

THE ETHICS OF TOUCH IN CONTEMPORARY PSYCHOTHERAPY

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INTRODUCTION

In this paper, I examine the reasons for recognising the body as an integral part of the therapeutic process in contemporary psychotherapy. I explore the question of whether appropriate touch might have a useful and ethical place in body-inclusive psychotherapy treatment. I draw on relevant research studies and case material to illustrate the range of situations in which touch is utilised, and consider their ethical implications.

With reference to relevant ethical frameworks, I provide a critical analysis of the literature on the risks and benefits of touch in therapy, and suggestions for when touch may be useful in psychotherapy. I conclude with recommendations for training psychotherapists in the ethical use of touch.

MY OWN BACKGROUND

To situate myself in this topic, I briefly describe my experience, training and practice of touch within psychotherapy. For five years, I had therapy with a psychotherapist who specialised in biodynamic psychology and massage, a form of body psychotherapy developed by Gerda Boyesen (Carroll 2002; Schiable 2009). During the first two years of the therapeutic process, massage was the main treatment I received, particularly for my back, neck and head. In later years, the focus shifted to verbal exploration of my relational experience, intrapsychic dynamics, and the transference.

The structure of my body, and my relationship to it, changed significantly during this time: the deep muscle tension in my back and neck softened, and I began to feel more nurtured and alive. This helped me contact and experience my emotions, and process these in therapy. I learned about self-care and emotional regulation in the context of a supportive psychotherapy relationship. Concurrently with this therapy, I trained in biodynamic massage as one intervention within somatic psychotherapy.

Three years later, in 1989, I began practice as a somatic psychotherapist, and included the option of touch or massage with clients for whom it seemed appropriate. I found that some gained benefit from combining a form of touch with verbal work, while others felt no wish or need to work directly with the body. I later studied and incorporated other modalities into my approach, particularly object relations theory and psychoanalytic self psychology.

Over time my use of touch has diminished, as I have learned to reflect on all my interventions and find more subtle ways to hold and connect with patients. I now focus on deepening emotional experience and building the client's sense of self, through empathic attunement and the intersubjective relationship. This reflects a general trend I perceive amongst somatic psychotherapists, away from active methods and towards more relational, integrative work, while continuing to recognise the body and affects as central to the experience of self.

For seven years, I taught students at the Australian College of Contemporary Somatic Psychotherapy how to understand, assess, utilise and integrate touch within psychotherapy. In my practice now, I use touch very occasionally but at times find it useful, even necessary. In what follows I examine and reflect on my use of touch in the light of contemporary theory, evidence and ethical considerations.

OBJECTIONS TO THE USE OF TOUCH IN PSYCHOTHERAPY

While the use of touch in therapy has gained wider acceptance in recent years, there remains a persistent strain of criticism from the worlds of both psychoanalysis and psychology. US psychologist Alan Karbelnig (2000) has summarised the traditional case against the use of touch. He identifies nine specific problems, all of which he believes 'risk harming the psychotherapeutic enterprise by destroying the psychotherapeutic frame'. He argues that the use of touch will render the transference and/or counter-transference 'concrete', by acting on feelings as if they are real, rather than something symbolic, to be explored therapeutically.

He also asserts that physical touch can easily be construed, consciously or unconsciously, as incestuous; that is, as sexualised touch, inappropriate to the therapeutic relationship. This belief leads opponents of touch to the view that clients who have experienced sexual abuse will be particularly vulnerable to confusion over the use of touch and, hence, at risk of retraumatisation.

Karbelnig suggests that touch might encourage a patient into ‘malignant regression’, as defined by Balint (1968), by attempting to meet an insatiable demand for gratification. He acknowledges that psychotherapists must continually distinguish between benign and malignant regressions, as they require different treatment responses, but he believes the inclusion of touch could render this distinction impossible to make.

He argues that ‘physical affection’ is not an appropriate gratification from psychotherapy, and that patients should be supported to obtain the intimate contact they need elsewhere in their lives. Karbelnig cites Gabbard’s (1989) view that one boundary violation can lead the therapist down a ‘slippery slope’ toward more serious violations, and that touch might restrict the range of feelings a patient may feel able (consciously or unconsciously) to express to the therapist. He further suggests that therapists who hug or comfort patients may be attempting to take away the patient’s (or their own) emotional pain, because unconsciously they are not able to tolerate those feelings.

These arguments echo those of Patrick Casement (2002), in his case of a patient who, in a state of regression, asked him to hold her hand. Casement at first agreed, but on fuller reflection, declined. He describes the subsequent working through of this as ultimately beneficial for the patient, and therefore a vindication of the rule of abstinence from touch (Fossage 2000).

Casement’s argument against touch in particular, and what Alexander termed ‘corrective emotional experiences’ in general, is that they fail to allow the analytic freedom for the patient ‘to use the therapist in those ways that relate to the earlier experience and inner world of the patient’ (Ball 2000/2002). This is an important aspect of the psychoanalytic method, and why it recommends abstinence as a ‘default’ position. The purpose is to leave the interpersonal field as clear and neutral as possible, so the projections and experiences of the patient can be made conscious and worked through.

However, Ball notes that Winnicott (among others) came to believe that certain patients do in fact need to regress to a dependent state where literal holding is necessary. She quotes from a 1949 letter by Winnicott that conveys the significance and complexity of including touch in response to a deeply regressed patient:

Naturally analysts always get worried when one talks about (physical) contact with patients and I realise this is dangerous territory. Nevertheless I feel that when there is

an absolutely genuine regression to a very early stage of development there must be something wrong with an analyst who cannot provide contact if it is needed. Such contact, when it has to be provided, puts a very big strain on the analyst and I would never give it if I could avoid it. (Ball 2000/2002).

Even for psychotherapists who do not practise classical psychoanalysis, the risks that Karbelnig enumerates are relevant, and generate questions such as:

- Will touch create confused messages in the client's mind about the nature of the relationship, or where the boundaries of the relationship lie?
- Will touch be interpreted as sexual, even if it is not intended that way?
- Will touch be used to gratify the therapist rather than respond to a need within the client?
- Will touch be used to gratify a patient's unmet developmental needs without sufficient working through of these issues?
- Will the client feel genuinely able to refuse touch and/or communicate their response honestly?
- Will touch be used, by either client or therapist, as a means to avoid what needs to be addressed in the therapy, such as emotional pain or confronting unmet needs?

Having outlined the objections to using touch in psychotherapy, I now turn to the evidence in its favour.

RELEVANCE OF THE BODY IN PSYCHOTHERAPY

To contextualise this question, I will briefly review the relationship between psychopathology and the body, particularly the research on child development, attachment and neuroscience. Allan Schore's (2003) extensive work on affect regulation describes how repeated failure by a caregiver to regulate an infant's distress can result in the infant experiencing a state of hyperarousal that is followed by dissociation. This pattern correlates with Bowlby's (1969/1999) 'protest and despair response to attachment ruptures'.

This cycle, given enough repetitions, becomes imprinted on the maturing limbic system of a child's brain, and 'endures as a basic strategy of affect regulation', in the form of dissociation and projective identification. Schore's research demonstrates the biological evidence that underpins psychological difficulties, and leads him to suggest that providing relationally based affect regulation is what will build the new brain pathways and hence, self-structure, in the patient.

Ashley Montagu's (1971/1986) comprehensive survey of the critical importance of touch in human life documents how essential touch is, particularly during childhood. Bruce Perry's (2006) work on childhood trauma demonstrates that the earlier the trauma, the deeper in the brainstem is the child or adult's unconscious fear response, which leaves them prone to thinking and acting in unreflective ways, which are not accessible to verbal interventions.

Perry has found that repeated nurturing experiences that calm and reorganise the trauma state are required to help traumatised children develop more functional behaviour patterns. He recommends nonverbal interventions, such as reassuring touch, rocking, quiet presence, humming and singing, to de-escalate the child's arousal state (Perry & Szalavitz 2007).

To advance our understanding of the possible benefits of touch in therapy, the field of contemporary psychotherapy needs to recognise the evidence regarding deep levels of attachment-related 'injury' in the brains of many patients. The implications of the work of Perry and others could be factored into an evidence-based approach to psychotherapy, and to assessing the ethics of non-traditional interventions such as movement and touch.

BODY-INCLUSIVE PSYCHOTHERAPY APPROACHES

A number of writers have documented ways to adapt psychotherapy to the neuroscientific evidence. Bessel van der Kolk (1996) is a long-time advocate of recognising the neurobiological underpinnings of trauma, and the need to adapt psychotherapy to help traumatised patients change their patterns of brain regulation.

Others include Daniel Siegel (1999), who recommends working within the emotional 'window of arousal', and Bonnie Badenoch (2008), who argues that the therapist's relational style should actively provide safety, support, psycho-education, and an emotionally connected 'right-brain' receptive state.

Psychoanalyst Susie Orbach (2004a) has long explored the significance of the body in psychotherapy. She notes that as touch plays an essential role in normal attachment, it may be appropriate to use touch at certain times in the analytic relationship.

Trauma practitioners Babette Rothschild (2000), Peter Levine (1997) and Pat Ogden (2006) have each developed specific treatment styles to work psychotherapeutically with the body-experience of traumatised patients. They focus on calming and regulating the nervous system in order to process traumatic memory. These schools of thought utilise close verbal tracking of the client's experience and graduated ways to access, retreat from, and reprocess traumatic feelings.

Rothschild, in somatic trauma therapy, discourages the use of touch and believes it is not appropriate for traumatised clients. However, the other schools recognise that touch may play an important part in the therapeutic work. Levine's school of somatic experiencing trains practitioners to reprocess patients' traumatic reactions and memories, by finding a creative organismic response to bodily-held trauma. The strategies used in this experiential approach 'might involve light touch work to support the subtle body as it moves from the immobile state of freeze or dissociation to the active sympathetic state of action' (Decker 2011).

Pat Ogden (2006) adopts a cautious position on the use of touch in sensorimotor therapy:

Although touch can be therapeutic, there are potential pitfalls and it must be used cautiously and judiciously, if at all. If therapists choose to use touch in their clinical work, they should be well trained not only in the use of touch itself, but also in combining touch with psychotherapy.

LITERATURE ON TOUCH IN PSYCHOTHERAPY

There are numerous writings on the methods, rationale and ethics of touch in the therapeutic relationship, including several research studies into patients' experience of receiving touch in this context. In their overview of the use of touch in psychotherapy, Hunter and Struve (1989) reference Carl Rogers' advice, that therapists should have faith in their ability to respond authentically to clients, making it possible, in a group setting, to 'respond with physical contact when this seems real and spontaneous and appropriate'.

Hunter and Struve note the shifting cultural trends that brought touch from having increased acceptance in the 1970s to fall into general disfavour by the late 1980s. This shift was possibly fuelled by the number of sexual boundary violations that occurred in group and individual therapy over that time (Pope & Keith-Spiegel 2008). Touch became associated with loose boundaries and the exploitation of clients (Ball 2000/2002), and an understandable tightening of standards followed.

Ofer Zur (2004/2006) has examined the clinical, ethical and legal implications of touch in psychotherapy. He notes that the Western scientific 'mind-body' split has contributed to an historical avoidance of the body in psychoanalysis. Zur suggests that despite the multitude of forms and intentions of touch in therapy, Westerners – particularly men – are socialised towards a sexualised view of touch, and therefore place a stronger taboo upon it in professional contexts.

Zur asserts that touch in psychotherapy is not inherently unethical, and that the meaning and appropriateness of touch should be assessed within the context of the particular client and therapeutic setting. He argues that non-verbal communication has an important place in many clients' recovery and that therapists can be educated to use touch effectively and ethically.

In considering whether it is beneficial or detrimental to the patient's progress to have touch added to their treatment, the origins of the taboo on touch are relevant. Although Freud and others used touch with patients in the early years of psychoanalysis, it soon became excluded from the model, as the principles of abstinence, neutrality, non-gratification and verbal free association were established.

Intersubjective psychoanalyst James Fossage (2000) notes that 'paradigm shifts from positivistic to relativistic science, and from an intrapsychic to an intersubjective or relational model'; mean that the classical analytic position is no longer an adequate reference point. He further states:

Recognising the analyst's contribution to the analysand's transference experience makes us far more aware of the subtle, complex verbal and nonverbal communications that take place... (and)... opens the door for us to consider a vast array of interventions, including touch, that may or may not be facilitative.

Margot Sunderland (2004), argued at the John Bowlby Memorial Conference that, ‘there *is* safe touch in the consulting room, when not to do so would be a failure of compassion’ (italics in original). This view suggests that caring, context-specific touch may be far more common in psychotherapy than many realise.

Susie Orbach (2004b) details several cases where a specific form of touch was pivotal to the patient’s recovery. One striking example is a patient with vaginismus who asked for a hug from her male therapist. Through consenting to the intervention, the therapist experienced a strong counter-transference of revulsion towards the client’s body. By processing his counter-transference in supervision, he was able to transform his response and communicate a deeper acceptance to his patient. This led to a significant shift in her self-perception and her acceptance of her own body. Orbach reports: ‘Her vaginismus dissolved... This woman could not progress delimited by words. She needed a body to accept her body’.

There are many similar examples in the literature of touch interventions that have been carefully reflected on and processed relationally by therapist and client. Kohut, for instance, once described offering two fingers to be held by a patient who was in deep despair (Fossage 2000). Balint was a psychoanalyst who recognised the importance of touch, not only for patients in deep regression, but also towards the end of treatment, to communicate affection and mutuality (Fossage 2000).

Winnicott reported several cases where he held patients’ hands at times, in an effort to create a sufficient ‘holding environment’; Margaret Little - one of Winnicott’s patients - gave a personal account of her psychoanalysis with Winnicott, describing it as a life-saving treatment which included touch (Ball 2000/2002). It may be that Winnicott’s willingness to explore beyond the analytic frame with regard to touch was in part due to his many years spent as a paediatrician, child psychiatrist and foster father, since the need for appropriate touch arises more commonly in work with children (Winnicott 1958/1975).

CLINICAL CASE EXAMPLES

Below are two brief treatment summaries that illustrate the effective use of touch within long-term psychotherapy:

‘Catherine’ is a 41-year-old woman who suffered physical violence during childhood and bullying at school. She bottled up her feelings for many years, experiencing pressure inside her chest and tension throughout her torso. In the second year of her therapy, Catherine moved to lying on the couch, and I began to use massage of her upper back and neck to relieve her muscular tension and free the constriction in her breathing.

As her body softened, Catherine began to access deep sadness and hurt, and gradually there emerged feelings of fear and rage, along with powerful memories of abuse. For several years, Catherine processed her childhood and adult traumas within the therapeutic relationship, with occasional use of both releasing and comforting touch. At times she asked for a hug at the end of a session, which provided support and reassurance. Over eight years of therapy, Catherine learned to regulate her emotions, assert herself effectively, and take care of herself in new ways, without accumulating stress and tension in her body.

‘Deborah’ began therapy at age 32, having experienced sexual abuse during childhood, which left her feeling betrayed by both parents and unable to form an intimate relationship. We explored many of her difficulties through verbal psychotherapy and, as her defensive layers softened, her trust towards me grew.

Touch was not typically part of Deborah’s therapy, however in one session she contacted a level of vulnerability and fear that seemed to overwhelm her. Deborah froze and became dissociated as she relived memories of crying alone as a young child. I asked if I might place my hand on her back, and she agreed. Her crying deepened into sobs as she spoke of the memories that arose. Deborah reported that this experience of touch helped her process her traumatic feelings with a knowledge that I was close by and supporting her. It allowed a ‘new relational experience’ to occur (Shane, Shane & Gales 1997), instead of a repetition of the isolation from her past.

EMPIRICAL RESEARCH STUDIES

A 1998 US survey explored patients’ positive and negative experiences of receiving touch in therapy. The 231 participants were 84% female and 16% male, and the vast majority had had same-gender therapists. Sixty-nine per cent of respondents said the touch ‘created a feeling of bond, closeness, or a sense that the therapist really cared, thereby facilitating increased

trust and openness'. Forty-seven per cent also said the touch 'communicated acceptance and enhanced the patient's self-esteem' (Horton 1998).

On the negative side, 15% of the sample reported they had experienced 'unwelcome, intrusive, seductive or outright sexualised touch' from a therapist. Three factors reportedly correlated with positive evaluations of receiving touch: (1) That the touch felt congruent with the patient's needs; (2) That the client felt the therapist was sensitive to his or her reactions to touch; and (3) That the patient was able to communicate openly about their feelings towards the therapist.

These results shed light on the conditions that may support a positive experience of touch. A limitation of the research, though, is that the sample comprised voluntary participants, and is not predictive of the number of clients overall who experience touch in their therapy, or the proportion who find touch beneficial.

Strozier, Krizek and Sale (2003) conducted a survey on the incidence, type and reason for touch by clinical social workers in the USA. In this sample of 91 experienced practitioners, 84% of whom were female, 95% used touch with clients at least some of the time, and 29% used it often or very often. Respondents came from a wide range of theoretical orientations, from psychodynamic to systems theory, and clearly distinguished those times when they chose not to touch, based on their assessment that it may be experienced as intrusive, threatening, or inappropriate.

THE ETHICAL DIMENSIONS OF TOUCH

While sexual contact between therapist and client is a universally prohibited behaviour, the foregoing review of evidence reveals that the meaning, risks and potential consequences of non-erotic touch are viewed differently in different theoretical paradigms and professional contexts.

The stance of traditional psychoanalysis on non-erotic touch is predominately prohibitive. Other schools of psychotherapy, such as gestalt, somatic and body psychotherapy, see a therapeutic role for non-erotic touch when it is utilised thoughtfully, appropriately and ethically; as do the relativistic psychoanalysts and intersubjectivists, who are prepared to consider the specificity of each situation and make a clinical judgement as seems appropriate.

To assess the ethical matters relating to the use of touch in therapy, I will review the ‘virtues and principles’ of good professional practice (Freeman 2000), and consider the consequences of using touch in the light of these. Recognising that moral standards are relative to culture and context, I will examine postmodern and feminist contributions to ethics and the question of touch.

In terms of the nine ethical values most cited by master therapists, Jennings, Sovereign, Bottorff, Mussell and Vye (2005) state that ‘beneficence and nonmaleficence’ are central to the primary therapeutic goal of advancing the client’s recovery and growth. Jennings *et al.* suggest that, rather than referring only to ideology or belief, a competent therapist will consider the evidence and be open to ‘complexity and ambiguity’, as well as valuing self-awareness and their own professional growth.

Kim Fuller (2006) has considered touch in light of the general principles of the American Psychological Association (APA) 2003 code of ethics. The APA code identifies the principles of beneficence and nonmaleficence as primary to ethical professional conduct. Other relevant principles in the APA code are informed consent, justice, integrity, fidelity, responsibility, and respect for the rights and dignity of the client, including their capacity to say no to any intervention. Fuller argues that any use of touch, to be considered ethical, must conform to these principles.

To implement ethical principles requires an understanding of what constitutes good practice (Bond 1993). Benjamin and Sohnen-Moe (2003) suggest that to use touch responsibly, certain core psychological concepts must be understood, namely: ‘the meaning of the therapeutic relationship; power differential; transference; counter-transference; projection; repression; and denial’.

These writers note that the therapeutic relationship is one in which the patient is particularly vulnerable, because of the immature or unconscious aspects of self that tend to activate in therapy. This point highlights the complexity of assessing the impact of touch for a patient, since it will depend very much on the individual patient’s experience prior to and during therapy, as well as the therapist’s theoretical and clinical perspective. It also highlights the responsibility of the therapist to be aware of the power imbalance in the relationship, and notice subtle cues from the patient, both verbal and non-verbal, regarding the idea or use of touch.

Donna Orange (2011) advocates a 'hermeneutics of trust', based on the philosophies of Gadamer and Levinas, in which 'our ethical response coincides exactly with our clinical vocation to restore dignity to... suffering human beings like ourselves'. She quotes Frieda Fromm-Reichmann's practice guidelines, which were simply: 'Find whatever will work for this particular patient, and... trust as your guide the patient's own capacity for healing'.

Bowden's (1997) ethics of caring expands on this perspective. She articulates how 'postmodern disenchantment with the universalities and exclusions of 'master discourses' has produced a focus on... contextual accounts... that encourage respect for the differences between persons and sensitivity to the complexity of our interconnections'.

It is noteworthy that many of the qualities that professional therapists bring to the therapeutic relationship arise from and overlap with caring behaviour by individuals, particularly women, in non-professional contexts. Such behaviours include listening, showing empathy, and touching to express care and support. It is possible that the 'professionalisation' of care, combined with the quest for a science of behaviour, have led the field of psychotherapy away from more traditional (and feminine) forms of caring.

This view gains support from Gilligan's distinction between the moral reasoning of women compared to that of men, wherein she asserts that women take a more concrete, contextualised and relationship-oriented view of ethical dilemmas (Grimshaw 1991/2000). A feminist ethic of caring may help to expand the critique of the effects of touch in psychotherapy beyond that offered by the 'master discourse' of psychoanalysis.

It has been suggested that touch is an activity which is thought about, and engaged in, differently by men and by women in our culture (Caldwell 1999). Caldwell cites evidence that male therapists associate touch with sexuality to a greater extent than do female therapists, which might influence their thinking on how easily touch becomes sexualised in the mind of client or therapist, and the other possible meanings it may have. Zur (2004/2006), cited above, echoes this view.

Bringing a postmodern perspective on ethics in psychotherapy, Louis Hoffman (2006) stresses that counselling and psychotherapy are socially constructed practices, and hence require us to recognise the validity of cultural variations. He cites touch as one example of a practice that varies in its use and meaning from culture to culture, and between men and

women. He recommends that therapists ‘think about touch contextually and critically’, rather than assume that the avoidance of touch is ethically correct.

RELEVANT AUSTRALIAN ETHICAL CODES

I will briefly review the Code of Ethics of four Australian professional associations in relation to touch: the Psychotherapy and Counselling Federation of Australia (PACFA), the Australian Psychological Society (APS), the Australian Association of Social Workers (AASW), and the Australian Somatic Psychotherapy Association (ASPA). Both the PACFA (2012) and APS (2007) codes makes no direct reference to touch; however, both include a clause requiring that members will only provide services within the bounds of their professional competence, as defined by their training, supervision and experience.

The AASW (2010) code of ethics refers to physical contact rather than touch, and makes provision that social workers ‘will avoid any form of physical contact which may violate professional boundaries, result in unintentional psychological damage or harm the professional relationship.’ It also requires social workers to be sensitive to the variety of ways in which physical contact may be interpreted, with particular regard to differences of culture and gender.

ASPA (2011), a member association of PACFA, specifically recognises therapeutic touch in its ethical code. It states:

The behaviour of the somatic psychotherapist should not be sexually seductive or create ambiguity or confusion about sexual boundaries. Physical touch is used by Somatic Psychotherapists for therapeutic purposes only. Physical contact, whether initiated by the client or Somatic Psychotherapist, which has as its purpose some form of sexual gratification, or could reasonably be construed by persons with a comprehensive understanding of the modality as having that purpose, is unethical.

The ASPA code draws a clear distinction between sexualised, seductive or ambiguous touch, and touch for therapeutic purposes. The deeper ethical questions remain, however: is touch actually beneficial to clients, what are the risks of using touch, and are they worth taking?

CRITIQUE OF ARGUMENTS FOR AND AGAINST TOUCH IN PSYCHOTHERAPY

The argument that touch necessarily disturbs the therapeutic frame, and destroys the symbolic space in which therapy takes place, is not convincing to me. The range of evidence cited above shows that many clients who undergo life-changing psychotherapy do experience and benefit from minor forms of touch as part of their therapy relationship, even though it is equally clear that for many others, touch would be unnecessary or intrusive. I suggest that with sufficient skill and knowledge, the therapeutic frame can be kept safe and professional while also reflecting the context, culture and individuality of both parties.

Most practitioners now recognise that there is no single meaning for any phenomenon, whether this be an action, a dream or a word (Stolorow, Atwood & Orange 2002). The responsibility to attune, reflect and understand the meaning for each patient is incumbent on the psychotherapist, and indeed, is central to the work.

While there is clearly a risk that using touch might reinforce a ‘malignant regression’, or a fantasy that the therapist will fix the patient through such means, this possibility should be carefully considered and factored into whether or not touch is appropriate. Likewise, the risk of retraumatisation for clients who have been physically or sexually abused must be thoughtfully considered before any touch is suggested or employed.

In my experience, transference (and counter-transference) are ubiquitous phenomena that will manifest in the consulting room whether touch has taken place or not. Neutrality and abstinence are no longer ‘de rigueur’ for many contemporary psychotherapists, and indeed, the neuroscientific evidence and common factors research (Imel & Walpold 2008) suggests that an interactive, supportive relationship is more conducive to healing. Nor is the body-mind split, and the attendant avoidance of the body and the affects, supported by the evidence on attachment, trauma and child development (Adults Surviving Child Abuse 2013; Schore 2003).

Postmodern psychoanalytic paradigms, such as relational and intersubjective psychotherapy, privilege what Howard Bacal terms the ‘specificity’ of the client-therapist dyad as the primary source of meaning derivation (Teicholz 2009). These approaches also recognise the inevitable co-creation of the analytic experience, in which the individuality of the analyst unavoidably plays a significant part.

Those who object to inappropriate, ill-timed, intrusive, imposed or non-consensual touch make a valid point: that touch is ‘more emotionally powerful... and more ambiguous... than verbal communication’ (Smith 1998), and, if used inappropriately, can harm the client. However, the bulk of the research surveyed above indicates that touch can be, and is, used to good effect by a significant number of psychotherapists, not all of whom are somatic specialists.

The evidence cited above suggests that supportive, affirming touch can add to a client’s sense of connection with, and care from, their therapist, and that appropriate touch at moments of deep regression can assist a patient’s growing sense of safety and recovery.

These studies further indicate that therapists who use touch make a clear distinction between nurturing, client-centred touch, and touch that is not therapeutic due to its sexualised or inappropriate nature. Bar-Levav (1998) suggests that therapists’ fears that touch will become sexualised in the mind of client or therapist, or that it will lead to confusion about where the professional boundaries lie, reflect their own anxieties and lack of experience regarding touch.

This survey of the theory and evidence surrounding touch in contemporary psychotherapy seems to point away from ‘if’ and towards ‘when, how and why’ to use touch in therapy. It also highlights the power of touch, for good or ill, and raises the importance of adequate training, experience and supervision for practitioners who wish to incorporate touch into their work.

RECOMMENDATIONS FOR TOUCH-INCLUSIVE PSYCHOTHERAPY

Contact and holding in psychotherapy are usually symbolic rather than real; hence, any physical touch should be consistent with the context of a ‘holding’ therapeutic relationship. Any intervention, be it verbal or non-verbal, should flow from the sensitivity and understanding of the therapist in response to the particular needs of the client. If touch is offered, it must be integrated within the therapeutic relationship and discussed appropriately with the client before, during and afterwards.

In general, I believe it is advisable not to touch a client who is experiencing strong affect, but rather, allow them space to feel and express their emotion, and offer regulation without touch.

Words, sounds and presence are often sufficient to support a client who is experiencing overwhelming feelings such as anger, fear or sadness. However, the literature, and my own experience, point to several key instances when touch may be appropriate and may potentially advance the therapeutic goals of a client. These are:

1. Touch can confirm and deepen the connection between therapist and client, communicating a sense of care, support and recognition of the client as a person. Examples include a handshake on first meeting or a hug at the end of a session.
2. Touch can provide safety and soothing to a client who is fragmented or overwhelmed by their emotion, on occasions when they cannot be regulated any other way. In such cases, holding a hand or supporting the back might offer a more concrete experience of the therapist's caring presence than words can provide.
3. Touch can be useful to help clients reintegrate their sense of self after a powerful emotional experience. This might occur rarely, or during a particular phase of a person's therapy. At such times, touch can help reinforce a client's new relational experience, in which safety and vulnerability are experienced directly within the therapeutic relationship.
4. There may be occasions when touch can help a client establish and deepen their connection to their bodily experience. Even though this might be achievable merely through words, if there is sufficient safety and trust in the relationship, the addition of touch may enhance the client's connection with their body and the feelings it holds.

RECOMMENDATIONS FOR TRAINING OF PRACTITIONERS

Learning to attune to the client and provide a 'holding' relationship are fundamental to body-inclusive psychotherapy training. In addition to verbal and relational skills, students need to learn to observe and respond to the whole range of a client's presentation, including their words, facial and bodily expression, gestures, affects and moods. The training process should integrate contemporary theory, clinical skills and experiential learning in a safe learning environment.

Just as all therapists need extensive experience in their own therapy to adequately understand and respond to clients at depth, therapists need to work through their own reactions to

receiving and giving touch, in order to comfortably offer touch in a thoughtful and sensitive manner. Such reactions can include the fear of invasion, engulfment, sexualisation or abuse, as well as unmet needs and hunger for touch. Practitioners need to develop a relationship with their own body and be sensitised to a client's potential range of affective-bodily experience, in order to make effective use of therapeutic touch.

Additionally, training in the different forms of therapeutic touch, and how these impact on different clients at different times, is important. There are specific styles and intentions involved in a range of techniques, that require understanding and practice in order to be used safely and effectively (Carroll 2002; Schiabe 2009). Just as verbal skills take many years to develop and hone, so too the skills of therapeutic touch require training, reflection and experience to mature.

CONCLUSION

Contemporary evidence on the role of the body in psychopathology, as well as contributions from the fields of neuroscience, trauma theory, postmodern and relational theories, suggest it may be time to re-examine the assumptions and implications of using touch in psychotherapy. The range of possible meanings that touch might hold for a client, and for the therapeutic relationship, will vary with the context, background and understanding of both therapist and client.

For some clients in psychotherapy, touch may be an appropriate and ethical intervention, providing the motivation of the therapist, the meaning for the client and the impact on the therapeutic relationship, are adequately reflected on. These considerations should be explored in professional supervision, in the usual way in which all interventions and responses are reflected on, so that clarity of understanding can emerge and guide the therapist's clinical decisions.

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