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Perceptions of Touch in Psychotherapy: A Survey of Clients Recovering from Substance Abuse and/or Childhood Sexual Abuse

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PERCEPTIONS OF TOUCH IN PSYCHOTHERAPY:

A SURVEY OF CLIENTS RECOVERING FROM

SUBSTANCE ABUSE AND/OR CHILDHOOD SEXUAL ABUSE

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An Abstract Presented to the Faculty of the Graduate School of Lindenwood University in Partial Fulfillment of the Requirements for the Degree of Master of Art

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Abstract

Differences in perception of touch in psychotherapy were studied among clients with childhood sexual abuse and/or substance abuse issues. Forty clients from the general context of the "recovery community" were recruited to fill out an eleven item Revised Touch in Therapy Survey. Participants also gave narrative responses to a single open-ended question asking what meaning their touch experience held for them. The researcher adapted this current instrument from the longer, 1995 Touch in Therapy self-report questionnaire developed by Horton, Clance, Sterk-Elifson and Emshoff. A mail back system was used, with surveys returned to a local post office box. The Likert scale responses of the forty participants were analyzed based upon chi-square analyses, the purpose being to investigate the relationship between client type of issue and client type of perception of touch in therapy. Use of descriptive statistics supplemented the chi-square analyses. Ability to interpret chi-square results was unfortunately limited due to small sample size. The descriptive data and narrative responses, however, indicated generally positive touch perceptions among this sample group. The results did not support a blanket statement of contraindication of touch for clients with sexual abuse issues, a particular stance sometimes presented in the professional literature. The survey results generally appeared to support the position that a circumspect, ethical use of touch in psychotherapy may well be of benefit to some clients. General implications of these findings are discussed, as well as recommendations for further research.

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Dedication

To all survivors of abuse

and to those who touch them in healing ways.

Acknowledgment

My greatest thanks to my husband Jim

for your love, friendship, and support.

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Chapter I

Introduction

A prohibitive stance regarding touch in therapy perpetuated through the psychoanalytic tradition, as well as a traditional focus on erotic touch in the professional literature, has created a climate in which negotiating the complexities of "to touch or not to touch" a client may well give even the most ethical therapist pause. Yet, touch has been incorporated in varying ways into a wide array of theoretical modalities, including non-body-oriented as well as body-oriented psychotherapies. Along many sectors of a conceptualized continuum of touch orientations may be found substantial percentages of therapists who do use touch with their clients (Borenzweig, 1983; Gibson & Pope, 1993). Acceptance of non-erotic touch in therapy among the counseling profession appears to be more openly acknowledged at present than at any previous time (Kertay & Reviere, 1993).

Despite such indications of prevalence in practices, the ethical use of non-erotic touch in psychotherapy has not received wide attention in professional literature and discourse. Most attention has focused upon the exploitative nature of therapist-client sexual involvement, as researched through surveys of professional attitudes and practices, and in studies addressing the known, agreed-upon harm done to victimized clients. Notably fewer surveys have been conducted regarding professional attitudes toward non-erotic touch, and only two studies have directly surveyed how psychotherapy clients perceive non-erotic touch in therapy (Geib, 1982; Horton, Clance, Sterk-Elifson & Emshoff, 1995).

Typically, studies are conducted from the therapist's point of view concerning the

proposed benefit, or proposed harm, of touch in therapy as it applies to specific client populations (Horton, et al., 1995). The two aforementioned studies from the client's viewpoint either used a very small sample of clients with a shared issue (Geib's 1982 study focused upon ten "neurotic" clients), or used a larger sample, collectively considering a range of issues gathered from a general outpatient group--Horton et al.'s 1995 study reported diverse client issues, e.g, depression, stress, eating disorders, relationship difficulties, concerns with sexual identity, anxiety, sexual abuse, (40%), and substance abuse (18%). The latter two categories comprise the focus of the current study. Gathering empirical data on differential patterns of touch receptivity among specific, identified client populations may lend structure and clarity to therapeutic guidelines and decision-making regarding the appropriate, effective use of touch in psychotherapy. It may also serve to expand the empirical data base in effort to counterbalance the weight of theoretical attention given to this often controversial issue.

Purpose

The most general purpose of the study is to view the pros and cons of touch in therapy in the light of client perception. More specifically, the purpose is to view these differing stances as they pertain to the specific client population of those who are: (a) either a client with issues of childhood sexual abuse or substance abuse; and (b) a client who identifies himself or herself as being "in recovery" from the pertinent abuse issue(s). This latter qualification likely means that many of those in the substance abuse category may be at or beyond the abstinence stage of a recovery

process. It may also mean that the sexual abuse survivor is employing self-help support systems in addition to therapy.

The purpose of the study in regard to "recovering" clients is to examine whether this particular client sub-population may more positively regard touch in therapy as an outgrowth of the cultural milieu of the twelve step recovery movement, a context generally known to encourage certain forms of physical contact among its members.

Hypotheses/Research Questions

The current study is designed in part after the work of Horton et al. (1995) in seeking to examine how the themes identified by Geib (1982) influence a client's perception of touch. The variables concerning client perceptions of touch were drawn from Geib and Horton in formulating null hypotheses for the current study. The variable of the client's issue category and the demographic variable concerning age were chosen by this researcher for the current study; as such, they were not drawn from the work of either Geib or Horton. The need to study how particular client populations respond to touch has been suggested by past researchers (Wilson, 1982; Willison & Masson, 1986). Age, also, has been implicated as a conditional factor in patterns of touch receptivity meriting further investigation (Howard, 1988; Eaton, Iola, Michell-Bonari, & Friendmann, 1986; Halbrook & Duplichin, 1994).

The null hypotheses for the current study relate to the five conditional factors of Geib (1982) and to the client's more global perceptions of touch as measured by Horton, et al. (1995). The null hypotheses for the current study are as follows:

1. There is no relationship between the perceive level of openness regarding the boundaries of touch in therapy and client's type of issue (i.e., whether the client has sexual abuse issues, substance abuse issues, or both).

1a. There is no relationship between the perceived level of openness regarding the boundaries of touch in therapy and the client's age (whether 40 and under, or over the age of 40).

2. There is no relationship between the perceived level of client control regarding touch in therapy and the client's type of issue.

2a. There is no relationship between the perceived level of client control regarding touch in therapy and the client's age.

3. There is no relationship between the degree to which the touch felt congruent (to either issues being dealt with in therapy or to intimacy with the therapist) and the client's type of issue.

3a. There is no relationship between the degree to which the touch felt congruent (to either issues being dealt with in therapy or to intimacy with the therapist) and the client's age.

4. There is no relationship between the degree to which touch was perceived to be for the client's benefit and the client's type of issue.

4a. There is no relationship between the degree to which touch was perceived to be for the client's benefit and the client's age.

5. There is no relationship between the degree to which the client perceived the touch as positive and the client's type of issue.

5a. There is no relationship between the degree to which the client perceived the touch as positive and the client's age.

6. There is no relationship between the degree to which the client perceived self-concept as benefited by touch and the client's type of issue.

6a. There is no relationship between the degree to which the client perceived self-concept as benefited by touch and the client's age.

7. There is no relationship between the degree to which the client perceived the therapist or therapeutic relationship positively as result of experiencing touch and the client's type of issue.

7a. There is no relationship between the degree to which the client perceived the therapist or therapeutic relationship positively as result of experiencing touch and the client's type of issue.

8. There is no relationship between the degree to which the client perceived work in therapy as benefited from touch and the client's type of issue.

8a. There is no relationship between the degree to which the client perceived work in therapy as benefited from touch and the client's age.

Because all but seven of the item-by-item chi-square analyses were found to be untenable (due to small sample sizes), the decision to instead use descriptive statistics resulted in a shift from statement of hypotheses to the formation of the following research questions. How will Geib's factors (as encoded by the survey items) be evaluated by the specific client populations in this study? Will certain factors draw more uniformity of response than others? Which factors will result in the greatest range and spread of responses? How will the overall experience of touch be

evaluated? How will the responses of the different client groups compare to one another? Will prohibitions by certain clinicians and researchers not to use touch in therapy with sexual abuse survivor clients be borne out by this set of responses (i.e., by the presence of negative evaluations)?

Lastly, an open answer question was also included in the survey asking clients to express (in as few or as many words as they liked) what meaning the touch held for them. These narrative responses were systematized in order to enhance understanding of the distribution of scores seen in the descriptive statistics results.

Chapter II

Literature Review

Touch in Therapy Continuum

An exploratory discussion of touch in therapy necessitates some consideration of the wide array of approaches currently in existence. Many of these approaches are specifically associated with a given theoretical orientation. Mintz (1969b), for example, has traced the no-touch prohibition in therapy through the psychoanalytic tradition. Alternatively, humanistic approaches have been typically recognized as more accepting of the use of touch in therapy (Holub & Lee, 1990). While such observed associations have been periodically noted, this writer suggests extending such observations by conceptualizing a touch-orientation continuum along which current psychotherapies are situated.

Along this proposed continuum, those approaches which treat the mind and body as separate, independent elements would be theoretically positioned on the left end. At this conceptual extreme, then, would be found the blank screen approach of psychoanalysis. From this point on, receptivity to the use of touch in therapy increases. Those therapies in which touch is used interactively with verbal strategies would be viewed as mid-range on the continuum. The human potential movement's affiliation for touch (as seen in the work of Rogers or Perls) has been distinguished, as has that of family systems therapists, notably Satir (Holub & Lee; Hunter & Struve, 1998). Moving toward the right of the continuum, a point is reached where

mind and body are treated as highly interdependent. Here would be found what Cornell and Olio (1992) have identified as two traditions, the somatic therapies tradition and the physiological/movement tradition.

Modern somatic approaches in psychotherapy have evolved from Reich's complete departure from the precepts of psychoanalysis. Reich has been termed "the father of body-oriented psychotherapy" (Hunter & Struve, 1998). Examples of somatic approaches are Reichian approaches, neo-Reichian approaches (e.g., bioenergetics), and the technique of Rolfing. Accompanying somatic approaches at the right end of the continuum would be the movement therapies of Alexander and Feldenkrais. Beyond these body-oriented therapies, at perhaps the furthest tip of the continuum, mind and body distinctions may dissolve altogether entirely, as with certain Asian or transpersonal psychotherapies. How the use of touch is interpreted by these therapies becomes even more elusive to attempt to characterize.

The supposed linear progression of the continuum is more likely recursive, with many interfacing processes. Rosenberg (1995), for example, has described his shift in touch orientation with one patient over a course of years from a bioenergetics approach to a psychoanalytic approach. Even deciding what is therapy in regards to touching is subject to debate all along the continuum. For example, Kertay and Reviere (1993) have noted that whereas the term "body oriented psychotherapy" is liberally referred to in professional discourse on touch, "there is tremendous variety in definitions of this area among its advocates" (p. 32). What some in the field might term integrating touch into psychotherapy, others would deny to be therapy at all. Rolfing is one such example from the continuum's more distant points, labeled by

some as "nonpsychology bodywork," and by others as body-oriented psychotherapy. Another example of theoretical debate could be found in Gabbard's (1992) claim that "therapy is a talking relationship." By definition, any counseling approach which used touch to any degree (i.e., most of the continuum) would be disqualified. This cursory overview of different viewpoints regarding touch in therapy begins to address the complexity as well as the controversial nature of this issue.

Another useful way to group touch-oriented modalities is through Smith's (1985) categorization of body-centered techniques as "hard," "expressive," and "soft." Hard techniques (e.g., bioenergetics) may cause discomfort or even pain, and are designed to release blocked feeling or memory. Rolfing exemplifies a hard technique, an approach involving deep tissue manipulation and the goal of re-educating the body, developed after Rolf noticed patterned rigidification of facial and body musculature and tissues in traumatized individuals (Halbrook & Duplechin, 1994). More moderate, and less invasive are a middle group of expressive techniques, seen in Gestalt or psychodrama therapies. These techniques are often still quite receptive to use of touch. Even less intrusive, and more educational in scope, are the soft techniques, designed to draw attention to, rather than to manipulate experience. A soft technique might be a supportive touch, or a noticing of tension in a given part of the body. Cornell and Oilo (1992) have noted that a "softening" of traditional somatic therapies has occurred due to the influence of feminist body psychotherapists such as Moss and Kepner. These "softer" modalities, rather than accentuating the role of stress or pain, evolved instead toward a client more gently re-claiming her body and experiences. It is often these "soft" techniques which

comprise the main focus of attention in discussion and research on nonerotic touch in therapy, and of the current study of this researcher as well.

Benefits of Touch in Psychotherapy

In the last thirty years, support has gathered to counter the "taboo tradition" of touch in psychotherapy. Forer (1969) is one such voice who has strongly advocated using touch in therapy, taking to task the "puritan ethic, and the engineering, technologic, anti-humanistic stance of our middle class society" which has "fostered ritualistic interpersonal relationships" (p. 229). Forer particularly points to psychoanalytic theory as a culprit in ritualizing the therapeutic relationship. For example, what the psychoanalytic tradition may label patient gratification, Forer alternatively frames as an internal re-structuring of the client whereby internalizing the therapeutic touch acts as "an antidote to the destructive residuals of early relationships and opens the closed system of the person to new interpersonal experiences" (p. 230). Borenzweig (1983) has likewise noted the irony of a psychoanalytic theory stance which grants prominence to "the critical connection between touch and basic trust in the oral stage of development," yet for whom "touch in therapy is taboo" (p. 238). For Forer and Borenzweig, touch is merely a natural form of expression to be used with freedom in the counseling context. Yet another humanizing aspect of touch emphasized by Forer is its ability to encourage a sense of mutuality and equality within the therapeutic relationship

Other notable touch proponents include Wilson (1982) and Older (1982). Wilson promotes the most significant use of touch in therapy as its ability to elicit

client self-disclosure. Older's 1982 book title announces his view on touch; for Older, touching is healing. He offers anecdotal evidence from his clinical work of the effectiveness of touch as "a releaser, a comforter, and a change agent" (p. 216). His viewpoint is summarized with the statement, "Touching is not a technique: Not touching is a technique" (p. 217). Older has accused the touch taboo to be limiting to the success of psychotherapy. He notes with irony, for example how "we live in a strange time in which it is perfectly acceptable to induce convulsions in a person with electricity, yet it may be illegal to hold that same person's hand" (p. 217).

Yet other proponents of touch in therapy include Alagna, Whitcher, Fisher, and Wicas (1979), as well as Willison and Masson (1986). Alagna et al. (1979) found in career-focused 25 minute interviews of 108 college students that the group of touched subjects evaluated their counseling experience more positively and participated in greater self-exploration than did an untouched control group. Clients touched (on the hand, the lower arm, or the upper back) by opposite sex counselors reported the most positive evaluations of any dyad combination. Alagna et al. determined no condition in which touch was responded to negatively by the subjects. Willison and Masson (1986) reviewed the literature on touch and concluded "touch facilitates the counseling process by increasing the client's positive evaluation of the experience" (p. 499). They further advocated the introduction of "touch concepts" (p. 499) into graduate counselor training programs to supplement existing verbal and nonverbal skills training. Kertay and Reviere (1993) have also found "sufficient theoretical justification to support at least some uses of touch in the psycho-therapeutic relationship" (p. 36).

While touch in therapy has been studied various ways (e.g., using a "no touch" control group, or simulating a counseling session), only two studies have directly considered the experiences of actual psychotherapy clients (Geib, 1982; Horton et al., 1995). Both of these studies identified positive themes and effects which clients had associated with their touch experiences. Geib's phenomenological study involved ten female "neurotic" clients, all of whom had male therapists. Geib found five positive themes associated in the clients' perceptions of nonerotic touch in psychotherapy. Clients positively reported that touch: (1) provided a link to external reality out of the client's inner world of pain, (2) concretely communicated the message to the client that she was not alone, (3) conveyed the therapist's acceptance, bolstering the client's self-esteem, (4) modeled a new way of relating, and (5) strengthened the client's connections to her own body sensations. Horton et al. (1995) found similar themes in a respondent group of 231 clients. Approximately two-thirds (67%) perceived touch to have nurtured a bond of trust and greater openness in therapy. Another 47% of respondents perceived touch in therapy as helping them to build self-esteem and feel accepted by their therapist.

Some practitioners have suggested certain contexts in which touching in therapy may be especially useful (Holub & Lee, 1990; Levitan & Johnson, 1986; Mintz, 1969; Older, 1982; Wilson, 1982). Clients in crisis or those with severe pathologies, for example, have been described as being particularly aided by physical contact (Holub & Lee, 1990). Whether the client's crisis is one typified by anxiety or rejection (Mintz, 1969a), or by grief, depression, or trauma (Holroyd & Brodsky, 1977), touch may reduce the sense of isolation and increase a sense of acceptance.

The client who copes with severe, chronic symptoms may also especially be aided by touch interventions. The power of touch to forge a connection with schizophrenic and schizoid patients (Wilson, 1982), or psychotic patients (Older, 1982) has been observed. Older has portrayed the connecting quality of touch as "a ground control for bringing a high flier down to earth" (p. 203).

For some clients coping with depression, also, touch may satisfy a distinctly articulated felt need of the client to be held (Hollander, 1970). Stein and Sanfilipo (1985) tested the purported association between depression and the desire for physical contact. From a sample of 129 college students, who filled out scales measuring depression and desire for physical contact, Stein and Sanfilipo found that, for both sexes, the intensity of a wish to be held was related to higher levels of an 'anaclitic, dependent" type of depression.

In addition to the context of crisis, psychotherapists surveyed by Holroyd and Brodsky (1977) offered these other general contexts for usefulness of nonerotic touch: (a) with clients who are socially or emotionally immature; (b) to reinforce, reassure, and support; and (c) at greeting or at termination. One less conventional context, that of regressive work with clients, has been exemplified by Smith (1990). Smith, from a transactional analysis perspective, describes how she uses touch "to hold, cuddle and touch regressed patients as children are held, cuddled, and touched by their parents" (p. 256). Similarly, touch for the purpose of modeling positive parenting has also been indicated by others. The therapist might symbolically parent a client through touch (Mintz, 1969), or show clients who are abusive parents alternative, healthy ways to touch their children (Wilson, 1982).

The context of group work is another area in which the benefits of touch have been observed and recorded (Dunne, Bruggen, & O'Brian, 1982; Hunter & Struve, 1998; Rabinowitz, 1991). Rabinowitz (1991) found touch (a postgroup embrace) in an all male therapy group to be a facilitator of individual disclosure, and of group connection. In discussing the dynamics of breaking the male-to-male touch taboo, Rabinowitz qualified that the physical contact may have been particularly powerful since it was initiated by group members, and since the group context may diminish the potential for touch to be misunderstood in the clients' view. He concluded, "Despite the cultural taboo for men to engage in physical touching, the act of embracing another man, in the context of the therapy group, does seem to encourage the expression of deeper feelings and lessen the isolation men often feel in our competitive society" (p. 576). Dunne et al. (1983) reported that bodywork techniques incorporated into group treatment for involuntarily admitted adolescents in a residential treatment facility encouraged participation and camaraderie among this often difficult to reach population

Benefits of touch for the elderly have also often been cited, as has this population's risk of suffering from touch hunger or touch deprivation (Eaton, et al., 1986; Fanslow, 1990; Halbrook & Duplechin, 1994; Howard, 1988). In an occupational therapy setting, Howard (1988) found touching (4-8 light touches on the shoulder in about a half-hour period) to significantly, positively influence geriatric patients' attitudes toward both a task and the occupational therapist. The "no touch" control group reported significantly more negative attitudes measured by an attitude questionnaire administered after the craft session than did the elderly patients

who were touched. Eaton et al. (1986) found that touch (experimental group subjects were touched lightly on the forearm briefly five times in the course of a meal hour) used as an adjunct to verbal encouragement to eat significantly increased nutritional intake in elderly, chronic organic brain syndrome patients.

Another therapeutic context in which touch has often been found particularly useful is that of hypnotherapy. Levitan and Johnson (1986) have described their use of physical touch in their own practice to enhance hypnotherapeutic effectiveness (e.g., resting a hand on the client's shoulder during induction, or covering the client's hands with one or both of the therapist's hands during suggestion to convey a non-verbal message that the client is, "now in good hands").

Touch Guidelines

A number of researchers and clinicians have offered guidelines for decision making regarding use of touch with clients. Goodman and Teicher (1988) review psychodynamic literature and distinguish between condoning judicious use of touch with "nondeveloped" patients while denying touch to "regressed" patients. Touch purportedly will cause a regressed person to further regress, and to become more dependent in the therapeutic relationship. However, for the patient with arrested development, who is "undifferentiated," touching may help communicate a concrete, ego-strengthening message. Kertay and Reviere (1993) have commented that, for them, so neatly classifying clients would prove to be an elusive endeavor. Since many clients present with mixed features, Goodman and Teicher's guidelines would seem not to offer sufficient clarity of direction.

In seeking to establish guidelines, other clinicians have also elucidated more general factors which may determine whether touch in therapy has a productive versus a counter-productive effect for the client. Geib (1982) has identified five such conditional factors: (1) the existence of openness and clarity regarding boundaries of touch, (2) the client feeling in control of the touch, (3) the client experiencing the touch as intended for her benefit rather than for that of the therapist, (4) the touch feeling congruent to the client with the issues being dealt with in therapy, and (5) the touch feeling congruent to the client with the level of intimacy between the counselor and the client. Geib also found four themes which clients negatively associated with a touch in therapy experience: (1) when the client felt trapped within "the gratification of being close" with the therapist, (2) when the client perceived the therapist as nurturing and therefore felt guilty for not appreciating the touch, (3) when the client felt caught in role-reversal of feeling responsible for the therapist, and (4) when the client perceived the touching as a reenactment of dynamics within her family of origin.

Hunter and Struve (1998) have provided another current, expanded collection of conditions which when present suggest it may be clinically appropriate to use touch in psychotherapy, such as when: " The client wants to touch or to be touched; the purpose of the touch is clear; the touch is clearly intended for the client's benefit: the client understands concepts of empowerment and has demonstrated an ability to use those concepts in therapy; the therapist has a solid knowledge base about the clinical impact of using touch; the boundaries governing the use of touch are clearly understood by both client and therapist; enough time remains in the session to

process the touch interaction; the therapist-client relationship has developed sufficiently; touch can be offered to all types of clients; consultation is available and used; and the therapist is comfortable with the touch" (pps. 136-146).

Alternatively, guidelines by the authors of when it is clinically inadvisable to touch are when: "The focus of therapy involves sexual content prior to touch; a risk of violence exists; the touch occurs in secret; the therapist doubts the client's ability to say no; the therapist has been manipulated or coerced into the touch; the touch is used to replace verbal therapy; the client does not want to touch or be touched, and the therapist is not comfortable using touch" (pps. 147-152). Hunter and Struve have developed a model informed consent form for the use of touch in psychotherapy (See Appendix D) for clinicians who desire a written record of permission granted by a client to allow the use of touch.

Kertay and Reviere (1993) echo a commonly expressed sentiment among those who do employ touch in therapy, that any "rigid, rule-bound approach is precluded by the complexities of this issue" (p. 37). A more rationale approach of considering the issue on a case-by-case basis is offered, taking into account the uniqueness of each therapist, each client, and the dynamics in that therapeutic relationship.

Touch in Related Therapies

Beyond psychotherapy lies a wide spectrum of touch-oriented therapies and alternative modalities. That there is a phenomenon at present of rapid proliferation of such modalities surrounding and often interfacing with psychotherapy is worth note. This current study, for example, surveys individuals who identify themselves

as being part of a recovery movement, itself possible to frame as a touch-oriented phenomenon in society today, one which may be generally accepting of alternative modalities. A brief overview of areas in which touch is valued may provide a helpful context from which to further examine factors of beneficiality related to touch in dealing with psychotherapy clients who are in recovery.

Greenspan and Schneider (1994) have noted that the "laying on of hands" for healing has taken place throughout history, citing examples ranging from classic Judaic tradition to modern scientific approaches, to the new discipline of psychoneuro-immunology, and to the holistic nursing practices called therapeutic touch (TT) with its "healing energy transfers." TT, developed by Krieger in the early 1970's involves the placing of hands on a client for several minutes during which time two factors, "the focused intention to heal," and "a transfer of energy from the environment through the toucher, to and through the subject" (Olson & Sneed, 1995) are present. Krieger's work reported statistically different hemoglobin levels in subjects given TT, versus those given routine touch. Her work, however, has been questioned due to her use of small sample sizes (Gagne & Toye, 1994).

With healthy subjects experiencing episodic stress (a group of professional caregivers), Olson and Sneed (1995) found that TT significantly reduced high levels of anxiety. Olson and Sneed also cited studies by Heidt in1981 and by Quinn in 1982 and 1984 which demonstrated that TT decreased anxiety in adult hospitalized cardiovascular patients. Similarly, Gagne and Toye (1994) reported anxiety reduction in 31 patients of a Veterans Administration acute inpatient unit who received TT interventions. Gagne and Toye also cited the 1986 work of Keller and

Bzdek regarding TT's effect on reducing headaches. In Keller and Bzdek's study, 90% of subjects reported a 70% reduction in tension headache pain after TT was administered. Fanslow (1990) has noted that TT is extremely useful especially to the elderly, explaining that the increased fragility of an elderly person's energy field may open the individual up to deeper and more profound effects of energy transfers. TT continues to gain acceptance by holistically minded health care professionals. For patients who cannot tolerate medication or who refuse to medicate, for newly diagnosed patients with serious illness who initially may be too anxious to learn self-regulating strategies, and for those unable to meet the expense of bioenergetics, holistic nursing has proposed TT as an effective, alternative intervention (Gagne & Toye ,1994; Olson & Sneed, 1995).

At times, TT more clearly crosses the line from nursing to counseling concerns. One such example of this blurring of boundaries may be seen in a study completed during the aftermath of Hurricane Hugo (Olson, Sneed, Bonadonna, Ratliff, and Dias, 1992). Olson et al. (1992) administered two TT sessions and one control session to each of 23 participants, measuring both physiological and psychological factors. All stressed subjects had experienced some form of loss attributable to the hurricane. Heart rate, blood pressure, skin temperature, and respiratory rate all indicated anxiety reduction after the TT sessions. Pre-session mean anxiety scores were lowered by more than 50% by the TT interventions. Control group scores indicated that either anxiety did not decrease, or in some subjects actually increased. That TT is being used for its palliative effects in granting physically or situationally stressed individuals emotional relief represents one sample interface of alternative

and traditional mental health care. TT's influence may be represented in many of the "soft" touch techniques employed by non body-oriented psychotherapy.

Questions on Touch in Psychotherapy

While a number of studies have shown the benefits of touch, others have reported the effects of touch to be inconsequential (Bacorn & Dixon, 1984; Suiter and Goodyear, 1985). Bacorn and Dixon (1984) compared effects of touching in a single interview between depressed and vocationally undecided female undergraduates, finding no significant differences in how either group viewed the counselor or the counselor's request for a second interview. In explaining the occurrence of some subjects' uncomfortable responses to the touch, the researchers mentioned the possible influence of premature timing in the overall context of the interview. Touch had been initiated by the counselor in this study, and was carried out as part of an experimental protocol, independent of client cues.

Suiter and Goodyear (1985) presented three minute, scripted, videotaped vignettes incorporating one of four levels of counselor touch (ranging from no touch to semi-embrace) to groups of counselors as well as clients. The counselor using the highest touch level received lowest perceptions of trustworthiness. The researchers postulated this negative perception may have resulted from subjects ascertaining an incongruent level of intimacy being assumed by the "toucher" considering the overall context of the simulated situation (a general, open-ended interview).

While reports vary, many counseling professionals do appear receptive to the idea of using nonerotic touch with their clients. Holroyd and Brodsky (1977)

surveyed 666 psychotherapists and found that approximately half thought nonerotic hugging, kissing or affectionate touching might at times benefit a client, with 27% engaging in such behavior on occasion, and 7% frequently or always engaging in such behavior. One third of humanistic therapists considered such nonerotic behavior to be frequently or always beneficial, whereas two thirds of psychodynamic therapists considered the same behavior as rarely or never beneficial. Most psychodynamic therapists thought the behavior would be frequently or always misunderstood. Most humanistic therapists thought it would rarely or never be misunderstood. Stake and Oliver (1991) have subsequently questioned Holroyd and Brodsky's distinction between erotic and nonerotic contact as too simplistic and in need of further clarification.

Borenzweig (1983) found in surveying 87 clinical social workers that 50% used touch in actual practice; however, a greater number (83%) positively rated the benefit of judicious use of touch in therapy for clients. Additionally, 79% of the clinicians indicated they seldom or never taught touching practices formally as part of therapy to their clients. Gibson and Pope (1993) surveyed 579 counselors certified by the National Board for Certified Counselors (NBCC) and found 99% endorsed as ethical offering or accepting a handshake from a client; 86% endorsed as ethical hugging a client, and a minority; 16%, endorsed as ethical kissing a client. Acceptance of the use of nonerotic touch in therapy seems to be more openly acknowledged at present than in any past years (Kertay & Reviere, 1993).

The Taboo History

Critics of touch may be traced through the history of the development of the touch taboo in therapy, that is, through the history of the psychoanalytic tradition (Borenzweig, 1983; Forer, 1969; Holub & Lee, 1990; Kertay & Reviere, 1993; Mintz, 1969). Freud is known to have employed touch in his early work with hysteria, and to have allowed his patients to touch him in return. He would encourage age regression at times through use of massage to the head and neck of patients. He also at times attempted to elicit free association through pressing upon the head of a patient. As Freud began to invest more importance into the analysis of the transference in the therapeutic relationship, he reversed his position sharply, decrying touch as interfering with the "blank screen" analyst's stance of neutrality. The tradition was set on course that touch avoidance in psychoanalysis ensured denial of patient gratification, allowed the transference to develop, and in so doing, allowed the therapy to move forward. Reich and Ferenczi, among others who failed to adopt Freud's reversal of position, faced criticism and professional banishment from the more traditional psychoanalytic field (Kertay and Reviere, 1993).

The touch taboo maintained precedence in the field for several decades. Levitan and Johnson (1986) have suggested additional possible precursors contributing to the development of the modern Western cultural taboo against touching, especially in therapy. Precursory influences include the Mosaic law, with Christianity's distinction between body and mind, as well as a historical fear of catching disease through contact (e.g., the Bubonic plague, the remnant influence from leprosy). Within the psychoanalytic tradition, the no-touch tradition gained widespread

acceptance. Mintz (1969) has cited Meninger's 1958 depiction of any type of touch in therapy as "incompetence or criminal ruthlessness." Borenzweig (1983) found that 92% of clinicians studied with a Freudian orientation refrained from touching. Forer in 1969, while noting the ensuing entrenchment after Freud of the no touch tradition, also identified what she saw as the stirrings of a shift in the taboo tradition, "in the past few years a small number of psychotherapists have dared to recognize that skin contact between therapist and patient can be a valuable form of therapeutic communication" (p. 230). By 1993, Kertay and Reviere's observation that "a strict taboo against touch appears at present to be a minority position" (p. 34) seems to indicate that a turning of the tide has indeed taken place over the last half century, however varied are the opinions concerning the subtleties of whom to touch in therapy, how, and in what context.

Current critics. While proponents voice the advantages of the use of touch in therapy, critics of touch contrastedly have claimed detrimental effects attributable to therapist use of touch with clients (Alyn 1988; Gutheil & Gabbard, 1992, 1993). In sharp contrast to Forer's (1969) claims that touch has the capacity to reduce the power differential in the therapeutic relationship and to increase intimacy, Alyn (1988) proposes just the opposite may occur when and if "therapeutic relationships reproduce culturally prescribed power differences" (p. 432). Alyn would likely view Forer's claim that touch promotes a more mutual, egalitarian therapeutic relationship as disregarding certain central feminist assertions. Patterns for touching and being touched, for example, differ for men than for women in this culture, influenced greatly by prevailing issues of power and status. Even ethical touch in a "typical"

dyad of male therapist-female client may reinforce cultural conditioning to the detriment of the client's recognition and development of self-worth and independence. Rather than helping to empower the client as Forer suggests, Alyn would contend that female clients may actually be disempowered by experiencing touch in therapy.

Holub and Lee (1990) have likewise noted the "touch privilege" afforded a higher status person in society, and have echoed gender-related concerns based upon the differences in socialization and feelings subsequently elicited in response to touch between men and women. Alyn (1988) points to the cultural combining of power and sexuality as compromising the ability of the client to differentiate between erotic and non-erotic touch. Therefore, the misinterpretation of touch in therapy as sexual becomes more problematic. Alyn, then, clearly disagrees with Willison and Mason' s 1986 claim that touch "does not lead to negative consequences in any counseling context" (p. 499). She in fact goes so far as to construe touch as "an extremely unclear, and possibly dangerous, means of communication in therapy" (p. 433). An incidental gender-related concern seeming to contradict Alyn's argument in part is Halbrook and Dulpechin's (1994) observation that the differential socialization of men in this society may leave males rather than females more vulnerable to regressive response to touch in therapy, considering more males may associate being touched with being a child.

Other research on gender patterns of touching introduces additional factors to consider in Alyn's (1988) argument that gender may be equated with power in the intentional initiation of touch. Hall and Veccia (1990) observed 4,500 dyads in

public places and found no overall difference in the frequency of intentional touch among the three possible dyad combinations. Age, however, played a significant role in touch frequency between men and women. With dyads under 30, males touched females significantly more than vice versa. This male-female asymmetry decreased with age. With older dyads, female-male touch was observed to be more the norm. Alyn's (1988) sociopolitical claims, then, may require consolidation with other empirical evidence as raised by studies on aging, or on male socialization regarding touch in therapy

Also related to the topic of the power differential in therapy is the chief claim of those who criticize touch in therapy that such contact paves the way for ensuing boundary violations and eventual sexual exploitation to occur. In seeking to address the question as to whether touching patients leads to the exploitation of erotic touch (specifically, to sexual intercourse), Holroyd and Brodsky (1980) surveyed 347 male and 310 female psychologists and found "differential touching," i.e., a clinician's pattern of touching only opposite sex clients, and not same-sex clients, to be reported as an antecedent of unethical touching. They found, however, no overall relationship between the use of non-erotic touch and the misuse of erotic touch. Nonetheless, the "slippery slope" argument regarding nonerotic touch remains popular particularly in psychoanalytic circles. One such example may be seen in Epstein and Simon's 1990 "Exploitation Index," a type of early warning system self-check list. Any touch beyond a handshake on this index would be labeled eroticism, and as "an early warning sign indicating unresolved conflict in the therapist that might impair the ability to prevent erotic feelings from contaminating treatment" (p. 458).

In this psychoanalytic view, a touch on the shoulder would be a red flag of likely impending, more serious boundary violations to follow. Mintz (1969) offers one practical consideration in refuting the argument that touch leads to sex, "this argument seems specious: a therapist who could be swept away by touching a patient's hand or embracing a regressed patient could probably not withstand the sustained intimacy of the therapeutic relationship in any case" (p. 234). A similar slippery slope rationale is advanced by Gutheil and Gabbard (1993) who discuss how to discourage hugs from patients and in so doing prevent client pursuit of a "golden fantasy." The client who is allowed touch will then pursue gratification of all other wishes in a fantasy belief that therapy will meet all needs in his or her life. The results of the study by Horton et al. (1995) have offered one example of empirical evidence at least that serves to contradict the notion this "gratifying" the client through touch will inevitably stall the therapy. The researchers instead concluded the converse possibility that touch in therapy "may alleviate shame and help the patient tolerate the pain enough to face and work through issues more quickly, or on a deeper level" (p. 455). Whether touch constitutes gratification or therapy appears to depend, at least in part, upon the theoretical orientation of the practitioner.

Wrongful Touch

Many therapists, whether psychoanalytic or of another theoretical orientation, do avoid touch in therapeutic sessions with clients out of a fear that physical contact my be misconstrued by the client (Levitan & Johnson, 1986). Even the most ethical therapist who does choose to touch must navigate the complexities of concerns

regarding how any action will be perceived (Horton, 1995). In part, such caution and concern has been generated based upon the actions of a minority of therapists, actions which up until but a few decades ago often went largely unexamined within professional literature and discourse.

The professional taboo against therapist-client sexual involvement may be traced through the code of Nigerian medicine men not to "sex the patient," through the Hippocratic oath to keep oneself "far from all intentional ill-doing and all seduction, and especially from the pleasures of love with women," through Freud's warning that sex in therapy is the "overthrow of the cure," and up to the appearance of modern ethical codes (Brodsky, 1989; Pope & Bouhoutsos, 1986). In spite of this long history of prohibition, sexual intimacies in therapy are reported with distressing prevalence. Stake and Oliver (1991) surveyed 320 psychologists in Missouri to explore incidence of sexual behavior with clients. Forty-four percent of the respondents had heard reports from clients of sexual contact with a previous therapist. Surveys report between 7 and 12% of therapists become sexually involved with their clients; some estimate the figure to be as high as 20% (Stake & Oliver, 1991; Strasburger, Jorgenson, & Sutherland, 1992). Salter (1995) has cited surveys estimating exploitation as occurring among 5 and 10% of male therapists, and among two to three percent of female therapists. Prevalence estimates vary, and must be considered in light of such factors as offender reluctance to self-report.

That this extreme form of exploitative touch does real harm to clients is generally agreed upon in the profession. Pope (1988) has enumerated aspects of "Therapist-Patient Sex Syndrome," sequelae including client experiences of

ambivalence, guilt, boundary and role confusion, suppressed rage, increased suicidal risk, and cognitive dysfunction. Strasburger, et al. (1992) estimate that 90% of patients who had sexual contact with therapists were harmed by it; some require hospitalization, and almost all face a recovery process that may take years. Yet, while surveys indicate professionals disapprove of this extreme, invasive, nonethical use of touch , willingness to address the reality of sexual misconduct by colleagues has been slow in coming. Pope and Bouhoutsos (1986) have supplied supporting examples of this collective professional reluctance. When Greenwald in the early 1960's wanted to study the issue, members of the New York Psychological Association tried to expel him; and Davidson in 1977 called the issue "the problem with no name." Not until the mid 1970's was therapist-client sexual involvement clearly acknowledged as unethical by various professional counseling organizations.

A parallel type of history may be seen in the profession's attention (or lack of attention) given to non-erotic touch. Non-erotic touch as a therapeutic issue gained little attention at all until the last few decades (Kertay & Reviere, 1993). Part of the increase in discussion of use of ethical touch can be explained in light of the extensive, often controversial changes undergone by ethical, administrative, and legal remedies for victims of therapist sexual exploitation. Mental health professionals divide into opponents and advocates of such conflict-ridden issues as mandatory reporting, criminalization, and extension of civil statutes of limitations. Within this climate of controversy, courts and professional organizations (whom lawmakers consult in drafting guidelines for new legislation) are called upon to characterize the professional relationship, especially in conceptual areas such as that of transference.

Discussion of nonerotic touch's role is inevitably implicated as such policy making continues to transpire.

The current climate thus needs to be taken into consideration in discussing how counseling professionals view touch in therapy at present. Hendrickson (1982) has stressed the value of therapists becoming well-acquainted with various liability issues in counseling, including touch-related issues. Even if touch is in fact treatment for the client's welfare, Hendrickson underscores that the touch must be considered reasonable in the eyes of the profession, and be done with the client's consent. The unconsented touching of a client, even when there is no proven intent to harm, may still be considered to be battery in a court of law.

One reactionary stance to outside, legal influences on the counseling profession may be seen in the "risk-management" focus adopted by some therapists with regard to client relations. Guthiel and Gabbard (1993) for example, concluded, "From the viewpoint of current risk-management principles, a handshake is about the limit of social physical contact at this time" (p. 195). Such critics challenge the transference-driven model of the therapeutic relationship, contending that the client is stereotyped, and robbed of autonomy by such a characterization (Clements, 1987). Gutheil and Gabbard (1992) argued that the transference model succumbs to the "lure of reductionism" in ignoring the client's potential to share accountability within the relationship. Gutheil and Gabbard (1993) suggest instead a more business-oriented paradigm of therapy as a "fiduciary relationship." The role and perception of nonerotic touch is clearly affected by an individual clinician's conceptualization of the therapy relationship. Against a backdrop marked by some controversy, individual

clinicians navigate their own pathways in deciding if, when, and how to use touch therapeutically.

Clients with Sexual Abuse Issues

A client group described as being at particular risk for exploitation by unethical practitioners is that of sexual abuse survivors. Survivors comprise substantial percentages (Daniluk & Haverkamp, 1995, estimate 30-33%) of many clinician case loads. In this researcher's current study, survivor clients comprise a large percentage of those surveyed. Pope and Bouhoutsos (1986) place incest survivors within as a high vulnerability, high risk group for re-victimization by abusive therapists. Salter (1995) has confirmed the observation that client sexual exploitation by mental health professionals is correlated with child sexual abuse. Salter cites studies by Gil in 1988 and by de Young in 1983, both in which approximately one third of the survivors in each sample had experienced revictimization by therapists. Not surprisingly, viewpoints on whether or not to touch this population of clients vary, sometimes sharply, among psychotherapists.

Vasquez (1988) has deemed as generally unsuitable the use of touch for incest survivors. Salter (1995) has warned of the infantilizing power of physical contact with survivors, characterizing empathy as a potentially addictive, dependency-producing "drug" for some clients. The need, she stresses, is for clients to learn self-soothing versus undue reliance upon external soothing, "When the client leaves the office, the means of soothing need to leave with him" and "soothing that stems only from the therapist will increase the client's distress" (p. 291).

Other trauma specialists, however, take a different view (e.g., Chu, 1992; Cornell & Olio, 1991; Hunter & Struve, 1998). Cornell and Olio have even argued that a neutrality stance as seen in many psychoanalytic and cognitive therapies may in fact reinforce patterns of denial concerning abuse already operative in so many survivor clients. Chu (1992) has echoed the contraindication of using a blank screen approach with sexual abuse clients for another reason. Chu notes that a traumatic transference may be accentuated by such an approach, and the client may perceive the therapist as a harmful figure. Even intelligent, usually discerning clients may be unable to distinguish (without direct input from the therapist) that they are safe from re-victimization or abandonment.

Along such lines of reasoning, decisions to use touch with survivor clients may emerge. Cornell and Olio (1991) state that they have "found a unique power in the trained use of direct physical contact with survivors" (p. 64). Hunter and Struve (1998) have likewise that "the appropriate and ethical use of touch with survivor clients can be invaluable in helping them heal and recover from their trauma experiences" (p. 216). Dahlheimer (1990) has described the touch/fear or touch/shame binding that often occurs as a result of being sexually abused. In order to let go of such pathological pairings and "regain power in the area of touch, survivors need to experience nurturing, nonsexualized touch that is paired with care, pleasure, and safety" (p.95). Dahlheimer depicts particular types of touch exercises with the accomplishment of that therapeutic goal in mind. Wilson (1982) also has agreed touch may be effective with physically or emotionally abused clients.

One manifestation of the perceived importance of touch for survivor clients may be seen in a current trend for some trauma specialists to refer their clients to a bodyworker. Timms and Connors (1990) have developed a treatment approach for survivors, the Psychophysical Model of therapy, which combines intensive psychotherapy with bodywork. The model was originally drawn from the personal clinical work of Timms, who at age 46, while pursuing bodywork, uncovered memories of his own sexual abuse. Stated benefits of the model include uncovering amnesiac, traumatic material, safely expressing powerful emotions, and increasing the survivor's body-awareness. Benjamin (1995a), a bodyworker, has likewise described the ability of bodywork to assist survivors in regaining a sense of control, in rebuilding personal boundaries, in experiencing safe, pleasurable, nonsexual touch, and in uncovering and re-integrating hidden memories. Timms and Connors, in discussing their model, acknowledge that their work is perceived by some colleagues as controversial (especially their use of the model with dissociative clients), and welcome open dialogue and public discussion with others.

Those psychotherapists who suggest use of touch for survivor therapy quickly qualify their advocacy stance with the injunction to proceed with alertness and caution. Hunter and Struve (1998) have emphasized that to use touch in working with survivors is " a precarious proposition to say the least," (p. 216) but one worth exploring for its possibly rich benefits. Cornell and Olio (1992) have underlined the possible counterproductivity from the misuse or poor timing of physical contact interventions. They specifically discourage using techniques Smith (1985) would categorize as "hard" or expressive in working with survivors. They also stress that no

single strategy, even in the "soft" category, will work for all survivors, and that some clients can tolerate no level of touch intervention whatsoever.

Timms and Connors (1990) also have cautioned that deep bodywork, as seen in bioenergetics, may be damaging to survivors. They have developed a less intrusive model for bodywork based upon the wok of Ilana Rubenfeld and Eric Marcus. Also concerning bodywork, Benjamin (1995a) strongly stresses the need for bodyworkers to work in conjunction with psychotherapists, and to become informed of trauma theory. Benjamin (1995b) warns, for example, against the unwise use of bodywork for early stage recovery clients. While some middle stage recovery clients may pursue bodywork, Benjamin stresses the need for collaboration from the client's therapist in decision-making. Late stage recovery clients probably gain the greatest benefit from such a collaborative approach.

Suggested guidelines among those psychotherapists who do employ judicious touch with survivors include Pearlman and Saakvitne 's (1995) discussion of countertransference issues in negotiating touch requests from a client. Pearlman and Saakvitne neither necessarily advocate nor discourage agreeing to meet a survivor client's request for touch. Instead, the main criterion offered for the therapist to consider is that a personal level of comfort exist for whatever approach is taken.

Cornell and Olio (1991, 1992) have outlined more specific guidelines for the use of nonintrusive, body-oriented strategies in integrating affect for survivors of physical and sexual abuse. (The 1992 article frames these interventions within a transactional analysis context). In their approach, they work at what they term "an affective edge," meaning a level with enough strength to connect the client's mind, emotions, and

body with the reality of the past trauma, but not so forceful as to trigger denial or dissociation in the client. Cole and Barney (1987) have termed this range of effectiveness "the therapeutic window." Cornell and Olio (1991) stress that while many expressive or cathartic body centered techniques may produce seemingly dramatic results, this is a temporary phenomenon which often fails to " result in the client's sustained understanding of, or connection to their experiences of abuse" (p. 62). The client may lose memory, suffer panic attacks, experience disintegration, or fortify defenses in response to such over-stimulation. To safeguard against such rebound effects, Cornell and Olio have stressed the guideline that the "therapist should use the minimum necessary intervention to facilitate movement and awareness" (p. 140). Pace and intensity of sessions need to be continually monitored whenever noninvasive touch is used in this delicate type of work.

Daniluk and Haverkamp (1995) provide a more general overview of ethical concerns regarding survivor therapy. Their statement of concern places particular ethical emphasis upon promoting survivor clients' welfare and right to disclosure, a reflection of ACA Ethical Standards A.1.a and A.3.a (ACA, 1995). Clinicians are reminded of the particular importance with survivor clients to: (a) first do no harm;. (b) to foresee and guard against, as much as possible, harmful effects from an intervention; (c) to attend to informed consent; i.e., to inform the client of the range of consequences of pursuing treatment including the often highly disruptive consequences of exploring abuse issues; (d) to discuss how such exploration might affect her or her significant others' lives (e.g., children); and (e) to reinforce throughout the process the client's right to set the pace and direction of treatment.

Hunter and Struve (1998) similarly offer the main guideline that at all times, the survivor client's safety and empowerment need to be placed foremost in any decision regarding the use of touch in therapy.

Clients with Substance Abuse Issues

While the literature relating to use of touch in therapy with clients recovering from substance abuse is notably less than may be found regarding sexual abuse survivor clients, Kaufman (1994) has suggested a few general guidelines, including that the touch be spontaneous and natural between therapist and client. He recommends use of touch more for clients in the middle stage of recovery from addiction, adding the caution from his clinical experience that touch in early recovery may be overwhelming for an already very vulnerable client. Kaufman also warns against encouraging a pattern of "enmeshed behavior" observed in many of these clients which may include hugging, kissing, or sitting very closely, and advises that to use "more primitive touching" (e.g., holding) would be "almost always" counterproductive with this client population.

Hunter and Struve (1998) have addressed the need to address the conditioning of some clients in twelve-step programs for touch (hugs) from a therapist based upon what may have become automatic touch behaviors experienced in substance abuse treatment or in program meetings. They propose the reeducative role of "concise and purposeful" touching in helping such a client examine more carefully what touch could or does mean to him or her.

Clients "in Recovery"

The clients surveyed in this current study reported issues of either substance abuse or sexual abuse, and also identified themselves as being "in recovery." Many may have been actively engaged in some type of recovery program (e.g., a twelve step program). The recovery movement has grown in recent decades and spawned a proliferation of self-help offshoots in this society. Dan (1991) has reported that in 1990, approximately two million people claimed membership in AA, and thousands of others in other types of twelve step programs. In considering the definition of recovery for substance abuse, Stevens-Smith and Smith (1998) have emphasized, "Recovery is defined as not only abstinence from mind-altering chemicals or nonproductive compulsive behaviors, but also changes in physical, psychological, social, familial, and spiritual areas of functioning. These changes are seen as a process and not as an event in the recovering individual's life" (p. 241). Pita (1992) has described recovery as a developmental and psychosocial growth process characterized by stages. Stage-specific tasks for the recovering individual to perform exist, ranging from the early recovery task of abstinence to such later recovery tasks as identity and intimacy development. Rousso (1995) has reinforced the concept that recovery is a process, demarcating certain psychotherapeutic tasks as also being stage-specific. An example of a typical early recovery therapy task would be confronting the common defense of emotional isolation in the client.

Specialists in sexual abuse also stress the process aspect of healing in the context of recovery. Herman (1992), in describing recovery from sexual abuse, in a parallel fashion, draws upon this central theme of process, stages, and stage-specific tasks.

For the survivor, stage one's task is the establishment of safety. Stage two encompasses the tasks of remembrance and mourning; and stage three involves the task of reconnection to daily life. Recovery models in both substance abuse and sexual abuse make references to early, middle, and late recovery. No matter how else the models may differ (e.g., regarding varying concepts of powerlessness versus empowerment), a central way in which they are the same is in centrally framing recovery as a process.

For those in the self-help recovery movement, that process more specifically is conceptualized as a spiritual journey (Pita, 1992; Schaub & Schaub, 1997) as may be seen in Schaub and Schaub's conception of recovery from addiction as "a process with early, middle, and advanced stages, a process that needs to lead, in time, to a new consciousness" (p. 40). The authors stress the central feature of spirituality in twelve-step recovery models, framing addiction as a mistaken spiritual, transpersonal impulse. For sexual abuse survivor clients in a twelve step program (e.g., Survivors of Incest Anonymous, SIA), they are "recovering" in a context in which the spiritual dimension of healing is openly promoted (Bass & Davis, 1988).

Both the recovery movement and the field of holistic health share a commonality of spiritually-based practices and beliefs. That these two movements often overlap is not surprising. Schaub and Schaub's (1997) holistic model of consciousness and their lament of the "neglect of spirituality in traditional psychology" probably offers a fairly representative example of how positively spirituality and holistic resources are viewed by the "recovery community." Halbrook and Dulpechin (1994) have registered the influence of the holistic movement upon traditional psychotherapies

and upon culture in general, resulting in a more widespread recognition of the inter-relationship between mind and body overall. In particular regard to how touch is viewed, holistic-based models by definition are receptive to touching as an adjunct to healing in comparison to either traditional psychotherapy or traditional health models. People in recovery, then, may be found to be more attuned to using such alternative modalities, or possibly, to the use of non-body oriented touch techniques in "talk" psychotherapy. Books on healing framed from a recovery model often incorporate suggestions for holistic adjuncts, such as mediation, yoga, Asian psychotherapies, breath awareness, etc. (e.g., Schaub & Schaub, 1997).

One example of touch endorsement for the sexual abuse survivor may be seen in Turner's (1990) anecdotal chapter narrating touch's power to heal women, including women survivors. Kaufman (1994) has described the ritual of touch in some recovery meetings known as a "twelve step hug," "an inverted V, with tops of shoulders touching and mutual back patting. It is warm. . .but without sexuality" (p. 182). The overlap of holistic models of recovery, spirituality, and psychotherapy has created one particular kind of client subculture perhaps as a whole more receptive to such approaches as the nonerotic use of touch in therapy.

Along the theoretical touch-orientation continuum suggested by this researcher, the recovery movement may be conceptualized in certain ways as "transformative" and in some regards, as transpersonal in theoretical orientation. David's (1991) characterization of the recovery movement as "transformative psychology" supports such a hypothesis A transpersonal, transformational realm is often alluded to in

recovery literature. The use of touch in therapy among such clients may be finding a more comfortable home amidst such semantics.

Conclusion

While the cultural climate surrounding the use of touch in therapy has undergone many changes over the last century, the controversy surrounding the issue has endured. Factionalism among clinicians may be seen in characterizations of touch in therapy as disparate as claims of touch to be alternatively ego-strengthening (Forer, 1969), exploitative (Epstein & Simon, 1990), healing (Older, 1982), possibly dangerous (Alyn, 1988), or possibly invaluable (Hunter & Struve, 1998). Multitudinous influences (e.g., Eastern-oriented or body-oriented therapies, the holistic health movement, and the recovery movement, to name a few discussed in this paper) have expanded the range of ways touch may be used in therapy into what this researcher has conceptualized as an intricate, dynamic continuum. A continuing insufficiency of research and open discussion will not likely accomplish the careful unraveling of the various complexities of this important clinical issue. The artful gathering of clinical data may.

Chapter III

Method

Participants

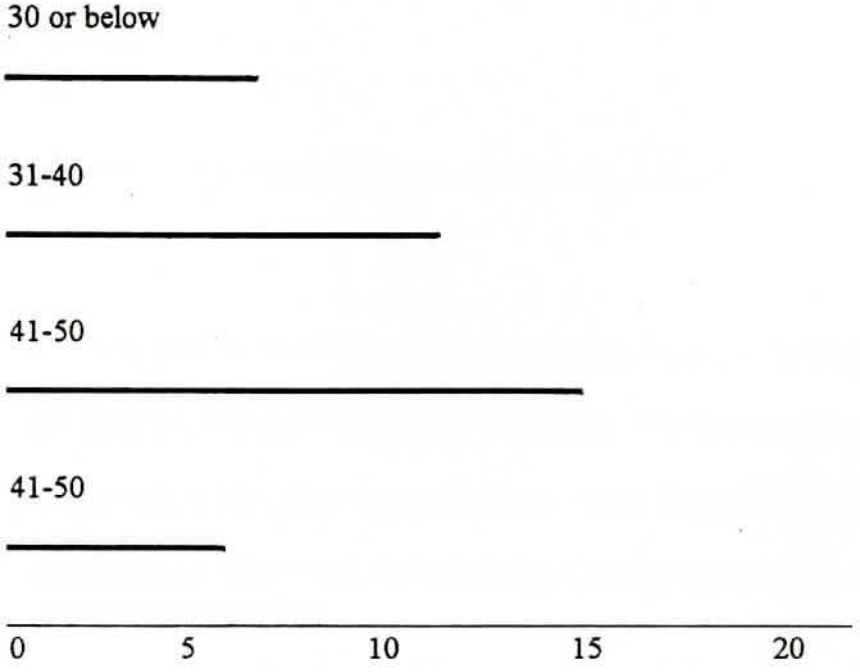
This study replicates in part a 1995 study by Horton et al. which surveyed actual client experiences of touch in psychotherapy. The current study, rather than broadly surveying many types of clients with diverse issues, instead focuses upon two client groups, those either recovering from substance abuse or sexual abuse. Some clients fell into both categories. The three criteria for client participation in the survey were: (a) the client has been in individual therapy for at least two months (or has been in therapy within the last two years for at least two months), (b) the client has experienced some form of touch in therapy beyond a handshake (e.g., a hug), and (c) the client's therapist does not describe herself or himself as a body-oriented therapist (e.g., a therapist who does "Rolfing" or Reiki). The criteria were drawn from Horton's study.

The sample for this study consisted of 40 participants. The survey was conducted between September and November of 1997. Survey participants originally were categorized according to three types of issues, those with substance abuse issues, those with childhood sexual abuse issues, and those with grief issues. The grief issue category was eliminated from the study. The sample was comprised of 13 (32.5%) clients with substance abuse issues, 16 (40%) clients with sexual abuse issues, and 11 (27.5%) clients with both sexual abuse as well as substance abuse issues.

The gender of the participants was primarily female, 33 (82.5 %) with a minority of males, 7 (17.5%) represented. Female-female client-therapist dyads were the most common, 28 (70%), with 5 (12.5%) male therapist-female client dyads; 4 (10%) male therapist-male client dyads, and with 3 (7.5%) female therapist-male client dyads. The sample was made up of 39 Caucasian clients and one African American client. As shown in Figure 1, participants ranged from age 14 to 60. (One fourteen year old was included in the survey; the next youngest age was 20). Six (15%) of the 40 participants were age 20-30; 12 (30%) were age 31-40; 15 (37.5%) were age 41 - 50, with 6 (15%) between the ages of 51 and 60.

Figure 1. Sample Distribution by Age

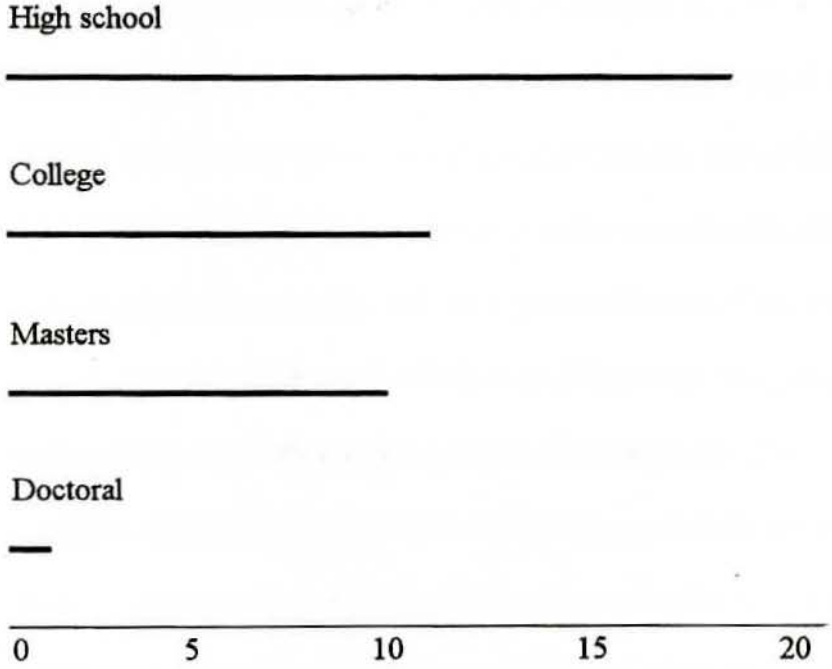
Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
30 or below	1.00	7	17.5	17.5	17.5
31-40	2.00	12	30.0	30.0	47.5
41-50	3.00	15	37.5	37.5	85.0
51-60	4.00	6	15.0	15.0	100.0
	Total	40	100.0	100.0	



Regarding therapist credentials, 26 (65%) of clients were seeing a master's level clinician, while the remaining 14 (35%) were seeing a doctoral level clinician. The educational level of the clients is shown in Figure 2.

Figure 2. Sample Distribution by Education Level

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
High school	1.00	18	45.0	45.0	45.0
College	2.00	11	27.5	27.5	72.5
Masters	3.00	10	25.0	25.0	97.5
Doctoral	4.00	1	2.5	2.5	100.0
	Total	40	100.0	100.0	



Fourteen (35%) of clients indicated getting the survey through AA, 4 (10%) through SIA, and 6 (15%) through a therapist. For the remaining 16 (40%) of the participants, it was either unspecified as to where they picked up the survey, or the client marked "other" without elaborating upon the exact origin.

Procedure

Volunteer participants for the client group of clients with grief issues were not successfully recruited. In contacting grief support groups, many of which were generally facilitated by a pastoral counselor or chaplain, the facilitators expressed reluctance to allow surveys to be conducted among their group members. The focus was then narrowed to the other two categories of clients.

Volunteer participants for the substance abuse and childhood sexual abuse client groups were recruited through the general context of "the recovery community." Survey packets were distributed through a variety of avenues, including outpatient treatment facilities, halfway houses, publicized regional contacts for self-help support groups, open twelve step events and program centers, as well as through therapists who advertised (in a publication aimed at a recovery clientele audience) as specializing in either substance abuse issues and/or sexual abuse issues. A mail back system was used which consisted of: (a) calling to introduce the survey and request permission to send either survey packets, or a sample survey (in some cases first contact was by mail); (b) mailing or distributing packets directly to receptive contacts; then (c) calling some contacts back to see how receptive they were to the sample survey, and whether more surveys could be sent. Each survey included a SASE. Cover letters which briefly explained the study (Appendix B) were sent to therapists or to treatment services. Surveys were returned to a local post office box.

Instrument

The instrument used, the Revised Touch in Therapy Survey, (See Appendix A) was an abbreviated adaptation of the Touch in Therapy Questionnaire used by Horton et al. in their 1995 study. Permission was granted by Judith Horton to this researcher to use and to alter the format of the original 1995 instrument for the purposes of the current study.

The survey first gathers client demographic information, age, gender, ethnicity, and education, as well as therapist demographic information, the gender of therapist, and therapist credentials. Clients are asked to check whether they are in recovery from substance abuse, sexual abuse, loss through death, or to indicate other additional issues. Eleven statements with options ranked on a Likert scale from 1 to 7 were selected from the 1995 Touch in Therapy Survey developed by Horton et al. Only those Likert scale questions relating to Geib's (1982) factors and themes were selected from Horton's 1995 survey use in the current survey.

The first seven questions of the current study's Revised Touch in Therapy Survey explore variables found by Geib to conditionally influence whether a client's perception of touch in therapy would be positive or negative. Geib (1982) identified five conditional factors: (a) openness and clarity regarding the boundaries of touch in therapy, (b) the client feeling in control of the contact, (c) the client experiencing touch as for her benefit rather than the therapist's, (d) the touch feeling congruent with the issues being dealt with in therapy, and (e) the touch feeling congruent to the client with the level of intimacy between therapist and client. A Likert scale with

seven options from "not at all" to "very much so" comprised the range of possible responses for these first seven survey items.

The last four questions of the current study's Revised Touch in Therapy Survey address overall perceptions of the experience of touch in therapy including how the touch affected the client's views of self, view of the therapist or therapeutic relationship, and view of the quality of work which occurred in therapy. The Likert scale for these overall perceptions offer seven options ranging from very negative to very positive. Lastly, clients were requested through a single question to express the meaning they attached to the physical contact which had occurred in therapy in their own words. Clients were invited to make their narrative responses as brief or as lengthy as they desired.

Reliability and Validity. Horton et al. have noted that their 1995 Touch in Therapy questionnaire asked for "global responses which should be relatively stable over time, barring a sudden shift in therapy such as a major empathic failure. Augmenting scaled information with descriptive information provided a check of internal consistency and validity" (p. 446). The current Revised Touch in Therapy instrument shares the same rationale for assuming the presence of a relative degree of temporal stability. The revised instrument also requests narrative information from the participants which aids in the confirmation of internal consistency and validity.

Reliability tests on the 1995 Touch in Therapy questionnaire yielded Cronbach alphas from .55 to .64 on scaled items testing Geib's factors (Horton et al., 1995). A high degree of internal consistency (a Cronbach alpha of .86) for the four evaluative

questions designed by Horton et al. was also reported by the authors. These four questions correspond to the current instrument's items eight, nine, ten, and eleven.

Design/Data Analysis

This study implemented a quasi-experimental design. Chi-square analyses were used in order to test the null hypotheses set forth (pps. 3-5). The data analysis used by Horton et al., that of multiple regression analysis, required a larger sample size than intended for the current sample (as well as expertise beyond the current statistical grasp of this researcher). In light of the nominal level data gathered, a Pearson chi-square test was chosen as an appropriate inferential tool. The initial item analysis involved a 3 x 2 contingency table per survey item to examine whether a relationship existed between the two nominal variables. For null hypotheses 1,2,3,4,5,6,7, and 8, the client's type of issue was crossed with the client's level of response to the survey item. Client response levels were divided into high or medium/low categories using arbitrarily chosen cut off scores. For null hypotheses 1a, 2a, 3a, 4a, 5a, 6a, 7a, and 8a, the client's type of issue was crossed with the client's age. The arbitrarily chosen cut off score dividing the two age groups was 40.

Survey items were categorized by this researcher according to Geib's factors, as well as according to the work of Horton et al. Table 1 shows Geib's five factors, Horton's questions, the thematic category assigned, the corresponding null hypothesis, as well as survey items matching each thematic category.

Table 1

Geib's Fators	Thematic Category	Null Hypothesis #	Survey Item #
Openness & clarity regarding boundaries of touch	Openness	1	1, 2
The client feeling in control of the contact	Control	2	3, 4
The touch feeling congruent with issues being dealt with in therapy	Congruence	3	5
The touch feeling congruent to the level of intimacy between therapist and client	Congruence	3	6
The client experiencing touch as for her benefit rather than the therapist's	Client's Benefit	4	7
Horton's General Evaluative Questions			
Overall response to touching	Overall benefit	5	8
The perception that touch changed feelings about self.	Self concept	6	9
The perception that touch affected positively feelings about therapist or the therapeutic relationship.	View of therapist	7	10
The perception that touch affected positively quality of work in therapy	Work in therapy	8	11

When all but seven of the total number of chi-square analyses run were found to be unreliable (due to small sample size), a decision was made to employ descriptive statistics in summarizing data. Complete, item-by-item crosstabulations were performed which included the elements of count, row percentages, column percentages, and total percentages. These frequency distributions allowed salient comparisons and contrasts to be drawn in discussing the descriptive data.

Narrative responses were categorized according to positive and negative themes identified by Geib (1982) as well as according to additional themes identified by Horton et al. (1995). The themes which emerged as most important in the clients' responses were identified and discussed. Narrative responses were also used in order to subjectively elaborate on certain findings within the descriptive data

Chapter IV

Results

Results are divided into two sections, chi-square analyses and descriptive statistics.

Chi-Square Analyses

Only seven chi-square analyses could be reliably run to test null hypotheses 1a, 6a, 7, 7a, 8 and 8a . Crosstabs for the other null hypotheses (2, 2a, 3, 3a, 4, 4a, 5, 5a, and 6) each displayed more than 20% of cells with expected values less than five; making them suspect. The alpha significance level was set at .05. An observed significance level of less than .05 would be considered statistically significant, leading to a rejection of the null hypothesis. Tables 2 and 3 tabulate SPSS statistics, decision rule outcomes, and conclusions for the chi-square tests reliably run.

Table 2

Crosstab Description	Pearson Value Significance	Continuity Correction Value Significance	Likelihood Ratio Value Significance	Mantel-Haenszel test for linear association Value Significance
Client issue by item one (level of openness)	11.09380 .00390 DF = 2	not given	12.37375 .00206 DF = 2	10.81438 .00101 DF = 1
Client age by item one (level of openness)	.97314 .32390 DF = 1	.44657 .50397 DF = 1	.97838 .32260 DF = 1	.94881 .33002 DF = 1
Client age by item nine (self-concept)	1.93150 .16459 DF = 1	1.12949 .28788 DF = 1	1.95982 .16153 DF = 1	1.88321 .16997 DF = 1
Client issue by item ten (perception of therapist)	1.37423 .50302 DF = 2	not given	1.37721 .50228 DF = 2	.00165 .96762 DF = 1
Client age by item ten (perception of therapist)	2.43133 .11893 DF = 1	1.54021 .21459 DF = 1	2.45359 .11726 DF = 1	2.37055 .12364 DF = 1
Client issue by item eleven (work in therapy)	8.91291 .01160 DF = 2	not given	9.40471 .00907 DF = 2	7.84747 .00509 DF = 1
Client age by item eleven (work in therapy)	.12253 .72631 DF = 1	.00101 .97461 DF = 1	.12264 .72619 DF = 1	.11947 .72961 DF = 1

Table 3

Crosstab Description	Observed significance >α level (.05)?	Accept null hypothesis?	Conclusion
Client issue by item one (level of openness)	no	no	There is a relationship between the perceived level of openness regarding boundaries of touch in therapy and the client's type of issue.
Client age by item one (level of openness)	yes	yes	There is no relationship between the perceived level of openness regarding boundaries of touch in therapy and the client's age.
Client age by item nine (self-concept)	yes	yes	There is no relationship between the degree to which the client perceived self-concept as benefited by touch and the client's age.
Client issue by item ten (perception of therapist or relationship)	yes	yes	There is no relationship between the degree to which the client perceived the therapist or relationship positively as result of experiencing touch and the client's type of issue.
Client age by item ten (perception of therapist or relationship)	yes	yes	There is no relationship between the degree to which the client perceived the therapist or relationship positively as result of experiencing touch and the client's type of issue.
Client issue by item eleven (work in therapy)	no	no	There is a relationship between the degree to which the client perceived work in therapy as benefited from touch and the client's type of issue.
Client age by item eleven (work in therapy)	yes	yes	There is no relationship between the degree to which the client perceived work in therapy as benefited from touch and the client's type of issue.

Table 3 shows that only two crosstab results (issue by item 10, issue by item 11) resulted in a rejection of the null hypothesis and a conclusion of relationship existing between the crossed variables. Age, at least according to four chi-square results in this study, does not appear to significantly influence touch perceptions for this subpopulation of clients. These conclusions must be tentatively accepted, however, in light of the limitation of being able to examine only a minority of survey items. Tables 4 and 5 provide complete crosstab results for the two tests in which relationship between variables was suggested.

Table 4: Crosstab of client issue with survey item 1: If you were not comfortable with your therapist touching you, how difficult would it be for you to tell him or her?

ISSUE BY Q1 (level of openness)

Count Exp V Row P Col P Tot P	High*	Medium/Low	Row Total
Substance Abuse .00	3 7.2 23.1% 13.6% 7.5%	10 5.9 76.9% 55.6% 25.0%	13 32.5%
Sexual Abuse 1.00	9 8.8 56.3% 40.9% 22.5%	7 7.2 43.8% 38.9% 17.5%	16 40.0%
Both Issues 2.00	10 6.1 90.9% 45.5% 25.0%	1 5.0 9.1% 5.1% 2.5%	11 27.5%
Column Total	22 55.0%	18 45.0%	40 100.0%

* A response of "1" or "2" was considered to be a high level response.

Minimum expected frequency - 4.950 Number of missing observations: 0

Cells with expected frequency < 5 - 1 of 6 (16.7%) Pearson observed significance- .00390

In a crosstabulation, the count is the actual observed frequency. The margins contain cumulative frequencies. The row percent is calculated by dividing the cell count by the row total; the column percent is calculated by dividing the cell count by the column total, and the total percent is calculated by dividing the cell count by the total number of outcomes. As shown in Table 4, 9 out of 16 or 56.3% of the sexual abuse client sample and 10 out of 11 or 90.9% of the dual issue client sample reported high levels of openness in their therapy relationship, whereas such high levels were reported only by 3 out of 13 or 23.1% of the substance abuse client sample. Overall, of the total participants, 22 out of 40 or 55% reported high openness levels.

Table 5: Crosstabulation of client issue with survey item eleven: Did the physical contact positively affect the quality of your work in therapy?

ISSUE BY Q 11 (work in therapy)

Count Exp V Row P Col P Tot P	High* level of positive influence	Medium/Low/No level of positive influence	Row Total
Substance Abuse .00	3 5.9 23.1% 16.7% 7.5%	10 7.2 76.9% 45.5% 25.0%	13 32.5%
Sexual Abuse 1.00	6 7.2 37.5% 33.3% 15.0%	10 8.8 62.5% 45.5% 25.0%	16 40.0%
Both Issues 2.00	9 5.0 81.8% 50.0% 22.5%	2 6.1 18.2% 9.1% 5.0%	11 27.5%
Column Total	18 45.0%	22 55.0%	40 100.0%

* A response of "1" or "2" was considered to be a high level response.
Minimum expected frequency - 4.950 Number of missing observations: 0
Pearson observed significance level- .01160
Cells with expected frequency < 5 - 1 of 6 (16.7%)

As shown in Table 5, 3 out of 13 (23.1%) of the substance abuse client sample and 6 out of 16 (37.5%) of the sexual abuse client sample reported high levels of positive influence attributable to touch on quality of work in therapy, in contrast to 9 out of 11 (81.8%) of the dual issue client sample. Of the total clients, 18 out of 40 (45%) reported high levels of positive influence of touch on quality of work in therapy.

Descriptive Statistics

The following tables, tables 6 through 16, provide crosstabulations for each of the eleven Revised Touch in Therapy survey items. (Crosstabulation results for survey items one and eleven are repeated. This time, the results are presented in entirety, without collapsing any of the Likert scale responses).

Table 6: Crosstab of client issue w/ survey item one: If you were not comfortable w/ your therapist touching you, how difficult would it be for you to tell him or her?

Count Row Pct Col Pct Tot Pct	1 High degree of openness	2	3	4	5	6	7 Low degree of openness	Row Total
Substance Abuse	3 23.1% 21.5% 7.5%	0 0.0% 0.0% 0.0%	5 38.5% 62.5% 12.5%	4 30.7% 66.7% 10.0%	1 7.7% 50.0% 2.5%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	13 32.5%
Sexual Abuse	6 37.5% 42.8% 15.0%	3 18.8% 37.5% 7.5%	3 18.8% 37.5% 7.5%	2 12.5% 33.3% 5.0%	1 6.2% 50.0% 2.5%	1 6.2% 100.0% 2.5%	0 0.0% 0.0% 0.0%	16 40.0%
Both Issues	5 45.5% 35.7% 12.5%	5 45.5% 62.5% 12.5%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 9.0% 100.00% 2.5%	11 27.5%
Column Total	14 35.0%	8 20.0%	8 20.0%	6 15.0%	2 5.0%	1 2.5%	1 2.5%	40 100.0 %

Table 7: Crosstabulation of client issue with survey item two: Is your therapist clear about the boundaries of physical contact in your therapy?

Count Row Pct Col Pct Tot Pct	1 High degree of openness	2	3	4	5	6	7 Low degree of openness	Row Total
Substance Abuse	8 61.5% 30.8% 20.0%	2 15.4% 33.3% 5.0%	0 0.0% 0.0% 0.0%	1 7.7% 33.3% 2.5%	1 7.7% 100.0% 2.5%	1 7.7% 100.0% 2.5%	0 0.0% 0.0% 0.0%	13 32.5%
Sexual Abuse	10 62.4% 38.4% 25.0%	3 18.8% 50.0% 7.5%	3 18.8% 100.0% 7.5%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	16 40.0%
Both Issues	8 72.7% 30.8% 20.0%	1 9.1% 16.7% 2.5%	0 0.0% 0.0% 0.0%	2 18.2% 66.7% 5.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	11 27.5%
Column Total	26 65.0%	6 15.0%	3 7.5%	3 7.5%	1 2.5%	1 2.5%	0 0.0%	40 100.0%

Table 8: Crosstab of client issue with survey item three: How secure are you in the belief that your therapist will maintain a boundary of no sexualized touch with you?

Count Row Pct Col Pct Tot Pct	1 Low degree of control	2	3	4	5	6	7 High degree of control	Row Total
Substance Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 0.7% 25.0% 2.5%	12 92.3% 33.3% 30.0%	13 32.5%
Sexual Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	2 12.5% 50.0% 5.0%	14 87.5% 38.9% 35.0%	16 40.0%
Both Issues	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 9.1% 25.0% 2.5%	10 90.9% 27.8% 25.0%	11 27.5%
Column Total	0 0.0%	0 0.0%	0 0.0%	0 0.0%	0 0.0%	4 10.0%	36 90.0%	40 100.0%

Table 9: Crosstabulation of client issue with survey item four: Do you feel in control of the physical contact in therapy?

Count Row Pct Col Pct Tot Pct	1 Low degree of control	2	3	4	5	6	7 High degree of control	Row Total
Substance Abuse	0 0.0% 0.0% 0.0%	1 7.7% 100.0% 2.5%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 7.7% 25.0% 2.5%	3 23.1% 33.3% 7.5%	8 61.5% 33.3% 20.0%	13 32.5%
Sexual Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 6.2% 100.0% 2.5%	2 12.5% 50.0% 5.0%	4 25.0% 44.5% 10.0%	9 56.3% 37.5% 22.5%	16 40.0%
Both Issues	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 9.1% 100.0% 2.5%	0 0.0% 0.0% 0.0%	1 9.1% 25.0% 2.5%	2 18.2% 22.2% 5.0%	7 63.6% 17.5% 29.2%	11 27.5%
Column Total	0 0.0%	1 2.5%	1 2.5%	1 2.5%	4 10.0%	9 22.5%	24 60.0%	40 100.0%

Table 10: Crosstabulation of client issue with survey item five: Does the touch feel congruent with issues you are dealing with in therapy?

Count Row Pct Col Pct Tot Pct	1 Low degree of con-gruence	2	3	4	5	6	7 High degree of con-gruenc e	Row Total
Substance Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	3 23.1% 60.0% 7.5%	1 7.7% 12.5% 2.5%	9 69.2% 37.5% 22.5%	13 32.5%
Sexual Abuse	1 62.5% 100.0% 2.5%	0 0.0% 0.0% 0.0%	1 62.5% 100.0% 2.5%	1 62.5% 100.0% 2.5%	1 6.25% 20.0% 2.5%	4 25.0% 50.0% 10.0%	8 50.0% 33.3% 20.0%	16 40.0%
Both Issues	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 9.1% 20.0% 2.5%	3 27.3% 37.5% 7.5%	7 63.6% 29.2% 17.5%	11 27.5%
Column Total	1 2.5%	0 0.0%	1 2.5%	1 2.5%	5 12.5%	8 20.0%	24 60.0%	40 100.0%

Table 11: Crosstabulation of client issue with survey item six: Does the touch feel congruent with the level of intimacy you have with your therapist?

Count Row Pct Col Pct Tot Pct	1 Low degree of con-gruence	2	3	4	5	6	7 High degree of con-gruenc e	Row Total
Substance Abuse	0 0.0% 0.0% 0.0%	1 0.7% 100.0% 2.5%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	3 23.1% 50.0% 7.5%	3 23.1% 42.8% 7.5%	6 46.1% 24.0% 15.0%	13 32.5%
Sexual Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 6.2% 100.0% 2.5%	3 18.8% 50.0% 7.5%	2 12.5% 28.6% 5.0%	10 62.5% 40.0% 25.0%	16 40.0%
Both Issues	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	2 18.2% 28.6% 5.0%	9 81.8% 36.0% 22.5%	11 27.5%
Column Total	0 0.0%	1 2.5%	0 0.0%	1 2.5%	6 15.0%	7 17.5%	25 62.5%	40 100.0%

Table 12: Crosstabulation of client issue with survey item seven: Do you feel the touch is for your benefit or to meet some need of your therapist?

Count Row Pct Col Pct Tot Pct	1 Client Benefit	2	3	4	5	6	7 Thera-pist Benefit	Row Total
Substance Abuse	8 61.5% 29.6% 20.0%	4 30.8% 44.4% 10.0%	0 0.0% 0.0% 0.0%	1 7.7% 33.3% 5.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	13 32.5%
Sexual Abuse	9 56.3% 33.3% 22.5%	4 25.0% 44.4% 10.0%	0 0.0% 0.0% 0.0%	2 12.5% 66.7% 5.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 6.2% 100.0% 2.5%	16 40.0%
Both Issues	10 90.9% 37.0% 25.0%	1 9.1% 11.2% 2.5%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	11 27.5%
Column Total	27 67.5%	9 22.5%	0 0.0%	3 7.5%	0 0.0%	0 0.0%	1 2.5%	40 100.0%

Table 13: Crosstabulation of client issue with survey item eight: How would you characterize your overall response to the touching that has occurred in therapy?

Count Row Pct Col Pct Tot Pct	1 Very negative	2	3	4	5	6	7 Very positive	Row Total
Substance Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 7.7% 100.0% 2.5%	0 0.0% 0.0% 0.0%	1 7.7% 20.0% 2.5%	2 15.4% 71.4% 5.0%	9 69.2% 34.6% 22.5%	13 32.5%
Sexual Abuse	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 6.3% 100.0% 2.5%	2 12.5% 40.0% 5.0%	3 18.7% 42.9% 7.5%	10 62.5% 38.5% 25.0%	16 40.0%
Both Issues	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	2 18.2% 40.0% 5.0%	2 18.2% 28.7% 5.0%	7 63.6% 26.9% 17.5%	11 27.5%
Column Total	0 0.0%	0 0.0%	1 2.5%	1 2.5%	5 12.5%	7 17.5%	26 65.0%	40 100.0%

Table 14: Crosstabulation of client issue with survey item nine: Were your feelings about yourself changed positively by this physical contact?

Count Row Pct Col Pct Tot Pct	1 Very positive change	2	3	4	5	6	7 No change	Row Total
Substance Abuse	3 23.0% 25.0% 7.5%	0 0.0% 0.0% 0.0%	5 38.5% 83.3% 12.5%	2 15.4% 33.3% 5.0%	2 15.4% 40.0% 5.0%	1 0.7% 25.0% 2.5%	0 0.0% 0.0% 0.0%	13 32.5%
Sexual Abuse	4 25.0% 33.3% 10.0%	2 12.5% 66.7% 5.0%	0 0.0% 0.0% 0.0%	3 18.7% 50.0% 7.5%	1 6.4% 20.0% 2.5%	3 18.7% 75.0% 7.5%	3 18.7% 75.0% 7.5%	16 40.0%
Both Issues	5 45.4% 41.7% 12.5%	1 9.1% 33.3% 2.5%	1 9.1% 16.7% 2.5%	1 9.1% 16.7% 2.5%	2 18.2% 40.0% 5.0%	0 0.0% 0.0% 0.0%	1 9.1% 25.0% 2.5%	11 27.5%
Column Total	12 30.0%	3 7.5%	6 15.0%	6 15.0%	5 12.5%	4 10.0%	4 10.0%	40 100.0%

Table 15: Crosstabulation of client issue by survey item ten: Were your feelings about your therapist or the therapeutic relationship affected positively by the physical contact?

Count Row Pct Col Pct Tot Pct	1 Very positive influence	2	3	4	5	6	7 No influence	Row Total
Substance Abuse	4 30.7% 28.5% 10.0%	4 30.7% 50.0% 10.0%	3 23.2% 50.0% 7.5%	1 7.7% 25.0% 2.5%	0 0.0% 0.0% 0.0%	1 7.7% 25..0% 2.5%	0 0.0% 0.0% 0.0%	13 32.5%
Sexual Abuse	6 37.5% 42.9% 15.0%	1 6.3% 12.5% 2.5%	2 12.5% 33.3% 5.0%	1 6.3% 25.0% 2.5%	3 18.7% 100.0% 7.5%	0 0.0% 0.0% 0.0%	3 18.7% 75.0% 7.5%	16 40.0%
Both Issues	4 36.3% 28.6% 10.0%	3 27.3% 37.5% 7.5%	1 9.1% 16.7% 2.5%	2 18.2% 50.0% 5.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	1 9.1% 25.0% 2.5%	11 27.5%
Column Total	14 35.0%	8 20.0%	6 15.0%	4 10.0%	3 7.5%	1 2.5%	4 10.0%	40 100.0%

Table 16: Crosstabulation of client issue with survey item eleven: Did the physical contact positively affect the quality of your work in therapy?

Count Row Pct Col Pct Tot Pct	1 Very positive influence	2	3	4	5	6	7 Very negative influence	Row Total
Substance Abuse	3 23.1% 25.0% 7.5%	0 0.0% 0.0% 0.0%	4 30.7% 66.7% 10.0%	3 23.1% 37.5% 7.5%	1 7.7% 50.0% 2.5%	2 15.4% 66.7% 5.0%	0 0.0% 0.0% 0.0%	13 32.5%
Sexual Abuse	5 31.3% 41.7% 12.5%	1 6.3% 16.7% 2.5%	2 12.4% 33.3% 5.0%	3 18.7% 37.5% 7.5%	1 6.3% 50.0% 2.5%	1 6.3% 33.3% 2.5%	3 18.7% 100.0% 7.5%	16 40.0%
Both Issues	4 36.4% 33.3% 10.0%	5 45.4% 83.3% 12.5%	0 0.0% 0.0% 0.0%	2 18.2% 25.0% 5.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	0 0.0% 0.0% 0.0%	11 27.5%
Column Total	12 30.0%	6 15.0%	6 15.0%	8 20.0%	2 5.0%	3 7.5%	3 7.5%	40 100.0%

Table 17 on the following page summarizes actual frequency data from tables 6 through 16 according to levels deemed high, moderate, or low. The middle three responses for each Likert scale are considered moderate responses, while the two responses on the positive end of the spectrum are considered high responses. The remaining two responses are considered to be either low level responses, or as indicating no response.

While assigning such designations to the Likert responses is an arbitrary exercise, and while the exact meaning of a high level response may vary from survey item to survey item, (e.g., a high level for item 1 & 2 means a high degree of openness, whereas a high level for item 7 means touch solely intended to benefit the client), it may be generalized nonetheless that high level responses may all be interpreted within a positive context, that is, one of benefit to the client. For example, as shown in table 17, 100% of clients reported high levels of perceiving safety concerning their therapist's touch, a result which may be interpreted within the more general, positive context that perception of safety within the therapeutic relationship is a desired and beneficial therapeutic condition.

Table 17

Survey item	Thematic category	High level Count Total percent	Moderate level Count Total percent	Low level to no influence Count Total percent
3	control (safety of touch)	40 100.0%	0 0.0%	0 0.0%
5	congruence	37 92.5%	2 5.0%	1 2.5%
7	client's benefit	36 90.0%	3 7.5%	1 2.5%
8	overall benefit	33 82.5%	7 17.5%	0 0.0%
4	control	33 82.5%	6 15.0%	1 2.5%
2, 6	openness congruence	32 80.0%	7 17.5%	1 2.5%
1	openness	22 55.0%	16 40.0%	2 5.0%
10	perception of therapist	22 55.0%	13 32.5%	5 12.5%
11	quality of work in therapy	18 45.0%	16 40.0%	6 15.0%
9	self-perception	15 37.5%	17 42.5%	8 20.0%

Concerning range of responses, item 3 displayed no range of response; items 5 and 7 also displayed low ranges of response, with the large majority of responses (92.5% for item 5 and 90% for item 7) of responses occurring within the high level category. (Face validity suggests that the one low level response recorded for item 7 is thought to be a recording mistake on that part of the participant since all of the other responses by this participant were highly positive.) Thirty-three (82.5%) of the total client sample rated their overall experience of touch as highly positive; an equal number and percentage reported feeling very much in control of the touch in therapy. Perception of touch as very beneficial to quality of work in therapy was

reported by a minority (45%) of the total sample. Change in self-concept attributable to touch also received high levels by only a minority (37.5%) of the sample. Most clients, however, did report at least a moderate level of influence of touch for items 9 and 11. Items 1 and 9 displayed the greatest evenness of all of the distributions.

Concerning comparisons based upon client issue type, the substance abuse sample reported fewer high level responses than did the other two client groups for three items: (a) item one with 3 (21.5%) of the high level responses, (b) item 9 with 3 (25%) of the high level responses, and (c) item 11 with 3 (25%) of the high level responses. For item 9, the sexual abuse client sample comprised the highest number 6 (75%) of low level responses of the total sample group.

Chapter V

Discussion

The discussion is divided into three sections: (a) implications, (b) limitations, and (c) recommendations for future study.

Implications

Based upon the chi-square results, there seem to be indications for lower levels of openness in substance abuse clients as well as for lower levels of perceived positive influence of touch on quality of work in therapy in these clients. A client's age (as categorized by this study) does not appear to make a difference in how the survey items are rated. Such general comments, however, must be tentatively considered in light of the data analysis limitations of this study, and perhaps are best viewed as offering possible directions for further research.

Perhaps the clearest, most comprehensive single indicator of how this client group evaluated touch in therapy experience is represented through the responses to survey item eight results in which 82.5% of the total client sample rated their overall touch experience as very positive (65% marked "1" and 17.5% marked "2"). Despite the considerable limitations of the current study, it remains nevertheless telling that such a high percentage of a client sample group rated touch so positively overall. This total sample group also reported experiencing highly positive levels of congruence, control, and openness regarding their touch in therapy experiences. They additionally overwhelmingly perceived touch as intended for their benefit in the therapeutic relationship. Most indicated that self-concept, quality of work in therapy,

and the view of the therapist or of the therapeutic relationship were all positively influenced by touch.

In general, such observations seem to lend support for the appropriate, circumspect use of touch in therapy. However, the fact that this particular sample group seems to validate such a conclusion cannot be generalized into a formulaic prescription framing touch as a unilaterally beneficial intervention. Ultimately, case-by-case evaluations and decisions regarding touch guidelines need to be the norm.

Geib's factors drew more uniformity of response than did three of the four more general evaluative questions designed by Horton et al. concerning touch. Particularly, clients gave a full range of relatively evenly distributed responses to the thematic category of openness. A clinical application from such results may be suggested for the clinician to pay particular attention to whether boundaries are being verbally discussed if touch is being used with a client. Some clients may accept touch and not feel uncomfortable in telling the therapist they feel uncomfortable with the touch. With substance abuse clients in particular, Hunter and Struve's (1998) observation that some clients may be engaging in automatic touch against their unspoken wishes is corroborated as meriting attention by this survey's results.

The observation that Geib's factors elicit distinctly positive responses in some clients, and ambivalent responses in others may carry additional clinical ramifications. For example, if a client does not see the touch in therapy as particularly affecting quality of work in therapy, self-concept, or the relationship with the therapist, but does find touch to be beneficial, it would be worth exploring what other factors are influencing the client's positive evaluation. Identification of such factors may prove

a tool with which the clinician finds clarity in thinking through touch guidelines with a given client.

What may be stated for the total sample group (in terms of high levels of positive context responses existing across the board for the survey items) may also be stated for the sexual abuse sample group. Such an observation appears to refute justification for unqualified prohibitions against use of touch in therapy with survivor clients as promoted by Vasque (1988) and Gutheil and Gabbard (1993). Certain rationales supporting such generalized prohibitions appear equally unfounded. Take for example, the common psychoanalytic argument that touch in therapy will be perceived by the client as erotic in nature (Epstein & Simon 1990; Gutheil & Gabbard, 1993). In item three, 87.5% of sexual abuse clients (and 90.9% of dual issue clients) indicated feeling very sure that the touch was to no degree erotic. Also, in item seven, most clients (67.5% marked "1;" 22.5% marked "2") perceived the touch as being for their benefit. This study's data, then, appears to indicate, at least for this sample of survivor clients, that the primary interpretation applied by the client to therapist touch was non-erotic in nature.

Limitations

Small sample size was a major limitation of this study. The originally planned statistical tests could not be carried out as intended, and reliance upon descriptive statistics limited generalizability of results greatly. Approximately 190 surveys were distributed with a return rate of 21%. Time constraints dictated settling for a smaller sample size than desired as did the economics of using a mail-back system. Overall,

this information is not easily obtained. Distinguishing how much of the difficulty may be attributable to the procedure of this particular study, and how much to more general factors (e.g., reluctance to participate due to a particular stance regarding use of touch in therapy) would require follow-up inquiry.

Horton et al. (1995) mentioned a related limitation of their study also reflected by this current study concerning the "impossibility of obtaining a random sample of patients who are touched in therapy" (p. 453). By design, the current study works with a selected group of clients; however, the design was intended to include both negative as well as positive evaluations of touch experiences. In the current study, there were no reported incidences of exploitative touch, and only a small percentage of ambivalent or negative evaluations of the touch experience. Study design must be implicated in considering this skewness of the results toward positive evaluations. It could be postulated that those individuals and institutions contacted, by virtue of agreeing to distribute the survey, were already of a "pro-touch" orientation. While this researcher attempted to circumvent this limitation to some extent by including support groups in the study, it remains difficult to distinguish how representative these 40 clients are of the larger population of psychotherapy clients with similar (substance abuse and/or sexual abuse issues).

Another factor contributing to the skewness toward positive results may be accounted for by the preponderance of female clients, as well as female therapist-female client dyads found in the study. Horton et al. (1995) have noted that women may be touched more in therapy than men, and female therapists may engage in more non-erotic touching behaviors in therapy than male therapists. Whether the

low response from male clients represents low incidence of touch in therapy, or not being as readily recruited for participation, or some other phenomenon is not clear.

The selection of client categories was originally intended to provide roughly discrete categories for comparison purposes. When clients with grief issues were excluded, it was not foreseen that there would be as great an overlap between the two remaining groups as the results demonstrated. A substantial number (27.5%) of the 40 clients reported both issues of substance abuse and childhood sexual abuse. More successful comparison may result from client categories with a lesser degree of overlap. Identifying the site where clients picked up surveys was intended to enhance understanding of the client categories; however, this demographic data can only be interpreted very loosely. While beginning to send out survey packets to halfway houses, outpatient facilities, and individual therapists, this researcher realized that to ask participants to specify from where they picked up the survey might result in some of them writing down the name of their therapist, information which would compromise confidentiality concerns. For this reason, the "other" item was subsequently excluded (some surveys had already been distributed). A related issue is that just because a client was distributed a survey by a therapist who advertised in a recovery-oriented publication does not ensure that the participant is herself/himself part of the recovery community. Such a client may have the type of issue sought by the survey and either participate, or not participate in twelve step program related activities and meetings.

Another limitation relates to the issue of time. The current study's survey did inquire into the duration of the client's therapy beyond establishing the two month

criteria; therefore, clients with two months in therapy may have been combined with clients with much longer therapy relationships. Also, the survey did not inquire into time in sobriety for substance abuse clients; the study, then, makes no distinction between a client sober for one day and a client sober for many years. Similarly, there is no way to distinguish whether a survivor is in an early, middle, or late recovery stage of recovery from sexual abuse issues.

Finally, the conclusion regarding age in the results section needs to be qualified. Clients were arbitrarily divided into categories of 40 and over, and under 40. In fact, the majority of the sample (67.5%) were 31 to 50 years of age. Concluding that age is not an influence when two decades comprise most of the spread of the distribution calls the conclusion into question. A larger sample size would have more accurately allowed for exploration of age related differences regarding factors which influence touch perception.

Recommendations

General recommended directions for further study of touch in therapy have been suggested (Horton et al., 1995; Hunter & Struve, 1998; Willison & Masson, 1986; Wilson, 1978). Willison and Masson (1986) have suggested the following areas: (a) baseline studies on nonclinical populations; (b) studies incorporating socioeconomic level, cultural factors, education, personality, and age; (c) longitudinal studies regarding touch in therapy; (d) studies comparing client issues; and (e) surveys of clinicians regarding practices and beliefs regarding touch. The need to study gender differences in touch use and receptivity in therapy has already been

mentioned. Horton et al. (1995) have suggested a research design utilizing gender matching of clients with therapists, to study who initiates touch, type of touch, and meanings assigned to touch by either gender. Hunter and Struve (1998) have additionally suggested the need to study "the effect of therapist and client affectional preference on the impact of touch," the effect of whether or not the touch is discussed in session, the effects of various types of touching, and "the effects of movement touch versus static touch" (p. 71). Hunter and Struve (1998) also suggested the need to expand studies of touch into family, group, and couples therapy contexts.

This researcher adds the recommendation that when including substance abuse issues or sexual abuse issues into a study, investigation of how early, middle, or late stage processes influence client touch perceptions would be of value. Horton's suggestion that further comparison of abused versus nonabused clinical populations would be useful is echoed as well. Also, recommendations originate from the observation that attention has been devoted in professional literature to elucidating the kinds of assumptions often underlying clinician thinking when boundary violations with clients regarding touch occur. Alternatively, attention needs to be paid to the kinds of assumptive reasoning that inform clinician decisions to use touch, and how these assumptions may be influenced by factors such as gender, age, cultural background, and type of client issue. Ideally, adapting Hunter and Struve's (1998) guidelines to particular client populations, even developing decision making trees specific for these populations, could lend empirical uniformity to this important therapeutic issue.

Appendix A
Revised Touch in Therapy Survey

I am a graduate student in counseling at Lindenwood University studying the client's experience of touch in counseling. If you meet the following criteria, would you please fill out the survey below and return it to me, Deborah Harris, in the postage-paid envelope provided. The survey is entirely confidential.

Criteria:
(1) You have been in individual therapy for at least two months. (You may answer the survey about a previous therapy as long as it was of at least two months duration and ended less than two years ago.)

(2) You have experienced some form of touch in therapy beyond a handshake (a hug for example). If your therapist never touches you, please do not answer the survey.

(3) Your therapist does not describe himself or herself as a body-oriented therapist (for example, a therapist who does "Rolfing," or Reiki).

Thank you for your help!
Gender: Female____ Male_____ Age_____

Ethnic Group: Caucasian____ African American ____ Hispanic American_____ Asian American____ Caribbean____ Native American_____ Other_____

Highest degree or grade completed? _____
Is your therapist Female____ Male____

What are your therapist's credentials?
PhD____ MA___ MSW____ LCSW___ LPC____ MD____
Other_____

Please check below if you are in recovery from:
Loss through death_____ Substance abuse/addiction_____

Childhood sexual abuse_____ Other_____

From where did you pick up this survey?
AA program _____ NA program_____ SIA program_____ Grief support group_____ Other (please specify)_____

Appendix A (Con't)

Please circle the number indicating the degree to which the statements below are true for you, your therapist, or your therapy.

1) If you were not comfortable with your therapist touching you, how difficult would it be for you to tell him or her?

Very easy			Slightly difficult		Very difficult	
1	2	3	4	5	6	7

2) Is your therapist clear (either verbally or non-verbally) about the boundaries (permission and limits) of physical contact in your therapy?

Very clear			Somewhat clear		Not at all clear	
1	2	3	4	5	6	7

3) How secure are you in the belief that your therapist will maintain a boundary of no seductive or sexualized touch with you?

Not at all secure			Somewhat secure		Extremely secure	
1	2	3	4	5	6	7

4) Do you (did you) feel in control of the physical contact in therapy?

Not at all			Somewhat			Very much so
1	2	3	4	5	6	7

5) Does (did) the touch feel congruent? (feel related to issues you are (were) dealing with in therapy)

Not at all			Somewhat			Very much so
1	2	3	4	5	6	7

6) Does (did) the touch feel congruent with the level of intimacy you have (had) with your therapist at the time?

Not at all			Somewhat			Very much so
1	2	3	4	5	6	7

7) Do (did) you feel the touch was for your benefit, or to meet some need of your therapist?

Solely for my benefit			Somewhat for my benefit			Solely for therapist
1	2	3	4	5	6	7

8) How would you characterize your overall response to the touching that has occurred in therapy?

Very negative			No response			Very positive
1	2	3	4	5	6	7

9) Were your feelings about yourself changed positively by this physical contact?

Very much so			Somewhat			Not at all
1	2	3	4	5	6	7

10) Were your feelings about your therapist or the therapeutic relationship affected positively by the physical contact?

Very much so			Somewhat			Not at all
1	2	3	4	5	6	7

11) Did the physical contact positively affect the quality of your work in therapy?

Very much so			Somewhat			Not at all
1	2	3	4	5	6	7

Please describe what the physical contact with your therapist means (meant) to you. Use as few or as many words as you like.

*** The Revised Touch in Therapy Survey was adapted (with permission granted by Judith Horton to the current researcher) from the 1995 Touch in Therapy questionnaire developed by Horton, Clance, Sterk-Elifson, & Emshoff.**

Appendix B

Date

Dear (Counselor's Name),

I am a graduate student in counseling at Lindenwood University researching the effects of physical contact in psychotherapy (or Thank you for speaking with me on--date. As I mentioned in my introduction to you, I am. . .). My research interest for this thesis grows out of a sense that more research has been done on the clearly harmful effects of erotic contact between client and therapist, and less on the topic of non-erotic physical contact. Even the most ethical therapist, in deciding "whether to touch or not to touch," may feel to some degree at risk. One researcher upon whose work I am building (Judith Horton) has stated this concern as, "Although prompted by genuine caring, intuition or theory to use touch with clients, ethical therapists may feel out on a limb at times in doing so." Horton's research seeks to distinguish which factors are associated with the client's positive or negative evaluation of touch in therapy. I hope my research will similarly lend clarity to the significance touch holds for clients.

I am particularly interested in the perceptions of clients in recovery from substance abuse and childhood sexual abuse, and by those in recovery from loss through death. I have distributed surveys through various avenues, including support groups, halfway houses, treatment facilities, as well as to therapists specializing in addiction, and/or abuse. Client participation is entirely voluntary and anonymous. Clients are asked not to identify their current or previous therapists. The criteria for taking the survey are outlined on the first page of the survey for the client. A client who has been in therapy for at least two months and who has experienced touch (beyond a handshake) in the course of therapy meets the criteria. The third requirement is that the client's therapist not identify himself or herself as a body-oriented psychotherapist.

Enclosed are (number) of surveys with SASE's. If you are willing to help me gather this information, either through distributing surveys to clients, or through leaving surveys in a waiting room for clients to pick up on their own, it would be much appreciated. If you would like a summary of the results of this project, please send your name and address along with your request to:

Deborah Harris
9912 Wolff Drive
St. Louis, MO 63123

Sincerely,

Deborah Harris

Appendix C

Narrative Responses

Of the 40 participants, 23 (57.5%) included a narrative response to the open-ended question, "Please describe what the physical contact with your therapist means (meant) to you." These descriptive comments were categorized based upon themes identified by Geib (1982) and by Horton et al. (1995). Table 18 summarizes response of the current study's participants based upon ten positive, replicated themes.

Table 18

Themes from Geib	Female Clients	Male Clients	Total
Theme 1: Touch provided a link to reality out of an inner world of pain	0	0	0
Theme 2: Touch communicated concretely "You are not alone"	2	1	3
Theme 3: Touch communicated acceptance, enhancing self-esteem	5	1	6
Theme 4: Touch modeled a new way of relating	4	1	5
Theme 5: Touch helped client with a better sense of her/his own body	0	0	0
Themes from Horton et al.			
Theme 6: Touch created a bond, a feeling of closeness, that therapist really cares	9	1	10
Theme 7: Touch helped client to feel strengthened, reassured, or comforted	6	1	7
Theme 8: Touch facilitated a breakthrough in therapy	0	0	0
Theme 9: Touch provided a sense of safety or closure	5	0	5
Theme 10: Touch met a current deprivation	0	0	0

The most positive common theme mentioned was that touching created a bond, a feeling of closeness, and meant the therapist really cared. The next most common positive theme was that touch helped the client to feel strengthened, reassured, or comforted, followed next by the theme that touch communicated to the client that s/he was not alone.

In similar fashion, narrative responses which mentioned any one of negative themes drawn from Horton et al. are summarized below in Table 19 .

Table 19

Negative themes from Horton et al.	Female Clients	Male Clients	Total
Theme 1: Therapist perceived as insincere or patronizing.	1	0	1
Theme 2*: Client tolerates uncomfortable or unwanted touch and does not address the issue with the therapist	2	2	4

*Two of these responses included a negative theme as part of a transition process from the client first feeling uncomfortable to later positively evaluating the touch (See "Related Issues")

The themes represented by client responses are discussed individually below, in order of the most common to the least common theme mentioned.

Positive Theme 6: Touch created a bond, a feeling of closeness, that therapist really cares. General comments from clients regarding this theme included that touch "makes me feel that she's supportive of me, and that she understands what I'm going through," that touch "brought more of a sense of trust to the relationship," and that as a result of touch, the client "felt genuineness and caring" from her therapist. One sexual abuse survivor wrote of the value of "being able to trust another person, because it's an honest, friendly kind of touch." Another client expressed that the touch, "means she is listening, aware of my situation, supportive of my struggles,

willing to listen, willing to help as best she can." One 43 year old female sexual abuse survivor indicated that the touch "affirmed feelings I had that it was OK to touch. The touching was a human bond, and showed me this just wasn't solely a clinical experience." A 44 year old, gay male indicated that touching strengthened the common bond he felt with his therapist, a woman, describing the bond as the fact that he and the therapist were both recovering alcoholics. A 38 year old male recovering alcoholic wrote of his therapist that the touch "gave support to his words, backed up what he was saying. It meant, I'm not just saying this, but I'm here."

Positive Theme 7: Touch helped client to feel strengthened, reassured, or comforted. One client simply indicated how her therapist "touched my shoulder to comfort me." A 31 year old female client with substance abuse issues stated, "The hugs my therapist gave me were very comforting. I draw strength and my spirit is renewed from the hugs I receive." A 38 year old female sexual abuse survivor similarly described how, "my therapist has placed her hand on my shoulder following a difficult session a couple of times. This has been positive for me, allowing a sense of I'm here with you and you'll make it attitude." Another survivor indicated that "the times I have hugged him I have felt comforted and accepted by him."

Positive Theme 3: Touch communicated acceptance, enhancing self-esteem. The meaning that a 33 year old female client with both substance abuse and sexual abuse issues drew from her therapist's touch was that "it means even though she knows my past life, I'm not too bad of a person to hug anyway." Another 47 year old female client with dual issues stated, "It means she thinks I am a worthwhile human

being." A male client with both issues wrote that touch "helped to boost my morale." Two other comments merely read, "I was accepted," and "It means she likes me."

Positive Theme 9: Touch provided a sense of safety or closure. One client reported touch providing a sense of closure for her, "when I have requested a hug, it's been for closure at the end of a session." Other clients indicated that touch communicated messages involving safety to them. A 31 year old female client with both issues indicated that touch "allowed me to explore my own boundaries in a safe environment." Another 38 year old female sexual abuse survivor recounted how touch, "has allowed me to feel OK about a safe touch in a non-threatening environment with a non-threatening person. . .I allowed myself to take in, 'it is OK to be touched in a hug' from a safe person." For another 57 year old female substance abuse client, the touch meant of her therapist that "she is a safe, healthy person with whom to relate."

Positive Theme 4: Touch modeled a new way of relating. A 37 year old female client with both issues described how touch in therapy constituted a corrective experience for her, "Physical contact was extremely difficult for me initially and developed over time. Because of the lack of nurturing in my childhood, once I was comfortable, touch became a crucial part of therapy for me." (The Likert scale responses of this client all gave the highest possible positive evaluations to touch on every item). Another 37 year old sexual abuse survivor also described a transition in what touch meant to her. At first, she thought touch was a "no-no," but described feeling safe with the touch over time. It is worth noting that the Likert scale responses of this client were more ambivalent in nature. A 38 year old female sexual abuse

survivor described how touching in therapist was setting the stage for her to relate to others in a new way, "my therapist is the only person I allow to hug me at this time but as I continue to recover I will allow myself to accept touching from other people." A 52 year old male recovering alcoholic introduced yet another way in which touch may model new ways of relating when he wrote "The hugs we shared were for the happiness of progress and thanks. Plus, I needed to affirm that it is OK to hug a friend who is a male. I know it's OK but I'm shy and was worried what others would think most of my life."

Positive Theme 2: Touch communicated concretely "You are not alone. For one 38 year old male recovering alcoholic, the nonverbal message of touch was, "hey, I'm here with you. I'm not leaving you out there on your own." The other two clients who echoed this theme conveyed basically that touch meant the therapist was with them in their struggles.

Negative Theme 1: Therapist was felt to be insincere or patronizing. One client, a 42 year old female sexual abuse survivor, described having an ambivalent reaction toward touch. Although she indicating appreciating the touch in some respects, she also expressed that "sometimes I felt like it was an act, like ' I'm your friendly therapist.' Sometimes I was suspicious of it because of that."

Negative Theme 2: Client tolerates uncomfortable or unwanted touch because she or he is unable to address the issue with the therapist. The most directly negative comment of any of the responses came from a male 46 year old client with substance abuse issues who complained, "I think she was trying to get feelings out of me, but I didn't like it." A 31 year old male recovering alcoholic wrote that at first touch "felt

intrusive, out of place, and/or weird. Eventually it became more comfortable and wanted as I became more accustomed to my therapist and groups which promoted contact." A 43 year old sexual abuse survivor (who gave moderate to highly positive Likert scale responses) explained that "after an intense session," her therapist hugged her and that she "didn't really need a hug. I just wanted to get out and hole up for a while. I had spent a good while getting myself to a place where I could leave and drive. It (the hug) almost made me fall apart again." It could also be inferred that the sexual abuse client mentioned in negative theme one had at times accepted touch with which she did not feel completely comfortable.

Related Issues. The most directly negative responses were two comments both made by male substance abuse clients. A rough parallel may be drawn with the descriptive results in that substance abuse clients reported lower comfort levels of communicating not wanting touch with their therapists (see pps. 50, 52, 62). The male who reported that his counselor's touch felt intrusive to him at first rated his openness level as that it would be "slightly difficult" (a "4") to tell his counselor about his discomfort. The other male client rated his difficulty as only slightly higher (a "5"), even though he directly stated not liking the touch. Hunter and Struve (1998) have emphasized the need to specifically discuss touch with substance abuse clients. Hugs are often a ritualized form of touch to greet others at twelve step meetings, or at the end of a meeting. Hunter and Struve have observed that a conditioning factor is at work to "hug strangers simply because they have shared a history of (substance) abuse" and that "these instances of nonnegotiable/ nonconsensual physical contact" (p. 172) have immediate ramifications for the counseling session.

A related issue was observed in the description from five clients who recorded undergoing a transition of some type regarding how they viewed touch. How a transition proceeds appears to depend on the individual client. In marked contrast to the hesitant transition of the male client who "became accustomed" to touch, for example, stands the transition of a 39 year old female sexual abuse survivor who described herself as touch avoidant for many years. She reported that touch for her early in therapy was very difficult. Without supplying intermediary details, she indicated briefly (and dramatically) that she had changed her attitude toward touch to the extent that she was currently training to be a massage therapist.

Conclusion. It is clear from these narrative responses that clients may assign many types of meaning to a therapist's touch. Perhaps the last word belongs to a female survivor client who ascribed the following meaning, " I had a therapist before who didn't touch me, and I still made good progress. But being able to touch my therapist I have now helps me believe I am going to make the journey all the way home, back to myself."

Appendix D

Model Informed Consent Form*

Informed Consent for the Use of Touch in Psychotherapy

Physical contact between human beings can have significant effects on those involved. Research has indicated that in certain situations, and under specific circumstances, touch can be a useful adjunct to psychotherapy (which is primarily focused on verbal interactions between the client and the therapist). One study found that one third of the psychotherapists surveyed reported using some form of touch with their clients.

Before you consider including touch as a part of your psychotherapy, you ought to be aware of some of the possible effects. There are several possible positive effects of touch between the psychotherapist and the client: It can lead to a reduction of anxiety, increase the level of trust, increase the client's awareness of emotions and physical sensation, and improve the client's ability to discuss difficult topics.

It is also possible that the use of touch can lead to an increase in anxiety, a reduction of the trust level, a triggering of unpleasant memories or emotions, or a fear of the touch becoming sexual.

It is unethical and illegal for psychotherapists to have sexual contact with their clients, in the office and elsewhere. Sexual contact is defined as touching or kissing of the genital area, groin, inner thigh, buttock, or breast or of the clothing covering any of these body parts. Requests for this type of activity are also considered inappropriate.

If you decide to include the ethical use of touch as a part of your psychotherapy, you are free at any time, for any reason, to withdraw this permission, without fear of punishment.

Even if you grant permission for the use of ethical touch, the psychotherapist retains the right to not use touch if it appears not to fit with the treatment goals, does not facilitate your psychological growth, or is otherwise not in your best interest.

I/We, the understated, have read and understand the material above and hereby grant permission for the following type(s) of touch to be offered if the psychotherapist deems appropriate (check all that apply):

____ Handshake

____ Hand on shoulder

____ Hand-holding

____ Hugs

____ Holding

____ Other (Describe) _____

_____

Client's signature _____ Date____/____/____

Client's name printed _____

Client's signature _____ Date____/____/____

Client's name printed _____

* From The Ethical Use of Touch in Psychotherapy by Hunter & Struve (1998)

References

Alagna, F. J., Whitcher, S.J., Fisher, J.D., & Wicas, E.A. (1979). Evaluative reaction to interpersonal touch in a counseling interview. Journal of Counseling Psychology, 26, 465-472.

Alyn, J.H. (1988). The politics of touch in therapy: A response to Willison and Masson. Journal of Counseling and Development, 66 (9), 432-433.

Bacorn, C.N., & Dixon, D.N. (1984). The effects of touch on depressed and vocationally undecided clients. Journal of Counseling Psychology, 31 (4), 488-496.

Bass, E., & Davis, L. (1988). The courage to heal. New York: Harper & Row.

Benjamin, B. (1995a). Massage and bodywork with survivors of abuse: Part I. Massage Therapy Journal, Summer.

Benjamin, B. (1995b). Massage and bodywork with survivors of abuse: Part II. Massage Therapy Journal, Fall.

Borenzweig, H. (1983). Touching in clinical social work. Social Casework, 64 (4), 238-242.

Brodsky, A. (1989). Sex between patient and therapist: Psychology's data and response. In G.O. Gabbard, (Ed.), Sexual exploitation in professional relationships (pp. 15-26). Washington, DC: American Psychiatric Press.

Chu, J.A. (1992). The therapeutic roller coaster: Dilemmas in the treatment of childhood abuse survivors. Journal of Psychotherapy Practice and Research, 1 (4), 351-370.

Clements, C. (1987). The transference: What's love got to do with it. Psychiatric Annals, 17 (8), 556-563.

Cole, C., & Barney, E. (1987). Safeguards and the therapeutic window: A group treatment strategy for adult incest survivors. American Journal of Orthopsychiatry, 57, 601-609.

Cornell, W.F., & Olio, K.A. (1991). Integrating affect in treatment with adult survivors of physical and sexual abuse. American Journal of Orthopsychiatry, 6 (1), 59-69.

Cornell, W.F., & Olio, K.A. (1992). Consequences of childhood bodily abuse: A clinical model for affective interventions. Transactional Analysis Journal, 22 (3), 131-143.

Dahlheimer, D. (1990). Creative approaches to healing sexual abuse trauma. In M. Hunter, (Ed.), The sexually abused male Volume 2: Application of treatment strategies (pp. 91-98). Lexington, MA: Lexington Books.

Dan, D. (1991). Beyond the gingerbread house: Addiction, recovery, and esoteric thought. Quadrant, 24 (2), 41-55.

Daniluk, J.C., and B.E. Haverkamp. (1996). The Hatherleigh guide to issues in modern therapy. Hatherleigh Guides Series (Vol.4). New York: Hatherleigh Press.

Dunne, C., Bruggen, P., & O'Brian, C. (1982). Touch and action in group therapy of younger adolescents. Journal of Adolescence, 5 (1), 31-38.

Eaton, M., Mitchell-Bonair, I.L., & Friedmann, E. (1986). The effect of touch on nutritional intake of chronic organic brain syndrome patients. Journal of Gerontology, 41, 611-616.

Eastland, L.S. (1995). Recovery as an interactive process: Explanation and empowerment in 12 step programs. Qualitative Health Research, 5 (3), 292-314.

Epstein, R.S., & Simon, R.I. (1990). The exploitation index: An early warning indicator of boundary violations in psychotherapy. Bulletin of the Menninger Clinic, 54 (4), 150-165.

Fanslow, C. A. (1990). Touch and the elderly. In Barnard, K.E. & Brazelton,T.B. (Eds), Touch: The foundation of experience (pp. 541-557). Madison, CT: International Universities Press.

Forer, B. (1969). The taboo against touching in intensive psychotherapy. Psychotherapy: Theory, Research, and Practice, 6 (4), 229-231.

Gagne, D., & Toye, R.C. (1994). The effects of therapeutic touch and relaxation therapy in reducing anxiety. Archives of Psychiatric Nursing, 8 (3), 184-189.

Geib, P. (1982). The experience of nonerotic contact in traditional psychotherapy: A critical investigation of the taboo against touch. Dissertation Abstracts, 43.

Gibson, W.T., & Pope, K.S. (1993). The ethics of counseling: A national survey of certified counselors. Journal of Counseling and Development, 71, 330-336.

Goodman, M. & Teicher, A. (1988). To touch or not to touch. Psychotherapy, 25 (4), 492-500.

Greenspan, M., & Schneider, S. (1994). Therapeutic touch and healing meditation: A threesome with education. International Journal of Adolescence and Youth, 51 (1-2), 115-125.

Gutheil, T.G., & Gabbard, G.O. (1992). Obstacles to the dynamic understanding of therapist-patient sexual relations. American Journal of Psychotherapy, 46, 515-525.

Gutheil, M.D., & Gabbard, G.O. (1993). The concept of boundaries in clinical practice: Theoretical and risk-management dimensions. American Journal of Psychiatry, 150 (2), 188-196.

Halbrook, B., & Duplechin, R. (1994). Rethinking touch in psychotherapy: Guidelines for practitioners. Psychotherapy in Private Practice, 13 (3), 443-457.

Hall, J., & Veccia, E. (1990). More touching observations: New insights on men, women, and interpersonal touch. Journal of Personality and Social Psychology, 59 (6), 1155-1162.

Hendrickson, R.M. (1992). Does the risk require insurance coverage? Personnel and Guidance Journal, 61, 205-207.

Herman, J. (1992). Trauma and Recovery. New York: HarperCollins.

Hollender, M. (1970). The wish to be held. Archives of General Psychiatry, 22, 445-453.

Holroyd, J., & Brodsky, A. (1977). Psychological attitudes and practices regarding erotic and nonerotic contact with patients. American Psychologist, 32, 843-849.

Holroyd, J., & Brodsky, A. (1980). Does touching patients lead to sexual intercourse? Professional Psychology, 11 (5), 807-811.

Holub, E-A., & Lee, S.S. (1990). Therapists' use of nonerotic physical contact: Ethical concerns. Professional Psychology Research and Practice, 21 (2), 115-117.

Horton, J.-A., Clance, P.-R., Sterk-Elifson, C., & Emshoff, J. (1995). Touch in psychotherapy: A survey of patients' experiences. Psychotherapy, 32 (3), 443-457.

Howard, D.M. (1988). The effects of touch in the geriatric population. Physical and Occupational Therapy in Geriatrics, 6 (2), 35-50.

Hunter, M. & Struve, J. (1998). The ethical use of touch in psychotherapy. Thousand Oaks, CA: Sage Publications.

Kaufman, E. (1994). Psychotherapy of Addicted Persons. New York: The Guilford Press.

Kertay, L., & Reviere, S.L. (1993). The use of touch in psychotherapy: Theoretical and ethical considerations. Psychotherapy, 30 (1), 32-40.

Levitan, A. & Johnson, J. (1986). The role of touch in healing and hypnotherapy. (1986). American Journal of Clinical Hypnosis, 28 (4), 218-223.

Mintz, E. (1969a). On the rationale of touch in psychotherapy. Psychotherapy: Theory, Research and Practice, 6 (4), 232-235.

Mintz, E. (1969b). Touch and the psychoanalytic tradition. The Psychoanalytic Review, 3, 365-376

Older, J. (1952). Touching is healing. New York: Stein & Day.

Olson, M., & Sneed, N. (1995). Anxiety and therapeutic touch. Issues in Mental Health Nursing, 16 (2), 97-108.

Olson, M., Sneed, N., Bonadonna, R., Ratliff, J., & Dias, J. (1992). Therapeutic touch and post-Hurricane Hugo stress. Journal of Holistic Nursing, 10 (2), 120-136.

Pita, D. D. (1992). Addictions Counseling. New York: Crossroad.

Pearlman, L.A., & Saakvitne, K.W. (1995). Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors. New York: W & W Norton.

Pope, K.S. (1988). How clients are harmed by sexual contact with mental health professionals: The syndrome and its prevalence. Journal of Counseling and Development, 67, 222-225.

Pope, K.S., & Bouhoutsus, J.L. (1986). Sexual intimacy between therapists and patients. New York: Praeger.

Rabinowitz, F. (1991). The male to male embrace: Breaking the touch taboo in a men's therapy group. Journal of Counseling and Development, 69 (6), 574-576.

Rosenberg, V. (1995). On touching a patient. British Journal of Psychotherapy, 12 (1), 29-36.

Rousso, J. (1995). From abstinence to sobriety: Psychotherapy and the recovering alcoholic. Alcoholism Treatment Quarterly, 12 (4), 71-78.

Salter, A.C. (1995). Transforming trauma: A guide to understanding and treating adult survivors of child sexual abuse. Thousand Oaks, CA: Sage.

Schaub, B. & Schaub, R. (1997). Healing addictions: The vulnerability model of recovery. New York: International Thomsom Publishing.

Smith, E.W.L. (1985) The body in psychotherapy. Jefferson, NC: McFarland & Co.

Smith, S. (1990). Regressive work as a therapeutic treatment. Transactional Analysis Journal, 20, 253-262.

Stake, J., & Oliver, J. (1991). Sexual contact and touching between therapist and client: A survey of psychologists' attitudes and behavior. Professional Psychology Research and Practice, 22 (4), 297-307.

Stein, N., & Sanfilipo, M. (1985). Depression and the wish to be held. Journal of Clinical Psychology, 41 (1), 3-9.

Stevens-Smith, P. & Smith, R.L. (1998). Substance abuse counseling: Theory and practice. Upper Saddle River, NJ: Simon & Schuster.

Strasburger, L.H., Jorgenson, L., & Sutherland, P. (1992). The prevention of psychotherapist sexual misconduct: Avoiding the slippery slope. American Journal of Psychotherapy, 46, 544-555.

Suiter, R., & Goodyear, R.K. Male and female counselor and client perceptions of four levels of counselor touch. Journal of Counseling Psychology, 32 (4), 645-648.

Timms, R. & Connors, P. (1990). Integrating psychotherapy and body work for abuse survivors: A psychological model. In M. Hunter, (Ed.), The sexually abused male Volume 2: Application of treatment strategies (pp. 117-136). Lexington, MA: Lexington Books.

Turner, K. (1990). Let my spirit soar. In T. A. Laidlaw & C. Malmo (Eds.), Healing Voices: Feminist approaches to therapy with women. (pp. 126-135). San Francisco: Jossey Bass Inc.

Willison, B.G., & Masson, R.L. (1986). The role of touch in therapy: An adjunct to communication. Journal of Counseling and Development, 64 (8), 497-500.

Wilson, J. (1982). The value of touch in psychotherapy. American Journal of Orthopsychiatry, 52:10, 65-72.