The Role of Touch in Therapy:
An Adjunct to Communication

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The authors examine the role of physical touch between counselors and clients, reviewing both research and clinical data. Although published findings are not conclusive, there is some indication that touch, when appropriately used, can have a positive impact on clients. Conversely, there is little evidence of negative effects of appropriately administered touch; yet, some clinicians still maintain a conservative bias against any physical contact between counselors and clients. The authors conclude by proposing guidelines for the use of touch in counseling.

Although other nonverbal behaviors have been studied considerably in the counseling context, touch, a powerful nonverbal stimulus and communication medium, has received only modest attention (Hill & Cormally, 1977; Patterson, 1976; Tepper & Haase, 1978). Moreover, strong taboos against any physical contact between therapists and clients, evolving from the early psychoanalytical era, have caused some counselors to oppose the use of touch. Even so, there are data to support the use of this therapeutic adjunct. The purpose of this article is to review the research and clinical literature on the therapeutic value of touch and to discuss the implications.

DEFINING TOUCH

Definitions of therapeutic touch offered in the literature range from simple hand contact to a full embrace. Consistent in all definitions, however, is the position that responsible therapeutic touch is nondirective. Bawor and Dixon (1984) defined touch as "physical contact between the hands of the counselor and the hands, arms, shoulders, legs, or upper back of the client" (p. 491). Suiter and Goodyear (1985) used three levels of touch—to the hand, on the shoulder, and across the shoulders in a semi-embrace. Wheaton and Borgen (1981) defined touch as "contact between the counselor's hands and/or forearm and the subject's hands, arms, shoulders, or upper back." Thus, in these and other studies (Alagna, Whitcher, Fisher, & Wicas, 1979; Hubble, Noble, & Robinson, 1981; Jourard & Friedman, 1970; Stockwell & Dye, 1980), touch to the hands, arms, shoulders, and lower and upper back and semi-embraces seem to represent the range of touch that is considered nondirective.

Regarding intensity, duration, and frequency of touch, Wheaton and Borgen (1981) referred to a 3- to 5-second counselor-client contact, and Bawor and Dixon (1984) suggested that touch "be long enough to establish firm contact, but not so long as to create an uncomfortable feeling in the client" (p. 491). Nguyen, Hesling, and Nguyen (1975) used four touch modalities: a pat, a squeeze, and a stroke. In a study conducted by Whitcher and Fisher (1979), hospital patients were touched on the hand at the beginning of a pre-operative instructional session, then on the arm at the end of the session, for a minute each time. In most empirical studies, the type, frequency, and duration of touch has been determined by the research design rather than the context of the counselor-client interaction.

LITERATURE SUPPORTING COUNSELOR TOUCH

Jourard and Friedman (1970) arranged interviews with 32 male and 32 female participants and had the interviewer vary the distances between himself and the participants. They found that the participant's level of self-disclosure increased as the personal distance was reduced and the participants were touched. Patton (1973) found that participants (female undergraduates) who were touched self-disclosed more than did control participants. Alagna et al. (1979) explored sex differences and touch by counselors with college undergraduates discussing career interests. Using a 2 (touch versus no touch) × 2 (male versus female client) × 2 (male versus female counselor) design, they found that clients who were touched (hand, upper back, lower arm) engaged in deeper self-exploration and evaluated counseling more positively than did the control participants. Results supported Deaux's (1976) hypothesis that because same-sex physical contact is more socially acceptable among women than among men, the touch effect is less of a factor when a male counselor touches male clients than when a female counselor touches female clients. Stronger effects were found when clients were touched by a counselor of the opposite sex.

Whitcher and Fisher (1979) also demonstrated sex differences in effective, behavioral, and physiological responses to a nurse's therapeutic touch of male and female patients during preoperative teaching of patients in the hospital for elective surgery. Women responded positively but men responded negatively to the touch. The researchers conjectured that in a context of dependency, as found in a hospital setting, men experienced threat and women experienced reassurance when touched. Aguiler (1967) found that physical contact between nurses and patients in a psychiatric hospital (a) elicited approach behavior from male and female patients, (b) increased verbal interaction and rapport, and (c) improved patients' attitudes toward the staff.

In a study by Fisher, Ryting, and Hesling (1976), a librarian touched college students who were checking out books. Women again were more positively affected by touch, although men did not react negatively. Students who were touched expressed more positive feelings toward the librarian and the library than did those who were not touched.

Suiter and Goodyear (1985) studied community counselors' (60 male and 60 female) and outpatient clients' (60 male and 60 female) perceptions of videotaped counselor-client interaction that depicted one of four levels of touch (from no touch to a semi-embrace). The counselor depicting a semi-embrace was perceived as less trustworthy by all participants; the clients viewing the vignette rated the counselor across all conditions of touch as more expert, attractive, and trustworthy than did the counselors viewing the videotape. Wheaton and Borgen (1981) examined the effects of counselor touch (or no touch) by either a male or female counselor on the perceptions of 60 male and 60
female undergraduates during discussions on the students' interpersonal relationships. Counselors who touched were perceived more positively than were counselors who did not, although male counselors who touched were rated as less ethical than were female counselors who touched.

The results of Hubble et al.'s (1981) study suggest that touch may be an evidential index of a counselor's expertise. Thirty-two college women participated in a counseling session to explore vocational interests and received either the touch (handshake, 4- to 5-second touch to the shoulder or back) or the non-touch condition. Subsequently, they were measured on anxiety, willingness to disclose, and opinions of the counselor's expertise, attractiveness, and trustworthiness. Results indicated that counselors were perceived as significantly more expert when they touched.

Holroyd and Brodsky (1977) found that approximately one-third of their survey respondents reported engaging in some type of touch with clients of the opposite sex. Within this group, 25% described themselves as humanistic therapists but fewer than 5% had a psychodynamic, behavior modification, or rational-cognitive approach. In further research, using questionnaires from 657 therapists, Holroyd and Brodsky (1980) concluded that older and more experienced therapists seem able to engage in touch behavior that does not lead to sexual encounters.

Examining the use of touch with children, Tripplett and Arneson (1979) randomly divided 63 pediatric patients, ranging in age from 3 days to 44 months, into two groups. When the children in Group A showed distress, they were given verbal comfort (talking, humming, singing, or making soothing sounds). If they were still distressed after 5 minutes, tactile comfort was offered as well. Children in Group B were given simultaneous verbal and tactile comfort as a first response to distress. Tactile efforts included patting, stroking, rocking, holding, and offering a pacifier. Of the 40 Group A interventions, only 7 quieted the children. But of the 60 tactile-verbal interventions in Group B, 53 were successful. The authors concluded that touching has a significant impact in changing infant and child behavior. From a clinical point of view, Woolams and Brown (1979) stated that touching is normal and helpful because it gives both therapist and client kinesthetic information regarding one another's feelings. Absence of any physical contact is likely to cause transference distortions (i.e., the client may view the therapist as a cold, withholding parent figure). Prevalent humanistic models hold that some forms of touch may facilitate development of openness and sharing (Jourard, 1968; Rogers, 1942).

LITERATURE NOT SUPPORTING COUNSELOR TOUCH

Some clinical opinions and several studies raise questions about the efficacy of touch. In a survey, Cowen, Weissberg, and Loptyciewski (1983) found that physical contact between a clinician and child does not predict how well a child responds to treatment, perhaps because touch may have minimal personal meaning for children, who are touched more frequently than adults. The authors also found that (a) female clinicians reported more frequent physical contact with children than did males, (b) doctoral-level practitioners reported less physical contact than did those without a doctorate, (c) private practitioners reported less contact with children than did practitioners working in agencies, and (d) social workers and psychologists reported touching children more often than did psychiatrists.

Stockwell and Dye (1980) studied the effect of counselor touch (hands, arm, shoulders, and upper back) on clients' evaluation of counseling and level of self-exploration. Six clusters of verbal and nonverbal procedures were administered at predetermined periods during the 50-minute session. Unlike researchers in many previous studies, Stockwell and Dye controlled for other nonverbal cues, such as eye contact and facial gestures. Touch per se had no significant effect on client evaluations.

Bacorn and Dixon (1984) used 40 undergraduate female students, randomly assigned to four groups, to compare the effects of touching on the hand, shoulder, leg, or upper back of depressed and vocationally undecided clients with a control group during an initial interview. There were no significant differences between the experimental and control groups regarding participants' judgments about the counselors or requests for second interviews. The vocationally undecided participants seemed more comfortable with the touch experience than did the depressed participants. The experimenters noted that adherence to a predetermined schedule of touch rather than response to client cues may have affected the outcome.

Although there is increasing knowledge to support the efficacy of touch, some therapists have expressed concern that touching will interfere with transference, foster dependency, and be detrimental to the therapeutic relationship (Menniger, 1958; Wolberg, 1967). The possibility of sexual misconduct troubled Berne, founder of transactional analysis (Woolams & Brown, 1979), and Render and Weiss (1959) absolutely forbade any touch in therapy for fear of arousing sexual or angry feelings.

In summary, according to both research evidence and clinical opinion, there is value in an optimal level of touch as a medium of communication. Touch seems to be effective with infants and younger children; however, because older children may be accustomed to touch from adults, the impact of touch with them is less clear. The data suggest that women are more comfortable being touched than are men and that all clients are more accepting of touch from women than from men. Male and female participants in hospital settings reacted differently—women were reassured by touch and men reacted defensively. In general, counselors who use touch are evaluated more positively and perceived as more expert. Touch was also found to increase clients' self-disclosure.

THE SIGNIFICANCE, VALUE, AND USE OF TOUCH

Fisher et al. (1976) suggested that there are three factors influence the degree to which touch is experienced positively. These factors are the extent to which touch (a) is appropriate to the situation, (b) does not impose a greater level of intimacy than the client can handle, and (c) does not communicate a negative message. According to Mintz (1969), touch can be useful as symbolic parenting, can convey therapist acceptance, and can strengthen anxious clients' contact with the external world.

Holroyd and Brodsky (1980) suggested the following uses for touch: (a) with clients who present themselves as socially or emotionally immature (e.g., those with histories of maternal deprivation); (b) with clients experiencing grief, trauma, depression, or other acute distress; (c) as a way of demonstrating general emotional support; and (d) as a greeting or at termination.

In working with schizophrenia, Seasler (1965) reported regressing clients to a form of preverbal communication and using touch to enable them to accept themselves and become connected with the outside world. Warkentin and Taylor (1968) reported a case study of a regressed schizophrenic man who was offered physical contact by the therapist. His social interest increased significantly; however, he reverted to his primitive, antisocial behavior when the tactile experiment ended.

Those with schizoid personalities, who are cut off from experiencing intimate relationships, can benefit from touch (Robertiello, 1974). Robertiello re-created the parental nurturing relationship by holding patients during therapy in response to their expressed wishes. Patients were able to work through fears...
of intimacy and feelings of detachment as well as to attain greater closeness in relationships outside therapy.

Touch has been used effectively with clients who have been physically or emotionally abused or neglected and with parents who abuse or neglect their children (Wilson, 1982; Woolams & Brown, 1979). Because many abusive parents were themselves abused, therapists, by touching, can model the role response of a healthy, loving parent and can provide a means for such clients' acceptance of their own bodies. Appropriate touch can communicate care on a very basic level to clients who want physical contact with the nurturing therapist but experience fear because physical contact with adults often means seduction and abuse. Touch, along with verbal encouragement as a social reinforcer, can desensitize clients to negative connotations from their pasts.

Wilson (1982) cautioned against the use of touch during the introductory stage of the relationship, when it is essential to establish trust. Touch can confuse and threaten a new client who may already feel a lack of control. An exception is in crisis intervention work, in which a touch on the arm or even holding may provide security and help certain clients through the emotional trauma. Touch may be most productive during the working phase of the counseling relationship to build rapport, demonstrate acceptance, and help clients change dysfunctional patterns and learn new ways of feeling about themselves and others (Wilson, 1982).

Older (1982) suggested additional uses of touch:

1. When practitioners wish one statement to stand out from others, they can rest their fingers lightly on the back of the client's hand or around the client's hand, which can help emphasize their words.
2. Touch can help focus the attention of clients who tend to lose contact with the therapist and can serve as a "ground control" for clients who are actutely disturbed or psychotic, bringing them back to reality.
3. Touch can enable the psychologically blocked client to begin meaningful therapeutic work. Older (1982) presented several case examples of the power of touch to release repressed fear and anger, help clients talk, bring back memories, and enable clients to deal with material long denied.

CAUTIONS AND CONTRAINDICATIONS

There are occasions when touch should not be used in therapy. Older (1982) suggested avoiding touch if the counselor (a) does not want to touch the client; (b) senses that the client does not want to be touched; (c) wishes to touch and senses that the client wishes to be touched but does not believe touch would be effective; (d) feels manipulated, conned, or coerced into touching, or (e) is aware of feelings of manipulating or coercing the client through touch.

Although many of the concerns regarding touch from the traditional psychoanalytical viewpoint relate to encouraging transference and dependency, not touching can complicate transference (Mintz, 1969; Older, 1982). Touch avoidance may (a) re-create the experience of physical rejection by caretakers; (b) reinforce the denial of body awareness, particularly with obsessive and schizoid clients; and (c) increase the likelihood that clients depersonalize the therapeutic relationship as a defense against feeling (Mintz, 1969).

Touch has power implications of which the counselor must be aware. Henley (1973, 1977) differentiated between reciprocal touch, a sign of solidarity, and nonreciprocal touch, which indicates status differences. Typically, a superior-status person touches an inferior-status one (e.g., physician-patient, man-woman, teacher-student, employer-employee). In addition, Henley postulated that nonreciprocal touch is a reminder that power lies in the hands of the toucher (a subtle threat). Counselors must be especially aware of the manipulative, paternalistic aspects of touch, such as a pat on the head for a "good" client. Reciprocity of touch can be achieved by responding to the client's wishes not to be touched and by allowing the client to touch the counselor (Older, 1982).

Although closeness can be fostered by touch, Older (1982) pointed out that to a teenage girl attempting to extricate herself from an "all-enveloping" mother, the counselor's embrace may seem like smothering. The sexually exploited or abused child may withdraw in fear and mistrust from too friendly a touch. Older (1982) stated that "appropriate touch becomes inappropriate when given at the wrong time, in the wrong dose or to the wrong person" (p. 241). Touch is not a substitute for talking and listening but an adjunct to the therapeutic process. Older suggested certain categories of clients for whom touch seems inadvisable: "Touch a paranoid and risk losing a touch; touch a seductress and risk losing your license. Touch a violent patient with a short fuse and risk losing everything" (p. 201).

Therapeutic touch may evoke response patterns and conflicts from early development, causing strong transference reactions. If the counselor is clear about the goal of touching and avoids countertransference feelings, the advantages of touch greatly outweigh the disadvantages in working through these intense reactions (Woolams & Brown, 1979). According to Mintz (1969), clients may use touch to act out impulses and avoid dealing with underlying feelings and conflicts. The counselor who responds indiscriminately to the client's every desire for physical contact may be working against the goals of therapy and may be being manipulated. A distinction should be made between reaching out for a temporary affectionate and dependent relationship that was absent in childhood and using contact to control the counselor and avoid self-confrontation.

Although we have focused on nonerotic, appropriate therapeutic touch, touch that is poorly timed or offered in the wrong context or without permission may lead to strong negative client reaction and potential litigation (Hendrickson, 1980).

GUIDELINES FOR COUNSELORS

Practitioners must be clear about their own attitudes toward touch and sensitive to both the readiness of the client and the impact of the physical contact may have on the relationship (Corey, Corey, & Callahan, 1984). There are two important guidelines regarding physical contact in therapy. First, the nature and duration of the contact should not generate discomfort in the therapist or the client; if it does, the therapist is doing something wrong. Second, any physical contact should be consistent with the needs of the client at that moment. Touch should not be used to precipitate a client reaction but should evolve from the context of the interaction.

CONCLUSIONS AND IMPLICATIONS

FOR FUTURE RESEARCH

The literature suggests that touch facilitates the counseling process by increasing the client's positive evaluation of the experience. Because the evidence indicates that touch does not lead to negative consequences in any counseling context, counselors may wish to reconsider reservations regarding therapeutic touch with clients. Counselor training focused exclusively on verbal skills and traditional nonverbal behaviors may not be adequate for preparing counselors to engage a client effectively. The introduction of touch concepts into graduate programs could expand the communication capabilities of practitioners.

There are many facets of touch as an adjunct to therapeutic communication that warrant study: (a) the development of baseline data on the effects of touch with normal populations, using interviews and direct observation; (b) an examination of touch response and socioeconomic level, cultural back-
ground, education, personality, and age; (c) an examination of the effects of touch in the counseling process over time; (d) the identification of critical junctures in the therapeutic process that can be inhibited or helped by the use of touch; (e) a determination of whether the effect of touch remains constant when studying a variety of client problems; and (f) an examination of current beliefs and practices of counselors regarding the use of touch and the origins of these beliefs. Touch co-exists with other forms of sensory communication such as eye contact, speech, body posture, and gestures. Although such variables pose difficulties in conducting research, researchers must continue to explore these areas so as to provide more extensive information to practitioners.

REFERENCES


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