated given the same theoretical perspective of the original researcher, same data gathering and analysis plus a similar set of conditions (Strauss & Corbin, 1990). They also made an important point: "the real merit of a substantive theory lies in its ability to speak specifically for the populations from which it was derived and to apply back to them" (Strauss & Corbin, 1998, p. 267) rather than through generalizability.

Limitations

This study was limited in both number and scope of participants. Participants were limited to six female professionals, living in the greater Los

Angeles area, with a minimum of twenty years as private practice therapists with adult clients. One of the limitations of this study was the research focused on touch occurring within a dyad without interviewing both the person touching and the person being touched. However, the experiences recounted by the participants during the interviews included their thoughts about their clients' experiences. Findings must be considered only in terms of the small number of research participants and cannot be generalized because the study was limited to a selected specific population.

CHAPTER 4: RESULTS

This chapter presents the results of interviews with six psychotherapists exploring their experiences of their use and nonuse of nonsexual physical touch with adult clients. It begins with a brief summary of the research question and methodology and a description of the study participants, followed by the data. The data, divided into thematic categories, is described with illustrations from the participants' interviews. The dynamic interrelatedness of themes and categories is discussed in Chapter 5.

Overview of Research Question and Methodology

The overarching question addressed by this research is: What influences a therapist to touch or not touch a client? Prior research found that therapists were influenced by their personal and professional history and experiences (Cronise, 1993; Dworsky, 2001; Milakovich, 1992; Moy, 1980; Pinson, 2002; Strozier et al., 2003; Taylor, 2002) and by their training and theoretical orientation (Clance & Petras, 1998; Milakovich; Moy; Pinson; Pope et al., 1987; Stenzel, 2002; Strozier et al.; Weisberg et al., 1983). Client characteristics (Cassatly, 2003; Clance & Petras; Dworsky; Holroyd & Brodsky, 1977; Horton, 1994; Kunkle, 2000; Moy; Taylor; Stenzel; Strozier et al.; Weisberg et al.; Zand, 1997) and the gender of both therapist and client (Holroyd & Brodsky; Milakovich; Stenzel; Weisberg et al.; Zand) were also shown to play significant roles. The researcher had presupposed that therapists were influenced by their life and professional stage, ability for self-

reflection, and their assessment of and relationship with the particular client in question. The researcher was also interested in exploring the participants' awareness of and incorporation of current research and trends. Additionally, the researcher was interested in the influence of risk management in today's litigious socio-political environment.

A qualitative grounded theory approach focused on participants' individual decision-making process, allowing them to give comprehensive descriptions of their experiences. Open-ended, semi-structured, conversational interviews provided the structure for in-depth exploration and reflection upon both expected and unexpected variables. At the beginning of each interview, the researcher asked the participants to think about a time when a client, explicitly or implicitly, had asked to be touched or a time when the therapist had experienced an inner urge to touch a client because of the emotional tone of the moment. The participants were asked to provide comprehensive descriptions of their lived experience of this instance. The researcher utilized gentle exploratory prompts to introduce any areas of possible influence that did not arise spontaneously. In the analysis of the data, the researcher used interview transcripts, which were verified for accuracy, and observational notes, which were taken immediately after the interview.

The data was analyzed utilizing Glaser & Strauss' "constant comparative method of analysis" (Strauss & Corbin, 1990, p. 62). The findings were analyzed through a lens comprised of the findings from prior research and the additional factors noted above. The researcher analyzed the transcription of the first

participant's interview before interviewing the second participant. Thus the first interview informed and enriched the second interview. As the researcher analyzed the data from the second interview, the first interview was also reexamined. This dynamic back and forth method was utilized between each interview so that each new interview was informed and shaped by the prior interviews. As the data from each new interview was analyzed, it was also compared with all prior interviews for similarities and differences. Using this process, the researcher identified subcategories and categories. The data was then examined for links between categories to find major unifying themes. The researcher's finding regarding the major unifying themes will be discussed in Chapter 5.

While conducting the interviews the researcher became aware of the participants' dedication and sensitivity to their relationships with their clients. The participants were extremely thoughtful as they described and reflected on their lived experiences with clients. The researcher will make every effort to convey the richness of this material in the following presentation. Therefore, the researcher would like to thank the participants and tell them how honored and privileged she felt to hear their experiences.

Participants

According to Polkinghorne (2005), "the richness and depth of qualitative findings depend on the quality of the sources from which the analysis is drawn" (p. 141). Participants were chosen because of their reputations in the professional community; their high levels of experience, expertise, and ethics; and their abilities

to reflect upon and clearly describe their experiences. Because the researcher sought an in-depth picture of the experience rather than multiple perspectives on the experience, the number of participants was determined by "the point of redundancy" (Lincoln & Guba, 1985 as cited in Patton, 1990, p. 185), that is, when sufficient information had been gathered to do justice to the subject in question. The researcher determined that the point of redundancy had been reached after reviewing six participants.

The participants, whose primary work setting is private practice, range in age from their early fifties to seventy. All participants have a minimum of 20 years experience in private practice and either current or previous experience in agency or hospital settings. Five of the six are currently or were previously involved in teaching, training, supervision, and/or consultation. Culturally, one therapist is African-American and five are Anglo, two of whom are of Jewish background. Five received a Master's in Social Work and one has a Master's in Marriage and Family Therapy. Four participants have PhDs: two in clinical social work; one in analytical psychotherapy; and one in psychology. The participants with PhDs in clinical social work and psychology have analytic training in addition to their education. One of the PhD participants reported training in sensorimotor psychotherapy. Two of the participants have in-depth training and experience working with domestic violence and sexual abuse victims. One of these also has extensive experience in crisis intervention and rape treatment. They all live and practice in the greater Los Angeles area. During the interview, the researcher observed that all participants appeared at ease when talking about themselves

and their practice. The researcher experienced all participants as compassionate and engaging. Each displayed the ability for humor, including the ability to laugh at herself. For the purpose of anonymity, the participants are called Ann, Betty, Carol, Dee, Emma, and Fran.

While all participants reported responding positively to clients who extended their hands for a handshake upon entering or leaving, their initial descriptions of their general management of touch between themselves and clients differed. One participant, Ann, described herself as never engaging in touch with her clients. Three of the participants, Betty, Carol, and Dee, described themselves as never initiating touch with clients within a session. However, Betty and Carol engage in some supportive touch, including initiating hugs with clients when they are at the door departing a session. Dee accepts hugs from clients under the same circumstances. A fifth participant, Emma, described lightly touching clients' hands as a planned intervention during session under certain circumstances. The sixth therapist, Fran, reported utilizing supportive touch, such as holding a client's hand, or hugging a client when she assessed that it would facilitate the client's treatment.

Categories

The four categories — Personal Approach to Touch, Professional Approach to Touch, Emotional Tenor of the Session, and Reflections and Realizations — are each pieces of the answer to the research question: What influences a therapist to touch or not touch a client when a client, explicitly or implicitly, asks to

be touched or in those moments when the therapist experiences an inner urge to touch the client?

Personal Approach to Touch encompasses the participants' family history, their childhood experience with touch, their personal therapy experience in relationship to touch, and their personal style of physically relating with others. Professional Approach to Touch relates to the participants' thought process, manner and methods when interacting with clients. This category is comprised of the participants' training and theoretical orientation, their experiences in receiving, interpreting and responding to requests for touch, and their experiences at the door with departing clients. Emotional Tenor of the Session, as a category, is a direct result of the researcher's analysis of the data. As the researcher studied the data she found that the intensity of the emotional tenor of the client-therapist interaction played a role in influencing the participants' movement toward or away from touching the client, sometimes overriding the participant's theoretical stance and their personal preference. Reflecting and Realizations is a combination of information gleaned from the data and the researcher's observations about the data. When analyzing the data the researcher noticed that the participants went through a process during the interview in which they began experiencing realizations, making connections, exploring questions for themselves, remembering forgotten incidents, and revealing internal contradictions.

These categories were seen as having relevance (Polkinghorne, 2005) because the concepts were repeatedly present across interviews. Each of these categories will be discussed separately. The lens through which the data was

analyzed was comprised of the prior research findings on touch (personal and professional experiences, training and theoretical experiences, gender and client characteristics); the participants' experience, assessment of and relationship with the particular client; the influence of the emotional tenor of the session; the influence of the participants' professional, social, political and cultural context; and the current infant and trauma research.

Personal Approach to Touch

During the interview participants were invited to describe their personal style in physically relating to others in their social systems. They were also asked to share their thoughts about how their style was influenced by their life experiences, including childhood, family, culture, and prior therapy experience.

Two participants, Ann and Fran, described very happy childhoods. Ann described her current intrafamilial interactions as very "huggy," however hugging occurs only rarely in her general social interactions. Fran described herself as someone who can easily initiate and share hugs with almost anyone.

A third participant, Betty also said she had a happy childhood. However, she described constantly feeling very pressured by her rather reserved parents to "avoid making mistakes." This pressure to be perfect had been mitigated by an extended family, which provided acceptance, nurturing, and hugs. Betty shares affectionate touch and hugs within her family and with close friends, but avoids initiating physical contact in social situations unless she feels assured of acceptance.

Three participants, Carol, Dee and Emma, described childhood histories lacking in nurturing touch. Carol said her childhood had provided scant physical affection, leaving her with a craving for the comfort of touch. She experienced her personal therapy as healing in this regard, especially hugs she received at the end of sessions. Carol described herself as very comfortable being physically affectionate with family and personal friends, but generally reserved with other people. Dee, an only child who lived with an emotionally unavailable mother, described receiving nurturing touch and hugs when she visited her father and step-mother. Dee also described herself as reserved except with family and close friends with whom she freely initiates and shares hugs. Emma described a childhood experience of touch deprivation. Touch, when used, had not provided protection or tenderness, leaving Emma with a "hunger" for comforting touch. Emma's personal therapy experience had been "heartbreaking" in this regard, as the supportive holding provided by her therapist did not provide the sought after comfort and served to reinforce her ambivalence toward touch. Emma described herself as unaccustomed to relating through physical touch.

Childhood – Family History

All six participants shared some degree of detail about their childhood experience relating to touch. Two participants, Ann and Fran, described very happy childhoods. Ann described a physically affectionate family with siblings and summarized her family history by saying, "I was lucky. I had a [truly] happy childhood." Fran, who grew up in a "touchy, feely family," also described touch as

a daily aspect of her family and extended community, "a cultural way of greeting and recognition." In Fran's childhood experience, the safety, warmth, and caring of touch were taken for granted, "It had a context. So there was no negative association or fear about that." A third participant, Betty, who was an only child and the first grandchild, talked about the importance of her extended family in providing nurturing and touch. She stated that her parents were not "punishing" but, "bent over so far backwards" to avoid spoiling her that she felt great pressure "to be appropriate and grown up and do things to make people proud . . . not make mistakes." On the other hand, she had special relationships with several aunts who were younger than her parents and she was "their little kid until they had their own." The extended family was "warm, and hugs were available, but you didn't just go hug anybody."

Three participants, Carol, Dee, and Emma, described a childhood history lacking in nurturing touch. Carol stated that her childhood lacked emotional and verbal nurturing and, "my early experiences were very sparse in terms of physical affection." Carol felt that her personal experiences provided her an appreciation "for what a patient's longing would feel like . . . not just the physical, but for comfort, just a loving, affectionate comfort. I can really appreciate what that feels like when they don't have it." Dee, an only child of divorced parents, received little nurturing or physical affection from her emotionally self-absorbed mother. However, she described receiving warmth and hugs during her holiday visits with her father and step-mother. Emma shared that in her early experience touch was "not used to convey warmth, protection, or tenderness" so she did not "necessarily

think of it in that way." Emma explained that while she had hungered for touch, "it wasn't wired in to be something that was a soothing experience for me," leaving her unaccustomed to relating via touch.

Therapy Experience

Only two of the participants, Carol and Emma, identified their therapy experience as professionally influential. These were the same two participants who had reported the most touch-deprived childhoods. Carol reported having had a few different therapists during her life, most of whom had provided hugs when leaving the session. She had found these moments with her therapists healing:

> So maybe there's a comfort level based on my own therapy experiences. . . .They were not stiff or worried, they didn't need to talk about it, none of them, and we never talked about it . . . nobody had to dissect it afterwards. . . . [It was] a natural experience that was healing . . . that influenced me to be a bit more liberal in that way.

Carol's experience led to being more comfortable with physical touch with clients. The second participant, Emma, described her therapy experience as a strong influence in her reluctance to engage in touch with clients. While she found her therapy helpful in other ways, the supportive touch and holding afforded by her therapist had not provided the longed-for comfort, which Emma had found "heartbreaking . . . my own experience makes me very reluctant" to touch or hold clients.

Personal Mode of Physically Relating With Others

All participants talked about their interactions with others in relationship to physical touch. Four participants, Ann, Betty, Carol, and Dee, described

themselves as reserved except with family members and intimate friends. A fifth participant, Emma, whose ambivalence toward touch had been reinforced by her therapy experience, said that relating through physical touch was something she was not "used to . . . I don't have tracks laid down for that." The sixth participant, Fran, saw herself as "a touchy, feely kind of person - period!" Fran, who reported a "very happy childhood" in which hugs were freely exchanged, is the only participant who described herself as comfortable initiating shared hugs with individuals other than family and intimate friends.

While all four reserved participants described being physically affectionate with family, there was some variation in their use and level of physical touch and hugging with friends and colleagues. Ann, who reported a "very happy childhood," described her intrafamilial interactions as very "huggy" but said hugging occurred only about five per cent of the time in her general social interactions, "It is really rare that anybody moves to hug me, and it is quite rare that I move to hug anybody else. I don't think I'm a person who invites hugs." Betty, who felt pressured to be a perfect child, described herself as "shy" and not reaching for any physical contact until she felt completely assured of acceptance, "I don't like to put myself out if I think somebody might reject me. . . . I think that's just [my] personality . . . and part of who I am." Although Carol, with a touch-deprived childhood and a healing therapy experience, described herself as initiating touch and hugs only with family and friends, she shared an experience from several years earlier that had left a deep impression on her. After an extremely frightening situation, a stranger approached her and asked if she was alright. Without

thought, Carol grabbed his hand, ". . . just human instinct. . . . And he—a stranger—took it." Carol remembered feeling comforted by the sense of "human connection" this had given her. Dee, who received her only nurturing touch during periodic visits with her father and stepmother, described being very comfortable initiating touch and hugs within her circle of family and friends.

Professional Approach to Touch

Professional approach to touch encompasses the participants' thought processes, manner, and methods in dealing with clients. The participants were asked to describe instances in sessions when clients, explicitly or implicitly, had requested to be touched or the participants had experienced an inner urge to touch a client and to give a detailed example of one instance when they decided to touch a client and another when they decided not to use touch. These detailed examples provided data on the influences that shaped the participants' decision-making and the circumstances under which their decisions were made. This category is comprised of the participants' training and theoretical orientation, their experiences of receiving requests for touch and their urges to touch, their experiences at the door with departing clients, the impact of the emotion tenor of the session, and participants' reflections and realizations.

Training and Theoretical Orientation

Participants reported that their training and theoretical orientations laid a foundation for their behavior in sessions. Five of the six participants, Ann, Betty,

Carol, Dee, and Emma, described being influenced by training that discouraged any physical contact with clients. Ann and Dee described themselves as never initiating touch. Betty and Carol stated they "sometimes, not very often" initiated touch or shared hugs when clients were leaving. Emma described utilizing touch as an intervention to "ground" and/or refocus disorganized clients. The sixth participant, Fran, said her MSW training focused her toward the use of touch with clients. Training and theoretical orientation includes: training related to touch; reasons to touch and not to touch; discussion of touch; and use of physical self in lieu of touch.

Training related to touch.

Four of the participants, Ann, Betty, Carol and Dee, have advanced analytical training and identified this as the contextual influence for their clinical work. All four pointed out the heavy emphasis this training placed on avoidance of touching clients. For example, when talking about not acting on an internal urge to reach out and comfort a grieving client, Betty explained:

> She's here for me to help her be able to have a place to cry and feel terrible, to be sad, and to talk about those feelings. So that's where my analytic training comes in - to facilitate her experience, not intruding with my own. That would have been totally my own experience to go over and touch her. That wasn't what she needed then. And more than that I think it would have been hazardous to the analytic treatment.

Ann, with extensive expertise in child sexual abuse, has practice experience that has included many clients who were molested by prior therapists. She described her thinking about the importance of keeping the therapist's self out of the therapy:

> It's not only this psychoanalytic training . . . it's valuable in doing work to keep some definitions about my role here, your role there . . . you [cannot] start mucking around with that by physical contact or too much emotionality on the part of the therapist. I think that it's so essential to keep a framework that keeps [clients] safe.

Ann, who had a very happy childhood with her siblings and is "huggy" within her own family, also talked about her strong belief in helping clients foster connections with someone outside the therapy situation: "intimacy with me doesn't make sense. No, I can be transitional, but not primary . . . the whole job is to get them to function out there, right? So, this physical thing is a big deal to me."

In addition to their analytical training, these participants' current orientation was also shaped by their pre-analytic training and/or experiences. In Ann's and Dee's experiences, prohibition against touch was emphasized, and in Betty's and Carol's experiences, it was not. The classic analytic prohibition against touch was reinforced by prior training, as illustrated when Dee discussed her early training as being an important influencing factor, "you just didn't touch patients. I mean, that was drummed into us." Dee, who never initiates touch, has also received training in sensorimotor psychotherapy but has not incorporated it into her practice saying, "I'm just not there yet."

Betty and Carol, who share mutual departing hugs with clients, had earlier career experiences where avoidance of touch was not emphasized. Betty, who described her parents as "not punishing," but accepting of nothing less than perfect adherence to their rules, spoke thoughtfully about this when she said she "probably . . . would have reached out and touched" the grieving client before she knew "as much about analytic work." Carol, with a touch-deprived childhood,

talked about her awareness of "having a different kind of practice" because she will hug a client, going against her analytical training in this way. This is consistent with her early experience working with latency-aged children in residential treatment and with her report of finding her personal therapy experience healing.

Although not analytically trained, the fifth participant, Emma, described being "raised within a tradition professionally" where it was "very unprofessional to touch a client." Emma described receiving her MSW training in the 1980s shortly after the Los Angeles McMartin child sexual abuse trial and being strongly impacted by her sense of the institutionalized fear of touch generated by the trial. She was the only participant who said "other professionals could have a reaction" to a therapist's use of touch as an intervention. Emma characterized her theoretical orientation as interweaving psychodynamic, cognitive behavioral, and relational theories. During the interview she became aware that she was also influenced by "the complexity of the body-mind connection" and the unpredictable "chain of associations and memories" that physical touch can trigger. Emma, with a touch-deprived childhood and an experience with touch in therapy that she found "heartbreaking," stated that she uses touch to "ground" or refocus a client.

The sixth therapist, Fran, who is "touchy-feely" and had a very happy childhood with siblings, stressed the importance of the therapist helping clients building safe relationships outside of therapy. Fran said her training in the sixties, when the humanistic and experiential psychological approaches were actively integrating physical contact into the therapist-client relationship, was a major factor in forming the contextual basis for her work. From these perspectives, touch

is viewed as communicating acceptance, nurturance, and support as well as helping to refocus clients, while the neutral analytic model is viewed as reinforcing a client's sense of isolation. Fran self-identified as a clinical social worker rooted in relational, Afro-centric and feministic perspectives. She stated that self-psychology, object relations, attachment theories, and sexual abuse training were now incorporated into her orientation. Fran described a strong theoretical belief that it was important to offer the use of safe touch, such as a hand clasp or an arm around the shoulder, to emotionally-deprived female clients to facilitate their ability to develop affect regulation, especially self-soothing, and their ability to learn to make emotional connections. This, she said, was an aspect of "the whole nurturing mother [transference] that can benefit women who have not been held or nurtured." She emphasized that therapists must be very clear and aware of their purpose when using touch because "one cannot really take for granted" that clients experience touch as soothing.

Stated reasons for touching and not touching.

During the interviews, participants discussed their reasons for using or not using touch as a treatment intervention. Each participant's reasons were consistent with her theoretical orientation. All six participants agreed that facilitation of treatment is the only reason to touch a client. All participants also agreed that familiarity with the client and her/his needs plus a thorough on-going assessment of the client is necessary before using touch. The theoretical orientation of only one participant, Fran, integrates touch into the therapist-client

relationship. The theoretical orientation of the other five participants suggests that providing supportive touch to clients during the session potentially interferes with the therapeutic process. Participants' reasons not to use touch during a session fall into two broad categories: potential for impeding the client's progress, and client characteristics that would contraindicate use of supportive touch. Regardless of theoretical orientation, each participant described situations in which she had used touch.

Ann, whose theoretical orientation proscribes the use of touch within the session or during the leaving process, described two examples of situations in which she reached the conclusion that touch was clinically necessary. One involved the client's physical safety. The other involved a situation in which a client's treatment was "stuck" due to extreme emotional and touch deprivation at an early developmental stage.

Betty, whose theoretical orientation proscribes the use of touch within the session, is one of two participants who viewed touch differently when it occurred upon leaving the session. She described instances of occasionally initiating supportive touch, such as placing her hand lightly on a client's shoulder, at departure as a compassionate gesture and sharing in mutual hugs.

Carol, whose theoretical orientation proscribes the use of touch within the session, said that if a client explicitly asked for touch during the session, she would view the request as "some type of reenactment", but would consider meeting the client's request after "careful thought" and discussion with the client. Carol, like Betty, viewed touch differently when it occurred upon departure. She

also reported sometimes initiating supportive touch; including sharing mutual hugs with clients. Carol believes mutual hugs at leaving, which feel "organic," that is, the hug grows out of the emotional tone of the session, are acceptable and possibly healing. Carol also described experiencing the hugs she received at departure during her personal therapy experiences as healing.

Although Dee accepts hugs from clients upon departure, her theoretical orientation proscribes the use of touch with clients at any time. However, Dee gave an example of making a decision to touch a client, a departure from her theoretical orientation, rather than reenact the client's childhood rejection. She also described an unusual clinical situation in which she used touch as a thoughtful, creative, experimental solution to an unusual therapeutic dilemma.

Emma described lightly touching disorganized clients' hands as a planned intervention to help clients refocus and avoid disintegration, although her theoretical orientation discourages physical contact with clients.

Fran described utilizing touch on an on-going basis as a relational intervention with clients, especially those who are experiencing profound grief. She views touch as providing a sense of connection and healing for clients.

All participants except Fran described supportive touch as potentially interfering with the therapeutic process. From their theoretical perspectives, Ann, Betty, Carol, Dee, and Emma view offering touch as intruding on their clients and confusing the framework that helps clients feel safe. They see supportive touch as having the potential to halt the client's process of opening up emotionally because it comforts and helps the client regroup; or the client might perceive that the touch

is offered because the therapist is experiencing difficulty sitting with the intensity of the client's pain.

Consistent with prior research, all six participants cited client characteristics as playing a role in their decision-making process. Five participants, Ann, Betty, Carol, Dee, and Fran stated that they would not use touch with "borderline" or "really disturbed" clients who lacked ego strengths and might "regress without the psychological resiliency to reconstitute." Three participants, Carol, Dee, and Fran described sexualized transference as a reason to say no to clients' requests for touch or as having been a part of their decision not to touch in certain cases. Carol and Fran said they would be less inclined to touch or hug males because of the male defensive tendency to sexualize female touch. All participants cited a client's history of abusive touch, physical or sexual, as either a reason not to touch or to utilize touch only with great care because of the unpredictable chain of associations and memories or trauma reaction that physical touch can trigger.

Discussion of touch.

The researcher analyzed the data about the discussion of touch from two aspects: Is touch a topic the participants regularly discuss with clients? If touch occurs, when and how is the touch verbally processed by the participant? Two participants, Ann and Fran, initiated a discussion of touch with clients as part of clients' treatment and educational process. Four participants, Betty, Carol, Dee, and Emma, discussed the use of touch during session if their clients introduced

the topic. Participants reported that touch occurring at the door at the end of the session was not discussed with clients.

Although Ann and Fran, the two participants with happy childhoods, had differing theoretical orientations, they both discussed touch with their clients as an aspect of their regular practice. This was part of their focus on helping their clients build healthy relationships outside of therapy and to learn to discern safe, nurturing touch from unsafe or sexualized touch. Ann, analytically trained, believes the discussion of touch rather than the provision of touch is what is healing within the session and facilitates the connection for touch in the client's real world.

Fran also introduced the subject of touch with her clients, exploring their ambivalence and working with them to separate safe, nurturing touch from sexualized or unsafe touch. She described the process with clients as developmental in nature with the goal of helping clients to feel more in control while also learning how to "hold and nurture" themselves. For example, with a grieving client, Fran asked what would be comforting in the moment and what the client would like her to do and then followed the client's lead. She offered choices, such as sitting closer or sitting next to the client, by asking, "Would it be helpful, if I . . .?" Then they talked about how the client could comfort the hurt, lonely child inside, reframing and normalizing this as a life-long need for connection.

Consistent with their described theoretical orientation and training, Betty, Carol, Dee, and Emma viewed their introducing the topic of touch, their inner

sense of the client's desire for touch or their inner urge to touch the client as intrusive. However, each stated she would discuss touch if it was explicitly brought up in some way by the client during a session. The intent of the discussion would be to clarify the dynamics behind the request, to gain understanding of the meaning and possible impact of the touch for the client, and to assess transference issues and ego strengths. The data illustrated that the belief that it would be intrusive if they were to introduce the topic of touch prohibited the participants' exploration of their inner sense of the client's desire for touch or their inner urge to touch the client. For example, Emma explained she did not explore the meaning of touch for members of the support group she facilitated because it "would be intrusive for me to ask about it" although she saw "touch had meaning" which she could not "understand" and that touch "was relevant" for the clients. Emma, who reported a touch-deprived childhood, is the participant who described that supportive touch during in her personal therapy was "heartbreaking."

Although three participants, Betty, Carol, and Dee, described receiving explicit and/or implicit requests for touch during the leaving process, no one described discussing these requests for touch. Carol and Dee assessed each request, whether implicit or explicit, for the client's underlying dynamics and motivations that would prompt them to initiate a follow-up discussion with the client. To date, none of these requests have required a follow-up discussion. Dee, who never initiates touch, reported that she sometimes felt discomfited when clients hug her at departure, but had not discussed this with them because

it would have been injecting her feelings into the clients' process. Betty and Carol reported experiencing moments of touch at departure as comfortable. They stated that processing these moments with clients would have made what felt "organic" feel "intellectual" or "awkward."

Use of physical self in lieu of touch.

As the participants recounted examples of their responses to requests for touch from clients, they began to describe ways they use themselves to provide clients with the sense of being held and supported without actually touching. When the participants talked about their interactions with their clients, the researcher observed that, consciously or unconsciously, their body language reenacted their nonverbal communication with their clients. This became an additional area of exploration in the interviews.

Regardless of theoretical orientation about the use of touch, all participants described responding to their awareness of the client's feelings through use of body positioning, facial expressions, hand gestures, and voice tone and modulation to convey empathic understanding. As the participants recalled experiences with clients, their affect often reflected what they were describing as having occurred; facial expressions softened, voice tones became lower and modulation slowed. Participants repositioned themselves: leaning forward, becoming very still, leaning their heads to the side as if listening, or reaching their hand out just slightly. Their facial expressions sometimes reflected

the client's described affect – surprise, fear, relief, sadness, disgust, confusion, or anger.

Three of the participants, Ann, Emma, and Fran, also described adjusting their physical proximity to clients in response to a client's assessed need or tolerance for touch. For example, Ann's work with a particularly traumatized client "started with this need for real distance between" them. The client could not sit across from Ann and couldn't tolerate looking at her. Therefore, Ann initially sat as far away as possible and made no eye contact. As their work progressed, Ann varied her physical distance and eye contact to mimic the client's need for emotional distance and/or closeness. Ann explained, "every movement was as if I was touching her, it felt very physical . . . although it wasn't . . . but it felt to me like the amount of intrusion from a visual contact would be the same as if I reached over and touched her."

Emma gave an example of relocating her chair after her assessment from a client's body language that he experienced her close proximity as invasive, as if she were touching him. Emma, whose personal therapy had failed to heal the pain of touch deprivation from childhood, expressed a deep awareness of the ambivalent feelings clients may have about touch. She said that her personal experience really helps her with clients who are exploring this sort of intimate physical proximity that may be new for them.

Fran described actively using her body in session with clients who presented with a high level of emotional intensity. For example, with grieving

clients, she asks what would be helpful. She responds to their requests, including physically moving herself closer to them.

Requests and Urges

In response to the researcher's question the participants talked in depth about their experiences when clients, explicitly or implicitly, had requested to be touched or the participants had experienced an inner urge to touch a client. They gave information about the types and frequency of requests received in the history of their private practices. Implicit requests were reported as occurring more frequently than explicit requests. Both implicit and explicit requests were reported as occurring with greater frequency during the leaving process.

The participants discussed detailed examples of their experiences with specific clients, providing the core data on the influences that shaped their decision-making. The participants reported that their assessment and interpretation of the requests, along with their theoretical orientation, were important factors in shaping their responses. However, this process varied for participants when the client was at the door departing the session (see The Leaving Process). This section includes: types and frequency of requests; and receiving, interpreting and responding.

Types and frequency of requests and urges.

During the interview process, the participants reported the types and frequency of requests received in their private practice. There was a general

consensus among participants that clients rarely ask directly for touch or holding in sessions. However, three participants, Ann, Dee, and Fran, reported both explicit and implicit requests. Ann and Dee, who described themselves as people who generally do not feel an urge to touch outside of their immediate family and close friends, reported receiving requests during sessions but reported no inner urges to touch. Ann and Fran reported receiving implicit requests conveyed via body language or sensing unspoken requests on an on-going basis. Fran reported no inner urges to touch.

The fourth participant, Betty, reported receiving no explicit or implicit requests for touch during a session. She did report having occasional urges to touch during sessions, but interpreted these as counter-transference rather than implicit requests. She didn't think she generated an openness to verbal requests which was "probably" the reason clients didn't ask. A fifth participant, Carol, thought she might have received a few verbal requests from female clients over the years. Carol, like Betty, interpreted any urge to touch as counter-transference rather than an implicit request. Carol believed that clients so rarely ask for touch in session because most clients are "educated that therapists are not supposed to touch."

The sixth participant, Emma, reported no explicit requests for touch. She described an on-going implicit request for holding from one client and an instance in which she responded to an inner urge to touch. Only one participant, Dee, reported an explicit verbal request from a male client.

Explicit and implicit requests, which were reported as occurring more frequently on the way out the door at the end of sessions, are discussed later in this chapter under *The Leaving Process.*

Receiving, interpreting and responding.

Participants described examples of situations when they decided to use or not to use touch. These examples provided the core data on the influences that shaped their decision-making process. Their individual theoretical orientations played an important role in shaping their interpretations and responses to explicit or implicit client requests and to their inner urges to touch. Three participants, Ann, Dee, and Fran, who did not report inner urges, interpreted explicit and implicit requests as a need for holding. The two participants, Betty and Carol, who had experienced inner urges to touch, interpreted these as counter-transference. Emma interpreted the implicit requests she reported as requests for connection.

Data on each participant's experience is presented individually. Each example is discussed in terms of (a) how the participant interpreted her inner urge to touch or assessed the client's request, (b) how the participant processed or discussed the request or urge with the client, (c) the decision to touch or not touch, and (d) follow-up with the client on the impact of the participant's decision.

Ann.

Ann, from a happy childhood and "huggy" within her family, said she is someone who does not "invite hugs" socially. Analytically trained, Ann has a stated position of never touching clients. She described a process with an extremely touch-ambivalent dissociative client that began with an implicit request, became an explicit request, and then became a very intense implicit request before becoming a final explicit request. Ann sensed a child part asking her, "Will you hold me?" Ann responded to this implicit request by helping the client talk about her desire for touch and her extreme fear of touch. This resulted in the client's decision that she would like to have hugs in her life. Ann and the client then worked on the client's ability to get safe hugs from people in her social environment. This successfully satisfied the need in the adult part of the client, however, it did not meet the need of the child part of the client who continued to request a hug from Ann: "the little one would say, you know I still am interested in the hug." They talked about how it was safer that they not change the way they worked together, but continue to find safe people outside of therapy.

Then a crisis occurred during a session when the client began banging her head on a table. Ann immediately responded with a physical holding intervention that kept the client safe. At the same time, she said to herself, "[I] better think hard about this. If she's willing to do something like that, and this has something to do with [her need for the] touch [which I denied her] . . ."

In later sessions they processed this event and explored the multiple meanings of the client's need for hugs – especially the need by the child part of

the client – for a hug from Ann. Ann then reconsidered her denial of the client's prior request for a hug. On one hand, the adult part of the client was terrified about touch from Ann; on the other hand, the child part suffered such "extreme physical deprivation" that touch seemed necessary in order to facilitate treatment. Ann described struggling with her own discomfort, but after much inner dialogue and professional study, she made the decision to work toward meeting the client's request for a hug. This took the form of a systematic, structured, progressive approach over time, which took the client through a developmental progression to help the client feel increasingly more comfortable with and in control of physical contact.

Bètty.

Betty, whose parents required perfection, described herself as "shy" and not reaching for any physical contact until she felt completely assured of acceptance. One of three participants who reported inner urges to touch, Betty interpreted these as her "counter-transference" urges that needed to be strictly contained, consistent with her way of analytical thinking. Betty described an example of not acting on her urge to reach over to a sobbing client in a grief state although she "felt moved [in] the moment." She knew that was not the way to show her understanding,

> So I had to work on myself and translate my own impulse . . . to my understanding of what was best for [the client]. And it went away. The feeling was gone. It wasn't like I couldn't wait to hug her when she got up or anything like that. The feeling was gone.

Betty said she was also influenced by her knowledge of the client's dynamics and history. The client "was very regressed" and had been in a variety of prior therapies, including "touchy-feely" therapy that had not been helpful. Betty "felt that the physical distance was absolutely necessary and appropriate." During the interview, Betty stated her conviction that it would have been "wrong to have reached out because [she] felt moved for the moment."

Betty shared examples of acting on her urges and reaching out to departing clients at the door (see *The Leaving Process* later in this chapter).

Carol.

Carol, whose touch-deprived childhood left her with an appreciation of a client's longing for the comfort of touch and whose experience of supportive touch in therapy was healing, was the second participant to report experiencing inner urges to touch. Analytically trained, Carol explained that she was reluctant to interpret her urges as anything other than "counter-transference," which she believed must be strictly contained. She said, "It's always hard in those moments to know . . . is it my impulse to want to do that, to want to provide that . . . [maybe] I'm projecting that impulse that they want me to [touch]." Carol recounted one instance when she did act on an urge and initiated touch with a "very tearful" client who was "sitting there . . . looking so like a little bird . . . so fragile. . . . [I] walked over and sat next to her, and, I think, put my hand on her shoulder." Carol had thought that it would be comforting, but instead "it was awkward" and Carol felt "a little stiffness" in the client. Later Carol thought, "Well,

that really wasn't necessarily a helpful thing I just did." She attributed the awkwardness to the fact that her action broke their usual therapeutic pattern and intruded into the client's process. Carol reported that she and the client never discussed the incident. At the time she felt that she had already intruded upon the client's process and that her initiation of a discussion would be a second intrusion.

Carol reported that there had been two or three times with this client, at the end of particularly painful sessions, that she had initiated hugs, where she "might have even patted" the client, and absolutely knew that it was helpful, and welcomed (See *The Leaving Process*).

Dee.

Analytically trained Dee, whose childhood lacked in nurturing touch, but who comfortably initiates touch and hugs within her circle of family and friends, described her default position as never initiating touch with clients during the actual session. Dee reported receiving two explicit verbal requests and one implicit request.

One of the explicit requests came from a long-term, older male client, who became visually impaired within the last few years. The client could get a limited sense of Dee's body language and "maybe a facial expression here and there" but was frustrated with his inability to read Dee's face. He asked to touch Dee's face. After processing this with the client, Dee assessed this as the client's "effort to try to make contact in a different way. . . . He really needed a chance to find

out how to make contact when he could no longer do it visually. He needed to have a sense of me, who I was." Although "it was a little awkward" because she does not use touch with clients in sessions. Dee decided that it was worth the experiment to see if it would be helpful for the client. The client lightly touched Dee's face with his hands. Afterwards, they processed what the experience had been like for the client. He said he was still frustrated because, "while he got a better sense of the structure of my face, he realized he still [missed] being able to see me, unlike a truly blind person who probably can use touch to form some sense [of connection]."

In another situation, Dee said no to a female client's explicit request for holding because of the client's erotic transference to Dee in prior years. They talked about the erotic transference as the infant part of the client wanting bodily contact for containment. Dee framed their relationship as the container for the client with their shared words and visual contact as their connections.

Dee experienced a physically implicit request for touch from a long-term client. The sobbing client unexpectedly got up off the couch, sat on the floor at Dee's feet and "sort of threw her body around" Dee's legs. Taken aback at first, Dee asked herself, "What do I do with this? . . . Then I decided this actually didn't feel terrible. She's sobbing . . . she was just feeling very, very alone and frightened by how much pain she was in." Dee assessed the client as a little girl overcome with grief. In opposition to her analytical training, she decided that not to provide supportive touch would feel too rejecting, so she put her hand on the client's shoulder. Dee, who had received little nurturing from her mother,

described her awareness of the client's family history of rejection and remembered thinking when it was happening, "I can't reject her. I'm not going to come up with some theory about why I can't touch her. This would be so rejecting."

After the client returned to the couch, they talked about the incident with the intent of understanding and clarifying the meaning of the "spontaneous gesture" for the client, "what she was feeling when she did that, what was her need."

Emma.

Emma described the most touch-deprived childhood, which left her unaccustomed to relating via touch and a therapy experience that reinforced her ambivalence regarding the comfort of touch. Emma stated that she "might interpret somebody's look as seeking connection, but [would never] think of it as [seeking] touch. . . . I just don't have [internal] tracks laid down on that part." Although Emma reported receiving no explicit requests for touch, she shared examples of an implicit request to which she did not respond and an inner urge on which she acted.

Emma described sensing, on a number of occasions, a dissociated client's unspoken urge to "just jump into my lap, almost as a kid . . . probably wanting to be contained or soothed." In describing the strength and nature of these requests, Emma described "a boundary-less experience where [she] literally [could feel the client] coming toward her." Emma questioned the appropriateness

of such behavior even for an actual child. Emma said she felt that the use of touch during those moments would be intrusive, thus she had made the decision not to touch. She reported thinking that she "might have attempted" to discuss these implicit requests with the client but thought that the client's dynamics and characteristics prevented these attempts from being successful.

Emma, who routinely uses planned touch to reorganize and refocus clients, described an instance when she spontaneously reached out and touched the hand of a sobbing, grieving client. Reflecting on the incident, Emma described feeling such a deep sense of attunement with the client that something shifted in her: "I . . . felt her." Emma talked about her awareness of how profound it was for this client "to let herself become conscious of this very painful thing . . . with me." Emma felt the touch communicated a sense of connection, "that I was there still, I was . . . bearing witness to the experience . . . with my presence, that I [understood] the significance of it by being there." Feeling the full presence of the client's grief, Emma reached out and put her hand over the client's knuckles. They never discussed this moment of touch.

Fran.

Fran described a happy childhood experience in which the safety, comfort, and caring of touch were taken for granted, within her "touchy-feely family" and in her extended community where it was a "cultural way of greeting and recognition."

Fran, whose theoretical orientation incorporates the use of touch, described a male client's implicit overtures for sexualized touch through the subtle use of voice tone and phraseology. She assessed his "flirty" overtures as coping mechanisms when feeling anxious and vulnerable, and interpreted his behaviors as questions about safety and boundaries in their therapy relationship. Fran believed addressing this issue while it was occurring would increase the client's anxiety. Instead she chose to provide reassurance through their dialogue when there was a strong sense of connection and the client was feeling calm. She described a discussion with the client during which he made a direct statement about how his ability to seduce women made his relationships unsafe. Fran choose this moment to respond to his implicit questions about safety and boundaries in their relationship by gently but directly stating: "you can rest assured that you will never [have sex with] me, okay? You're safe here. This is a different type of relationship." Thus, in moments when she would have offered supportive touch to many clients, she did not do so with this client because she knew that *not* touching provided him with a sense of safety.

Fran also described receiving a verbal request to "wrap her arms around" and hold a depressed female client with limited ego strengths and no viable social supports. Fran *heard* this request both explicitly and implicitly. She assessed the ambivalence the client felt toward being held and comforted. She experienced the request as containing the client's unresolved rage at the world and at herself, and as a desire to disappear into and *devour* Fran completely. Because of the intensity of the client's emotional state and the client's inability to

recover from regression, Fran believed that saying yes to the client's request was contraindicated. Instead, Fran offered to and did sit next to the client and held her hand as an attempt to provide a balanced therapeutic experience of comforting within safe boundaries.

The client continued to repeat the request over the course of approximately three sessions with increasingly intensified emotionality. At one point during the process, Fran offered to and did put her arm across the client's shoulders in an increased effort to reach a balance between comforting and boundaries. With each request, Fran attempted to process what was happening with the client; to validate the client's right to be angry at what she perceived to be Fran's rejection; to connect the current experience to past rejections and hurts; and to help the client stay with the process and work toward some understanding and resolution. However, the client replayed the same pattern that had occurred in other relationships and with several prior therapists by demanding a referral and ending therapy. Fran provided the referral and followed up to ensure the client's safety.

The Leaving Process

The leaving process is described as a unique time that occurs after the formal session when the participants and their clients are standing together at the door before the clients leave. Participants describe both themselves and their clients as behaving differently during this time. During the interview, four of the six participants, Ann, Betty, Carol, and Dee, spontaneously talked about requests

and urges that occurred during the leaving process. The researcher does not know about the other two participants because it was not a focus of the research questions.

While the four analytically-trained participants, Ann, Betty, Carol, and Dee said that clients rarely asked directly for touch or holding in session, they reported that explicit and implicit requests occurred more frequently during the leaving process. Ann reported that one of the two verbal requests for a hug received in her thirty plus years of experience had occurred as the client was departing. Betty and Carol both said they could talk about what occurred at the door much more easily because requests for touching and urges to touch happened more frequently when clients were at the door leaving. Dee pointed out that the researcher had left out the "whole issue of [clients] hugging you at the end of the session" which was "important" for the discussion of touch because "sometimes people will reach out to hug" when leaving.

The researcher observed that these participants spoke differently about their urges to touch and/or clients' requests for touch that occurred at the door during client departure. Some of the participants described a different process and/or behavioral response. For example, Ann's one-time experience of saying yes to a client's request for a hug without prior processing and discussion occurred as the client was departing a final session. This experience took place a few years after Ann's intensive in-session experience with touch.

Three of the four participants, Betty, Carol, and Dee described being less bound by their training and the *no touch* rule of classical analytic theory when at

the door with departing clients. Accepting hugs from or sharing hugs with clients at the end of session was not uncommon for Betty, Carol, and Dee, all of whom rarely hugged people other than family or intimate friends.

Betty and Carol, the two analytically trained participants who interpreted their internal urges to comfort clients during sessions as counter-transference and did not act on those urges, reported responding to their emotional urges to reach out to clients leaving difficult sessions. They also reported responding to implicit and explicit requests for touch at the door during departure. Betty and Carol described this *space and time frame* as differentiated in some way from pure *session* space and time. Betty, whose childhood required strict adherence to the rules, described the leaving process as having "a cultural piece" that indicates "something different is happening" which impacts the rules allowing a slightly more social connection to occur. Carol, whose touch-deprived childhood had given her an appreciation of a client's longing for the comfort and who had experienced being hugged at departure in her personal therapy as healing, said a "threshold is crossed" when the client is in the process of departing and at the door which gives tacit permission for her to be more responsive to implicit and explicit requests and/or the emotional tenor of the session. Both Betty and Carol described initiating supportive touch, such as a hand on a shoulder, and sharing mutual hugs with departing clients that grew out of the emotional tenor of the session. They felt their use of touch at the door conveyed a "sense of shared trust" and "respect" for the client's pain.

Case example: Betty.

Betty reported no instances of using touch during a session but shared examples of acting on her urge to touch and her reaching out to departing clients at the door. Whether the touch was planned or spontaneous, Betty's description related her action to her emotional attunement with the client during the session. For example, Betty described being very moved by a client's struggling with Aspergers syndrome, sharing about his pain and despair because he was "weird" socially. As they stood at the door, Betty asked herself about any concrete example of interacting socially that she might give him, ". . . and just give him something hopeful." Acting spontaneously, Betty said, "For example," and extended her hand for a handshake. To her surprise, the client shook her hand. This interaction allowed them to talk briefly about his having been taught this behavior by his deceased father with whom he had experienced a sense of real connection. Betty, who in her personal approach initiates physical contact only when she is certain of acceptance, said normally she would never initiate touch with persons with autism because of her awareness that touch is often discomfiting for them. While describing this situation, Betty found her own behavior interesting because she was willing to act on her urge and put her hand out to see what the client would do, while thinking, "he might ignore it;" instead "we connected."

During the interview process, Betty recalled a few situations of "being impelled" to "kind of reaching out to somebody as they're going out the door" after a "very moving session . . . I guess, to say I know how you feel. Sometimes

they respond, and sometimes they need to get away. Whatever their response is, I honor that . . . just pulling my hand back if they're not responding." Betty could not "remember exactly who or when" and did not think that she had "actually given into that kind of impulse [often] but there [had been] times." Betty described this as going against her usual pattern because usually the request for touch at departure, whether implicit or explicit, comes from the client.

Case example: Dee.

Another participant, Dee, whose childhood lacked nurturing, shared her lack of resolution with "that whole issue of people hugging you at the end of the session . . . sometimes people will reach to hug me, and it's not always felt comfortable, and with other people it's fine." Dee never initiates touch with departing clients, but responds to their implicit and explicit requests for shared hugs at departure. She described initially saying to herself, "what's going on here?" but after assessing clients' motivations she is more comfortable responding in the moment.

Emotional Tenor of the Session

Emotional tenor played a significant role in causing a break in the participants' established approach to touch. The researcher is defining the emotional tenor of the session as an intensity of client affect that seemed to have a profound impact on the participant. All participants described incidents in which

they had broken their usual manner of dealing with touch with clients due to the emotional tenor of the session.

Participants did not always state what they had been feeling, but it was clear to the researcher from their descriptive words, body language, and voice tones that the experienced emotion was of such intensity that it overrode their theoretical stance. Five participants, Ann, Betty, Carol, Dee, and Emma, whose standard mode was never to touch or to initiate spontaneous touch, were moved by the emotional tenor of the session to touch clients with whom they had long standing relationships. The sixth participant, Fran, who "typically" hugged clients, was moved by the emotional tenor of the session to say no to a client's verbal request to be held.

Three participants, Betty, Carol, and Emma, who described their use of touch as completely spontaneous acts, did not remember these incidents until they were engaged in the interview process. They each described feeling a deep sense of resonance with the emotional intensity of the client's pain. Betty had felt "impelled" to reach out with "just a slight touch on the shoulder." Carol sat next to and put her hand on the shoulder of a sobbing client who "felt so fragile . . . like a little bird." Emma reached out and put her hand over the client's hand when feeling the full presence of the client's grief.

Two participants, Ann and Dee, who never touch clients in session, were confronted with completely unpredictable, emotionally intense situations, requiring in-the-moment responses. In these two instances, there was a quick *freeze* and decision-making process to touch the client. Dee was "taken aback"

when a grieving client unexpectedly moved from the couch and "threw her body" around Dee's legs. Asking herself "what do I do with this?" she decided that the client was like a very bereft child, frightened and overwhelmed by pain; that theoretical intellectualizing with the client about why she could not touch would be too rejecting; and she put her hands on the client's shoulders.

The unpredictable moment faced by Ann came when a client started banging her head on the coffee table. The intensity of the moment influenced Ann in two ways. First, Ann used touch because she feared that the client "was going to hurt herself so badly that [it was] going to be irremediable." As she physically intervened she "was thinking of the misery and the pain" that drove the client to do this. Secondly, the incident caused Ann to reconsider her prior denial of the client's request for holding. She said:

> And I'm thinking at the same time, oh my God, I wonder if this is to get the touch, and she knows I'll come. And I'm thinking, okay, you better think hard about this, because if she's willing to do something like that, and this has something to do with [her need for] touch [which I didn't give].

The sixth participant, Fran, whose theoretical orientation includes the belief that holding provides healing in cases of severe developmental deprivation, uncharacteristically said no to a depressed and socially-isolated client's verbal requests to be held. The emotionality behind the requests intensified as the client continued to repeat the request over the course of two or three sessions. The participant said she had a concern about the client's ability to reconstitute from the regression that holding often precipitates. Therefore, she decided not to meet the client's full request, but rather to provide a less intimate form of touch, by sitting next to her and then by holding her hand. But as Fran talked to the

researcher, she described her intense inner discomfort, resulting from her resonance with the client's excessive neediness, which caused her to say no. In describing this she said, "I just felt uncomfortable. . . . And I mean, I can hug anybody and touch anybody. But there was this inner thing in me . . . about *what* that neediness felt like that was emanating from her." When attempting to express to the researcher what this had felt like, the participant's body cringed, as she described a sense that the client wanted to devour her, "it felt like she wanted to crawl inside of me . . . to get inside of me."

Reflections and Realizations

The researcher's study of the process and content of the interview data revealed that the participants' reflections during the interviews led to new realizations. Five of the participants, Betty, Carol, Dee, Emma, and Fran, indicated that they gained new insights during the interviews as a result of talking about their experiences related to touch. They went through a self-questioning process of making connections, remembering forgotten incidents, revealing internal contradictions, and coming to new realizations about themselves and their clients. There was a recurrent use of some form of the phrase "that's really interesting" as the participants gave new thought to situations related to touch. In addition, participants repeatedly used phrases such as, "now as we talk about it and I think about it more," "I'm realizing as I'm saying this," "thinking about it now, and not necessarily thinking about it then."

The interview process enabled the participants to make connections in three major areas that they had not made before. Connections between their childhoods and their clinical approach to touch are illustrated by the following comments: ""I'm sure that comes from my, my background. . . . So, I think probably in this incredibly intimate setting that's what gets invoked, right? It's all that old stuff." Connections between their therapeutic experiences and how they manage the issue of touch are illustrated by this comment: "Maybe that's some aspect of it, too, a comfort level based on my own therapy experiences." Connections between their personal approaches to touch and their interactions with clients are illustrated by these comments: "I probably am a bit reserved, and I probably don't generate [clients' explicitly requesting touch]. I'm certainly not provoking it with people—I don't—just even verbally or nonverbally, I don't think I generate that personally."

All five participants experienced clinical insights related to their use or nonuse of touch. Participants raised and explored questions for themselves: "I really have to think about that," "I'm not sure," or "Let me see if this is true. I've never thought about this." Dee looked at the differing reasons various clients have for their implicit and explicit requests for hugs when departing and her own process in deciding how to respond. In exploring when and why she sometimes shares hugs with some clients at departure, Carol realized that it was her sense of mutual trust that gave her permission to do so. At the same time, she realized that her sharing a mutual *hug* was her way of showing her very "deep respect and appreciation for how painful and hard it is to share personal sadness and

experience with another human being." Fran recognized that a deeper level of a maternal transference and reenactment had occurred than she had previously realized. Emma realized that in addition to her stated theoretical orientations, she was also strongly influenced by her awareness of "the complexity [and unpredictability] of body/mind stuff." Reflecting upon discussing clients' requests for touch, another participant realized that she did not process the mutual hugs shared upon departure because it felt like it would "intellectualize an emotional experience" and destroy the healing aspects of the experience.

Psychological and behavioral contradictions were revealed. Participants who felt sure that their feelings about touching were resolved or were aware of their use of touch sometimes surprised themselves. For instance, during most of the interview, Carol described herself as "very naturally" hugging some departing clients and having "no problem with it afterwards." However, an internal contradiction was revealed at the end of the interview, when she realized that there are still times when she feels like she is "breaking the rules." Three participants, Betty, Carol, and Emma, who previously felt sure that they were completely aware of their use of touch, surprised themselves when they remembered incidences of initiating touch. For example, during the interview, Betty remembered acting on impulse and reaching out to touch clients as they were going out the door after a painful session; Carol initially stated emphatically that she simply would never rise from her seat, walk over, sit next to a client and provide supportive or comforting touch during a session, yet, as the interview

progressed she remembered an incident where this had occurred; and Emma remembered that she had reached out and held more than one client's hand.

The following two quotes from Betty and Emma highlight the participants' process, which was initiated by talking about touch in the interview. They begin by vaguely remembering something and then struggle to remember the previously forgotten incidents of touch:

> ". . . when you mention a, you know, tap on the shoulder, tap on the arm, if it's been a very moving session with somebody and I know they are leaving still feeling very pained, I—I, I can't remember exactly who or when, but I sort of have a slight image in my head, you know, kind of reaching out to somebody as they're going out the door and just pulling my hand back if they're not responding. Just, you know, not—trying not to be—kind of trying to say, being impelled, I guess, to say I know how you feel. I know it's hard—with just a slight touch on the shoulder in an unusually difficult situation—I'm not talking about everyday thing—and then, just pulling back. Sometimes they respond, and sometimes they need to get away. Whatever their response is, I honor that. But, um, yeah, I—I can't think of too many times really where I have actually given into that kind of impulse. But there are times."

> "So, um, I'm actually just thinking for a second. I did have a client, a woman, in my practice, and I think I may have touched her. Um, I'm just trying to think. I-I've-I, actually now that I'm talking about it, I'm trying to remember the client. I think I have used touch sometimes when I'm, um, *I can remember* using touch one time with a client. . ."

All participants reported that because touch is not talked about, they lack opportunities to explore and process incidents like these and found the interview experience rewarding. Betty's comments summed up the participants' attitude, "It's so interesting how all of these things play into this issue, 'cause they really do. I mean [our talking made me] much more aware of my MO, actually, in terms of how I operate. That's so fascinating."

CHAPTER 5: DISCUSSION

Introduction

The intent of this research project was to gain an understanding of what influences a therapist to touch or not touch a client when the need to make this decision arises. A client may ask, verbally or non-verbally, for a hug or the emotional tone of the session may be particularly intense or the therapist may experience a deep sense of attunement with a client. Any of these circumstances might move the therapist to want to offer a supportive touch or embrace. This study used Smith's (1998b) definition of touch as "an expression of the therapeutic relationship" (p. 39), which includes but is not limited to the therapist putting an arm around the client's shoulder for comfort or holding the client when he/she is distraught or grieving, hugging the client, placing a hand on the client's shoulder, or holding a client's hand.

A qualitative approach allowed research participants to describe and reflect upon their lived experiences within this process. Participants were asked to consider: What was their experience? What was its meaning for them? Did they integrate the experience into their professional reality, and if so, in what ways? Some of the most interesting aspects of the research were the additional questions, reflections and realizations, which arose from the participants' thoughtful consideration of the original questions during the interview process.

This research is a result of the researcher's professional quest to more fully understand participants' thinking regarding the use and the nonuse of touch

as clinical interventions. Growing up in a small Southern town where warmth and caring were expressed through touch and hugs left the researcher with an unconscious and deeply internalized assumption that nonsexual physical touch was as comfortable for others as it was for her. MSW training in the late seventies emphasized the psychosocial approach of Florence Hollis and Mary Woods combined with the humanistic psychology of Carl Rogers. The researcher's early training and supervision provided the standard admonition against having sex with clients, but little other discussion regarding touch. Thus, unconscious preconditioned assumptions remained unaltered.

As a new therapist, the researcher had little awareness of the power and impact of touch and too few questions. Due to a lack of awareness of her bias, the researcher's use of touch lacked conscious thoughtful consideration of each client's dynamics. With clinical experience, she learned that touch can have many different meanings for clients and can trigger a variety of reactions in them. As she became conscious of the multiple influences on her decisions to touch or not to touch a client, her questions surrounding these decisions increased, and she became more curious about influences on other therapists' decision-making process.

According to Strauss & Corbin (1990) it is through systematically studying and validating the relationships of each category to other categories that "one's own and others' assumptions about phenomena are questioned or explored, leading to new discoveries" (p. 62). As the research participants talked about and reflected upon their experiences, the interactive dialogue carried the participants

and the researcher into both expected and unexpected territories. This chapter will first discuss the major findings drawn from the research data in relation to the original research question, to prior research, and to assumptions with which the researcher began this research. There is a kind of circular flow to the interrelatedness of the findings. This is followed by an overall conclusion regarding the phenomena studied. Finally, limitations of the study are addressed and recommendations for further research are discussed.

Findings

Overall Attitude

The researcher discovered a multi-layered complexity in the participants' way of thinking about touch, which was not apparent when the participants initially stated their approaches to touch. One way to consider this is in terms of the participants' *overall attitude* toward touch. The researcher believes that overall attitude is shaped over time by a confluence of many factors, including but not limited to the factors in this study: self-perception of nurturing in childhood, personal therapy, professional training and the way in which the participants assimilated their training, the participants' socialization into their professional field, described theoretical orientation, past experiences with clients, life and professional stages, and life experiences. Participants' current life situation other than their personal approach to touch was not explored in depth. The multi-layered and dynamic complexity of overall attitude is evidenced in the

changes in behavior that often occurred during the leaving process and in participants' responses to the emotional tenor of the session.

The researcher was surprised to find that risk management in today's litigious society was not a greater influence in the participants' overall attitude and decisions to touch or not to touch. While all participants expressed a clear awareness of the risk management aspects of using touch, this awareness was not discussed as a factor in their in-the-moment decision-making process. The researcher surmises that this is related to the participants' professional and personal life stages and years of experience. The relationship between risk management as an influencing factor and therapists' life stages would be an interesting area for further research.

Even the Therapists Who Do Not Touch - Touched

Regardless of theoretical orientation or training, all six participants described incidents in which they had touched clients. With two exceptions, participants assessed their actions during these incidents as clinically effective. Five of the participants held theoretical beliefs that providing supportive touch to clients during sessions potentially interferes with the therapeutic process. However, one of these five, Emma, occasionally utilizes touch as an intervention to "ground" and/or refocus disorganized clients. The sixth participant, Fran, was the only participant whose humanistic orientation integrates the therapeutic use of touch into the therapist-client relationship. Fran's use of touch is consistent with previous research (Milakovich, 1992; Moy, 1980; Pope et al., 1987; Stenzel,

2002), which found that humanistic therapists used touch significantly more than psychodynamic therapists.

The finding that these five participants did touch seemed especially significant to the researcher because they self-described as being reserved in relation to social touch, in addition to holding therapeutic orientations that prohibit the use of supportive touch. The number of the incidents varied between individual participants, ranging from extremely rare for Ann to "not uncommon" for Carol (see the section on Overriding Circumstances below). The circumstances also varied for each participant. Two incidents involved unpredictable, emotionally intense situations, requiring in-the-moment decisions and responses. Three participants acted completely spontaneously in response to the emotional intensity of a client's pain. Two incidents were thoughtful, creative solutions to clinical dilemmas. In the researcher's opinion, some incidents were *allowed* by the participants during the leaving process (see The Leaving Process below). Although some incidents were initiated by the participant, most occurred in response to a client's explicit or implicit request. In the researcher's opinion, the participants were always cognizant and respectful of the client's reaction, even when acting spontaneously.

While it was clear to the researcher that the participants' motivations for using touch were within ethical boundaries and were for the clients' benefit, the use of touch with clients always involves elements of potential legal and clinical risk. How is it that the participants allowed themselves to act in what they believe to be the clients' best interests, setting aside these inherent risks and the rules of

their training? The researcher believes participants' motivations for using touch to be more complex and multilayered than previous research has indicated.

It seems to the researcher that the participants were influenced by multiple factors. In the broadest sense, the participants' individual personal approaches to touch seem to shape the participants' relationships with the classic touch prohibition rules of therapy. For example, Ann, who very rarely engages in physical touch socially, held the strongest view against touching clients. Whereas Betty, Carol, and Dee, while physically reserved, freely engage in hugs with close friends. These three participants also allow supportive touch to occur during the leaving process (see The Leaving Process below). Professional and personal life-stage seems to be a factor in shaping the context for the participants' decision-making, as pointed out by Ruderman (2002). At this stage in their professional and personal lives, the participants seemed to have a sense of confidence and competence that allows them autonomy and flexibility in their decision-making and trust in their intuition, which is consistent with prior research (Dworsky, 2001; Strozier et al., 2003; Taylor, 2002). More specifically, with one exception, the participants had an established and ongoing relationship with the clients.

In the researcher's opinion, the circumstances that precipitated these incidents, while varied, resulted in a convergence of these multiple factors with a particular client at a particular time. This convergence allowed the participant's freedom to be deeply connected and attuned with that client. This attunement then allowed the participants to sense beyond the cognitive, and their experience

allowed them to act, setting aside the rules and entering the *gray area* of using touch.

Perhaps the most important discovery was that all six participants reported facing decision-making moments regarding touch. It seems to the researcher that each decision, regardless of the outcome, was accompanied by another decision, which was whether to discuss and/or how to discuss with clients what occurred or did not occur in these moments. The participants arrived at their decisions in isolation and lacking an arena that encouraged dialogue on this issue. The participants, with one exception, never processed their experiences. Some of the participants had forgotten incidents of touching until the interview process, which was their first opportunity for reflection. The reflections and realizations experienced by the participants while talking with the researcher emphasized the effectiveness and the need for this type of forum within the clinical community.

Overriding Circumstances

The researcher found two circumstances that could override the participants' stated approach to touch: The Leaving Process and The Emotional Tenor of the Session. The leaving process refers to that unique time after the formal session is over and before the clients actually depart. One aspect of the leaving process was socio-cultural, a simple acceptance that some people say good-bye with a hug. The second aspect of the leaving process was associated with the emotional tone of the session. Emotional tenor of the session is defined

as an intensity of client affect having an impact so profound that it overrides the participant's stated attitude toward touching.

The Leaving Process

This theme emerged from the interview process itself. The four analytically trained participants described themselves as exhibiting behavior during what the researcher is calling *the leaving process* that was at variance with their stated theoretical approach. Three of these participants, Betty, Carol, and Dee, made a clear distinction between the formal session and the leaving process. Although the fourth participant, Ann, did not say she made the same distinction, one of only two times that she agreed to a client's request for a hug had been during the leaving process.

Of the three who make a distinction between the formal session and the leaving process, one participant, Dee, only responds to implicit or explicit requests for hugs from clients. Two, Betty and Carol, respond to implicit and explicit requests, share mutual hugs, and may also initiate supportive touch – including hugs – during the leaving process. Betty and Carol described mutual hugs and touch or hugs initiated by them as emanating from the emotional tenor of the session. It is interesting to note that Carol described experiencing hugs received from her therapists during the leaving process as healing, which influenced her attitude toward the use of touch.

In the researcher's opinion, differentiating the formal session from the leaving process allows these participants to feel less restricted by the prohibition

against touch. There may also be a *socio-cultural* aspect to the differentiation because good-bye embraces, within boundaries, are an accepted part of the leaving process for some people, especially after a time of emotional sharing. Smith's (1998b) taxonomy of touch in psychotherapy calls this "socially stereotyped touch" (p. 39), putting it in the same category as handshakes. This view permits the participants to allow the client's normative behavior, rather than risk rejecting or shaming the client. It permits all three participants to respond positively to their assessed need for a sense of connection or closure in clients' requests for hugs when leaving after difficult sessions. It provides tacit permission to respond to the emotional tenor of the session or to act on interpersonal intrapsychic urges to comfort clients, which participants experienced during the formal session.

None of the participants reported discussing the supportive touch that occurred during the leaving process with the clients. Initially, the researcher thought this appeared to be in conflict with the participants' described theoretical approach of verbally processing any touch, or request for touch, which might occur during a formal session. However, as the researcher discovered the distinction between the formal session and the leaving process, it became evident that the participants also apply different rules regarding the need to discuss touch during the leaving process. Discussing an appropriate comfortable *cultural* hug initiated by the client or processing the supportive touch and shared hugs that seemed to develop organically from the emotional tone of the session seems clinically inappropriate to the participants.

Somewhat like a decompression chamber, the leaving process is conceptualized as an in-between space with a concomitant variance in the therapist's role and in some rules that allow supportive touch to occur after a difficult session and before returning to the outside world. It is as if in moving from their seated positions, participant and client step across a threshold, leaving behind the formal session and its rules. Crossing this threshold, they enter and together traverse this in-between passage from the intensity of their shared connection or attunement to separation and the client's departure.

It was surprising to the researcher that the participants made this distinction between what they considered the formal session, where the analytic prohibition against touch applied, and the leaving process, where the prohibition against touch could be set aside in the best interest of the client. In the researcher's opinion, distinguishing between the formal session and the leaving process serves to reduce the cognitive dissonance between the participants' analytical ego-ideal of *not touching* and their relational ideal of providing the healing comfort of *touching*. Although their decisions about using touch were in a distinctive boundaried time and space, the interviews revealed that some conflict still existed for the participants. For example, Carol shared that she sometimes feels like she is "breaking the rules," even though she consciously believes that the use of touch during the leaving process can be healing.

It appeared to the researcher that the participants had not discussed the issue of touch during the leaving process with colleagues, leaving them isolated in their decision-making and with any conflicts they felt. The researcher wonders

what learning opportunities might be offered by an open, nonjudgmental dialogue with their colleagues about touch and the leaving process.

Emotional Tenor of the Session

All six participants described situations in which they had deviated from their stated theoretical approach to using touch with clients due to the emotional tenor of the session. Three participants, Ann, Dee, and Fran, described being confronted with situations requiring a conscious decision about touching a particular client, as in the incident when Ann's client was banging her head and was in danger of injuring herself. Three participants, Betty, Carol, and Emma, recalled previously forgotten incidents of using touch so spontaneously with deeply grieving clients that they were unaware of having broken their patterns until after they had acted. The researcher noted that, with one exception, each participant's action remained consistent with her *overall attitude* toward touch even when she deviated from her stated theoretical approach. In the one instance when the participant acted against her *overall attitude,* she experienced her action as ego dystonic.

While the circumstances that precipitated these situations varied, in the researcher's opinion, the following elements were present in each situation: The event emanated from a deep sense of connection and attunement between the participant and the client, the participant's action involved risk-taking, and the participant's action demonstrated an ability to be open to interpersonal intrapsychic sensations and a *confidence* in acting on these sensations. The

researcher believes that the combination of these elements impacts the participant's *overall attitude* allowing her to override the rules of her theoretical orientation. It seems to the researcher that, whether consciously or spontaneously, entering this gray area between their theoretical and relational ideals involving legal risks, revealed that *who* the participants are as empathic individuals and clinicians became more important than theoretical orientation.

The researcher would suggest that the participants were at a place in their personal and/or professional life stage at which their experience provided the confidence to take risks – to do something outside of the bounds of their theoretical training. Perhaps their experience has provided a level of flexibility in their decision-making, allowing them to inhibit themselves less and to be more attuned to their unconscious intuition. The researcher cites, as an example, Carol's making a decision that goes against the analytic frame of her training and reshaping, within boundaries, the therapy rules of the leaving process to allow for physical responsiveness to the emotional tenor of the session.

With two exceptions, participants assessed their actions during these incidents as clinically effective. Although their experiences cannot be broadly applied as a general rule, the fact that the participants considered these instances worthy of inclusion in the interview process is significant. That they assess these incidents as clinically effective makes them worthy of discussion and further enhances the importance of open dialogue and sharing of information.

It was interesting to the researcher that the three participants who had not remembered their spontaneous instances of touching were also the three who had not processed these instances with their clients or with colleagues. Perhaps there was no opportunity for processing or they may have been hesitant lest they be censored. For this reason, creating an atmosphere that fosters on-going discussion of individual cases and situations is necessary. It is through this process that theory evolves and mental health practitioners become more effective.

The finding that all the participants touched was important because it demonstrates the high probability that therapists, whether they plan to touch or not, will be faced with decision-making moments regarding touch. Open dialogue about touch can prepare therapists to use themselves spontaneously as appropriate or if their spontaneous touch was imperfect they could be more prepared for processing the incident.

Two Participants With Self-Perceptions of Happy, Nurturing Childhoods

In analyzing the data, the researcher found that the two participants, Ann and Fran, who reported childhoods of readily available nurturing safe touch, were very similar to each other and different from the other four in the following ways: they demonstrated a wider range in their ability for conscious use of *self* in relation to touch; they were significantly more at ease and dynamic in the way they worked with clients in relation to touch; and they were without ambivalence regarding touch. Finding this parallel pattern in Ann and Fran's data was

especially interesting for the researcher because this similar parallel did not exist in their professional approach to touch. Ann had the strongest orientation against the use of touch, while Fran's orientation incorporated the use of therapeutic touch. Therefore, the difference between Ann and Fran and the other four participants does not seem to be related to their training and theoretical orientation.

The researcher surmises that Ann and Fran have internalized their childhood experiences of touching. Both participants experienced touch as nurturing, safe, readily available and clearly boundaried, fostering an internal attitude regarding touch that was without ambivalence. Thus, as children, Ann and Fran were free to use themselves in active, self-motivated ways in relation to touch. However, in the researcher's opinion, there was an important variant in Ann's and Fran's childhood experience that explains their differing approaches to the use of touch with clients. In Ann's childhood experience, physical touch, especially hugs, was an expression of familial closeness and was rarely used with those outside the family circle. In Fran's childhood experience, physical touch, including hugs, incorporated her extended community where it was a recognized "cultural way of greeting and acknowledgment." These childhood patterns, including boundaries, are mirrored in their personal and professional adult lives. Ann's choice of analytical training, with its emphasis on professional neutrality and prohibition against touch, is entirely consistent with her history and personal approach to touch. Ann engages in hugs with approximately five per cent of her very close friends and does not engage in touch with clients. Fran

was actively drawn to the humanistic and relational approaches to therapy when studying for her MSW. She viewed "traditional analytical models" as antithetical to the socio-cultural experience of her childhood. Fran is "touchy, feely" with the capacity to initiate and share hugs with almost anyone within her community and integrates therapeutic touch in her clinical practice.

Perhaps these two participants' early experiences with secure, nurturing attachments facilitated an internalized comfort for trusting, questioning, and acting on inner sensations, as well as a strong ability for managing ambivalence. Ann and Fran internalized a comfortable boundaried relationship with touch, each according to her family pattern. This internalization influenced their very different theoretical choices and provided them with an almost innate flexibility to work with touch in ways that differed from the other four participants. The researcher considered the following five differences important: Ann and Fran were freer to and did explore the meaning of touch with and for clients more frequently; they displayed an openness to reflecting on their own intrapsychic sensations regarding touch and utilizing these in the service of the client; they could question themselves and tolerate their own and their clients' feelings of ambivalence about touch; and they used themselves physically, adjusting their physical proximity to a client in response to the assessed need or tolerance for emotional closeness and/or distance. The researcher's ideas are supported by attachment theory and research, which discusses and documents the impact of early environment in shaping adult patterns (Schore, 1994, 2003; Siegel, 1999; Stern, 1998).

On the basis of this research, no direct associations were made between the early childhood experiences of the other four participants and their approach to the use of touch. While the other four participants created some flexibility related to touch, they tended to view touch in more theory-bound terms of the classic prohibition against touch. They viewed initiating any discussion of touch as intrusive. The researcher wonders if this could be related to some internalized ambivalence about touch stemming from these participants' childhood experiences in which nurturing touch was available on a limited basis or not at all. This would be an interesting area for future research.

The finding detailed above is of particular interest to the researcher because it suggests early childhood experience as an important factor in influencing these participants' overall attitudes toward touch, including comfort level with a particular theoretical orientation. It further suggests an internalized sense of boundaries and flexibility that underlies their clinical work and goes beyond their different theoretical orientations toward touching or not touching.

If childhood experience is a factor which impacts therapists' overall attitude toward touch, then it seems important to acknowledge that not all mental health professionals experience secure childhoods of nurturing, safe touch. Therefore consideration needs to be given to understanding the ways in which childhood experience, as well as other factors, increases or constricts flexibility in using oneself in relation to touch. Safe nonjudgmental dialogue within the therapeutic community, such as within consultation groups, could facilitate self-awareness and flexibility and comfort levels in relation to touch.

Two Participants Impacted by Personal Therapy

The researcher had expected participants' personal therapy experience to be cited as an influencing factor and was surprised that only two participants, Carol and Emma, did so. This may be a result of the specific nature of the research questions rather than a statement about the overall impact of therapy for the other four participants. In the researcher's opinion, it is significant that these were the two participants with the most emotionally and touch-deprived childhoods. Carol's experience moved her to be more comfortable in her use of supportive touch, while Emma's experience moved her away from using supportive touch with clients.

Carol had experienced her therapists' hugs at departure as healing. She and her therapists never discussed her response to these moments. Emma was disappointed by the supportive touch she requested and received from her therapist and talked about this disappointment with her therapist. In both cases, these experiences influenced the participants' overall attitude toward touch and the way in which they conduct themselves with their clients. In Carol's case, it is a factor in overriding her analytical training.

This researcher sees Carol's personal therapy experience reflected in her integration of the use of touch during the leaving process into her practice. Carol, like her personal therapists, does not discuss these moments of touch, thinking that doing so would move the experience from the emotional to the intellectual sphere. The researcher wonders if Carol might have a different attitude about the benefit of discussion of touch had she been encouraged to comfortably process

and explore the healing impact of her therapists' hugs. Would she see clinical advantages to connecting the organic and the intellectual? Would they have moved into a deeper understanding of the de-shaming nature of the touch, of the impact of the touch deprivation in childhood, and of the human necessity of touch? Is it possible that Carol would more actively and more comfortably help her clients explore the meaning of her moments of touch and their needs and/or ambivalence related to touch?

Although Emma uses a light touch on the hand as a planned intervention to help clients refocus and avoid disintegration, her experience in personal therapy strengthened her training against the use of supportive touch. It was the researcher's impression that Emma hoped the supportive touch and holding provided by her therapist would fill the void left from her childhood; that, rather than helping to provide a safe space to grieve an irretrievable loss, these hugs would replace the hugs she did not receive as a child. Her unmet expectation left her more than disappointed; it left her "heartbroken." The researcher wonders if Emma's discussion of her feelings with her therapist allowed Emma to experience and process the full range and depth of her emotions in the grieving process, i.e., her anger as well as her sadness. Perhaps their discussion focused too much on the environmental failures of the past and not enough on the in-the-moment failure of the therapist's holding to provide Emma with the *cure* for which she yearned. Could a different level of dialogue and exploration have provided a different attitude toward the use of touch?

Prior to the interview process neither participant, to the researcher's knowledge, had reflected on the impact of her personal therapy on her own clinical work, with respect to the issue of touch. From the researcher's point of view, their two examples illustrate the potential of therapeutic touch for both healing and pain or distress. Carol's experience is consistent with prior research (Milakovich, 1992), which found that those participants whose personal therapy had included touching experiences were significantly more likely to use touch than those participants whose personal therapy had not. Emma's experience demonstrates that touch, regardless of how well meaning, can result in painful wounding for clients.

Perhaps, more importantly, they illustrate the value of open in-depth discussion of touch. The benefit that the participants and others could gain from such discussion is lost without opportunity for open dialogue.

Conclusions

A Change in Focus

The researcher began this project with the anticipation of a theory emerging from research data. However, data analysis showed no direct correlation between any one factor considered in this research and the participants' decisions regarding touch. Analysis of the data revealed a serendipitous product of the interview process itself and demonstrated what can happen when there is open, nonjudgmental dialogue about the issue of touch. This dialogue facilitated unanticipated reflections and realizations for the

participants and the research process engendered reflections, realizations, and unanticipated changes in the researcher's thinking as well. The researcher discovered that participants' decision-making process was much more complex and multifaceted than previous research had indicated. This recognition reshaped and broadened the researcher's thinking and focus. The question of individual factors that may influence decisions to touch or not to touch became less important than the significance of understanding the complexity of the conscious and unconscious influences that shaped the participants' decisions and the need for dialogue on this subject. Within the clinical community there are not only questions and decisions to be made about touch, there is a wealth of unexplored experience and knowledge. Understanding the complexity of these decisions and sharing the benefit of this experience requires open discussion among professionals and between therapists and clients in sessions.

Overall Attitude

Regardless of whether or not participants used touch, it became clear to the researcher that participants had a way of thinking about touch, which this researcher called *overall attitude* toward touch. This *overall attitude* comprises a multilayered, intricate integration of the participants' personal and professional histories, life-stages, their current life situations, and the current socio-political climate. The interplay of these multiple facets at any given time is what determines levels and areas of flexibility in the overall attitude. For example, a finding in this research suggested early childhood experience as an important

influencing factor in the internalized sense of boundaries and the comfort level and flexibility in the area of touch that underlie therapists' clinical decisions. This finding further suggested that early childhood experience may be more influential than theory. Personal therapy experience played a major role in shaping two participants' decisions about use of touch with clients. In the researcher's opinion, a level of confidence gained from the participants' personal and professional life-stage experiences provided a significant context for all participants in their decision-making. It seems to the researcher that it is a given that all therapists have an overall attitude, which includes some degree of predisposition about touching.

Participants' overall attitudes determined how and in what ways the participants were open to or prevented from responding to the emotional tenor of the session, and it influenced how reflective they were in the moment. Firmly entrenched predisposed attitudes can result in acting and reacting without thought. Thus, when an inner sensation is experienced, the predisposed attitude defines how this sensation is interpreted and whether or not the therapist explores its meaning in terms of the client-therapist dynamic. However, a predisposed attitude may be overridden by one or more facets, such as professional and personal life-stage experiences and relationship with a particular client. Based on this research, this appears to be especially true when these facets are combined with the emotional tone of the moment or session. The manner in which participants worked with and processed their overall

attitudes toward the use of touch, within themselves and with their clients, shaped their decisions regarding their use of supportive touch.

Ann's and Dee's decision-making and reactions when confronted with intense, unpredictable, improvisational moments in response to the emotional tenor of the session illustrate the researcher's points about overall attitude. It seems to the researcher that the deep attunement of these moments, and the confidence and flexibility in decision-making gained from the participants' personal and professional life stages combined with their knowledge of the particular client to create a synergy that overrode their predisposed attitudes against using touch.

Open dialogue is crucial for increasing self-awareness of predisposed attitudes toward touch and open dialogue increases therapists' ability to be more comfortable, reflective, and flexible in using themselves professionally.

Now Moments

With two exceptions, participants' use of touch in response to the emotional tenor of the session facilitated and deepened their work with clients. In the researcher's opinion, the participants' responses during their unpredictable, improvisational moments seem consistent with Stern's (1998) "unpremeditated now moments." Stern believes that it is during these moments of improvisation when communication is through the domain of the senses that the most therapeutic change occurs. Conclusions from infant, trauma, and neuropsychobiology research support the idea that the use of therapeutic touch

has implications as a healing intervention that can go beyond that of a verbal intervention (Geib, 1998; Harper & Steadman, 2003; Hughes, 1997; Lawry, 1998; Schore, 1994, 2003; Siegel, 1999; Solomon & Siegel, 2003).

During these unpredictable, improvisational moments of synergy, participants, as empathic individuals and clinicians, took the risk of reaching out and touching in the best interest of their clients. The participants' risk-taking held the probability of healing for their clients, according to the above theorists. Most participants were unaware of this research which validated their view that their use of touch had been healing because they had not had an opportunity to talk about it before the interview.

Although the profession of psychotherapy is based on talk, perhaps there are times when touch, as well as talk is needed. In fact, there may be times when touching or holding is more effective than talking. Without knowing the meaning of touch for the client, how are therapists to discern these differences? This can only be accomplished though dialogue with the client about touch. In a few incidents, the participants helped the clients process their needs and feelings, especially of ambivalence, about touching, but most incidents were never discussed. The researcher wonders: Were chances for enhanced transformation missed by not using the incidents to open a dialogue about touch? Would processing what occurred during an incident interfere with the healing of the organically attuned *now moment*? How do therapists assess the impact of touching and of not touching without talking about touch with the client? How do

therapists learn to talk with clients about touch when there is so little dialogue about touch in the clinical community?

Need for Dialogue

The fact that the open, nonjudgmental dialogue of the interview process functioned as a change agent for both the participants and the researcher poses a convincing argument that this forum has real value for therapists. Prior to the interview process, the participants simply had not given much thought to touch or to their actions and reactions relating to touch with their clients. It was through the dialogue fostered by the interview that they began to access their unconscious. The lack of a forum for open discussion within their clinical communities seemed to be the primary reason for this, rather than feelings of shame and guilt related to the taboo against touch, as the researcher might have thought. Although there is a growing body of literature that discusses the consideration of supportive touch as a therapeutic intervention, only one participant had discussed a touching incident with her consultation group. Unless there is concerted effort in their larger clinical communities to focus attention on the issue of touch, therapists just do not tend to think and talk about this issue.

The researcher wonders if the prohibition against touch has been so deeply and powerfully internalized into the clinical community that dialogue is often stopped before it begins. Sometimes the message may be very direct, "don't talk about touching or you will be negatively judged" as a well-meaning colleague warned Graeme Galton as he began work on his 2006 book on touch

in psychotherapy., The researcher thinks that this message of negative judgment is more frequently embedded in tonality, wording, and nonresponsiveness, or in the nonverbal language of raised eyebrows and shocked expressions when a therapist introduces the subject of touching clients.

The issue of open, nonjudgmental dialogue gained increased significance for the researcher as she realized the complex nature of the overall attitude, which she believes influences decision-making related to touch. Open discussion within the clinical community offers the opportunity for understanding predisposed attitudes and reflecting on the ways in which they influence decision-making, for reflecting on the clinical impact of not touching as well as touching, and for increasing our ability to be more reflective on our inner sensations. Therapists need to learn how to talk about touch with their peers so they can talk about it with clients, trainees, and interns. It is not about whether a therapist decides to touch or not to touch, but about working more effectively in the area of touch with clients. Open, nonjudgmental dialogue allows reflection, which can bring new perspectives and realizations that may reshape, change, and enrich attitudes. As one participant expressed to the researcher, it was "fascinating" to talk about her experiences because in doing so, she had become much more aware of how and why she made her choices regarding touch. This would not have happened without the active intervention of the research process.

Summary

This research generated five important findings which can be used to build a theory that would aid therapists in their decision-making process about the use of touch. The researcher discovered that the participants' decision-making process regarding touch was shaped by their overall attitude toward touch, rather than any direct one-to-one correlation between a specific factor and the decision to touch or not. In addition to participants' overall attitude, decisions about touching were influenced by the nature of their relationship and history with the particular client and the specific set of circumstances. A significant finding was that the dynamic interplay of the multilayered, multifaceted influences within the overall attitude enhanced or constricted levels and areas of flexibility in therapists at any given time. Another significant finding was that the emotional tenor of the moment or session could alter the interplay of these factors and override the participants' stated theoretical stance. An unexpected finding was the distinction made by some participants between the formal session and the leaving process in terms of their decision-making regarding the use of touch. While finalizing this study, the researcher discovered an article by Tune (2001) describing similar findings from his qualitative study conducted with therapists in England.

Most importantly, this research demonstrated the value and effectiveness of open nonjudgmental dialogue about touch. Talking about their decisions to touch or not to touch resulted in increased self-awareness, knowledge, and change for the participants and the researcher, and it revealed that even the participants in the study who do not touch – touched.

Validity and Limitations

Polkinghorne (2005) points out that "the validity and trustworthiness of qualitative research is related to the selection of viable sources that promote a deepening of the understanding of the experience inquired about" (p. 141). Participants were chosen because of their reputations in the professional community; their high levels of experience, expertise, and ethics; and their abilities to reflect upon and clearly describe their experiences. The sampling was purposeful and focused on participants who were the most likely to provide substantial contributions to describing the structure and character of the experience being studied. Qualitative research focuses on collecting a series of intense and full descriptions until sufficient information had been gathered to do justice to the subject in question or "the point of redundancy" (Lincoln & Guba, 1985 as cited in Patton, 1990, p. 185). The point of redundancy was reached after six interviews.

There are both strengths and limitations in the use of in-person interviews for research. The strengths of the in-person semi-structured interview were evidenced during this study as the participants' described their experiences and dialogues with the researcher. The researcher could hear voice tone and observe facial expressions, nonverbal gestures, and posture, thereby getting a greater sense for what was being conveyed than could have been communicated in a written survey. For example, the participants often talked about their experiences of touching by demonstrating, consciously or unconsciously, their actions for the

researcher, i.e., a change in voice level and tonality or using a hand to indicate a pat on a shoulder.

There are inherent limitations in research that relies on participant self-reports. As Polkinghorne (2005) pointed out, they are dependent on the participants' ability to reflectively discern and to effectively communicate aspects of their own experience through language; and the lived experience of the participant is altered by time, by the re-telling, by the process of the transcribing of the data, by the memory of the speaker, and by the perspective of the listener. Additionally, in this type of research, the researcher is both the interviewer in the data collection process and interpreter of the data in the analysis process. These facts make it essential that the theoretical perspective, personal values, assumptions, and biases of the researcher be identified and articulated, as they were at the outset of the study.

Findings from this research must be considered in terms of the limitations of this study. The research findings cannot be generalized because of the small number of research participants and because they were limited to a selected, specific population. However, Strauss and Corbin (1998) stressed that the merit of grounded theory research is in "its ability to speak specifically for the populations from which it was derived and to apply back to them" (p. 267) rather than through generalizability. It must also be noted that the researcher's findings suggest attitudinal connections without having access to the participants' unconscious. This research focused on the therapist's experience, which included their thoughts about their clients' experiences, but limited the discussion

to only one half of the therapeutic dyad and must be taken into consideration when looking at these findings.

Recommendations

As a result of this research, the researcher is convinced more strongly than ever that dialogue about the very complex issues surrounding touch is both relevant and necessary. In the researcher's experience, current discussions on the use of touch by therapists, with a few noted exceptions, seem to be limited to litigiously-focused risk-management seminars, which tend to heighten therapists' anxiety and lower their inner flexibility. A forum for open, nonjudgmental dialogue would provide insight, knowledge, and valuable skills to professionals in all fields of mental health. It would provide clinicians, social workers, psychologists, psychiatrists, and educators with an understanding of the complexity of the use and nonuse of touch and of the decisions each will undoubtedly face. Through this dialogue, mental health professionals can thoughtfully explore their own attitudes and decision-making process, become more informed about relevant research and literature, and enhance and expand their levels of comfort and flexibility in talking with clients about touch. To be thoughtful about the use of touch is different and more difficult than to abide by a blind prohibition or to provide comforting touch routinely. Therefore, the researcher recommends establishing ongoing forums for open, nonjudgmental dialogue on the use of therapeutic touch in every mental health field in the clinical community. This

would be an important topic for supervision and consultation groups, university and training institutions, and professional seminars and conferences.

Future research should replicate this study with different populations, including, but not limited to, gender, culture and ethnicity, life and professional-stages, practice setting, and geographical location. The following findings discussed in the summary merit consideration for further exploration. Have most therapists experienced a touch-related instance with a client? What is the relationship between therapists' overall attitude toward touch and their decision-making process regarding touch? What is the impact of the emotional tenor of the moment or session on therapists' decision-making process regarding touch? Do therapists make a distinction between touch occurring during the formal session and touch occurring during the leaving process? Do early childhood experiences influence therapists' overall attitudes toward touch?

The impact of the therapists' personal and professional life-stages raised several questions for further exploration: Would a larger sample of therapists similar in orientation to those included in this research show similar patterns of approaching touch differently at the door when clients are leaving? Is the client attunement and ability to act on that attunement as expressed by these therapists primarily a function of years of experience or would this be true with less experienced therapists? Can more experienced therapists particularize or individualize clients in a way that less experienced therapists cannot? How does the relationship between a therapist's awareness of the need for risk

management in today's litigious society and his/her professional and personal life stage influence his/her use or nonuse of touch?

This research illuminated the need for dialogue in order to understand the complex, often ambivalent, feelings surrounding touch for both the therapist and the client. Future research needs to explore the following questions: How do therapists decide when it is clinically effective to talk about touching? In what situations is it more effective not to talk about touch that has occurred? How do therapists make this distinction? How do clinical professionals assess the impact of not touching as well as touching?

The researcher's review of the literature shows that prior research on the use of touch has primarily focused on either the client or the therapist. While additional in-depth qualitative research on both the client's point of view and the therapist's process is needed, research conducted on the therapeutic dyad would be the most effective way to hear both voices of an experience.

APPENDIX A

INTERVIEW SCHEDULE GUIDE

Introduction

There are times in a session when a client, explicitly or implicitly, asks to be touched or because of the emotional tone of the situation a therapist experiences an inner impulse to touch the client. These moments by their very nature are not predictable and we as therapists are faced with making an immediate in-the-moment response to the client's implicit or explicit appeal, to the situation, or to our own internal pressures. There are no right or wrong answers or correct responses.

I'm seeking to gain an understanding of the influencing factors that shape a psychotherapist's process as he/she responds to this type of situation.

I would like you to describe a particular instance when you decided to touch a client and another when you decided not to use touch. It is your overall experience as perceived and lived by you that would be helpful to understand. From your point of view, what was your experience, how did you experience what you experienced, what was its meaning for you and how did you fit the experience into your professional reality?

Please go into a lot of detail about your own experience – I'm interested in exploring any and everything that might have influenced or shaped your thinking and any processing you did of the instances at the time or later.

Schedule with Prompts

1. Under what circumstances have you touched a client and under what circumstances have you not after considering the possibility?

2. Would you describe in as much detail as possible what was going through your mind, your body and your feelings at those times?

3. Prompt questions to be used if the following areas do not arise spontaneously:

   - As you look back, could you reflect on:
     - How you felt before the session?
     - The feeling tone of the session?
     - How you felt after the session?

   a. As you remember it now:

- What feelings, needs were evoked in you?
- How did you process your decision after the fact?
    - Self-reflection
    - With the client?
    - With a colleague?
    - In consultation?

b. Even though you may not have been consciously thinking of it at the time:

- Do you think theory or training played any part . . . ?
- Do you think prior supervision may have influenced . . .?
- What role, if any, do you think your understanding and/or experience with this particular client and/or this particular relationship may have played in . . . ?
- Did the context of the practice setting play any part . . .?
- Did any legal or ethic issues come into play in any way . . .?
- Do you think that issues such as gender, ethnicity or culture played any part . . .? If so, in what way . . .?
- What influence, if any, do you think your own early experiences with touch may have played in . . .?
    - Family
    - Life
    - Own therapy

➢ What moved you to participate in this interview process?

APPENDIX B

RECRUITMENT LETTER TO COLLEAGUES

[date]

Dear

I am about to begin the data collections phase of my doctoral dissertation at The Sanville Institute, and am writing to ask your help in recruiting participants.

My qualitative study will be looking at the issue of non erotic supportive touch in psychotherapy. The research seeks to understand what influences a therapist to touch or not touch a client at those moments in a therapy session when the client seems to need or asks, verbally or non-verbally, for physical contact or the emotional tone of the session or a deep sense of attunement with a client might move the therapist to want to offer a hand clasp or an embrace. It is not concerned with whether touch occurred or did not occur but rather the influences and pressures that guided the therapist in this unpredictable improvisational decision making moment. There are no right or wrong answers or correct responses to the situations.

I am looking for five to seven psychotherapists with a minimum of ten years in private practice and who work primarily with adults. They can be from any of the mental health professions who identify themselves as psychoanalytically oriented, but who are not psychoanalysts. I will spend approximately sixty to ninety minutes with each participant in an unstructured interview that will be tape recorded.

Can you think of someone who might be interested and appropriate for this study? If so, you could tell them about it and suggest they contact me, or give me their names and contact information and I will get in touch with them directly.

My address and phone number are at the top of this letter. I can also be reached by email at lkw74@sbcglobal.net. Please let me know if you have any questions.

Sincerely,

Linda K. Waters, LCSW

APPENDIX C

LETTER TO PROSPECTIVE PARTICIPANTS

[date]

Dear

[For individuals who have contacted me directly: Thank you for the interest you have expressed in participating in the research on the issue of non erotic supportive touch in psychotherapy.] [For individuals whose names I have received from a colleague: I was given your name by _____ because (s)he thought you might be interested in participating in a research study I am conducting on the issue of non erotic supportive touch in psychotherapy.] I am writing to give you some information about the study and to invite your participation because of the unique contribution you can make to this research.

I am a doctoral candidate at The Sanville Institute. This study seeks an understanding of what influences a therapist to touch or not touch a client at those moments in a therapy session when the client seems to need or asks, verbally or non-verbally, for physical contact or the emotional tone of the session or a deep sense of attunement with a client might move a therapist to want to offer a hand clasp or an embrace. It is not concerned with whether touch occurred or did not occur only to gain insight into the influences and pressures that guide therapists in this unpredictable improvisational decision-making moment. There are no right or wrong answers or correct responses to these situations that are inherent in our work.

I am using a qualitative research model in order to get a clinically useful understanding of the influences at play during the examples you will be sharing with me. Your participation in the study means that I will interview you for sixty to ninety minutes, at a time and place that is convenient for you. I will tape record the interview. I might also follow up with a brief phone call if I need clarification of something that we discussed. If you choose to participate, I hope you will find the process to be helpful in clarifying your thoughts about this aspect of practice being studied. I will be happy to send you a summary of the study results if you wish.

The information you give me will be treated as confidential and your anonymity, as well as that of any clients you discuss during the interview will be completely protected. I have enclosed a copy of the consent form for you to review and which I will ask you to sign at the time of the interview.

If you would like to participate in this research project, please complete the brief personal information form and return it to me in the enclosed self-addressed envelope as soon as possible. I will then be in touch with you regarding the possibility of your participation.

I hope this project is of interest to you. Please feel free to contact me at one of the above phone numbers or at lkw74@sbcglobal.net if you have any questions.

Sincerely,

Linda K. Waters, LCSW

Encl.

APPENDIX D

INFORMED CONSENT FORM

WORKING TITLE OF THE STUDY: TOUCH IN THE UNPREDICTABLE IMPROVISATIONAL MOMENT: WHAT INFLUENCES THE THERAPIST?

This doctoral research project will be conducted by Linda K. Waters, LCSW under the direction of Alexis Selwood, Ph.D., principle investigator and faculty member, under the auspices of the Sanville Institute.

1. I agree to have Linda Waters interview me in a sixty to ninety minute unstructured taped interview in order to obtain comprehensive, narrative descriptions of my experience of situations involving my use or nonuse of touch within psychotherapeutic situations.

2. The purpose of this interview is for the interviewer to understand the essence of narrative themes as they may reveal themselves in my experience, and to gain an understanding of what guides me regarding this issue. I understand that any case material I present will be entirely at my discretion.

3. The audio-taped interview will occur in a confidential setting to be arranged between myself and the researcher.

4. I am aware of the following potential risks involved in the study:

   Although highly unlikely, the possibility exists that I might experience emotional discomfort. Should that happen, I will be able to contact the researcher who will make provisions for me to receive professional help, up to three sessions, to resolve issues related to participation in the research study, at no cost to me.

5. I understand that I may refuse to answer any questions and can withdraw from the study at any time without jeopardy. I also acknowledge that the researcher may choose not to use our conversation in her study.

6. I understand that this research may result in a dissertation manuscript which will not be of immediate value to me personally. I am not receiving any compensation for participating in this study.

7. I understand that this study may be published and that my anonymity and confidentiality will be protected – that is, any information I provide that is used in

the study will not be associated with my name or identity. The researcher has explained that my name will not be recorded on the tape or transcribed material, nor will my name appear in the final document or any future reports or publications from this study. My identity will only be known to Linda K. Waters.

8. Information about this study and the place of my interview in it has been given to me by Linda K. Waters. I can reach her at any time I have questions by calling (323) 469 8459 or (323) 871 2032.

_____
NAME – PLEASE PRINT

_____ _____
SIGNATURE DATE

If you would like a copy of the results of this study, please provide your name and address:

Name _____

Address_____

_____

APPENDIX E

LETTER TO PROSPECTIVE PARTICIPANTS NOT IN STUDY

[date]

Dear

Thank you very much for the interest you have shown in the research study that I am conducting as a doctoral candidate at The Sanville Institute. At this time I have recruited enough participants to begin the study and will not need to schedule an interview with you. If it becomes necessary to interview additional people I may contact you again to see if you would still be interested and available.

If you would like to know about the results of my study when it is completed, feel free to contact me.

Thank you once again for your interest.

Sincerely,

Linda K. Waters, LCSW

APPENDIX F

PERSONAL INFORMATION FORM

NAME:_____
Please Print

BUSINESS ADDRESS:

_____

_____

_____

TELEPHONE:
Day:

_____

Evening:

_____

Cell:

_____

EMAIL ADDRESS:

_____

WHAT IS YOUR PROFESSIONAL LICENSURE?
Licensed Clinical Social Worker _____
Marriage and Family Therapist _____
Psychologist _____

NUMBER OF YEARS IN PRIVATE PRACTICE:

_____

WHAT IS YOUR THEORETICAL ORIENTATION?

_____

_____

APPENDIX G

THANK YOU NOTE FOR PARTICIPATING

[date]

Dear _____,

Thank you for participating in the interview on (date). I appreciate your willingness to share your experiences and valuable time. I am grateful for your contribution to this research project and hope that you found the experience to be of some benefit to you as well.

Again, thank you for your time and participation.

Yours truly,

Linda K. Waters, LCSW

APPENDIX H

THE SANVILLE INSTITUTE
PROTECTION OF RESEARCH PARTICIPANTS APPLICATION

Title of Research Project: The Unpredictable Improvisational Moment and Touch: What Influences the Therapist?

Principal Investigator: Alexis Selwood, PhD
(print name and degree)

Investigator: Linda K. Waters
(print name)

I have read the *Guidelines, Ethics, & Standards Governing Participation & Protection of Research Participants* in research projects of this Institute (in Appendix D of the Student and Faculty Handbook), and I will comply with their letter and spirit in execution of the enclosed research proposal. In accordance with these standards and my best professional judgment, the participants in this study (check one)

_____ Are not "at risk."

__XX__ May be considered to be "at risk," and all proper and prudent precautions will be taken in accordance with the Institute protocols to protect their civil and human rights.

I further agree to report any changes in the procedure and to obtain written approval before making such procedural changes.

Alexis F. Selwood, PhD 8/27/08
(signature of principal investigator/date)

Linda K Waters, LCSW 9/15/08
(signature of investigator/date)

Action by the Committee on the Protection of Research Participants:

Approved __XX__ Approved with Modifications _____ Rejected _____

Sylvia Glassman Ph.D. Date 10-9-08
(Signature of representative of the Committee on the Protection of Research Participants/date)

Judith Kay Nelson Ed.D. 10-17-08
(signature of Sanville Institute dean & date)

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