THE USE OF TOUCH IN PSYCHOTHERAPY: ETHICAL AND CLINICAL GUIDELINES

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With the emergence of humanistically oriented therapies, and given recent developments, a different view of the therapist–client relationship has evolved. Although touch has long been associated with healing in most cultures, Freud and other psychoanalysts established a no-touch rule in the therapist–client relationship. Critics of the touch taboo argue that the blanket screen stance of therapists recreates the cold and distant environment that contributed to the client’s dysfunction, and it ignores the value of touch as a powerful therapeutic ingredient, one which emphasizes a more open and intimate relationship between client and therapist. Today there is a lack of consensus about the use of touch and the complex ethical and clinical issues surrounding its use. This article reviews the clinical and research literature and explores views for and against using touch in therapy. Given the powerful effect of touch and the legal climate in our society, ethical and clinical guidelines are presented to assist the therapist in using touch appropriately, with sensitivity and skill.

Introduction

This article reviews the relevant literature and presents ethical and clinical guidelines for the use of touch, exploring research implications as well. Touch is one of the most important senses; it is critical to human development. Harlow (1958) has documented the importance of physical contact in animals. In his famous study of motherhood in monkeys, he found that the intimacy of physical contact was more important than feeding. For the human baby, being touched is a necessity (Bowlby, 1958, 1977). Snuggling and sucking create biochemical reactions in the brain that affect functioning and development (Restak, 1979). Infants seem to develop a sense of self from inner feeling states and from the sensing of caregiving from parents (Mahler & McDevitt, 1982). Montagu (1978) documented the importance of touch in interpersonal relationships during infancy as well as later in life, suggesting that the ability of the individual to enjoy giving and receiving physical nurturing is a measure of his or her development.

In many cultures, as infants grow, physical contact diminishes. Cultural taboos about interpersonal tenderness tightly control touching behavior. Intended to curb pleasure and sexual activity, these taboos arise out of a failure to discriminate sexual from nurturant touch (Edwards, 1981). By describing the touch between mother and infant as essentially erotic, Freud (1955) carried this confusion into psychoanalysis. Infants’ needs, however, are distinct from sexual needs. If the needs for touch and fondling are not fulfilled, sexual activity later in life cannot make up for their lack.

Even though the use of touch has been long associated with healing in most cultures (Frank, 1974), the touch taboo has been carried into psychotherapy. Today, although used in some forms of therapy, it has been excluded by many approaches of mainstream psychotherapy. There is no consensus about the benefits of touch in psychotherapy nor are there clear clinical and ethical guidelines regarding its appropriate use. The use of touch as an ethical and clinical issue has not
been sufficiently addressed in clinical training and supervision (Holub & Lee, 1990). Little attention has been paid to the use of nonerotic touch clinically and in research (Horton, Clance, Sterk-Ellison, & Emshoff, 1995). Kertay and Reviere (1993) have suggested that discussions on touch frequently take on an all-or-none approach that misses the complexities of the issues involved.

**Historical and Theoretical Overview**

**The Touch Taboo**

The touch taboo has kept many therapists from using touch as a therapeutic tool. This taboo has perhaps resulted from a cultural stance that misinterprets touch as erotic (Frank, 1974). Jourard (1966) suggested that psychotherapy developed in Germanic, English, and American societies characterized by a strong taboo against touching.

Most analysts in this country, such as Menninger (1958) and Wolberg (1954), considered touch to have a detrimental impact on transference and countertransference as well as a potential to lead to sexual arousal.

Initially, Freud and other analysts recognized the importance of touch in their clinical work. Freud stroked the client’s neck or forehead in order to increase responsiveness to hypnotic suggestion, but he subsequently abandoned these practices and focused on the cultivation of a therapeutic stance that emphasized a detached analytical behavior (Edwards, 1981). Freud may have found his initial approach to be ineffective, or he may have been influenced by the cultural climate of his time.

As Levitan and Johnson (1986) have suggested, the touch taboo in psychotherapy may have been influenced by Mosaic Law and Christianity that ordained a metaphysical distinction between the body and the mind and soul. This view replaced the Hellenic image of the body and its glorification as shown in sports and art. Western medicine has also followed this dichotomization into those who touch the body and those who do not, that is, psychiatrists (Burton & Heller, 1964).

Proponents of the touch taboo claim that touch will disrupt the client’s ability to work through transference issues and will dilute the therapist’s ability to tolerate negative transference. Transference refers to the process where the client reacts to the therapist on the basis of previous expectations and stereotypes; these distortions are derived from unresolved parental attachments. Classical psychoanalysts argue that touch leads to gratification of unresolved experiences, thwarted expectations, and fallacious stereotypes, which comprise the transference constellation, thereby creating a deadlock in treatment progress. Gratification is seen as interfering with the client’s motivation.

Casement (1982) illustrated this point of view in a case study of a client who had received an operation as a child. As the procedure began, the mother fainted, letting go of the child’s hand.

This event had many repercussions in the client’s life and, upon recalling the incident, the client implored the therapist to hold her hand in order to reexperience it. Casement claimed that touching the client would have been colluding with her delusional perception of the therapist as mother, leaving the trauma unresolved. Yet, after the therapist presented this dilemma to the client and stated his readiness to tolerate her feelings of anger and distrust towards him, the client’s response to the therapist was that she now felt that he (the therapist) was in touch with what she had been feeling, and she felt able to reexperience the painful event. By not touching her, the therapist was able to identify her anger and distrust and promote her healing.

Countertransference refers to the therapist’s distorted perceptions and feelings about the client, distortions that are based upon his or her own unresolved parental attachments. Proponents of the touch taboo suggest that touch adds to the countertransference and loss of objectivity.

Other critics of the use of touch, such as Alyn (1988), have suggested that although nonerotic touch may not be unethical, it can nevertheless reinforce the culturally prescribed unequal power relationship between genders and reproduce the routine violation of women’s boundaries. Sex and status determine the politics of who touches whom, where, and how (Jourard, 1976), and women are touched more than men. Until the effects of touch on therapeutic outcomes are consistently determined, Alyn suggests that it is premature to use touch as an adjunct to communication in therapy.

Touch beyond a formal handshake is seen by some (Guthell & Gabbard, 1993) as a boundary crossing that places the therapist on a slippery slope toward the gratification of the therapist’s or client’s needs one which can lead to the arousal

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of sexual feelings that may in turn be acted upon. This is perhaps the strongest basis for the origin of the touch taboo in psychotherapy.

Relatively few analysts have supported the use of touch. Fromm-Reichmann (1950) advocated the use of touch as an important intervention, and Winnicott (1965) also discussed the efficacy of touch in his work. Reich (1949) refused to accept the cultural norms of his time, boldly arguing for the use of touch to fill a basic human need. He developed a body-centered psychotherapeutic approach that decades later influenced the development of several forms of therapies that advocate working with the body and bodily experiences as a way to therapeutic growth.

The use of touch for psychotherapeutic purposes is prevalent in many forms of healing today and dates back thousands of years in most healing traditions. In classical Chinese acupuncture (Worsley, 1990), for example, touch is used to enhance rapport, to provide caring as well as to assess a client’s emotional reactions and to establish a diagnostic framework.

Historical, philosophical, research, and clinical developments during the last 40 years have contributed to a change in the climate underlying the use of touch in psychotherapy. First, the human potential movement gave rise to a number of therapies that make use of touch for providing safety, nurturing, and corrective emotional experiences and therapies that enhance self-exploration and emotional expression (Brown, 1979; Castiel, 1976; Howard, 1970; Kepner, 1987; Lowen, 1958; Ruitenbeek, 1970). Second, the emerging somatopsychic approaches have made use of bodily interventions such as touch and movement in order to effect change in psychological and physical functioning (Alexander, 1974; Bernstein, 1980; Duggan, 1981; Feldenkrais, 1972; Juhat, 1987; Rolf, 1977). Third, discoveries in the field of psychoneuroimmunology (Feltén & Cohen, 1991) and the growing recognition of the interrelatedness of physical and psychological functioning (Geller, 1978; Hanna, 1973; Kelemen, 1975) have heightened the role of touching.

Three additional influences have contributed toward valuing touch as: (a) research on mothering, attachment, and early bonding (Bowlby, 1958, 1977; Mahler & McDevitt, 1982; Montagu, 1978); (b) the development of the exercise culture with its body focus and (c) the influence of eastern practices that emphasize, among other things, the monitoring of bodily experience to promote psychological change (Cash & Pruzinsky, 1990). Contributions from all of these approaches have brought about the application of a wide range of touch behaviors.

Types of Touch in Psychotherapy

Touch can refer to a wide range of behaviors from a handshake to a touch on a shoulder or back or even to holding a client. Edwards (1981) describes a typology of nine types of touch in interpersonal situations, most of which are often encountered in clinical work: (a) information pick-up touch, (b) movement facilitation touch, (c) prompting, (d) aggressive touch (for example, restraint), (e) nurturing touch, (f) celebratory touch, (g) sexual touch, (h) cathartic touch, and (i) ludic touch that occurs in games and fun.

Touch may be used to communicate a variety of feelings, as well as to strengthen, center, or help a client enter an altered state of consciousness. Another type of touch, “repatterning,” involves the manipulation and reorganization of muscle structures for body/mind integration, emotional expression, and self-exploration. These last two types of touch are encountered in body-centered psychotherapies and somatopsychic approaches for growth.

This article addresses the use of therapeutic touch for nonbody-centered psychotherapies as a means to nurture, strengthen, and facilitate growth. Touching may include the hands, the shoulders, mid and upper back of the client, or in the context of group therapy, holding or hugging in standing or sitting positions.

Therapeutic Touch

Proponents of nonerotic touch in psychotherapy claim that therapeutic touch is a facilitator of change when used for growth and when used judiciously, that is, based on the evaluation of the client, at the appropriate time in the therapeutic process, and in appropriate situations. Advocates of this view do not use touch as a technique or a substitute for verbal interpretation or working through conflicts. According to Mintz (1973), appropriate touch seems to have three important functions: it can convey acceptance and worthiness when the client is overcome by feelings of unworthiness; it can supply symbolic mothering when the patient is not able to communicate; and it can help the patient establish contact with exter-
nal reality when overcome by anxiety. Kupfemann and Smaldino (1987) along with Spotnitz (1972) believed that not touching may actually serve to build resistance to treatment; for example, clients with conflicts related to the wish to be close to someone may need to be touched or held in order to be reassured that the therapist will not reproduce the original non-affectional and distant atmosphere that nourished earlier traumas. Thus the avoidance of touch may recreate the original rejection and strengthen the defenses against expressing feeling, contaminating the transference by its avoidance rather than by its presence (Mintz, 1973).

When touching regresses the client to an earlier stage, it catalyzes the emergence of past unresolved conflicts, provides the means for gratifying unsatisfied needs (Brown, 1979; Casier, 1972; Durana, 1994, 1996a, 1996b), strengthens the client’s sense of reality, engages the client in the therapeutic process (Satir, 1972), and enhances the client’s awareness of feelings for others (Spotnitz, 1972). Thus a therapist’s touch may be a resistant solvent and a facilitator of transference when verbal interaction does not produce the effect sought, thereby forming the basis from which further analytic work may take place. Touch may help the patient tolerate pain and alleviate the shame that interferes with working through issues at a deeper level (Durana, 1994, 1996a). The sense of safety and trust in self and others may help in the reinterpretation of a fragmented ego (Kupfemann & Smaldino, 1987). All of these studies show positive therapeutic benefits from the use of touch.

Fromm-Reichmann (1950) used touch to encourage self-disclosure. Sarles (1965) claimed that there is a stage in therapy with schizophrenic clients during which regression to preverbal forms of communication is necessary, a stage when touch helps patients to accept themselves and connect with the outside world. In working with clients diagnosed with schizoid personalities, Robertiello (1974) discussed the importance of touch and holding in helping these clients work through their detachments and fears of intimacy. Touch can provide a corrective emotional experience when used in a supportive mode to correct deficits in parental experiences (Winnicott, 1965). Wilson (1982) used touch with parents who have physically or emotionally abused their children. These clients have often been abused themselves and respond favorably to therapeutic physical contact; touching increases trust and self-acceptance. Touch may have a deconditioning effect when there is a history of physical punishment or abuse (Woodmansey, 1988). Touch is valuable for elderly clients who are often untouched and lonely (Eaton, Mitchell-Bonair, & Friedman, 1986; Smith, Tobin, & Gustafson, 1987) because it communicates caring and the feeling that these clients are still physically intact and attractive. Fuchs (1975) suggests that holding and embracing are essential during suicidal crises and psychotic breakdown. In group therapy Hallowbrook and Duplechin (1994) recommend touching from the group leader and touching involving groups members in order to accelerate group cohesion and participation. In psychoeducation and in male therapy groups, touch provides a means for experiencing interpersonal contact, for catalyzing deeper emotional issues, for addressing the restrictive emotionality so characteristic in male-role orientation, and for differentiating the need for bonding from the need for sex (Durana, 1994, 1996a, 1996b; Rabinowitz, 1991). Goodman and Teicher (1988) have recommended touch for emotionally immature or nondeveloped clients for increased focus and to shift to meaningful speech. Touch has been recommended during periods of acute distress (grief and trauma), and for general emotional support, reassurance, and caring (Satir, 1972; Wilson, 1982). Spotnitz (1972) best summarizes the views of proponents of nonerotic touch—"not touching is as objectionable as touching the client when this might foreclose therapeutic progress" (p. 462).

Research Studies

Empirical studies on the use of nonerotic touch in psychotherapy have been scant. The research and clinical literature have focused much more on the effects of erotic contact between therapists and patients (Pope, 1990). Despite the increased climate of physical openness in the '60s and '70s for promoting client progress, a climate brought about by the human potential movement, this shift toward using touch in some forms of therapy has not caused an increase in the incidence of client sexual abuse. Approximately 10% of male therapists and 2% of female therapists have some form of sexual contact with their clients. Although 25–30% of humanistic therapists engage in nonerotic hugging, kissing, and touching versus 5% for psychodynamic and cognitive behavioral therapists, the number of sexual incidents does not
differ according to therapeutic orientation (Holroyd & Brodzky, 1977). Nonerotic forms of touch such as hugging or affectionate touching occur rather frequently. In a sample of 456 psychologists, 41% reported hugging patients somewhat frequently (Pope, Tabachnick, & Keith-Spiegel, 1987). In Holroyd and Brodzky's findings, 27% of the therapists engaged in nonerotic contact occasionally. In a further analysis of their data, Holroyd and Brodzky (1980) found that differential application of physical contact (with therapists touching opposite-sex patients but never same-sex patients) was associated with sexual involvement. It seems that differential touching places a therapist at high risk for sexual contact.

A number of research studies on touch have demonstrated its positive effect in enhancing self-disclosure. A study by Pederson (1973) showed a statistically significant relationship between touch and self-disclosure. Jourard and Friedman's (1970) study showed an increase in self-disclosure as an interviewer reduced the distance between himself and his subjects by touching the subjects. Using experimental conditions of touch and nontouch in an initial interview setting, Pattison (1973) found significant differences at the p < .01 level between touched and nontouched clients for depth of self-exploration; clients who were touched engaged in more self-exploration than those who were not. Alagna, Whitcher, Fisher, and Wicas (1979) also reported that touched clients engaged in deeper self-exploration and evaluated their experiences more positively. Dies and Greenberg (1976) looked at the effect of touch in a brief encounter group experience. Based on a randomized experimental procedure of touch, moderate touch, and no touch, their findings revealed that increased touch enhanced feelings of closeness, willingness to engage in risk behaviors in the group, and favorable attitudes toward self and group members.

These studies, although valuable, fail to capture the meaning of touch in actual psychotherapeutic relationships. Horton et al. (1995) suggest that experiments with touch are limited and artificial, or in some cases analogs of psychotherapy where touch is sensitively used with respect for the patient's needs. A phenomenological study by Gelb (1982) identified four factors associated with clients' evaluations of touch in therapy. These were: (a) clarity regarding touch and boundaries, (b) clients' perceptions of control in initiating and maintaining contact, (c) congruence of touch related to degree of intimacy and issues discussed, and (d) clients' perceptions that touch was for their benefit and not that of the therapist. Horton et al. (1995) tested and extended Gelb's factors by conducting a survey of the experiences of 231 patients and their attitudes toward physical contact in intensive psychotherapy. Their findings supported Gelb's work and supported the idea of appropriate use of touch, as indicated by patients, to demonstrate the caring and involvement of their therapists. The safety created by this perception facilitated patients' taking more risks and going deeper in therapy.

Ethical Guidelines

Despite the powerful effect of touch in psychotherapy and the legal climate in our society, ethical and professional standards set by states and professional organizations have been lacking in providing therapists with sound advice as to the appropriateness of touch in the psychotherapeutic setting. Ethical standards warn about the risk of exploitation, dual relationships, and sexual intimacies (Corey, Corey, & Callanan, 1988); however, guidelines about touch are not standardized.

The clinical evidence and scant research findings available suggest that the use of touch can have powerful ramifications in the psychotherapeutic setting. Careful deliberation, however, must precede its use. Using touch requires that the therapist have an understanding of his or her own attitudes and motivations about touch and must be sensitive as well to issues of power, boundaries, and gender. The therapist must know the client and understand his or her readiness for touch, have an understanding of how to touch, know when touch is appropriate, and recognize which clients would benefit from touch. The therapist needs to use touch with sensitivity and skill, be aware of the client's expectations and responses, and understand the transference and countertransference issues. The therapist must be aware of the potential harm caused by inappropriate nonerotic touching.

Moreover, there are several important personal issues that the therapist must understand before deciding to engage in physical contact, issues with ethical implications for the therapeutic relationship. First, therapist must understand their attitudes towards physical contact. If there are personal difficulties or negative attitudes about touch, these will override the message of caring and acceptance that may be intended. The lack
of therapist congruence may be interpreted by the client in negative ways that may, for instance, increase the client’s sense of worthlessness and shame. Intent influences interpretation, and physical contact must be a genuine response to the client’s need for touch. If a therapist is uncomfortable with touch, it is important to communicate to clients that this feeling stems from a clinical stance so that clients do not feel shame in their need for comfort and physical contact.

Second, therapists must be aware of their motivations when considering touch. Touch must be for the benefit of the client, not the therapist. This is not to say that the therapist should refrain from touching out of fear of experiencing pleasure. When it is done responsibly, both therapist and client may experience satisfaction in the same way a parent and a child would experience the pleasure of touching. Nonerotic physical contact for the benefits of the therapist would be exploitative and would constitute an ethical violation.

Finally, therapists should be sensitive to issues of power and of how sex and status determine who is touched, when, and how; touch by male therapists could reproduce in some female clients the routine violation of their boundaries that is prevalent in our society.

A full understanding of the issues that surround the use of touch constitutes the background necessary for therapists. Before considering touching a client, therapists should be aware of several important guidelines based on this understanding. These guidelines will help the therapist determine whether therapeutic touch is appropriate.

First, the therapist must learn about the client and his or her readiness for physical contact. This knowledge may be gained by taking a thorough family history, one that includes experiences, rules, attitudes, expectations, and needs about affection and other forms of physical contact in the family of origin and presently in the client. A family history should also enable the therapist to learn about the client’s cultural or ethnic background. This information may be useful, but touch is idiosyncratic. Some clients may not ever want to be touched and may never be ready for physical contact despite what may be surmised to the contrary from the individual’s history. When in doubt, it is best not to touch.

Second, before each instance of physical contact, the therapist needs to determine the appropriateness of the potential contact. For instance, are the level of intimacy and the touch congruent with the issues being addressed at that moment?

Third, the therapist needs to be aware of how physical contact is being interpreted by the client since responses are based on prior experience, expectations, and perceived intent (Levitan & Johnson, 1986). Positive evaluation of touch is partly related to its congruency with the client’s expectations of therapy and physical contact (Gelb, 1982). Is the physical contact being interpreted sexually? Are sexual feelings aroused? Are boundaries being violated? The client’s responses need to be explored openly and promptly to see if the contact is productive or destructive. The client needs to be questioned to determine if he or she experienced the physical contact as a violation of boundaries; this exercise teaches clients to identify their boundaries as well as to enhance the therapist–client relationship. The client must feel in control of initiating and maintaining the physical contact.

Fourth, the therapist must be aware of possible erotic counttransference and how to handle it. If the therapist is in control of his or her emotional reactions, he will stop the physical contact and explore effectively the feeling aroused. Otherwise, professional consultation or counseling may be necessary. If the therapist cannot resolve the situation appropriately, the therapeutic relationship must be ended and the client referred to another therapist. When appropriate, however, clients can benefit by knowing that they are valued by another as an emotional and sexual being without the sexual contact.

Fifth, the therapist needs to be aware of the possibility that the physical contact may be misconstrued by the client’s family as a sexual overture (Bennett, Bryant, Vanden Bos, & Greenwood, 1990). Whenever possible, it is helpful to educate the family. In instances when the therapist is concerned about being misinterpreted by the client or the family, it is advisable to have a third party in the room; this is particularly relevant when the client is in need of holding. This person may be a spouse, friend, or family member who may in actuality act as a parent surrogate. This strategy is also clinically useful in that it can enhance the client’s network of relationships and reduce dependence on the therapist (Durana, 1994, 1996a).

Finally, therapists need to be keenly aware of patterns of differential touching with respect to gender; some patterns of touch are often a prelude to
sexual intimacy and a signal to discontinue physical contact (Holub & Lee, 1990). A helpful reminder used by this author is to consider the ethical justification of the physical contact and whether the therapist would feel comfortable with this behavior in the presence of a spouse or colleague.

The decision to touch or not to touch should be based on the client's needs. It is not enough for the therapist to touch a client based on a feeling to do so. And, as Kertay and Reviere (1993) have suggested, any decision to touch must be based on ethical, clinical, and theoretical principles. Of these, ethical considerations are paramount.

Clinical Guidelines

Nondirective physical contact is a powerful change agent when based on client evaluation and when used in the appropriate situation and at the appropriate therapeutic stage. Its relevance to the therapeutic process includes four areas. First, in the enhancement of the therapeutic alliance, touch can increase the level of trust and the quality of the therapist-client bond. Second, in its supportive role, touch can provide reassurance, acceptance, and containment as during a traumatic crisis, by enhancing feelings of worthiness and by reducing shame. Third, it can facilitate emotional corrective experiences in cases where there have been deficits in development (by supplying good enough parenting) and where there has been a history of abuse (by reducing the aversion to being close). Fourth, as a facilitator of change, touch enhances self-disclosure and focus, acts as a resistance solvent, catalyzes unresolved conflict, precipitates regression, and facilitates the transferance. It helps the patient tolerate pain so that therapeutic work can be carried out at a deeper level, and it increases the level of emotionality.

The question of therapist self-knowledge is paramount with regard to touch. In addition to understanding personal attitudes and motivation about touch, as previously addressed, it is incumbent upon the therapist to be experienced at receiving touch in his or her own therapy. In the event that clinical training includes the use of touch, it is still necessary to augment it with personal experiences of receiving touch in one's own therapy. Such supplementary experience may enhance the therapist's sensitivity in using touch and build awareness of gender and power issues. Body-centered approaches to psychotherapy provide the broadest range of experience for the therapist in training, and it is advisable to investigate these approaches whenever possible, even if only as an adjunct to training and therapy.

For what types of clients is touch most useful? The idiosyncratic nature of touch suggests that the answer really depends on the individual, regardless of diagnostic categories, and on the specific situation and therapeutic stage. Clinical experiences, however, suggest that touch in therapy may be more appropriate for certain types of clients than for others. Several authors have published clinical opinions about the efficacy of using touch with the following types of patients: schizophrenic patients at a certain phase in therapy (Searles, 1965), schizoid personalities (Robertillo, 1974), and maternal deprivation and arrested emotional development (Goodman & Teicher, 1988; Holroyd & Brodsky, 1977; Woodmansey, 1988). Touch may be useful during suicidal crisis, psychotic breakdown (Fuchs, 1975), and grief and trauma (Wilson, 1982); for anxious and severely depressed patients (Hollender, 1970); for psychotic and borderline patients (Mintz, 1973); for the physically and sexually abused (Cornell & Olio, 1991; Woodmansey, 1988); and for elderly clients (Smith et al., 1987). Wilson (1982) advises that touch is most relevant during the working-through phase and during crisis interventions when it can instill hope and trust. Touch may also be appropriate during the termination phase to convey love and celebration.

This author has also found various forms of touch to be useful with rigid, overly controlled clients, those with restricted emotionality, and those with hysterionic and narcissistic personality disorders. Physical contact may be useful in individual, couples, family, and group therapies as well as in psychoeducation (Durana, 1996a, 1996b; Halbrook & Duplechin, 1994; Rabinowitz, 1991; Satir, 1972). Psychoeducational or therapy groups can probably provide the safest context where a client can have the experience of being held for extended periods of time by a parent figure (another participant or a therapist).

Levant and Johnson (1986) underline the importance of obtaining permission prior to touching. Advising the client as to the areas to be touched avoids anxious anticipation and unpredictable reactions. The most acceptable parts to touch are hands, mid and upper back, and shoulders. Touch accompanied by verbal communication reinforces the message sent: for example, "This is difficult for you," accompanied by touching the arm or shoulder.

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Touch may be contraindicated with clients who are acutely hostile (which includes many borderline), aggressively responsive, or paranoid, since these patients may be likely to misinterpret the therapist’s intention. Goodman and Teicher (1988) advise against the use of touch for the regressed client who has blocked capabilities or tossed them aside, because it may enhance the pathology; for these clients, in this author’s experience, the use of touch may help prompt the release of anger or may help celebrate a risk taken toward greater autonomy. Touch is also contraindicated when it represents a response to a spoken or unspoken demand from a client. After the client has worked through the demanding phase, touch may be beneficial. This situation represents a clinical instance when transference interpretation must precede the use of any form of touch before touch can be therapeutically meaningful. The therapeutic task is first to work through the demands and understand the underlying needs, thus facilitating growth and autonomy.

For clinical assessment of transference, development of self-understanding, and discovery of conflict areas, recognizing client interpretation or misinterpretation of touch or avoidance of touch provides golden opportunities for treatment. Much of the therapist’s work involves decoding the client’s verbal and nonverbal messages. These interpretation skills, in particular, are relevant for understanding responses to touch. The client’s verbal messages may indicate acceptance, but the nonverbal messages may indicate the contrary. Clients need help recognizing the need for touch, its origin, and the resistances surrounding it. Open communication and questioning are vital in assessing client’s responses to touch.

In addition to questioning the client, therapists can look for signs and cues to help them know if they have violated a physical or psychological boundary. There are somatic cues, feeling cues, countertransference cues, and energetic cues. Somatic cues refer to both the client’s and therapist’s own somatic responses to the therapist–client interaction (physical countertransference) (Moore, 1988). Somatic cues provide information about responses in the client, how a specific touch intervention affects the client, and so on. Interpretation requires that the therapist be attuned to his or her own body. For example, when I listen to the client, I may begin to feel a slight tightening in my upper abdomen, a familiar sensation. Having learned to recognize this personal sensation allows me to distinguish it from potential countertransference and to use it as a professional cue to engage the patient. I then use this somatic cue to explore the client’s experience of the therapeutic interaction in the present.

There are also somatic cues that are exhibited by the client, for example, changes in breathing patterns, contraction of body parts, changes in facial color, changes in body odor, temperature changes in physical proximity to the therapist, changes in posture, and incongruity between physical presentation and internal reality.

Feeling cues refer to the therapist’s ability to feel the client’s emotional state directly and intuitively, rather than through the intellect. The therapist can use his or her countertransference reactions (perceptions, feelings, fantasies) as cues to guide his or her work with touch. If, for example, the therapist feels disgust for the client, this feeling may be a helpful cue in questioning the client about feelings of disgust towards self or others.

Finally, there are energetic cues. These fall in a subtle area. The notion of boundaries may help clarify this concept. Boundaries have a palpable and usable reality that can be experienced by the therapist as a sense of how the clients are present, their energetic presence, if you will. The therapist can use the perception of boundaries as one of the cues to guide therapeutic touch.

The therapist, for instance, may experience the energetic aspect of a client’s boundaries by noticing how much personal space the person occupies. Where does the client’s world begin or end? Listening to a good speaker creates a feeling of his or her presence throughout the room—his or her magnetism, aura of respectability, and so on. Some clients, by contrast, seem to have energy boundaries pushed in, as if their personal space were much smaller than the physical space occupied by their bodies. Clients may experience themselves as nonexistent, collapsed inside with a shrunken sense of personal space. In some clients it is as if they are not fully inhabiting the body; this disembodiment may be experienced by the client and/or therapist as an emptiness or deadness in the rest of the body.

The client’s energetic presence can be used as a cue. This presence will shift and change if the client perceives an invasion of a boundary; for example, sexually abused clients may disembody partially or contract energetically more in upper areas of their bodies. These cues may be more
readings than the words of the client, since the client may not even be aware of the changes taking place. If a boundary is violated, the energy or fullness in the room may change. These changes are often accompanied by somatic cues, for example, a change in breathing pattern or the physical constriction of one part of the body.

If the client is well defended, however, the somatic cue may be less palpable, but the energetic cues will still be there. For instance, clients who have been chronically sexually abused unwittingly invite you beyond their boundaries. These clients need to learn when intrusions are taking place even before words are exchanged. By constantly inviting clients to respond to questions such as “What do you want to work on?” “Is this enough work for today?” “How are you feeling about what just happened?” “What do you feel in your body?” and so on, the therapist can teach the client the development of proper boundaries. Yet, the therapist must be careful in not respond fully to a client’s invitation, because the client’s words may be saying yes while the body is saying no. Using touch to teach clients about the reembodiment of experience when disembodiment has been the norm helps them identify and develop proper boundaries.

To read clients’ cues as well as their own somatic and emotional responses to clients requires sensitivity and skill on the part of therapists. It requires therapists to be attuned to their own bodies and experiences. Reading cues can provide the therapist with much information about the client, but can also be dangerous territory open to misinterpretation, particularly if the therapist is not well attuned to bodily and emotional experiences.

Given the potential ethical and legal complications that may arise with touching patients in a litigious society, some psychotherapists may prefer to maintain the separation of body and mind that exists in other health practices. Might a client derive the same benefit by simultaneously seeing a psychotherapist and a massage therapist or body-worker, without potential legal complications. Any emotional material released by the body-worker could then be processed with the psychotherapist at a later time, possibly the only benefit from touching available to clients in many states and communities, given attitudes about touching. For those therapists who find the difficulties associated with touch insurmountable, this author supports this alternative over ignoring touch altogether. Psychotherapists, however, are at an advantage in using touch, since they can help clients, in an integrated manner, to process deep emotional states and work through conflicts along with the transference issues that emerge from their touch. Touching can provide coherence in treatment and promote a smooth psychological integration.

Case Studies

Example 1

The client is a 54-year-old married male executive with two grown children. Mike came into the first session quite distraught; his wife had moved out of the house. A year earlier he had stopped couple’s therapy, thinking he was “cured” and saying he did not respect the therapist. Now he was ready to make a new attempt at change, recognizing that he was difficult to live with and wanting to change: “Sometimes I think I am so great and important that I don’t respect others around me,” he said. He has always wanted to have his own way, and during his marriage he has had over 50 affairs (mostly one-night stands), that he described as “conquests.”

Mike’s previous counselor suggested that he separate from his wife because of her statement, “I want her when I am away but not when I am close to her.” Now he feared that if he were to tell her that he cares about her, she would leave him anyway. They married after high school because she was pregnant, and he felt he missed out on fun. He is the second child of a family of five children. He described his father as “Blowing into temper fits and beating me when he got upset... he was very strict and rarely showed affection... never seems to appreciate me... My mother and I never hugged and she didn’t show affection.” Mike was sent away to a boarding school at age 13.

My clinical impression suggested an adjustment disorder with mixed features, a partner relational problem, and a narcissistic personality disorder with obsessive compulsive personality features. During the first session he began to talk about his pain. When I prompted him to illicit his emotions further, he began by fidgeting and then he burst out crying. He confessed that he could not control the situation with his wife. He looked scared and in great pain, like his life was caving in and he did not know why. I got up and handed him a tissue and then sat closer to him. I reached out and put my hand on his upper back. Through this touch I conveyed respect, caring, and calm to create a safe containment wherein he could go deeper with his emotions.

This was a man who has probably never expressed his pain through tears nor in someone else’s presence. His body felt tough and well protected. Yet he seemed to welcome my touch, and he relaxed a bit. But then when he looked at me, there was an expression in his face of distrust. He cried some more. Through my ongoing touch and my words I conveyed acceptance and empathy for his pain. When I withdrew my hand he seemed less comfortable in expressing his feelings. As I tested the waters and again placed my hand on his back, he seemed more at ease in his pain and connected to me as if the touch melted the distance between us. As I touched him, I found through his body language how he was receiving me. I believed I had to maintain my presence close enough yet respectfully distance enough to avoid invading his sphere of comfort. Later when I questioned him about his level of comfort with my touch, he said that he was not sure what to make of it at first, wondering...
if I was gay but feeling accepted by me. Then he said he liked me and “No one has treated me that way before.”

After 2 months of individual therapy, I recommended that he and his wife join the Practical Application of Intimate Relationship Skills (P.A.I.R.S.) course for couples and that he join a men’s group that I lead. This therapy group makes use of holding and emotionally expressive techniques. The holding techniques were used for enhancing self-disclosure, conveying acceptance, comfort, dissolving resistance, and facilitating group experiences. Mike held a lot of anger, pain, and conflict about closeness; the holding techniques helped him bring out these conflicts and tolerate the pain of working at a deeper emotional level. It was difficult for Mike to get physically close to others—an anxiety that he described as a death fear. The holding helped him learn to trust men physically and emotionally, and it softened his defenses about feeling superior and not needing anyone. It also elicited the experience that “something is missing” which propelled his desire to “want to feel  ____1____ which propelled his desire to “want to feel close to every woman, because I need them to like me.” When he stopped therapy, Mike shared with me that he could now touch and hug his grandchildren and his daughter, “I insist on their hugging me, but I still have trouble with my sons. We never did it for 25 years. . . . My self-esteem is a lot better. I respect others. One-night stands are not far to others. . . . I am still together with my wife.”

Example 2

Joan is a 36-year-old housewife married to a police officer. They have an 8-year-old child. She is active in her daughter’s school activities. She came into therapy complaining, “I don’t feel much . . . don’t trust myself or feel important, and I am not sure what I want in my marriage.” Joan was the firstborn of three children. She reported not fitting into her family and feeling that her mother hated her. She complained that her father told her how to feel; she believed she had to hide her opinions and subsequently, felt she did not exist. Joan described her childhood home life as empty, hidden, and unreal. Her happy-go-lucky air served to create a facade that concealed her depression, hopelessness, and unworthiness. She was alienated from herself and wanted to know who she was and where she was going. At times her confusion resulted in experiences of derealization, depersonalization, passivity, and emotional immaturity.

Joan had a history of disappointments in her personal and family relationships. She desired affection and warmth, but she withdrew because she expected disappointments. Her vacillating behavior and her interpretation of minor slights as rejections drove Joan to express hostility. Much of her anger was directed towards men. Her father abused her sexually when she was a child. Her ambivalence about closeness and her fear of being controlled manifested itself as a push-pull (demanding and unpredictable). For her, sex was disturbing and disappointing; she complained about lack of affection and touch. She had difficulties with expressing emotion and with psychological boundaries. The major complaints, behaviors, and personality configuration paralleled the diagnosis of bipolar disorder II with borderline personality disorder.

This woman’s fragile personality structure, her difficulties with emotional and psychological boundaries, and her history made touch by a male therapist during the earlier stages of therapy inappropriate. Joan was placed in a woman’s group where she became comfortable with touch and being held through some very difficult periods. She stated that at first it was uncomfortable, undignified, and scary to see someone in the group being held as she expressed pain. Later she grew comfortable and realized she could not remember being held as a child; she found the physical contact was a palpable way of being accepted and comforted. It made her aware of what she had and did not have throughout her life in the realm of affection and closeness. It also allowed her to resolve her push-pull ambivalence about being close.

A year and a half later, when she was placed in a mixed group, she was ready to receive touch from male participants in the group and from the male therapist. These experiences of touch helped her distinguish further the need for affection and touch from the need for sex. She learned as well to improve her boundaries around males. During several regression experiences when she would disembodied, the use of touch was instrumental for her in learning about reembodiment. Joan’s case represents one of the most difficult for a therapist because it includes so many clinical issues about the appropriateness of touch at different stages in treatment.

Conclusions and Recommendations

Touch is a form of communication more than a technique; at its best, touch is a heartfelt expression of caring and love. As one of the senses, it is critical to human development yet underused in psychotherapy. In society, touch is reserved for the deepest forms of communication. In therapy, as well, therapists communicate deeply with clients, since therapy involves teaching about attachment, love, and self-differentiation—all of which take place within a context of intimacy.

Touch has become an integral part of the clinical practice of many psychotherapists. Its importance as a facilitator of change has been documented. Clinical and research evidence thus far available and the theoretical support for the use of touch suggest that its benefits outweigh its risks. Ethical and clinical guidelines for its use, although useful, cannot be reduced to a simple set of rules. By its very nature, touch is complex; and its appropriate and nondetrimental use requires self-knowledge, clinical sensitivity, and skill. Otherwise, the use of touch can be detrimental.

Legal and ethical considerations combined with transference and countertransference issues make touching in psychotherapy a sensitive area. Further research is needed to assess its dynamics and its effect over time. What types of psychiatric populations respond best to it? At what stage in the treatment is it most appropriate and under what situations? The deconditioning effect of touch, and in particular, its impact on physically and sexually abused clients merits in-depth evaluation. The role of touch in facilitating deeper emotional explorations, in particular, has been amply documented clinically although barely
researched empirically. The role of touch is especially relevant with regard to males; an area researched by this author and one in need of further evaluation.

Clinicians would benefit from research that looks at client's cues in eliciting touch from the therapist and at the impact that educating the client about the use of touch prior to therapy has on subsequent receptivity. The effects of types, level of touch upon receptivity and physiological changes, and therapeutic impact of touch are also areas in need of research. Continued research into the use of touch in psychotherapy, along with its inclusion in clinical training in all its complexity, will help further define ethical and clinical guidelines for the appropriate applications of touch. Until then, therapists must rely on their own best clinical judgment. Results of further research and knowledge from clinical training and supervision may make therapeutic physical contact a viable option for more clinicians.

References


