

# An exploration of the Role of Touch in a Therapeutic Setting

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# An Exploration of the Role of Touch in a Therapeutic Setting

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### **Abstract**

This research took on both qualitative and quantitative aspects to further explore the use of touch in a therapeutic setting. The qualitative research explored six accounts from psychologists on why they use or don't use touch within their practise. Semi-structured interviews were conducted, and interviews were transcribed and analysed using Interpretative Phenomenological Analysis. Four superior themes were found between the accounts of each therapist; Professional boundaries and power imbalance, Individual clients and the context, Touch in therapy and Limiting the client. Two cases specifically discuss the use of touch during the process and their experiences with it and the reasons for not using touch are discussed. The importance of touch as a departing gesture is examined although the rarity of touch outside of this is emphasised and it is also suggested that touch does not need to have a place in the therapeutic process. Qualitative research is also conducted to assess everyday individual's need for touch and whether they feel they would value touch as comfort in a therapeutic setting and whether their gender affects their answer. Results showed that an individual's need for touch is important but that people are unsure if they would value it in a therapeutic setting. It was also revealed that gender was a significant predictor of whether individual's would value touch in the therapeutic process. This research further expands on the knowledge in the area of touch both from a therapists perspective and individual's in general.



## **1. Introduction**

Undeniably, bodily touch is an important element among humans. It has been shown to be necessary for normal growth and is considered one of the most important senses as it is the first sense that is developed within an embryo (Montagu, 1978) and is also one of the last senses to go when dying (Montagu, 1971; Fosshage, 2000). During an individual's development they rely on the experiences they have of touch to form ideas about attachment and safety in the world and they develop a sense of self from the care giving that is provided to them by parents which is often provided through touch and also through their own feelings (Barnett, 2005; Turp, 2000).

### **1.1 Freud and Touch**

Touch as a tool of healing has been handed down through modern healers over decades and has ancient roots in magico-religious practises, thus as a form of healing, psychotherapy inherited the use of physical touch as treatment with patients (Wilson 1982). Within psychotherapy touch has been present since the beginning of psychoanalysis with Freud utilising touch with patients himself. Freud (1923) acknowledged that the experience of ego develops in an individual as experience of body and the ego is derived from bodily sensations. This has important implications to an individual's development, as it implies a lack of bodily sensations will affect an individual's ego development. If a child does not receive adequate experiences of being held securely, being picked up and rocked, than that child will likely have a deficit in their self-support function according to Freud. The view Freud had of the body ego provides a rationale for why touch should be used within psychotherapy as he suggests it promotes healthy development. One technique which he used to help a patient who was having a difficult time responding would be to hold their head between his hands (Breuer & Freud, 1956) believing that in response to the pressure placed on the individuals head that the appropriate memories and associations would appear. However, Freud later abandoned this hypnotic technique and distanced himself from patients in any form of touch as with the development of the pleasure principal he believed that touching a patient could bring gratification of infantile sexual longings and fixate the individuals at an infantile level.

### **1.2 Touch in animal and infant research**

Numerous studies have been conducted within infant research such as the work done by Bowlby (1952) and Harlow (1958) which can attest to the importance of touch in the physical, emotional and social development of all individuals. According to Bowlby, just as

food and thirst satisfaction are primary drives so is primary object clinging which is an individual's need for physical contact which is often provided by the mother. Conversely, this view was contradicted by Harlow who believed an individual's basic drives, particularly those of hunger, thirst, pain and sex are primary drives and love and affection are an individual's secondary drives. In the same paper he also discusses that the mother is associated with reducing an individual's primary drives and how through this individuals develop love and affection. Harlow's study, which was conducted on rhesus monkeys has shown how physical contact is a necessity to the degree that baby monkeys will choose the intimacy of physical contact over the need to be fed showing that contact comfort is important in their development. With this study it was also noted that the cloth mother is preferred over the wire one and this only becomes enhanced with the age of the monkey. When a fear stimulus was provided the nursing monkey is shown no importance over the soft mother as the monkey will seek comfort over being fed. Research done by Lovic & Fleming (2004) which assessed the performance of isolate reared rats on attentional set shifting and pre-pulse inhibition of the startle response. Results showed that isolated rats who received 2 minutes of stroking with a paintbrush 8 times a day performed as well as the control group - of maternally reared rats who received regular touch - on the two tasks. These results also reflect on infant research by Spitz (1945) who found that infants portrayed more signs of depression and developmental arrest when they were infrequently touched.

Research on infant studies have also looked at other aspects of skin to skin contact. One Cochrane study conducted by Moore et al (2012) did a systematic review of 34 randomised trials, which had used skin to skin contact as an intervention with mothers and their children. Results found that even with differences in how skin to skin contact was implemented, early contact promoted more interaction between the mother and child, the child cried less and also had better cardio-respiratory stability. These results have been replicated in others studies such as Bera et al (2014) who also used similar skin to skin interventions with infants. Kangaroo mother care (KMC) was utilised within this study which consisted of over 500 mother and baby pairs who were split into groups of five. The 3 children with the lowest birth weight received KMC while the remaining 2 received standard care. This was done until the infant was at 40 weeks of corrected gestation. Results showed that infants who received KMC achieved physical growth parameters similar to that of the

control group and they also out grew the control group despite being smaller at the beginning of the research.

### **1.3 Touch and professions**

Touch has always been present within the therapeutic setting, there are three distinct areas within psychology who support the ethical and cautious use of some forms of touch as being beneficial. These are found in certain psychodynamic theories, humanistic psychology and also in Reichian and Neo-Reichian theories. In body centred psychotherapies the body and mind are viewed as a continual loop as opposed to two separate systems and it recognises that the events individuals experience impact them in a holistic way (Zur & Nordmarken 2011) Techniques commonly used by body centred psychotherapy are supportive hugs, deep manipulation which is used to release body blocks and holding and also breath movement. According to the code of ethics of both the IAHIP and PSI there is no specific code that promotes the prohibition of touch within therapy, however, it is stated that the psychotherapist must not exploit their client sexually and in any other way ("Code of Ethics | IAHIP", 2016 ; "PSI Psychologist Online Register - Code of Professional Ethics", 2016)

There are many other professions that utilise touch with patients or clients such as massage therapy or nursing and it has been shown to have many benefits within these areas (Gleeson & Timmins 2004). Research was done by Seskevich, Crater, Lane, & Krucof (2004) to assess the effect of touch therapy, stress management, standard therapy and imagery on the mood of individuals waiting for assistance on unstable coronary syndromes. The results demonstrated that mental interventions may contribute to a better emotional state of mind when provided during a stressful period. In the same article it was also revealed that patients who had acute ischemia responded well to healing touch and stress management and showed reductions in feelings of worry, highlighting the benefits touch can have towards an individual's health. Touch has also been shown to make people more present in their own healthcare according to Guéguen & Vion (2009) who found in health care when a patient was touched on the shoulder or hand when they were asked to take a particular type of medication there was a greater compliance than patients who weren't touched.

### **1.4 Therapeutic Touch**

Therapeutic touch was described by Willison & Masson (1896) as physical contact between the therapist and the hands, shoulders, legs or arms or upper back of their client. Although touch has been shown to be crucial for an individual's development and

relationships (Stenzel & Rupert, 2004), there is, however, a sense that in counselling and psychotherapy it is not appropriate. In recent years the main problem is between the research and knowledge that has shown touch as an essential aspect for a human's healthy development and within human relationships (Barnett, 2005) and on the other side is the apprehension in relation to ethics in terms of exploiting a client and also the misinterpretation of touch (Glickauf - Hughes & Chance, 1998). Wolberg (1967) believed that physical contact between a therapist and their client was an absolute taboo as it could possibly create sexual feelings between the therapist and the patient. This was similarly seen in work by Glickauf - Hughes & Chance, who suggest a focus on risk management and ethics has impacted the use of touch in therapy. They believed it can be viewed as risky with clients who may misinterpret it for something more than it is, for those who use therapy to fulfil relational needs or for those who avoid touch. As such many therapists and counsellors argue against touch out of a recognition of the power and the sexual connotation that touch conveys in western society.

Psychotherapists are reported to put a great amount of thought into their decisions as to whether to use touch according to a study done by Clance and Petras (1998). They found that therapists who used touch did so to help clients access their feelings, to offer comfort, to model what safe touch is and also at the request of the client. Research done by Harrison, Jones, & Huws (2012) looks at the use of touch in therapy from the therapists perspective. Six therapists accounts were explored during this study to comprehend why they chose to include or exclude touch with their own clients. It was revealed that depending on the situation and the client, that in certain situations touch could provide support for the client and can help focus them on the therapy although the rarity of its use was emphasised.

### **1.5 Transference**

Since psychotherapy is predominantly considered a therapy of talk, the inclusion of touch can cause many problems since it can so easily be misinterpreted (Young, 2005). With transference the aim is to avoid or remove any input from the therapist that could possibly impact the experiences of the patient in order to highlight the patient's own projections and displacement. When a patient is looking for help from a therapist they tend to be in a vulnerable position and are trusting towards their therapist which automatically leads to an imbalance of power between the therapist and their client, as the therapist is seen to have authority, experience and status above the patient (Lazarus & Zur, 2002). The article also discussed the role of transference and how it may cause the therapy to be sexualised when

infantile yearnings are revived which may lead the therapist or client to misinterpret these as adult sexual feelings which could lead to violations within the relationship. This finding is reminiscent of Fosshage's (2000) research who believed touch is a deviation from a neutral stance by the analyst that is associated with transference and thus is viewed as confusing the issue, as it is intrusive of the therapist to interfere with an individual's internal psychological processes. Zur and Nordmarken (2011) in their article discuss that when trying to prevent sexual contact in the client-therapist relationship careful attention needs to be placed on boundary violations which although might not be harmful could also possibly lead to sexualised behaviours or power differentials between the therapist and client.

### **1.6 Caution when utilising touch**

However, viewing any touch that is non-erotic as the first step towards a sexual relationship is one of the foremost beliefs and biggest obstructions when it comes to comprehending how important touch in therapy is (Lazarus & Zur, 2002). Lazarus & Zur believed that the sexualisation of all forms of touch is something that has become embedded in human society and has manifested from beliefs that are prevalent within psychotherapy. Sexual touch is not the only reason touch is not often used, there is also the impact of power as the argument suggests that power differentials allow and in some cases encourage therapists to exploit their clients or can also limit the client within therapy and make them feel powerless (Bersoff, 1999 ; Zur, 2009.) As an individual if you have ever been "herded" through a door or been patted on the knee by a stranger or an employer it can demonstrate the possibility of individuals interpreting messages of a condescending, sexual or threatening nature in gestures that are typically seen as harmless. Therefore an individual's intent, context and situation on the meaning of physical touch must be understood before touch can be even considered as a technique within therapy. Although Willison & Masson (1986) condone the use of touch within therapy, they state that touch has power implications that a therapist needs to be aware of. This was similarly found by Alyn (1988) who found that touch in general is typically seen as reciprocal and is associated with enhancing an individual's empathy, but touch can also be seen as showing dominance when it is considered non-reciprocal by the client.

Research on a national sample of 470 psychologists was conducted by Stenzel & Rupert (2004) in relation to the use of touch in psychotherapy. Results showed a high degree of caution is required when utilising touch with clients. It was revealed that almost 90% of the

psychologists never or rarely offered physical contact to patients and that a handshake was the most commonly offered form of touch, although some were reluctant to even offer a handshake. The degree of caution which surrounds touch could be due to the greater awareness of risk management and also the fear that the touch may be misinterpreted which has been discussed in many other studies (Glickauf - Hughes & Chance, 1998 ; Zur, 2009) The research in this article suggests that a greater focus should be placed on procedures that could reduce the potential for physical contact being misinterpreted or misunderstood and also could investigate further the benefits or limitations of touch. It could also look further into whether therapists are trained in this area as it was not investigated within this research.

### **1.7 When and why touch is used**

Touch would be openly used by all therapists of all areas if it were not surrounded by the taboo of management of erotic and counter transference according to Carere-Comes (2007). Research conducted by Zur and Nordmarken (2011) attempting to understand the motivations and reasons of therapists who utilise touch in psychotherapy developed a taxonomy which further described the different types of touch that were most often used between a therapist and their client, some examples of which are a grounding or re-orienting touch which might be used to help reduce a clients anxiety or a reassuring touch which may be used to keep a client comforted or to encourage them.

Within therapy it is important to understand the how's, when's and why's and also with whom touch is used within therapy. Research conducted by Strozier, Krizek, & Sale (2003) consisted of a nationwide snowball sample of experienced clinical workers who had a minimum of five years experience post masters degree. Information was obtained through a touch questionnaire which assessed demographics, education, general use of touch and also when and how touch should be used. The results showed a higher frequency of touching among clients with patients than had been expected. It was also revealed that the majority of therapists reported shaking hands with their client or touching them on the arm or back, while over half reported hugging clients and nearly a third held the hand of their client. A variety of reasons were described by the therapist as to why they offered touch; to show empathy, to portray healthy touch and to communicate acceptance. Research also showed that over 40% believed that touch could be healing, and that the situation they are in at the time is a contributing factor to whether touch is offered. However, the definition of touch was broadly defined which made it difficult to further analyse some of the responses and also within the

small sample size. Implications of this research suggest that future studies should aim to be clear about what types of touch are being used between a therapist and a client and also at what times they use touch with clients. It also suggests that future research needs to delve further into the complicated reasons for and against touch. These results are also reminiscent of Caldwell (2002) in which she agreed that it is important for therapists to know when, how and how frequently to have physical contact with clients and also to be trained on using touch.

### **1.8 The Client**

In research on the use of touch it is important to not only understand the therapist's point of view but also the clients as well. An exploratory study was done by Pinson (2002) through interviews of four psychoanalytically oriented therapists who had used touch with their clients. The research examined both how the therapist and also their client perceived the experience. In relation to the therapists they reported that their decision to touch a patient was guided by the needs of that particular client and the patient's circumstances rather than their own orientation or their own attitude towards the use of touch. Of the five cases, four clients reported it to be positive experience while the results for one client remain unknown. For these patients touch was reported as having provided them with a feeling of safety, promoted growth and kept them grounded and present during therapy. However there were limitations to the research due to the small sample size and also due to the selectiveness of the sample. An emphasis was placed on the need for more research on touch. Similar results were found in Geib (1982) who found that 6 out of the 10 participants who were in long term therapy found touch to be positive. However the remaining 4 participants had negative outcomes reporting they felt their trust and boundaries had been violated and that they felt it was their therapist who needed the comfort and that they felt trapped as a result of the touch.

### **1.8 Present study**

As the frequency of touch in therapy appears to be mixed throughout the literature, it is important for future research to investigate touch within the therapeutic setting as touch is both an ambiguous and powerful form of communication and its use requires careful consideration. This study aims to further investigate the role that touch has within the therapeutic setting and gain an insight and deeper understanding of why therapists choose to use or avoid touch and also the benefits and the problems they face in doing so. Through the analysis of the research above many of the studies have suggested the need for future research to focus on understanding more on the motivations as to why therapists use or avoid touch

(Strozier, Krizek, & Sale., 2003).The study seeks to explore the experiences of six practicing psychologists and the reasons they choose to use and avoid touch, whether they have been trained on it and also their experiences on using or avoiding it. The study will also include a questionnaire on touch for the general population to assess the need for everyday touch in the general population, to assess whether they would value touch in a therapeutic setting and to see whether gender plays a role in their answer.



## **2. Methodology**

### **2.1 Qualitative Design**

Within this section of the paper, the participants, materials, research design and procedure will be outlined.

The design of this study is both qualitative and quantitative. In the qualitative research Interpretative phenomenological analysis (IPA: Smith, Flowers, & Larkin, 2009) was utilised within in the study as it is designed to explore the meaning participants place on their experiences. In interpretative phenomenological analysis the participants attempt to make sense of their own experiences while the researcher analyses the answers they provide and attempts to make further sense of these experiences. This aspect of the research will involve purposive sampling as for IPA the researcher is looking for individuals with knowledge in a particular area.

### **2.2 Participants**

The sample was made of six practising psychologists around Ireland, all from a background in psychotherapy. Initially nine possible participants were contacted, upon contact six agreed to take part within the study. As the aim of Interpretative Phenomenological analysis is to further understand the experiences of its participants, the individuals are selected according to aspects of homogeneity. The recommended sample size for IPA is between 3 to 15 participants (IPA: Smith, Flowers, & Larkin, 2009). The inclusion criteria within this sample was that they had to have a minimum of 5 years' experience post qualification, anyone with less than 5 years' experience was not eligible for the study. Of the six psychologists three were male and three were female.

### **2.3 Materials**

As this aspect of the study was interview based, questions were developed by the researcher prior to the interview so as to provide a starting point. The participants were asked basic demographic questions to assess the area they specialised in and also how long they had been working in that area. Further questions were developed during the interview based on the answers provided by the participants. Also utilised within the data collection was a recording device so that all answers would be documented accurately and pen and paper was also utilised to document answers as well as to develop further questions.

## **2.4 Procedure**

For the research, participants were obtained through one therapist who provided the researcher with contact details of further practicing psychologists to see whether they would be interested in the study. Once initially contacted information sheets about the study were sent to the nine possible participants through email prior to the study describing what the study was about and how they take part of it if they chose to (See appendix A). They were also informed that interviews would be recorded, and that only the researcher would have access to these recordings and once transcribed the recordings would be disposed of efficiently. The potential participants were provided with the contact details of the researcher if they had any further questions and were given time to decide if they wished to take part. All participants were made aware that the study was completely voluntary and that they could revoke their participation at any point and also may remove their results from the study if they wished.

Once confirmed that the participant was willing to partake in the study each participant was met in a location most convenient to them and on a prearranged date. Research was collected over a six week period. When meeting with a participant they were once again informed that participation was voluntary and that if they wished to withdraw from the study they could do so at any time. Participants were also ensured of their anonymity within the study and were provided with pseudonym for the use of direct quotes. Once informed and written consent had been obtained background demographics were asked of the participants before beginning the interview to assess how long they had been practising and also what area they specialised in. The interview was semi structured as this provided a guide for the interview and also allowed further questions to be developed based off the answers provided by the participant (See Appendix B). Participants were made aware both through their information sheet and prior to beginning the interview that all interviews would be recorded so as to allow the information gathered to be transcribed by the researcher. Interviews ranged between thirty and forty minutes with each participant.

After the interview had been completed each participant was thanked for taking part and reminded again that they may remove their results if they wished and were also reminded that the experimenter would be publishing the results, but that the results would be completely anonymous

## **2.5 Quantitative Design**

In this study, quantitative research was also utilised in The Need for Interpersonal Touch questionnaire (Nuszbaum, Voss, & Klauer, 2013) The questionnaire was used for data collection purposes. A convenience sampling of people was utilised to assess individual differences in the need for touch. According to a study conducted by Nuszbaum, Voss, & Klauer, (2014) the questionnaire was shown to have a Chronbach alpha of ( $\alpha = .78$ ) The design was deemed suitable as it assesses individuals need for touch, and as it was modified to suit an additional question it also provided information about whether the individuals would appreciate touch as comfort if they were client seeing a therapist (See Appendix D) . It also will assess whether gender is a contributing factor on whether individuals would value touch as comfort in a therapeutic setting.

## **2.6 Participants**

A sample of 70 participants was used within this study. Each participant within this study as part of the exclusion criteria was over 18 years old. Both gender and age were obtained from the participants. Of the 70 individuals taking part 35 were male and 35 were female. The participants age ranged between 18 -53 years ( $M=29.53$ )

## **2.7 Materials**

Each individual received The Need for Interpersonal Touch Questionnaire (Nuszbaum, Voss, & Klauer, 2013) which was modified slightly to add an additional question to suit the nature of the study. The participants were required to state their age and their gender and then complete the questionnaire which consisted of twenty questions which were answered using a likert scale of one to seven ranging from strongly disagree to strongly agree. The first page of the questionnaire consisted of a cover letter explaining the nature of the study, how they could take part, ensuring the anonymity of the participant and also informing them they could withdraw at any time (See Appendix C).

## **2.8 Procedure**

Each individual was accessed through a convenience sample. Information sheets with the questionnaire and an informed consent sheet attached were passed out to the participants. The information sheet debriefed individuals on what the study was about and the role they would play within the study and ensured them of their anonymity in the study. The participants were then required to sign at the end of the consent form if they wished to take

part, however all participants were made aware that the study was completely voluntary and that they could revoke their participation at any point and also may remove their results from the study if they wished. Once consent was obtained individuals were handed their questionnaire to complete at their leisure and provided with contact details of the research if they and any questions.

After they had answered the questionnaire they were thanked for taking part and reminded again that they may remove their results if they wished and were also reminded that the experimenter would be publishing the results, but that the results would be completely anonymous.

### **3. Results**

#### **3.1 Qualitative Research**

Accounts relayed by the therapists clustered around four themes; Professional boundaries and power imbalance, Individual clients and the context, Touch in therapy and Limiting the client. Quotes from participants are provided throughout the results section discussing touch and its role in therapy each under a pseudonym, so as to protect the individual's anonymity. It also should be noted that none of the client's had been trained in the use of touch although one had experience in body psychotherapy.

#### **3.2 Individual clients and the context**

“In my opinion touch is very much dependent on the client and client therapist relationship. I think how a client will react to touch is too unpredictable to be useful.” As reported by Aaron and emphasised by the other therapists, a client's reaction to the use of touch through a session is something that is unpredictable and depends solely on client individuality which is one of the many reasons throughout literature as to why it is avoided. The situation and your knowledge of the client have to be carefully considered before touch should be instigated as you can never fully know how a client will react. Conversely permission can be sought from a client but even the client themselves may not understand their own reaction when touch is initiated. As there are no clear rules around the use of touch in therapy it becomes that much more complicated on knowing whether it should be used and when or if it should be used, especially if it is requested by the client as was an experience had by Sean;

“One client asked for a hug at the end of a regular session and said that this is what they need. I declined the request”; “The client left the process shortly after that session.” Sean felt that physical comfort with this client would not be appropriate as he sensed this would have to become a regular occurrence within their relationship. In using touch he believed he would be crossing boundaries in the relationship which he wasn't comfortable with and felt wouldn't be beneficial to his client. However the refusal of touch affected the client, as is seen in the client leaving the process shortly after. Conversely, when discussed with Ann she found that if it is the client who initiates or asks for touch during a session and the client is able to talk about it, it is something that they should discuss or something that the therapist should bear in mind.

When a client is in distress touch in the form of a gentle touch of the elbow or hug can acknowledge what the individual experienced. Beth discussed an experience in which a client who had been dealing with abuse had just opened up about it for the first time within a session. She used the contact to connect with her patient when she was in an agitated and withdrawn state and felt she couldn't reach the patient with words alone. "Sometimes in clients who are so lost in their own pain, even just touching their hand or elbow can be an incredibly powerful experience" In this situation she found touch was useful as it can acknowledge and validate what the individual experienced, and bring them back to the reality of therapy. However Beth also reported discussing this experience with her own supervisor later, as although she felt it was effective for the client she felt she had crossed her professional boundaries by doing so and struggled with it, which could be due to the lack of training on it. While Kathy doesn't feel touch would be unhelpful, she believed that touch was not necessary at all within therapy as even in emotional sessions she felt she was able to express understanding and kindness to a client without the added complication of touch believing that touch can create a dependency in some clients.

### **3.3 Professional boundaries and power imbalance**

When discussing the issue of power imbalance and boundaries in the therapeutic relationship all emphasised the cautious use of touch as they questioned both whether it would be beneficial to the client and why they felt the need to use it. It was commonly felt that they are possibly disempowering the client or augmenting the power differential between the client and therapist by using touch. "I think that it's a very difficult area. Whenever touch happens within a session I consider it a boundary broken"

When discussing the use of touch with Sean he felt that within Irish life it's a social norm among many to shake hands when meeting and leaving someone, and that this form of touch on arrival and departure was appropriate. However in the use of other forms of touch such as hugging or hand holding he felt it crossed a boundary in the relationship and could put the therapist in a position of power above the client and could jeopardise the process "Hand holding, hugging, arm around shoulder etc., crosses a boundary and could have the effect of putting the therapist in a position of power thus disempowering the client" a view which was similarly expressed by Ann and Shane.

While Beth had used touch and acknowledged its importance - although she was later unsure of her choice - she also said that as a therapist it's their job to empower the client to find these relationships outside of the therapeutic relationship with their own friends and family "We're just someone that's trying to help them, we can't be that person in an individual's life, it should be sought outside of us"

The belief of touch being taboo in therapy was agreed by two of the six psychologists. Among the other four there was a common opinion that touch is an important part of how we communicate and that it's the use of it and also why they feel they need to use it with a client that needs to be carefully considered according to Aaron "I don't consider touch taboo, but it has to be mutually instigated" ; "my training is to check with myself why I feel that need to comfort the client or myself" This view was similarly expressed by Shane who also spoke about the question of who's needs are being met when touch is instigated within a session the therapists or the clients. Irrespective of their approach to therapy each individual acknowledged professional boundaries which appears to be a defining factor in how they act as clinicians.

### **3.4 Touch in therapy**

It was noted at times there can be a natural tendency to touch a clients elbow or put a hand on their back as a sign of support or encouragement through a session as mentioned by Shane and Ann although neither have ever acted upon this thought. This was similarly expressed by Kathy who found that offering physical comfort was something she did among her friends and family regularly, but was not something she found to be helpful for herself or her clients in the long term. Within the powerful exchanges that can happen during therapy she found by finding alternative ways to offer comfort or support to her clients without the use of touch she has added to the process and benefited the client more. There may also be consequences for the therapist following touch as can be seen in Beth's account. Although Beth found that utilising touch with a client helped them, she found herself struggling with stress and worry about whether she had affected the relationship and crossed a boundary she shouldn't have and had to discuss it over a few sessions with her own supervisor.

However Sean, who works with individuals from age six and onwards found that when working with children when they reach a particular goal that a simple high five can be beneficial towards the child and continue to encourage them "When working with primary

school children, I might high-five them if they achieve a goal that we set together” although he does acknowledge that this should be done rarely.

Touch as an ending was openly discussed by each therapist all of which found it to be a moving and beneficial experience and also a healthy way to end to the relationship "When the sessions are finished, at times it marks and acknowledges the journey you have shared and the trust which has built between you" although none of the therapists denied touch at the end of the process, it was noted by Shane, Kathy, Aaron and Sean that they would always wait for the client to instigate touch before it happened.

While touch at the end of the therapeutic process was common, each saying it brought their relationship to a healthy end and acknowledged the journey that they took together, it also could be to the fact that they no longer feel bound to a relationship in which an increase in power could affect the process? “A hug upon ending offers no opportunity for a precedence to be set” or it could just be the tendency touch has to signify a goodbye?

### **3.5 Limiting the Client**

A question arose around the topic of the therapist being the client and if they themselves felt they would value touch as comfort during the process. Out of each participant interviewed only Aaron and Beth mentioned that although they feel it wouldn't be helpful to them, initially a part of them may feel that the touch is comforting.

A clear consensus among the psychologists was that as the client they would want the therapist to just sit with them in their despair and allow them to express themselves verbally or emotionally. They each acknowledged that if the therapist were to touch them, they would feel that the therapist is unable to handle their emotions and by trying to comfort them they would be limiting their experience of these emotions. “I think if they touched me it would be a signal that they are unable for the despair and that they are trying to save me from the pain of the process”

“My therapist was able to model something very important to me. She spoke about what it would be like" Ann discussed her own personal experience in which her own therapist spoke about what touch would be like and gave her the opportunity to process the experience. It appeared that it was more important for her to talk about touch within therapy rather than to actually experience it, as it gave her the opportunity to think about what it would be like to be held and comforted in such a way and she wouldn't have been able to have had that



experience had the therapist just provided the comfort. This view was similarly reflected by the other therapists who believed that part of therapy is learning to take care of and comfort yourself, and if they were to experience physical comfort from the therapist they feel it would limit their ability to learn to comfort themselves.

Reflecting on each individuals account of being the client in the therapeutic setting it appears that each individual would rather their therapist express and articulate their feelings to them at that moment than try to offer physical comfort.

### **3.6 Quantitative Research**

#### **3.7 Descriptive Statistics**

*Table 1; Descriptive Statistics*

	Mean	SD	Range	Cronbach's Alpha
Age	29.53	9.89	18-53	-
Gender	1.50	1.92	1-2	-
NFIT21	4.93	1.59	1-7	-
NFIT Total Score	99.21	16.65	67-126	.83

The study consisted of 70 participants with ages ranging between 18 and 53 (Mean = 29.53) The sample was evenly distributed among males and females. The sample consisted of 35 males and 35 females. Possible scores from the NFIT scale ranged from 67 and 126 (Mean =99.21) and had a chronbach Alpha of .83. The NFIT21 which assessed touch in a therapeutic setting reported a mean score of 4.93 with a standard deviation of 1.59. The need for interpersonal touch scores ranged from 67 to 126 showing considerably high scores among individuals for the need of touch across the sample. While the question NFIT21 which assessed whether an individual would appreciate touch as comfort in a therapeutic setting was

average to slightly above the average, the SD of 1.59 suggests that the population was mostly unsure whether they would value touch in this setting.

### **3.8 Independent Samples T-test**

An independent samples t-test was conducted to compare the Value of touch as comfort in a therapeutic setting between males and females. There was a significant difference in scores between both males and females,  $t(68) = -2.93$ ,  $p = .005$ , two-tailed with Females ( $M = 5.46$ ,  $SD = 1.58$ ) scoring higher than males ( $M = 4.40$ ,  $SD = 1.45$ ). The magnitude of the differences in the means (mean difference =  $-1.06$ , 95% CI:  $-1.79$  to  $-.34$ ) was large (eta squared =  $.11$ ) These results suggest that there is a statistically significant difference between males and females in value they would appreciate touch as comfort in a therapeutic setting.

## **4. Discussion**

### **4.1 Discussion of Findings**

In this final section of the study, the main aims of the research will be discussed again as well as the results of both the qualitative and quantitative analysis. The strengths and limitations of this study will be presented and finally the suggestions for future research will be discussed.

This study adapted both a qualitative approach to further assess the role that touch plays in a therapeutic setting and also a quantitative approach to assess individual's need for touch and whether gender plays a role. By utilising Interpretative Phenomenological Analysis (IPA: Smith, Flowers, & Larkin, 2009) the insights and perspectives of six practising psychologists on touch could be explored to expand on the existing knowledge within the area of therapeutic touch. Among the participants of the study there was a clear consensus that although touch is an important form of communication, and as an introductory or parting gesture it may be appropriate depending on context it is not something they believed had a strong value within therapy. Each therapist highlighted that touch depended on a myriad of factors such as the individuals and the context in which it is used.

Glickauf - Hughes & Chance (1998) believed that the use of touch in therapy was impacted by the focus of risk management and ethics. They found that touch was viewed as risky due to the possibility of clients misinterpreting it or using it to fulfil relational needs and as such due to the recognition of its power try to avoid it. The power and boundaries around touch were discussed and considered by each therapist within the study and the implications of its use, such as the potential affect it could have on the client therapist relationship and also to whose benefit would it be used. The decision on whether to use touch was typically seen to be guided by whether they “felt” it would be beneficial and also on why they “felt” the need to use it. Of the six therapists none had been trained in the use of touch, although two participants had mentioned discussing it with supervisors and one had done some work in body psychotherapy. Client individuality and the context were greatly considered in whether to use touch, among the therapists only two individuals mentioned offering touch in the form of hand holding or hugging during a session. In the instance with Beth in which she held the hands of the client who disclosed abuse she described the use of touch as a powerful and beneficial experience in this instance which coincides with Llewelyn and Gardner (2009) who found that at particular times violations of boundaries can be successful in helping a client.

However although finding the touch helpful to the client Beth later discussed it with her supervisor feeling she had crossed professional boundaries and was unsure of how to cope with this. This was also discussed by Zur and Nordmarken (2011) who believed that using touch in therapy could augment power differentials and affect the relationship. Beth's stress and worry with using touch and feeling she crossed her professional boundaries could also have been affected by the lack of training in the use of touch?. Kathy expressed an experience in which she had offered a hug or hand holding at times to a client who was in distress and although initially it appeared to provide comfort it became something that the client requested when Kathy no longer felt it was beneficial for them. Although a lot of the risk around touch in the literature focuses on the misinterpretation of touch in a sexual way (Lazarus & Zur, 2002) none of the accounts by the therapists, particularly from both Kathy and Beth, expressed this view when explaining why they don't use touch. One of the many reasons provided as to why touch should not be utilised was discussed by Ann who believed that touch could bring too much reality in and may be manipulative which can ruin the symbolic aspect of the therapeutic process.

The most common forms of touch described by the therapists and their clients were that of handshakes, hugs or a touch to the elbow which was similarly found by Strozier, Krizek, & Sale (2003). Whilst the rarity of touch was emphasised by each individual within their practise, when it came to the end of the therapeutic process this reluctance disappeared suggesting that touch at the end of the relationship is viewed differently than during the process. This finding was similarly found by Harrison, Jones, & Huws (2012) in which the therapist's reported hugging clients at the end of their relationship. As mentioned by Kathy this may be due to the fact it offers no precedence to be set? Or it may be because it's considered a societal norm when saying goodbye?

No research could be found investigating the opinion of therapists being the client and if they would value touch within therapy as the client. Through the investigation of the six therapists in this study it was a common belief among all of them that they believe touch would not be beneficial to them in a clinical setting. It was commonly expressed that they would much rather the therapist simply be there and express their emotions and thoughts to them verbally as they considered this more valuable to them. They also felt that if the therapist were to offer them touch that it would indicate the therapist is unable to handle their

stress or grief and that by providing touch they would be limiting them. These results however contradict the work of Pinson (2002) in which the research examined both how the therapist and also their client perceived the experience of touch in therapy. The clients of these therapists reported touch as having provided them with a feeling of safety, promoted growth and kept them grounded and present during therapy. This difference however could be due to the knowledge of the therapist in that area trying to put themselves in a client's perspective.

The need for interpersonal touch questionnaire was utilised as part of the qualitative research to assess an individual's need for touch, whether as a client if they would value it in a therapeutic setting and also whether gender impacted the results. Observing the descriptive statistics it could be seen that an individual's need for touch is moderately high suggesting touch is important in people's everyday lives. While assessing whether touch would be appreciated as comfort in a clinical setting the results reported weak to moderate relationship suggesting that most are unsure, this contradicts Pinson's (2002) work in which individuals found positive experiences with touch in therapy. However, as it wasn't investigated whether the individuals who completed the NFIT questionnaire had ever been a client in a therapeutic relationship this could explain the difference in results. An independent samples T-test was also conducted to see who valued touch more in a therapeutic setting more males or females. The results reported a statistically significant difference between males and females in the use of touch as comfort in a clinical setting indicating that women would value it more.

#### **4.2 Limitations of the current Study**

As like most, if not all research there were some limitations within this study. One of the limitations within this study is that it failed to look at whether the gender of the therapist and their client affects whether touch is utilised within in the therapeutic setting. Through the quantitative research conducted it could be seen there was a statistically significant difference in whether touch would be valued by men or women more in a clinical showing that women appear to value it more. However, as it wasn't investigated whether the individuals who completed the NFIT questionnaire had ever been a client in a therapeutic relationship this could have affected the results.

Another limitation of this study is the NFIT questionnaire as it assessed in an individual's need for interpersonal touch. This aspect of the research may have benefited more with the Comfort with interpersonal Touch scale and the NFIT combined or the CIT alone as

it assesses an individual's comfort with touch which would have been more appropriate in this study.

As the interviews for IPA are analysed by the researcher and they have to make sense of people's own experiences the results can be biased by the researcher. Although this is accepted within the IPA approach future research could benefit from having another researcher analysing the transcripts to possibly obtain more accuracy and also a further perspective from the information.

#### **4.3 Strengths of the Current Study**

Although there were a number of limitations within the study there were all some strengths. This study took an interview approach in which not many studies have utilised, and due to the use of interviews and purposive sampling direct knowledge from people in the area was acquired, and expanded on the current knowledge within this area further.

Compared to the research found within the literature this sample consisted of individuals who, although may have used touch at some point, found that it should not be used within a therapeutic setting which was an interesting finding. The sample was also equally split among men and women providing an equal perspective.

Another strength within this study was also looking at the perspective of the therapist being the client and if they felt they would appreciate touch as comfort which was an aspect that had not been looked at before.

#### **4.4 Future Research**

If this study were to be repeated future research should aim to develop a broader range of questions for the IPA approach prior to the interviewing process as to gather as much knowledge in the area, and include further questions such as whether gender affects the use of touch. A larger sample size also may be beneficial, as although the sample in this research is an acceptable size for an IPA approach more information could be gathered from a broader range of clinicians.

As the need for interpersonal touch questionnaire didn't specifically target people who had been a client in a therapeutic process it would be interesting if future research would look at clients in a therapeutic setting to see whether their gender affects whether they would appreciate touch in such a setting.

#### **4.5 Conclusion**

Whilst the importance of touch in healthy development and as a form of communication has been acknowledged the use of touch in therapy is still an area which needs to be challenged in order for our understanding of touch in a clinical setting to move forward. From the research obtained within this sample the use of touch is not advocated by any of the participants during the process unless as an introductory or parting gesture as this appears to be socially acceptable and offers no precedence. Although two participants discussed their use of touch during the process they found through their experiences that they should express feelings of comfort or empathy verbally rather than with contact. Although sexualisation of touch was a common reason as to why touch isn't used in literature this was not mentioned by the participants of this study, the many facets of why touch should not be utilised within therapy mentioned were; limiting the client, crossing professional boundaries, augmenting power differentials and the individual client. Also none of these therapists had been trained in the use of touch which could explain why none advocated its use or were unsure after they had used it. This study also investigated the perspective of everyday individuals need for touch which was found to be high though they are unsure if they would appreciate it in a clinical setting. There was a statistically significant result between men and females and if they would value touch in therapy suggesting that females would value touch as comfort in therapy more than males. However this finding would have been better investigated had it been done on individuals who had experience as a client in a clinical setting. It is important for future research to investigate touch within the therapeutic setting as touch is both an ambiguous and powerful form of communication and its use requires careful consideration. It is hoped that this research will further expand on the knowledge within the area of touch and promote a more open dialogue on the topic such as investigating a client's perspective as well as encourage the training of touch.

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## **Appendix A**

### **Qualitative consent form**

Hello, my name is Meagan Kearney and I'm currently in the final year of my BA(Hons) Psychology degree at the National College of Ireland and you are being asked to take part in a research study on the role of touch in a therapeutic setting.

Please read this consent form. If you have any questions, please feel free to e-mail me ([meagancarmel@gmail.com](mailto:meagancarmel@gmail.com)) and I will answer as soon as possible.

The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and you will not be subjected to reprimand or any other form of reproach.

My study will be looking at therapeutic touch - which was described by Willison & Masson (1896) as physical contact between the therapist and the hands, shoulders, legs or arms or upper back of their client - and the questions asked will be to assess your opinion in the area. Your participation in this study, and any answers you provide, will remain anonymous. The data generated during this study will be stored by the researcher and will only be accessed by the researcher. This data will not be given to any outside body. Also, when using direct quotes - with your permission - pseudonyms will be provided to protect anonymity further. If you feel there is a question that should have been asked or would like to discuss please feel free to supply any information on that topic during the interview.

The interviewing process shouldn't last longer than forty five minutes and interviews will be recorded to ensure all answers are obtained correctly and can be analysed correctly, all audio and written scripts will be deleted and shredded after they've been analysed.

“I have read the above statement and have been fully advised of the procedures to be used in this study. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risk involved. I likewise understand that I can withdraw from the study at any time without being subjected to reproach”.

Please sign your name or tick the box to show your consent to take part within this study

Participant Signature: \_\_\_\_\_

Researcher Signature: \_\_\_\_\_

## Thank You

## **Appendix B**

### **Interview Questions**

(1) Gender; Male or Female

(2) What area of psychology did you specialise in? And also how long have you been practising in this area?

(3) (a) What is your opinion on the use of touch in a therapeutic relationship?

(b) Do you feel touch when combined with appropriate language can have the propensity to benefit the client?

(c) Do you consider it taboo?

(4) Have you yourself had positive or negative experiences, if you have used touch as part of therapy?

(5) (a) Is touch something that you are trained on the use of?

(b) Do you expressly try to avoid it in your therapy and if so, why? If not, how do you view it.

(6) A bond is formed between a client and therapist, do you feel that when a client is ready to move on that a hug or other form of touch is appropriate?

(7) What forms of touch would you most commonly use? (eg. handshake, hand on the shoulder)

(8) If you were in a therapeutic setting would you value physical comfort if you were upset?

## **Appendix C**

### **Quantitative Consent form**

Hello, my name is Meagan Kearney and I'm currently in the final year of my BA(Hons) Psychology degree at the National College of Ireland and ask if you could please spare some time to answers some questions.

You are being asked to take part in a research study investigating the role of touch within therapy. If you have any questions, please feel free to e-mail me ([meagancarmel@gmail.com](mailto:meagancarmel@gmail.com)) and I will answer any questions you may have.

The following information is provided so that you can decide whether you wish to participate in the present study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and you will not be subjected to reprimand or any other form of reproach.

My study will be looking at the role of touch in therapy - which was described by Willison & Masson (1896) as physical contact between the therapist and the hands, shoulders, legs or arms or upper back of their client. You will be provided with the “Need for Interpersonal Touch” which you will be required to fill out. It should take no longer than 5-10 minutes. Your participation in this study, and any answers you provide, will remain anonymous. The data generated during this study will be stored by the researcher and will only be accessed by the researcher. This data will not be given to any outside body.

“I have read the above statement and have been fully advised of the procedures to be used in this study. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risk involved. I likewise understand that I can withdraw from the study at any time without being subjected to reproach”.

Signature of participant: \_\_\_\_\_

Signature of Researcher: \_\_\_\_\_

**Thank You**

## **Appendix D**

### **Questionnaire**

#### **Need for Interpersonal Touch Questionnaire**

1 = strongly disagree

4 = neither agree or disagree

7 = strongly agree

Age \_\_\_\_\_

1. Gender

Male / Female

2. In some situations, touch can be more meaningful than language.

1, 2, 3, 4, 5, 6, 7

3. Birthday congratulations just have to include a hug.

1, 2, 3, 4, 5, 6, 7

4. Interpersonal touches strengthen trust.

1, 2, 3, 4, 5, 6, 7

5. I frequently use physical contact in conversations with members of the opposite sex.

1, 2, 3, 4, 5, 6, 7

6. During a conversation it may well happen that I touch the arm of my conversational partner.

1, 2, 3, 4, 5, 6, 7

7. It is important to me to shake hands when saying goodbye.

1, 2, 3, 4, 5, 6, 7

8. In general, I avoid having physical contact with other people.\*

1, 2, 3, 4, 5, 6, 7

9. It is a pity that people depend so much on the internet for communication, because it allows no physical contact. 1, 2, 3, 4, 5, 6, 7

10. For me, greeting someone with a hug is normal, even if I do not know the person that well.

1, 2, 3, 4, 5, 6, 7

11. Shaking hands helps me to appraise the personality of a foreign person. 1, 2, 3, 4, 5, 6, 7

12. During a discussion among friends it happens that I touch my opponent to emphasize a statement. 1, 2, 3, 4, 5, 6, 7

13. I don't mind if someone touches me on my arm to get my attention. 1, 2, 3, 4, 5, 6, 7

14. In conversations with friends, touches are an important form of communication.

1, 2, 3, 4, 5, 6, 7

15. Hugs as greetings make me uncomfortable.\* 1, 2, 3, 4, 5, 6, 7

16. Physical contact is important when you want to console a friend. 1, 2, 3, 4, 5, 6, 7

17. I frequently use physical contact in conversation with members of the same sex.

1, 2, 3, 4, 5, 6, 7

18. By physical contact I can convey my affection for someone. 1, 2, 3, 4, 5, 6, 7



19. If my conversational partner softly touches me during a conversation, that doesn't bother me.

1, 2, 3, 4, 5, 6, 7

20. When communication via the internet or cell phone I miss physical closeness.

1, 2, 3, 4, 5, 6, 7

21. I don't like when strangers touch me in a conversation.\*

1, 2, 3, 4, 5, 6, 7

22. If you were in a therapeutic setting would you value physical comfort if you were upset?

1, 2, 3, 4, 5, 6, 7

Need for Interpersonal Touch Questionnaire NFIPT PsycTESTS™ is a database of the American Psychological Association