“We’re people who don’t touch”: Exploring clinical psychologists’ perspectives on their use of touch in therapy

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There is a paucity of research that explores the use of touch within psychotherapy from therapists’ perspectives. This qualitative study explored clinical psychologists’ accounts of offering or excluding touch within therapeutic practice. Semi-structured interviews were conducted with six clinical psychologists working within adult mental health services. The interview transcripts were analysed using interpretative phenomenological analysis (IPA). Five superordinate themes emerged from the data: (1) the touch instinct; (2) touch and professional boundaries; (3) individual clients and contexts; (4) the value of touch in therapy and (5) the cost of touch in therapy. It is suggested that the perspectives of professionals and clients be given greater consideration in the future as such open discussion may serve to challenge the taboo status often surrounding the issue of touch, and highlight its potential roles in therapy.

Keywords: touch; boundaries; clinical psychologists; interpretative phenomenological analysis (IPA)

The use of touch has long been associated with healing (Frank, 1957; Hunter & Struve, 1998), yet little is known about why some professionals use touch while others do not (Durana, 1998). Freud (cited in Galton, 2006) suggested that therapeutic transference would be exacerbated through touch; thus its exclusion was considered necessary to ensure psychoanalytical, boundaried and effective interventions. Although adherence to a psychodynamic model may be considered particularly incompatible with touch (Bonitz, 2008), many professionals hold fast to this legacy of touch exclusion for a myriad of reasons: potentially as their beliefs genuinely fit these models; perhaps to fulfil the criteria deemed necessary to retain group membership; or, to maintain the special or unique nature of their approach. Consequently, touch exclusion can be perpetuated, irrespective of practitioners’ therapeutic approaches.

Others deem touch to be appropriate and even beneficial within therapy. Hunter and Struve (1998) suggest that touch has the propensity to establish, maintain or deepen therapy relationships; to assist clients to overcome distractions and be

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present; to provide nurturance and reassurance; to facilitate the access, exploration and resolution of emotional experiences; to provide containment and safety and to promote touch as a healthy component of relationships outside therapy. Those advocating the use of touch suggest that its prohibition is as unacceptable as touch itself when this could exclude the opportunity for therapeutic progression (Sponitz, 1972).

Pope, Tabachnick, and Keith-Spiegel (1987) found that 41% of their sample of 456 psychologists within the Psychotherapy Division of the American Psychological Association reported that they hugged their clients somewhat frequently. In this questionnaire study, 30% of humanistic therapists believed that touch might be beneficial in terms of clients’ progress, while only 6% of psychodynamic therapists held this view. In addition, the psychodynamic therapists deemed the risk of misinterpretation as being high enough to warrant touch exclusion. However, Stake, and Oliver’s (1991) survey of over 200 psychologists indicated that some forms of touch within therapy (e.g. hugging; touching the shoulder, arm or hand of the client) were rarely thought to constitute misconduct, nor were they typically seen as overtly sexual or suggestive.

Stenzel and Rupert (2004) found that approximately 80% of 470 psychologists practicing in adult psychotherapy sometimes shook hands with clients. This form of touch was most likely to occur at session beginnings or endings. Close to 90% of these respondents claimed that they never or rarely offered other forms of touch to clients during sessions. This suggests that handshakes and touch within sessions were appraised quite differently possibly due to social norms, theoretical considerations or training experiences.

Milakovich (1992) used a telephone questionnaire to explore the differences between 84 therapists who used touch and those who did not. Therapists who used touch were more likely to be female and had received more training on its use. Therapists who used touch positively valued touch in therapy; believed in the touch need/deficit; and considered the gratification of the touch need as therapeutic. Participants who did not utilise touch were inclined to negatively view touch within therapy, typically as gratifying need was considered detrimental to the process. The therapists who employed touch tended to trust their own instinct in relation to its appropriateness and appeared less concerned about potential risks.

Clance and Petras (1998) used questionnaires to explore psychotherapists’ decision-making in relation to touch in psychotherapy. Therapists who used touch did so in an effort to help clients access feelings; to comfort and support; to model safe touch; to respond to clients’ requests for touch; to address histories of touch deprivation; or, to say goodbye. Decisions not to touch were made when there was a possibility of misinterpretation; when touch would be invasive; because the client was able to access feelings without touch; because of the clients’ needs for clear boundaries; or, if touch would be unbearable for the client.

In the last two decades, a shift in focus towards risk management and ethical practice within therapy has impacted on the use of touch. Physical contact may be viewed as risky with: clients who use therapy to fulfil relational needs; those with poor attachment histories, poor boundary control or who display ‘borderline functioning’; or, those who act seductively (Glickauf-Hughes & Chance, 1998). By associating touch with risk, even those who typically avoid touch may be
reluctant to discuss rare use of touch for fear of the suspicion of misconduct (Stenzel & Rupert, 2004).

The present qualitative study aimed to investigate the views of clinical psychologists in relation to touch in therapy by focussing on the reasons why participants chose to incorporate or avoid touch. There appears to be no existing qualitative research on touch in therapy solely within a sample of clinical psychologists in the United Kingdom. Studies that focus on touch have typically utilised survey or questionnaire measures, and although there have been some opportunities for elaboration within certain studies (Clance & Petras, 1998; Milakovich, 1992), the use of questionnaires may have restricted participants’ accounts.

Method

Qualitative perspective

Interpretative phenomenological analysis (IPA: Smith, Flowers, & Larkin, 2009) was utilised in this study as its emphasis is on exploring the meaning that participants assign to their experiences. Two stages of interpretation, or a double hermeneutic, are involved in the dynamic exploration of experiences: participants attempt to make sense of their experiences (as they recall and verbalise their thoughts); and the researcher attempts to analyse and make sense of participants making sense of these experiences. These interpretations are not free from bias and, in accordance with IPA methodology, these biases are embraced and deemed necessary by the researcher in order to make sense of the participants’ lived experiences (Smith & Osborn, 2004).

Participants

The aim of IPA studies is to understand frames of reference for small groups of individuals who are selected according to aspects of homogeneity (Smith et al., 2009). Following national and local research ethics approval, three female and three male clinical psychologists were purposively selected on the basis that they were employed by the NHS and delivered one-to-one therapy within adult mental health services in a rural area of Wales, UK. They were aged between 35 and 55 years, and had a minimum of five years post-qualification experience (range 8–25 years, mean 15 years). They all described their therapeutic orientation as “eclectic” or “integrative.”

Data collection

Six potential participants were sent an information sheet relating to the study. Then the first author (CH) met with individuals to discuss the research in more detail. Each individual was informed that they could take up to a week to decide if they would like to take part and all subsequently participated in the study.

Each participant was met at their place of work by the first author on a convenient, pre-arranged date. Individuals were informed that participation was voluntary, that they had the right to withdraw from the study at any time, and they
were assured of anonymity and confidentiality. Participants were asked whether direct quotes from their interviews could be included in the reporting of the study. They were informed that some details relating to clinical practice (such as issues that were previously known to co-workers) might compromise their anonymity; however, all participants agreed that direct quotes could be included in the reporting of the study following the application of pseudonyms.

After obtaining informed, written consent, participants were asked to provide basic demographic and professional information. In accordance with the guidelines for IPA studies (Smith et al., 2009), a semi-structured interview was utilised to guide the interview and further questions were asked based on the answers given. This ensured that responses reflected individuals’ experiences and beliefs. Participants were aware that each interview would be recorded and later transcribed for the purposes of analyses. The interviews ranged in duration from 35 to 60 min and upon completion, participants were given the opportunity to ask further questions about the research.

Analysis
An idiographic method of analysis (Smith et al., 2009) was adopted. First, each transcript was read in detail and the left-hand margin was used to write initial ideas, to highlight specific points, to summarise and make connections within the data. Then each transcript was re-read and the right-hand margin was used to note emerging themes and more abstract terms. These themes were listed and clustered prior to returning to the transcript to confirm that the analysis was firmly grounded in the accounts. This process was repeated for each transcript, and the analysis led to the creation of a master list of themes representative of the experiences of all participants. Consistent with the IPA approach, themes were not necessarily selected due to prevalence, but rather in relation to the richness of participants’ accounts.

To ensure the validity of the analysis, issues of transparency and credibility were addressed. Prior to embarking on the research, the first author (CH) recorded her own thoughts and perceptions about the topic, and reflected upon these with the second author (RSPJ) within a supervisory context. This fostered a self-awareness of researcher-bias. The third author (JCH) carried out credibility checks of the analysis by reading the transcripts and theme lists to ensure that the interpretations were identifiable within the data.

Results
Participant accounts clustered around five superordinate themes: the touch instinct; touch and professional boundaries; individual clients and contexts; the value of touch and the cost of touch. The importance of the topic of touch to the participants was confirmed by the fact that all agreed that direct quotes could be included in the reporting of the study following the application of pseudonyms.

The touch instinct
Participants considered touch an instinctual response and appropriateness was not thoughtfully considered, but inherently experienced as a sense of being “right” in
context. Despite this, all participants emphasised the rarity and cautious use of touch in their practice. For example:

I’m just responding to non-verbals from the client and sort of sensing, I’m not sure I’m thinking (James).

…it’s something that has to be used very, very carefully. It’s not my first response (Elsie).

As advocates for the cautious use of touch, James and Lydia used terminology such as “light touch” and spoke of a need for considered restraint. Even though its use was viewed as being instinctual, Elsie and Lydia believed that obtaining clients’ consent was central if touch was to be used to meet clients’ needs:

I would definitely ask her before I did it. I’d say “would you like a hug?” (Elsie).

...you have to get somebody’s permission to do it, but they don’t have to give it verbally (Lydia).

Although Elsie outlined a direct approach to gaining consent, Lydia discussed how client need and acceptance of touch was sensed intuitively without the exchange of words. Irrespective of whether clients were asked directly or not, Sylvia raised an additional issue in relation to the use of touch and consent:

Do we ever know that they are ever consenting to it? (Sylvia).

Therefore issues relating to informed consideration, decision-making and client consent regarding the use of touch remained, however, the three female participants all recommended the promotion of client choice, irrespective of the different ways that assent and need were assessed.

**Touch and professional boundaries**

Clive, Sylvia, John and Elsie discussed how clinical psychologists were generally perceived as not offering touch:

...there is a sense that we’re people that don’t touch (Clive).

Expectations and the non-touching identity appeared to be strengthened from within the profession through an absence of actual touch, a dialogue on touch or specific training, thus perpetuating and retaining the taboo status of the topic. The belief that touching was something clinical psychologists should not do was discussed by the three male participants. For example:

I think the therapist’s role is to help the person to find the people who will do the touching. We’re not the person in people’s lives, we’re not their friend, we’re certainly not the person they are having a physical relationship with, we’re simply someone who is trying to help (James).

Whilst acknowledging the need for touch, James suggested that this was outside the remit of clinicians who instead endeavoured to empower clients to establish such interactions outside therapy.

Clive, Sylvia and Lydia spoke of the unique, intimate nature of therapeutic relationships yet all the participants (except for Clive) spoke of how professionals working within the confines of certain therapeutic approaches are destined to practice without touch, as particular models seemingly dissuade its inclusion.
Irrespective of approach, all participants spoke of professional boundaries within therapy relationships. In this sense, the therapeutic model and boundaries of individuals define who and how professionals are as clinicians.

*Individual clients and contexts*

...it has to be taken in the particular situation with the knowledge of that client (Sylvia).

Sylvia’s recommendation that professionals appreciate client individuality and context was also emphasised by Clive, Elsie and James. Participants referred to the lack of a clear sense of right or wrong in relation to touch and recommended a stance within which absolute rules were questioned. The participants (except James) described how client distress could evoke or necessitate a touch response. Lydia suggested:

> When it’s touch, I’m seeing that they need some kind of acknowledgement, because they’re so distressed, it’s a grounding type thing. I’m saying, “I’m here” when they are just so away with the emotion (Lydia).

Lydia reported that extreme distress can “remove” the client from the therapy and touch is used to bring the client back. By enabling therapy to continue, touch is utilised as a therapeutic tool to illustrate recognition of experience and to facilitate progression.

Certain client diagnoses or presentations were described as necessitating touch avoidance and John, Elsie and Lydia specified that the exclusion or careful consideration of touch was required with clients presenting with specific issues in line with a personality disorder diagnosis:

> I’ve had clients who would fall in the borderline personality disorder realm whereby touching could quite easily be misinterpreted and/or used in quite a negative or difficult way (Elsie).

Clients’ life circumstances were also viewed as impacting on the use of touch. Two of the male participants considered loneliness:

> ...if I had a patient who was very lonely, wanting to have someone and then I give them a hug, that’s not a very good thing to do (John).

> I’m painfully conscious of my clients’ isolation and I’m sure that makes me feel like I’d like to give someone a hug, or a pat on the back (James).

John felt that physical contact with an isolated client would be inappropriate, while James focused on his urge to touch lonely clients, although he identified his tendency to notice, rather than act upon the feeling. In both instances, client isolation impacted on touch.

Participants also spoke of the use of touch with clients who had been abused:

> I can remember just holding the client’s two hands in mine, she was very, very distressed, just disclosed abuse, I think for the first time (Elsie).

> ...for many of our clients, touch in terms of physical/sexual abuse has been present, so that probably leads to the feeling of a need to be very careful, and yet, in my experiences with some of those clients who have felt so abhorrent, so repulsive, that’s made it all the more powerful (Sylvia).
Sylvia not only reported how these clients were perceived as a group with whom touch needed to be tentative, but also suggested that touch was appropriate and most effective when working with such clients.

All participants referred to the impact of client gender on touch. Elsie stated:

I certainly would not offer touch to a male client. If a male client asked me to hold them I would instantly go into quite a different mode. I hope that I would stay empathic and tuned in, but I would not respond in that way because of the different interpretations that can be put on that (Elsie).

The male participants discussed the potential complexity of touching a female client and described their reservations. The female participants were more definitive, and stated that touching male clients, beyond a handshake, had not and would not occur. It is apparent that client–therapist gender difference influenced professional decisions.

The majority of the participants had experienced client-led touch, for example:

...it’s very much dependent on client initiated behaviour, there’s no way that I would touch somebody, unless, well when the hugs are involved I don’t hug them, they hug me and I just don’t reject them (Lydia).

Hence, this touch may be more permissible as the desire is located with the client. However, Sylvia stated that on occasions, she felt she had “no choice” in such interactions. Elsie described client “signals” such as details of their abhorrence of touch, which she interpreted as an instruction not to touch. The behaviours and presentations of clients appear to influence professional responses and decisions around future physical contact.

**The value of touch in therapy**

The majority of participants commented that touch could provide support. James stated:

... perhaps the best thing we could do would just be to say “look, let’s leave all that for a minute” and just do something [gestures reaching out] just to be very supportive or empathic if someone is very upset (James).

It seems touch may support and simultaneously demonstrate empathy in a way that words might not. Participants also referenced other benefits, such as its acknowledging and validating impact:

...they have seen it as a further extension of acknowledging they are having a difficult time and that I’m here (Clive).

Touch was also viewed as being of benefit for the professional:

... I think it has helped in that moment to just calm things down, enable the client to come back, to being able to contain their distress (Elsie).

Lydia, James and Clive also believed that touch could assist the professional, particularly in the communication of their feelings, but John did not agree:

...touching has a meaning in those situations, it means empathy: they are showing empathy by touching the patient when they are distressed during the session. I don’t think that. I don’t see any therapeutic value in touching (John).
John acknowledged that touch has a meaning, and perhaps therefore a value for some professionals, but disagreed with the other participants such as Sylvia who described touch as having the potential to be a “pivotal moment” in therapy. All participants referred to the use of touch at session or intervention endings. For example:

...shaking the hand at the end in kind of a sealing the deal way, if you strike a bargain with somebody or an agreement you shake hands, and often by the end of a session, there’s that sense that’s what you’re doing (James).

James described the handshake as a signification of the therapeutic contract that communicated an agreement to what had passed. This is expanded upon by Lydia in her account of touch at endings:

They haven’t hugged me after each session for the year or two that they’ve seen me, but it’s an end point when they are not going to see me anymore (Lydia).

As touch was deemed prevalent at therapy endings by all participants, one value of touch may be its propensity to signify farewell to the client. Alternatively, at the end of therapy, professionals may no longer feel bound by the nature of the relationship and consequently touch occurs.

The cost of touch in therapy
Issues of misinterpretation, confusion and dependency were common in a number of the accounts, and James’s reflections encapsulated these:

...you don’t want to hug your clients because you might create all kinds of strange ideas for them, you might make them dependent, it might be misinterpreted, blah blah blah... What is the risk that they are going to think this is sexual or that they are going to get dependent on me? You have to weigh it all up, then you give them a big hug [laughter] (James).

Whilst acknowledging a variety of potential negatives, James somewhat minimised the impact of these costs by implying that there are an infinite number of possible consequences with his remark and laughter. Clive spoke of the capacity touch has to “destroy” the therapy relationship if misapplied, which necessitates careful thought. It is apparent that clinicians can reflect on these issues in different ways: James insinuated that in practice, touch is led by feeling, while Clive appreciated the need for a more cautious approach due to associated risks.

The most frequently considered negative consequence of touch was the possibility that it could be misconstrued by the client:

...if they misinterpret my intentions then that muddies the waters in a way that isn’t going to be helpful (Elsie).

Elsie suggested that misinterpretation could negatively impact on the effectiveness of the therapy process. Clive sensed that costs may be less when the perceived probability of misinterpretation was reduced.

The group identified consequences for the professional following touch. Sylvia described an incident of client-initiated touch after a therapy session:

...there was almost a slight feeling of shame. I can remember thinking maybe my colleagues around me think this is what happens with all my clients (Sylvia).
Sylvia may be referencing the aforementioned theme that professionals are not expected to touch and as a result, shame is experienced when colleagues witness this interaction. When asked to elaborate on the impact of using touch, Clive added:

...there is always the no smoke without fire type things, damage to your reputation amongst your peers and I think, for the added advantage that maybe a reassuring touch would have given over comforting words, I don’t know whether the benefit outweighs the risk.

Clive believed that lasting damage to the professional’s reputation could occur without malpractice or sanction. Reflecting on the benefit-risk ratio, he felt uncertain whether the value of touch was greater than the cost, implying that the prospect of negative outcomes may be enough to deter professionals.

Discussion

By adopting an IPA approach, insights into touch from the perspectives of clinical psychologists were captured, and meaning was dynamically explored. The existence of the double hermeneutic and the inherent embracing of researcher biases fostered a “making sense” of participants’ lived experiences and allowed an insider perspective on the issue to be obtained. Only one participant (John) reported that he did not believe touch had any value within therapy, although he could appreciate the meaning of touch for some. The other participants suggested that touch could be both helpful, and harmful, depending on a myriad of client, contextual and professional variations.

Clance and Petras (1998) reported that psychotherapists put a great deal of thought into their decisions regarding touch. Although participants considered issues relating to touch within the current study, it was apparent that decisions in therapy were typically guided by instinct or a “feeling” without extensive “thinking.”

All participants emphasised the rarity of touch within their practice and a number described contact as “careful” or “light.” Participants discussed touch as being outside the remit of clinicians, and considered how limited discussion and training perpetuated this belief. These findings support the theories of Stenzel and Rupert (2004) that discussion on touch within professional groups is limited due to the focus on risk relating to accusations of misconduct. This results in a vicious cycle whereby professionals are not expected to touch, therefore they avoid talking about it due to the perceived risks. This reaffirms the belief that touch does not occur, thus maintaining assumptions regarding touch-free, good practice. Moreover, therapeutic orientation was discussed in relation to professional boundaries, and psychodynamic practice was considered the least compatible with touch due to the neutrality necessitated within this approach. This finding was consistent with Sinason’s (2006) belief that psychoanalytically informed professionals adopt a philosophy of “no touch.”

Glickauf-Hughes and Chance (1998) suggested that clients with unfulfilled relational needs and those who displayed so-called borderline functioning might warrant the exclusion of touch in therapy. The results of the current qualitative study supplement these findings as participants made the distinction that client isolation increased a desire to touch, but not necessarily actual contact. Although touch with clients who had experienced abuse necessitated a need to be careful, participants reported that touch had been most helpful for these clients. This supports the findings of Horton, Clance, Sterk-Elifson, and Emshoff (1995) that clients who had
experienced abuse found touch beneficial. While some participants in this study would grant touch following client requests, Mintz (1969) believed that clients who were assertive enough to request touch were likely to have this need met outside therapy and consequently, touch was deemed less of a necessity. Milakovich (1992) found that therapists who offered touch were more frequently female, however, within the current qualitative study both male and female participants offered touch and it appeared that the female participants more vehemently excluded the possibility of touch with clients of the opposite gender.

The values of touch included the ideas that touch could offer clients support, acknowledgement and containment, and that it had the propensity to ground or bring the client back to the reality of the therapy. These findings support the suggestions of Hunter and Struve (1998) that touch can enable clients to be present in the therapy by overcoming distractions. In this study, the potential for touch to lead to change and its description as a “pivotal moment” were findings consistent with those of Durana (1998) and Llewelyn and Gardner (2009) who reported that specific boundary violations might be appropriate in treatment.

Although all participants discussed the risks associated with touch, reluctance at therapy endings seemed to disappear. In line with the findings of Stenzel and Rupert (2004), the results of this study suggest that touch at endings is perceived as symbolically different from touch within therapy. This may be because such touch is more consistent with societal norms or, as the relationship ceases to exist, perhaps professionals are freed from the shackles of the therapeutic relationship and can more clearly show their humanity to clients.

In reaching our conclusions, we are mindful that the accounts provided by the participants may have been censored due to the perception that touch within therapy is a taboo. This potential limitation will be a factor within all studies that endeavour to focus on controversial issues; however, this is not to imply that these topics should not be addressed, rather that they should obtain further recognition so as to challenge the taboo status.

Future research on client views on touch and the perspectives of other professional groups may be particularly useful. The findings of this study implied that gender differences between therapists may influence the use of touch in therapy and this warrants further attention. The primary recommendation in terms of future research is for more exploration to occur to ensure that this topic becomes recognisable as an issue for therapists and that in turn, professionals feel more able to be open about the issue in both theory and practice.

It is hoped that this study will communicate that professionals are not alone in their ethical dilemmas, that it will encourage discussion of the topic and potentially promote training on touch as this was typically deemed to be lacking by the participants. In addition, this and future studies that demonstrate the potential value of touch in therapy have the propensity to challenge ingrained ideas and to change the perceived parameters of therapeutic relationships to incorporate touch within best ethical practice.

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