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Michelle Lynn Waddell  
Therapists' Attachment Style  
and the Use of Touch in the  
Therapeutic Relationship

ABSTRACT

This study seeks to answer the question: In what ways is the current adult attachment style of experienced mental health professionals associated with their use of touch in practice with adult clients? The hypotheses were that therapist with fearful and dismissive attachment styles would be less likely to engage in touch with clients, while those with a preoccupied style would engage in touch more often, and those with a secure attachment would show no particular pattern in their use of touch. This study was undertaken in order to further understandings of the factors involved in therapists' decisions to and not to use touch in therapy, allowing for more therapist self-awareness and intentionality in the use of touch in therapy. This was studied through a quantitative, cross-sectional, relational project involving an Internet survey of experienced mental health professionals. The sample was 63 full time, masters' level, adult therapists with five or more years of experience. The sample was predominantly white, female, psychoanalytically oriented, social workers. 45 therapists displayed secure adult attachment, 8 fearful/disorganized, 5 preoccupied, and 3 dismissive. The results included many findings on therapists' touch behaviors in therapy but no significant relationships were found between the therapists' touch behaviors and their attachment styles. Nevertheless, by examining touch behaviors in therapy this study furthers the field's knowledge on touch, specifically its near ubiquity, prompting further research, improved theory, and better practice.

THERAPISTS' ATTACHMENT STYLE AND THE USE OF TOUCH IN THE  
THERAPEUTIC RELATIONSHIP

A project upon an independent investigation, submitted in  
partial fulfillment of the requirements for the degree of  
Masters of Social Work.

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2010

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## CHAPTER I

### INTRODUCTION

The use of touch in therapy is a controversial one. Beginning with Freud, who used touch in his own practice for many years, then later instituted “the rule of abstinence,” prohibiting the use of touch in psychoanalysis, therapists have struggled over the appropriate use of touch in therapy (Bonitz, 2008; Fosshage, 2000; Geib, 1982; Greene, 2001; Hetherington, 1998; Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Kertay & Reviere, 1993; Phelan, 2009; Totton, 2003; Tune, 2001). In recent years, as relational theory has risen in the field of psychotherapy there has been an increased focus on “therapists intersubjectivity.” Research has begun to question how factors from within the therapist affect the therapeutic process. There has also been much research done on attachment theory from the original work of John Bowlby and Mary Ainsworth, to contemporary research in areas such as Mentalizing, by Peter Fonagy and others.

In this vein, this study will examine the question: In what ways is the current adult attachment style of experienced mental health professionals associated with their use of touch in practice with adult clients? Based on the literature the expected findings for this study are as follows. Those therapists with fearful/ avoidant or disorganized attachment will likely be uncomfortable with touch and less likely to use it in therapy. Therapists with ambivalent/ preoccupied attachment may seek to touch clients often but will often not be satisfied with that experience. Those with dismissive/ avoidant attachment will also probably be less likely to touch clients. Finally securely attached therapists will



likely show no specific pattern because they will likely base their use of touch on factors other than their own attachment style and needs.

The question of the role of the therapist attachment style in their use of touch in therapy has not been explored in the literature. As the controversy over touch continues in the field of professional social work and in the field of mental health more widely, this study may serve to guide therapists to look at their attachment styles and needs and how that motivates them to perform or not perform certain therapeutic actions, such as engaging in touch with clients. The results of this study will enable therapist to better understand the way in which their attachment styles affect their interventions, touch especially. This will allow them to make better-informed decisions about when and how to use touch in a more effective way. By making more informed and thoughtful decisions about touch, the therapist can better discern when this will benefit clients and when it is harmful, including helping to reduce touch-related boundary violations. In general raising the issue of therapist attachment in relation to their decisions about touch in therapy allows for a deeper understanding of the issue and a better approach to treatment and best practices in relation to touch.

## CHAPTER II

### LITERATURE REVIEW

The present investigation seeks to explore the relationship between the therapists' attachment styles and their use of touch in the therapeutic relationship. Relevant to this question is an understanding of the theoretical framework of attachment theory and both historical and current understandings of touch in therapy. Finally the relationship between touch and attachment and the implications that relationship could bring to bear on therapy and the study at hand will be discussed.

#### *Attachment Literature*

Attachment Theory is built mainly upon the initial work of John Bowlby and Mary Ainsworth who have since been followed by others (Berzoff, Flanagan, & Hertz, 2008). Ainsworth (1989) lists the main characteristics of attachment relationships as: (a) persistence, (b) specificity to a particular individual, (c) emotional significance, (d) desire for proximity or contact, (e) distress at involuntary separation, and (f) security and comfort seeking. Though Bowlby (1979) initially theorized that attachment was important "from the cradle to the grave" (p. 129) it was originally observed in infants in an experiment known as the strange situation (Ainsworth, Blehar, Waters, & Wall, 1978). Infants were placed in a room with their mothers and some toys. A stranger entered and the mother left and returned a number of times. The infant's behavior during each of these instances was observed (Berzoff et al., 2008). There were notable patterns of responding which fit into four distinct categories, or attachment styles. Most infants

showed “secure” attachment meaning they were upset at the mother’s leaving, but when she returned they sought closeness, were comforted, and began to explore and play. Insecure infants were of two sorts “avoidant” and “ambivalent.” Avoidant infants responded to the mother’s leaving by continuing to explore the room, showing little outward distress, yet increases in biological markers of anxiety were observed. Upon the mother’s return they showed a myriad of avoidance behaviors including ignoring the mother completely, looking away, turning their backs, and refusing physical contact, amongst others (Ainsworth, 1978). Ambivalent infants were upset by the mother leaving and drew close to her upon her return, but demonstrated anger and/or passivity rather than comfort, as a result of that closeness (Ainsworth, 1978). A fourth category “disorganized” infants did not fit into the other three patterns nor did they show a consistent pattern or strategy of their own (Berzoff et al., 2008). Attachment theory states that these styles of attachment become internal working models (IWM’s) that direct behavior throughout the life span (Bowlby, 1983). This results in adult attachment styles correlating to the infantile attachment styles. Secure adults correspond to securely attached infants and show an ability to relate to others without being overwhelmed by avoidance or anxiety. They seem to make sense of their relational experiences in a coherent way. Dismissive adults correspond to avoidant infants minimize their attachments and the value thereof. Preoccupied adults correspond to ambivalently attached infants, overemphasizing attachments without any resolution of the meanings of those experiences. Unresolved/ disorganized adults correspond to disorganized infants. This category is still used for those adults who do not fit into any of the other three styles (Berzoff et al., 2008).

Following the work of Bowlby and Ainsworth attachment has been conceptualized in a number of ways. These have included conceptual attachment types or styles as outlined in a rudimentary way above, but has also included ideas of attachment as existing on continuous scales, in clusters, or as quadrants (Brennan, Clark, & Shaver, 1998). In her original study of the Strange Situation, Ainsworth et al. (1978) used two continuous rating scales to classify the infants' attachment. Brennan et al. (1998) label these two scales as analogous to a rating of the child's anxiety (when the mother leaves) and avoidance (upon the mother's return). Other studies also endorse the idea of attachment existing along these two dimensions (Feeney, Noller, & Callan, 1994; Simpson, Rholes, & Nelligan, 1992; Strahan, 1991). Bartholomew translated the idea of IWM's into "models of self" and "models of other" which can be either positive or negative (Bartholomew, 1990; Bartholomew & Horowitz 1991). The positive self is one that is worthy of love, the negative self unworthy of love, the positive other available and responsive, and the negative other unreliable (Feeney, 1999). Bartholomew (1990) then took these two models, corresponding to the continuous rating scales/ dimensions explored by others, namely avoidance and anxiety, and made placed them as axes on a graph forming four quadrants. The four quadrants correspond to the four attachment styles: secure, dismissive, preoccupied, and disorganized. Brennan et al. (1998) did a meta-study of many attachment measures and found that attachment did indeed organize, as Bartholomew (1990) suggested, along these two dimensions into four clusters analogous to the four attachment styles. Fraley and Waller (1998) found no evidence for the attachment styles as existing as distinct entities, therefore pointing toward the use of

concepts more along the lines of continuous scales, dimensions, clusters, or quadrants as more useful. Brennan et al. (1998) conclude that:

in line with previous work by Simpson, Bartholomew, and their coauthors, that everyone is working with the same two dimensions that Ainsworth and her colleagues identified in 1978: Avoidance and Anxiety. The origins and implications of people's scores on those dimensions are what all attachment researchers deal with, whether knowingly or not. (p. 23).

Bowlby's original theory of attachment (1980) included the idea of IWM's and the continuation of one's attachment style from the time of infancy through adulthood. Ainsworth (1989; 1991) wrote about the sex pair bond as the adult analogue to the infant caretaker attachment. Hazen and Zeifman (1999) surveyed adolescents and found that 83% of older adolescents (ages 15-17) named a romantic partner as their primary attachment figure. Adult attachment mimics infantile attachment in as far as adults exhibit proximity seeking under stress, being comforted by attachment figures, and separation anxiety related to the attachment figure's absence (Shaver, Hazen, & Bradshaw, 1988; Weiss, 1991; Crowell, Fraley, & Shaver, 1999). Further adult pair bonds have the same features functions, dynamics, and processes as parental attachments (Crowell, Fraley, & Shaver, 1999). These findings together point to pair bonds as the adult analog to the infant-caregiver attachment relationship. Cassidy (2000) postulates that some of the factors involved in creating this continuity in infantile and adult attachment, may include: internal working models, child response, effects on attention, memory, and brain development, the role of early attachment in future partner choice,

and the idea of early relational patterns reinforcing themselves through the lifespan. There is however the important distinction that adult pair bonds are, in ideal circumstances, reciprocal, whereas infant-caretaker bonds are not (Crowell, Fraley, & Shaver, 1999). This distinction is important but does not necessarily mean that attachment is not present.

“Attachment effects therapy as with all important relationships” (Slade, 1999, p. 586). This statement is not only true concerning the ways in which attachment effects clients but also in the ways in which it can “influence therapist’ feelings about and responses to the patient” (Slade, 1999, p. 586). Attachment as a system is based upon the act of caregiving, from parent to infant, between members of a pair bond, or from therapist to client (Slade, 1999). In studies of mothers’ caregiving and attachment dismissing mothers were found to be less responsive, preoccupied mothers were inappropriately responsive, and secure mothers were most apt at responding to the needs of their infants (Hesse, 1999). In pair bonds secure individuals showed more caretaking behaviors toward their partners (Hesse, 1999). Similarly with therapists secure therapists are more able to hear and respond to dismissing patients while being less vulnerable to strong reactions with preoccupied patients (Dozier, Cue, & Barnett 1994). This begs the question “What aspects of the therapist’s response...evolve from the therapist’s own history and attachment classification?” (Hesse, 1999).

### *Touch Literature*

Touch is a common human experience that does not happen merely in the context of therapy. Touch is a powerful, fundamental, and ambiguously meaningful form of communication in the human experience (Durana, 1998; Fosshage, 2000; Frank, 1957;

Jones & Yarbrough, 1985; Kertay & Reviere, 1998; McLaughlin, 2000; Montagu, 1986; Smith, 1998a). Jones and Yarbrough (1985) did an observational study of touch and considered a number of factors: who initiated the touch, parts of the body involved, place in which the touch occurred, timing of the touch, verbal statements that preceded or accompanied the touch, the level to which the touch was accepted or rejected by the person being touched, the type of touch, the purpose of the touch, whether or not others were present, the relationship between the two individuals, the social occasion, the status of the person being touched, age, sex, race, and body position (Jones & Yarbrough, 1985). Though these factors were considered in non-therapeutic touch a number of these same factors may be worth investigating in therapeutic touch. It is notable for the idea of therapeutic touch, and the arguments against it, that in the findings 12 types of touch were distinguished, only one of which was sexual or erotic in nature (Jones & Yarbrough, 1985). Similarly Edwards (1981) classified touch into nine types: information pickup, movement facilitation, prompting, aggressive, nurturant, celebratory, sexual, cathartic, and ludic. These too can be considered as existing within the therapeutic relationship as well as outside of it and again only one is sexual in nature.

That distinction between erotic or sexual touch and all other forms of touch is central to the issue of touch in therapy because of both the history of the use of touch in therapy, and current therapist attitudes toward touch. Freud, in the beginning of his practice used touch as an intervention with many of his clients (Bonitz, 2008; Fosshage, 2000; Geib, 1982; Greene, 2001; Hetherington, 1998; Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Kertay & Reviere, 1993; Phelan, 2009; Totton, 2003; Tune, 2001). He later renounced touch as an appropriate intervention because of the risks of sexual

encounters and of giving into the client's desires rather than creating the needed frustration to move the client forward in therapy (Bonitz, 2008; Fosshage, 2000; Geib, 1982; Greene, 2001; Hetherington, 1998; Horton et. al., 1995; Kertay & Reviere, 1993; Phelan, 2009; Totton, 2003; Tune, 2001). This caused disagreement between Freud and his colleague Ferenczi, who advocated touch, creating two camps within the psychotherapeutic community (Bonitz, 2008; Fosshage, 2000; Geib, 1982; Greene, 2001; Hetherington, 1998; Horton et. al., 1995; Kertay & Reviere, 1993; Phelan, 2009; Totton, 2003; Tune, 2001). Hetherington (1998) summarizes the two arguments as follows:

Ferenczi (1955) considered physical contact to be an effective means of repairing early damage to the individual. Conversely, Freud (1915) believed that touch with its erotic connotations interfered with the transference and could serve to gratify an infantile wish at the expense of the motivation for growth and independence. (para. 3)

This debate has continued in theory and literature to the present and varies from staunch adherence to abstinence from touch to viewing it as a fundamental medium of the therapeutic process (Durana, 1998; Kertay & Reviere, 1998; Smith, 1998b).

Freud's initial argument against the use of touch continues to be expressed and is clearly articulated, by Schamess (1999) and Casement (1982). Schamess highlights the sexual nature of touch, challenging the idea of nurturing and loving relationships as asexual, including parent-child and therapist-client relationships (1999). In that challenge sexuality and sensuality, love and eroticism are, in some way, conflated (Schamess,1999). Casement argues the other rationale, that touch is counterproductive to



the forward movement of therapy. The act of touch is a collusion that allows the client to escape facing the work they are doing in a more direct way (Casement, 1982). Rather than a reparative experience touch can be a reenacting experience that fails to move the client forward (Casement, 1982). Conversely Ferenczi's approach to touch as a positive therapeutic tool is seen as continuing in the work of Winnicott (1965) who would sometimes hold patients not only figuratively through his idea of the "holding environment" but also literally, and the work of Little (1981) with particularly regressed patients.

The debate around touch can be viewed as a theoretical disagreement. Those who condemn the use of touch argue that it results in unproductive gratification of the patient, muddies the transference, and can result in inappropriate sexual behavior with patients (Toronto, 2002). The "rule of abstinence" (Freud's prohibition on touching) is based in the theoretical construct of the therapist as a blank screen (Fosshage, 2000). Based in classical theory, touch, like other things, is driven by sex and aggression, which excludes the consideration of other possible meanings of touch (Fosshage, 2000). Those who argue for the use of touch generally take a more relational stance on the issue viewing it as another interaction that happens in the intersubjective space between the client and the therapist (Toronto, 2002; Fosshage, 2000). The ideas of the blank screen and therapist neutrality are then dismissed and both touching and not touching are seen as meaningful actions (Fosshage, 2000).

The possibility that both touching and abstaining may hold meaning in the therapeutic context prompts us to look at touch in more complex ways. First it is important to note that touch in therapy with adults is different than touch in therapy with

children (Holder, 2000). The meanings, boundaries, and literature are distinct and this study will focus exclusively on touch in therapy with adults. Orbach (2003b) discusses the uncomfortable atmosphere regarding touching in therapy and the way in which both solid rules or “fuzzy” uneasiness are both inadequate in addressing the issue and making meaning of it within the therapy. Sponitz (1972) points out that “(1) the same touch can have divergent meanings for different recipients. (2) the message one is attempting to convey through touch can be modified by the attitude of the recipient. (3) repetition alters the meaning of the touch” (p. 456). Others have tried to make sense of and categorize the ways in which touch plays out in the therapeutic relationship. Goodman and Teicher (1988) divide touch into two main types: holding and provocative. Holding touch serves to “delimit the patient’s distress, to minimize pain, or/ and to protect the patient from harming himself or herself” whereas provocative touch is seeks to uncover new therapeutic material (Goodman & Teicher, 1988). Therapists may touch for reasons of: “promoting personal growth and improving the therapeutic relationship,” relief of “acute distress such as grief, trauma, or severe depression,” for “emotional support, including warmth, reinforcement, contact, and reassurance; or for greeting or at termination,” (Holroyd & Brodsky, 1977) Mintz (1969a; 1969b) lists four meanings of touch in therapy assisting the clients maintain a sense of reality, expressing to the client a sense of acceptance by the therapist, serving as a symbolic mother, and gratifying libidinal urges of the therapist or client. Geib (1982) conducted a study of touch in therapy and found five distinct meanings: assisting the client to remain connected to reality, communicating to the client that they are not alone, expressing acceptance of the client, relating, and helping the client be in touch with their own bodies. Smith (1998a) developed seven

types of touch that can occur in therapy including: sexual and aggressive touch which are not appropriate in the therapy, inadvertent touch which is unintentional like bumping, and brushing clients, touch as a conversational marker for directing attention or creating emphasis, socially stereotyped touches which are culturally sanctioned and ritualistic (e.g. handshakes), touches as expression of the therapeutic relationship which are situation specific and mirror much of comforting and filial touch outside therapy, and touch as technique which include formalized body work practices. These various classifications of therapeutic touch may overlap in some ways but clearly fail to present any coherent or absolute idea on how to consider and manage the issue of touch in therapy.

Rather than classifying touch in to various types it may be more helpful to look at the ways in which touch may be helpful or harmful in the therapeutic setting. Some of the potential benefits of using touch in therapy include: bonding between the therapist and client (Bonitz, 2008; Clance & Petras, 1998; Durana, 1998; Jourard & Friedman, 1970; Phelan, 2009), dissipating client shame about the desire for closeness, relieving acute stress states of client (Bonitz, 2008; Mandelbaum, 1998; Torracco, 1998), providing the client with comfort and support (Pinson, 2002), increasing client self-esteem, expressing therapist acceptance of and empathy for the client, controlling client aggression, facilitating healing, releasing repressed emotions, communicating therapist affection, removing barriers in therapy (Phelan, 2009), allowing the client to feel loveable, helping the client stay in contact with reality (Phelan, 2009; Sponitz 1972), reassuring the client, sensitizing to other peoples feelings, maturing the client (Sponitz, 1972), increasing client trust of therapist (Clance & Petras, 1998; Durana, 1998; Jourard & Friedman, 1970;

Phelan, 2009), access pre-verbal material (Bar-Levav, 1998; Liss, 1977), providing an emotionally corrective experience (Durana, 1998; Kupfermann & Smaldino, 1987), helping deeply regressed clients (Balint, 1952, 1968; Winnicott, 1975), treating psychotic anxieties and delusional transference (Little, 1990), and modeling realistic boundaries (Horton et al., 1995). Another benefit of touch as a therapeutic intervention is its ability to be potentially reparative of early touch and attachment experiences including attachment disorders (Phelan, 2009; Hetherington, 1998; Liss, 1977; Wilson, 1982). Indeed, Bonding Psychotherapy (BP), a treatment method involving touch has been shown to be an effective treatment for insecure attachments (Phelan, 2009). Touch outside of BP has also been shown to help with attachment, self-soothing, and emotional regulation (Phelan, 2009). Conversely touch deprivation has been related a wide variety of clinically significant disturbances (Turp, 2000). Despite these benefits therapists are tentative to admit having used touch in therapy (Phelan, 2009).

The counterargument to the use of touch in therapy, outside of the theoretical concerns about therapist's neutrality, is the possibility of touch as a slippery slope toward physical and sexual boundary violations with clients. The issue of touch as therapeutic intervention versus touch as exploitive is compounded by the fact that therapist who engage in ethically inappropriate, sexual, and exploitive practices often endorse the use of non-erotic touch (Strean, 1993) and offer justifications for their actions that closely mirror some of the benefits of therapeutic touch detailed above including: sex with clients as emotionally reparative (Gartrell, 1986; Herman et al., 1987), and as a means for increasing client self-esteem (Herman et al., 1987). This difficulty in distinguishing therapeutic and erotic touch is part of the reason for therapists completely forgoing or at

least severely limiting touch. This is seen in writings such as Gutheil and Gabbard (1993) in which for reasons of boundary concerns, legal liabilities, and risk management they suggest limiting touch to handshakes only. Studies however have not supported an empirical connection between the use of touch in therapy and sexual/ erotic encounters with clients (Holroyd & Brodsky, 1980; Pope, 1990). It seems rather that the therapist's attitude toward the touch as erotic or non-erotic is more predictive of sexual boundary violations (Hetherington, 1998). In emphasizing the possibility of sexual boundary violations though "an atmosphere of suspicion surrounding the use of touch" (Stenzel & Rupert, 2004, p. 332) is created. Beyond the idea of touch leading to sexual encounters there also exist arguments that some of the benefits of touch, such as providing an emotionally corrective experience, are not as feasible as those advocating touch may claim, and that the failed attempt to do so may actually be more harmful (Goodman and Teicher, 1988). Finally Alyn (1988) brings up the point that regardless of therapist intention clients may interpret touch in ways that they were not intended. Further because of who has the socially sanctioned rights to touch whom, the use of touch across various social identities and differentials of power can recreate the same oppressive dynamics that are present in society within the therapy, which is clearly not beneficial (Alyn, 1988). Again the debate on touch in therapy is a complex and multi-faceted one to which the literature does not necessarily offer clear answers directing therapists.

Given these conflictual points it is important to examine what therapists actually do in their practices with regard to touch with clients. In general there are some widely varying findings on the frequency of touch in therapy. Phelan (2009) stated that 95% of social workers touch a client at some point in their career. Conversely Stenzel and Rupert

(2004) found that 90% of psychologists never touch clients. This discrepancy could be a difference in the frequency of touch in the two professions or could be resultant from differences in the designs of the studies. The most common situation in which therapists touch is termination with 11% of the sample in Stenzel and Rupert (2004) never doing so, the rest did. Holroyd and Brodsky (1977) found that 27% of therapists in their sample touched clients occasionally and only 7% touched frequently or always. Stake and Oliver (1991) similarly found low rates of touch in therapy though touching the shoulder, arm, and or hand occurred at least rarely or sometimes. Overall handshakes seem to be the most common form of touch in the therapeutic setting with different studies finding that upwards of 76-80% of therapists engage in this behavior (Pope, 1987; Stenzel and Rupert 2004). This is not surprising as it was endorsed as acceptable by Gutheil and Gabbard (1993) and is socially sanctioned as an appropriate form of greeting. Pope (1987) found that 44.5% of therapists engage in hugging with clients rarely and 30% do so sometimes. Kissing was found to occur never or rarely by Stenzel and Rupert (2004) and in Pope (1987) 24% of therapists kissed rarely, while 4% kissed sometimes. Stenzel and Rupert (2004) found that massage, touching clients on the leg, and holding clients all happened rarely. One criticism of Stenzel and Rupert (2004), as well as many of these studies is that they focus on therapist-initiated touch, when in reality this is not the only way in which touch occurs in the therapy (Stenzel and Rupert, 2004). In fact it is recommended that touch be initiated by the client or that the therapist ask permission first in order to reduce the potential harm of touching (Durana, 1998; Geib, 1982; Greene, 2001; Horton et al.1995; Torracco, 1998). However this type of discussion was found never or rarely in almost 50% of therapists in the study by Stenzel and Rupert (2004). Further

recommendations to reduce harm and increase benefit include: discussion about touch and touching, the client feeling in control of the touch, the client having the sense that the touch was for their benefit not the therapist's, congruency in therapeutic expectations, and emotional intimacy in matching with the use of physical touch (Geib, 1982).

Given the potential benefits and risks associated with touching in therapy and the low incidence of touch reported in studies it is important to examine what therapists touch which clients, where, and why. Therapists who use touch were also more likely to be humanist in orientation and female in gender, as well as had had supervision and training in touch as an intervention (Bonitz, 2008). Additionally they were more likely to have had a positive experience of touch with a therapist in their past (Bonitz, 2008; Pinson 2002). Therapist's attitudes on touch have also been explored, specifically with regard to various variables including: family background, tendency toward affection, age, gender, race, years of practice, professional education/training, professional experience, and origin of development of philosophy of touch (Jones, 1999). Despite studying variables such as family background, however, attachment was not looked at specifically. Past history of both client and therapist is considered important in looking at the potential risks and benefits of using touch in therapy (Phelan, 2009; Pinson 2002). When considering clients for whom touch is beneficial, factors include; perceived client pathology, client gender, therapeutic situation, clients' general ability to hold boundaries (Bonitz 2008), client ego strength, client-therapist dynamics and relational patterns, clients' body language, clients' culture, length of time in therapy, the clients' need or desire for touch (Pinson 2002), religious and cultural differences between the client and therapist, client expectations of the therapy, clinical setting (Phelan, 2009), social-

emotional maturity of the client, clients' need for parental nurturing, clients' presenting concern, the stage in therapy (e.g. termination) (Willison & Masson, 1986), and the strength and quality of the therapeutic alliance (Horton et. al. 1995). Though this list of variables is lengthy it is mostly focused on client or situational variables and though there has been some research on the characteristics of therapists who use touch there is not yet a full understanding of what factors in a therapists might motivate them to touch clients. Holub (1990) discusses the possibility of therapist acting out of early object loss or object hunger, and advocates therapist awareness. Since it is imperative in the writing of Goodman and Teicher (1988) and Geib (1982) that touch benefit the client not the therapist this makes looking more closely at the therapists own factors in why they touch necessary.

### *Touch and Attachment*

Therapists who use touch also generally relate it to attachment theory (Pinson, 2002). Orbach (2003 a,b) speaks of attachment as the basis of relational psychotherapy, the approach often used for advocating the use of touch, and further dismisses attachment as merely mental but rather points to the physicality apparent in the theory itself. In exploring the issue of touch Turp (2000) describes attachment as a "useful conceptual framework" (p. 65). Most convincingly however Hazen and Zeifman (1999) state "physical contact is crucial in attachment formation" (p. 348). This is seen in Harlow's studies with monkeys who chose a soft surrogate mother (physical contact and comfort) over a surrogate mother who provided food (Orbach 2003, b) and in early attachment work with infants (Ainsworth, 1978; Main, 1990) where touch within the attachment dyad was directly observed. It should be noted that Bowlby (1958) does not explicitly



discuss the role of touch in attachment yet touch between infant and caregiver as a vehicle for attachment does seem to be implied (McRae, 2008). Attachment relationships in pair bonds are, in part, distinguished by the types and amounts of touch present in the relationship, including but not limited to, sexual relations (Hazen and Zeifman, 1999). More generally attachment is defined by the act of “proximity seeking” that is trying to maintain physical closeness with the attachment figure (Berzoff et al., 2008), which can and does involve touch or at least “close physical proximity” (Hazen and Zeifman, 1999, p. 338). Finally, a relationship between touch and attachment is logical, in that, attachment occurs in a developmentally preverbal stage of life, therefore it cannot be based in language (Toronto, 2002). This points to touch as the more likely mechanism for the establishment of attachment. There must be more exploration however of the links between touch and attachment and more specifically how that relates to the actions of the therapist in practice (Orbach, 2003, b).

Behavior regarding touch varies across different attachment styles. In general those with avoidant attachment tend to reject touch, or at least show less enjoyment for it, and had mothers that were uncomfortable with touch (Cassidy, 2000; Feeney, 1999). Those with ambivalent attachments can literally cling to attachment figures and generally enjoy touch but find that closeness not satisfying enough (Cassidy 2000, Feeney 1999). Secure individuals generally enjoy touch but not to the extent that those with ambivalent attachments do (Feeney, 1999). These attachment styles likewise translate to the way in which that individual exhibits caregiving (Cassidy 2000). This makes the therapists’ personal attachment style and history pertinent to the way in which they attach to clients in therapy, which would, in theory, also affect their use of touch. In the current study I

will look specifically at therapist's adult attachment style in relation to their choices to or not to touch clients.

### *Summary*

The current literature views attachment as existing on the two continuous scales of anxiety and avoidance, traces it from infancy to adulthood through infant- caretaker relationships and pair bonds, and views attachment as an important factor in therapy for both therapists and clients. Touch remains a contentious area in regards to therapy, and has been so since the time of Freud. Touching and not touching within the therapeutic context may carry a number of meanings, benefits, and risks. There is not much conclusive evidence about what exactly happens with regard to touch in therapy. There is some understanding of which therapists touch and why yet this area is also clearly lacking. Though touch and attachment are believed to be related in some ways, there appears to be no research relating the therapists' attachment style to their behaviors regarding touch in therapy. Many call for further research into the factors regarding why therapists choose to use or not use touch in the therapy, citing the lack of existent literature and the importance of therapist self-awareness on the issue (DeLozier, 1994; Durana, 1998; Hetherington, 1998; Kertay & Reviere, 1998; Orbach, 2003, b; Smith, 1998a; Stenzel and Rupert, 2004). The tie between attachment and caretaking, as well as attachment and touch, makes attachment a logical area to explore in regards to touch in the therapeutic relationship.

## CHAPTER III

### METHODOLOGY

The study aims to answer the question: In what ways is the current adult attachment style of experienced mental health professionals associated with their use of touch in practice with adult clients?

#### *Sample*

The sample in this study is mental health professionals, including: 48 social workers, 7 psychologists, 1 psychiatrist, and 3 licensed mental health counselors. All of the participants had at least five years of full time clinical practice following the receipt of their corresponding master's level (or above) degree. They have current direct caseloads that consist predominately (at least 50%) of adult clients. The sample was predominately (79.4%) White, 6.3% Black or African American, 3.2% Latin or Hispanic, 1.6% Asian, and 6.3% Other. The sample was 69.8% Female and 23.8% Male. In terms of primary theoretical orientation the sample was 47.6% psychodynamic/psychoanalytical, 20.6% cognitive/behavioral, 9.5% Rogerian/client centered, 4.8% systemic/cultural, 1.6% existential, 1.6% feminist, 1.6% humanistic, and 4.8% stated that none of the orientations listed were close to their own. Participants required Internet access, and a command of written English language. Notably the study was not limited to those who engage in touch but also includes those who categorically do not do so, as the abstinence from touch simply presents one end of the spectrum of touch behaviors, and is likely still related to the attachment styles of those therapists as

well. The sample size was 63 participants, who have been recruited from various geographic areas. The recruitment process began with an email request sent to personal and professional contacts of the researcher who may have fit the inclusion criteria stated above. The researcher also sent an email sent to all current Smith College School for Social Work students asking that they also forward the email request to their personal and professional contacts within the field. Since Smith College School for Social Work Students and alumni are placed throughout the United States and internationally, and because they come from a diverse set of background experiences this helps facilitate more diversity within the sample beyond the researchers personal contacts. The survey was also sent to the SA (San Antonio) NASW branch listserv. The recruitment email was sent to other mental health professional listserves to which the researcher and the researcher's personal contacts had access as well. Recruitment continued through a snowball sampling process. The email request included a request that the email recipient (who could choose whether or not to become a participant themselves), forward the email request to their personal and professional contacts they have within the mental health field. The recruitment took place electronically.

Diversity has not been directly targeted as a salient factor in the recruitment process of this study because although the personal identities of the participants may be important in terms of their behaviors regarding touch in the therapeutic relationship the focus is the characteristic of therapist's attachment style. Questions regarding the racial/ethnic identities, gender, etc. of the participants were gathered along with other demographic information at the end of the survey and are used to gain a greater understanding of the sample, not as a variable in the study. Including various forms of

diversity as a variable in the study or as a focus in recruitment process would provide potentially compounding variables for the study. The relationship between diversity in its various forms and the use of touch in the therapeutic relationship is an area that could certainly be explored in further research but is not the specific focus of this study. It is therefore also not a focus of the recruitment process.

The sampling process here is not random. Though a random sampling would represent a more ideal sample in terms of sound research design the convenience based-snowball sample is simply more feasible for a study of this magnitude. A true random sample would be more expensive and time consuming and would likely not result in the desired sample size of more than 50 participants due to the stringent inclusion criteria. Efforts have been made to get a more diverse sample in terms of geographic location and professional field by sending the survey out nationally to Smith College School for Social Work students and other contacts nationally and internationally and in a variety of clinical contexts.

#### *Data Collection*

The email request included a link to the survey on Survey Monkey, an Internet survey site. The survey began with a welcome page thanking participants for their interest and screening the participant for eligibility for the study. Each question appeared in a yes or no format and corresponded to one of the inclusion criteria. When participants responded, “yes” to all questions they were immediately directed to the informed consent form. When participants answered “no” to any one question they were thanked for their time and informed that they are not eligible for the study. The informed consent was obtained by the participant checking a box at the bottom of the form that says, “I agree.”

In the informed consent participants were presented with the risks of participation such as: emotional discomfort and psychological stress due to personally and professionally revealing questions. Because these risks are minimal and the participants are mental health professional it is not necessary to offer recourses. Once they read the informed consent and checked the “I agree” box were then directed to the data collection instruments.

The participants then took an attachment measure, the ECR developed by Brennan, Clark, and Shaver, which asks them questions about their personal relationship patterns, thoughts, feelings, etc. This measures the attachment style of the participant and groups them accordingly. This is a publicly available measure and is being used with the permission of the authors. The developers were emailed regarding permission and responded with both permission and a copy of the instrument. There is then a series of questions regarding the participants’ use of touch in the context of the therapeutic relationship. These questions on the use of touch have been developed by the researcher and are based on the literature. The following passage appeared at the beginning of the touch questionnaire in order to explain the operational definitions of touch as well as other terms used in the study questions:

“The following series of questions will ask you about your use of touch in the professional therapeutic relationship. For the purposes of this study touch is defined as intentional physical contact of any kind between yourself and the client. Touch may involve any combination of body parts and may occur for any duration of time. It may be initiated by either party and may have a variety of purposes. In this study touch does not include accidental physical contact i.e.

tripping and bumping into a client or contact that is explicitly sexual or aggressive (i.e. hitting, punching, slapping, formal restraint positions, or various sex acts.)

Touch includes but is not limited to: handshakes, touching arms, hands, backs, legs, heads, hugging, kissing, holding, etc. The context of the therapeutic relationship will be defined as all professional contact inside and outside of the therapy room beginning at first contact with the client and continuing through the end of termination. Clients will refer to adult clients only.”

Finally there are six demographic questions. This is the end of the data collection portion of the research participation. The survey also included a series of optional links that appear after the informed consent form has been completed. The first leads to a site at which the participants can provide an email address at which they would like to receive results from the study if they so choose. This is unconnected to their responses to the initial survey. The second is a link to a third site at which the participants can list an email address to be entered into the incentive drawing for one of four \$25 gift certificates to Amazon.com. This email address will be used to contact them in the event that they win. This too is unrelated to information gathered in the survey or on the site for receiving the study results. It has been made clear to the participants in the informed consent and on the link sites that by leaving their email addresses at either of these two sites they are waiving their anonymity in the study. Confidentiality however has been maintained.

The ECR was specifically chosen as the best measure for this study based on the literature regarding its applicability and considerations such as time and cost. The ECR

measures adult attachment by asking self-report questions about adult attachment relationships or pair bonds. There is much research supporting the viability of pair bonds as adult attachment, some of which is presented in the literature review. Given the understanding that pair bonds function as the primary adult attachment relationship several measures have been developed to assess adult attachment style. These measures exist in two main types: interview measures and self report measures. Attachment style can be determined to be different by a self-report measure than it would be by an interview measure (Gjerde, Onishi, & Carlson, 2004). These differences may be, in part, accounted for by biases in self report measures such as: self-serving bias, social desirability bias, acquiescence, response bias, depending on honesty in participants answers, levels of participant insight, fears and defenses presented, and the effect of meaning transparent questions (Brennan, Clark, & Shaver, 1998; Gjerde, Onishi, & Carlson, 2004). Further there are potential theoretical difficulties in assessing an unconscious process (attachment) with a conscious (self report) measure (Crowell & Treboux, 1995). Self-report measures operate on the basis that can answer questions about their emotional experience and relationship behavior without overwhelming bias and that the unconscious process of attachment and the conscious process of evaluating those emotions and behaviors will yield the same, or at least reasonably similar results (Crowell, Fraley, & Shaver, 1999). Interviews seemed less permeable to the biases present in self-report measures (Gjerde, Onishi, & Carlson, 2004). There may be some degree of an advantage to interview type attachment assessments however there is question as to whether that advantage is outweighed by the additional time and effort interviews require, which may make their use in research less feasible (Brennan, Clark, &



Shaver, 1998; Gjerde, Onishi, & Carlson, 2004; Hesse, 1999). For the purposes of this research it is more reasonable to assess clinicians using a self-report measures because of the feasibility issues of using interview measures.

Lyn and Burton (2004) report the methodological strength of this instrument making a strong argument for its potential use in this project. Lyn and Burton (2004) looked at other methodological issues relevant to use of this instrument including: its retroactive nature, possible self-selection bias, and the relation of current attachment to infantile attachment. Lyn and Burton (2004) reported that retroactive questioning of attachment is appropriate because attachment itself is based on the interpretation of past experiences already. Having participants self-select to complete a survey on attachment may be biased to favor higher response rates from individuals with fearful attachment and lower response rates from those with dismissive attachment (Lyn & Burton, 2004). Finally Lyn and Burton (2004) brought forth the issue of the relationship between adult attachment style and infantile attachment.

On the other hand the ECRI, being a self-report measure of attachment has been shown to lead to some differential evaluations in comparison to an interview style measure (Gjerde, Onishi, & Carlson, 2004). The general trend was for those with dismissive attachments to present their attachment as more secure, by dismissing insecure behaviors and feelings, whereas secure individuals could appear less secure due to a higher level of self-awareness (Gjerde, Onishi, & Carlson, 2004). Despite these biases the ECR appears to be the most easily administered attachment measure for the limitations of this study

The ECR has been deemed to have high degrees of validity and reliability by a large metastudy conducted by Mikulincer & Shaver (2007). The initial chapter written for the development of the instrument reports the reliability of the two scales of the measure to be as follows: Avoidance (alpha = .94) Anxiety (alpha = .91), N=1082 (Brennan, Clark, & Shaver, 1998). Lyn and Burton (2004) reported the same values for alpha in their study.

### *Data Analysis*

In general the data was first examined in terms of descriptive statistics. Then the attachment styles of the participants have been determined by scoring the ECR according to the scoring instructions provided by the authors. This provides both a numerical score for anxiety and avoidance in terms of attachment as well as the participant's attachment style. This data has been used along with the participant's responses to the questions on touch to answer the original research question: In what ways is the current adult attachment style of experienced mental health professionals associated with their use of touch in practice with adult clients? There were a number of tests run to determine the statistical significance of the relationship between therapists' attachment style and their touch behaviors in the therapeutic relationship. First the participants were grouped by the four attachment styles and a series of one-way ANOVAS and crosstabulations were run on the participants' responses to the various touch behavior questions. This was done in order to explore the significance of differences in touch behaviors between clinicians with differing attachment styles. Chi-squared tests could not be run on the crosstabulations due to insufficient numbers of participants in some of the groups. Additionally correlational tests were run between the participants' scores on the ECR in

terms of anxiety and avoidance and their answers to the touch behavior questions. Due to the small number of therapists with certain attachment styles this additional test was done in order to explore the possible relationship between avoidance and anxiety, the two substrates of attachment style, and touch behavior. For these correlational tests Pearson's R and t-tests were used.

In order to complete the above analysis a codebook was created in order to code the variables for each question and streamline data analysis. Nominal variables were coded by assigning a numerical value to each categorical answer. Ordinal variables, like the Likert scales included in the ECR and some of the other questions, were assigned numeral values in a similar fashion. These numerical values were often present in the questions as they were presented to the participants as well. Questions that involved "check all that apply formats" such as the demographic question on race/ethnicity, and questions on therapists and client body parts used in touch, were divided into and coded as separate questions. The ECR, an interval measure was coded and scored using the scoring guide provided by the authors. Ratio variables were already numerical and did not require further coding. Finally the one qualitative question in the study "Can you describe some of the types of situations in which you have or are most likely to use touch with clients?" was coded using theme and content analysis. The themes coded in that analysis were also influenced by previous research delineating various themes of touch both with in therapy and outside of it.

## CHAPTER IV

### FINDINGS

The initial aim of this study was to answer the question: In what ways is the current adult attachment style of experienced mental health professionals associated with their use of touch in practice with adult clients? Some hypotheses from the literature were as follows. Those therapists with fearful or disorganized attachment will likely be uncomfortable with touch and less likely to use it in therapy. Therapists with ambivalent/preoccupied attachment may seek to touch clients often but will often not be satisfied with that experience. Those with dismissive/avoidant attachment will also likely be less likely to touch clients. Finally securely attached therapists will likely show no specific pattern because they will likely base their use of touch on factors other than their own attachment style and needs.

When the tests for significance were run there was no significant difference in patterns of touch amongst therapist with differing attachment styles. There were also no significant findings regarding correlations between the participants ECR scores for avoidance and anxiety and therapists' touch behavior. This fails to accept or reject the hypotheses above.

#### *Descriptive Findings*

First are descriptive statistics of the sample population and the responses given to various survey questions. Then the relational aspects of attachment and touch are examined in an attempt to answer the original study question.

### *Sample*

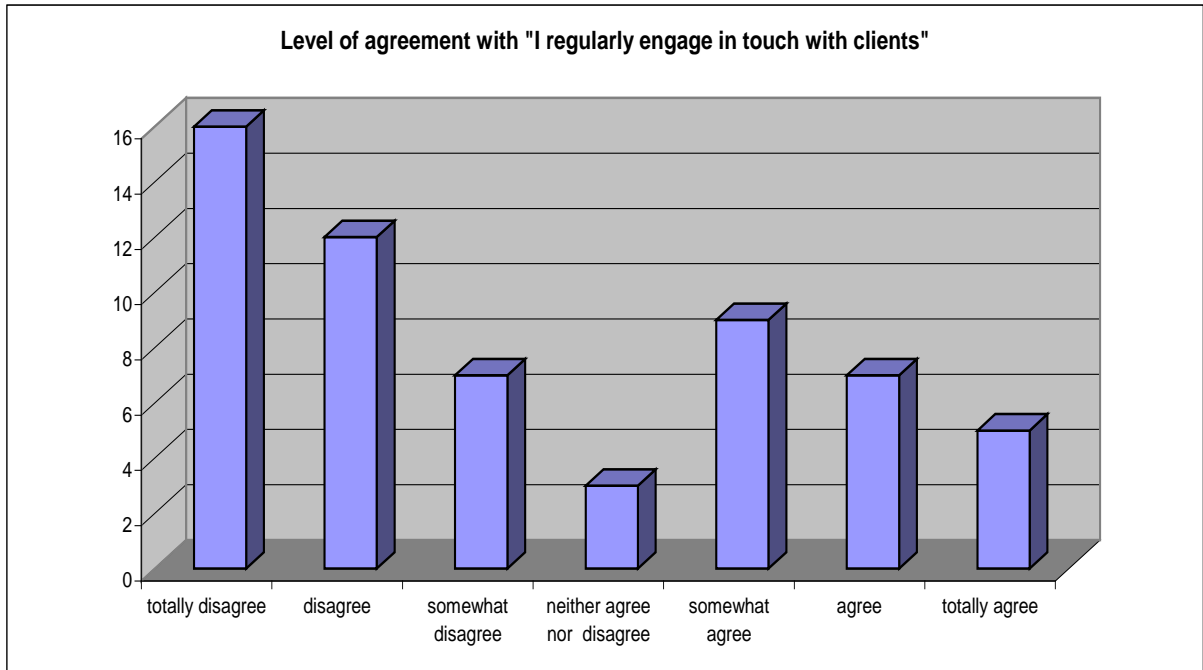
Much of the demographic information on the 63 mental health professionals surveyed appears in the methodology section. In addition to these demographics participants were also asked to report the number of years they had been in practice. All participants had been in practice five or more years as this was an inclusion criterion for the study. The range for years in practice was 5 to 44. The mean, median, and standard deviation were as follows:  $X = 17.10$ ,  $M = 14.50$ , and  $SD = 9.918$ . In these years of practice only 18 therapists (28.6%) endorsed having had formal training in the use of touch in therapy. 33 therapists (52.4%) said they had no formal training on the subject, and 8 therapists (12.7%) marked “not certain” or “not applicable.” Additionally, scoring of the ECR resulted in information about the therapists’ attachment styles. In implementing the scoring guide provided by Brennan, Clark, and Shaver (1998) the therapists were classified as follows: 45 therapists displayed secure adult attachment, 8 fearful/disorganized, 5 preoccupied, and 3 dismissive. Given the comparatively small number of therapists classified in any of the three forms of insecure attachment (fearful, preoccupied, or dismissive) some comparisons between the various attachment styles in terms of touch behavior have been difficult.

### *Findings on Touch*

In terms of touch this study explored a variety of dimensions and behaviors of the mental health professionals within the therapeutic relationship. The findings are as follows. The large majority of therapists (87.3%) stated that they had at some point in their career used touch within the therapeutic relationship, though only about a third of the sample marked some level of agreement (somewhat agree, agree, or totally agree)

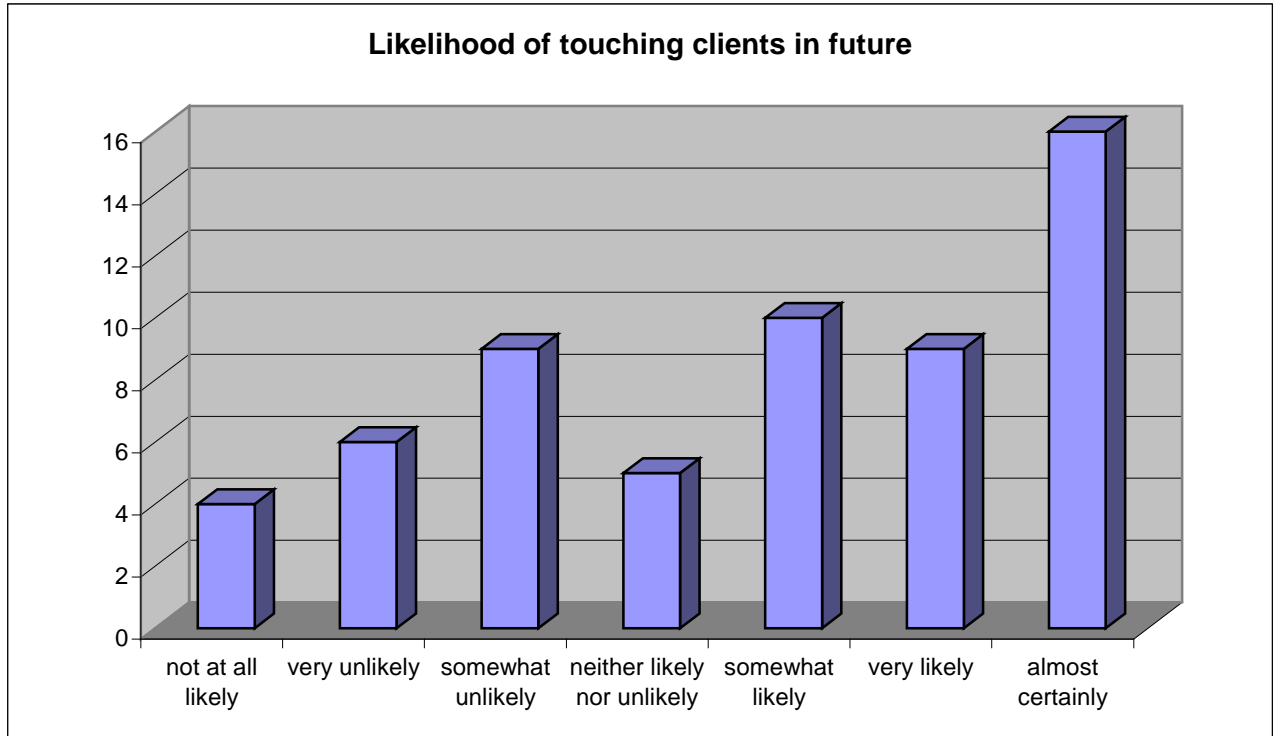
with the statement “I regularly engage in touch with clients.” Conversely only 3 therapists said they had never used touch, while 55.5% disagreed with the statement that they used touch regularly.

Figure 1: Level of agreement with “I regularly engage in touch with clients.”



Further, most therapists (55.6%) also endorsed that they were somewhat likely, likely, or almost certainly going to engage in touch with clients sometime in the future, the highest amongst these being almost certainly (25.4%). Of the 30.1% who thought their use of touch in the future to be at least somewhat unlikely almost half of them (47.4%) said they were only somewhat unlikely.

Figure 2: Likelihood of touching clients in future



A series of more specific questions were asked in terms of the number of occurrences of touch the therapists had had in the last 7 days, 30 days, and the last year, and number of clients with whom they had engaged in touch within the last 7 days, 30 days, the last year, and in their careers. The median and range will be reported for these data sets because the distributions are non-normal and contain noteworthy outliers. The ranges and medians for number of touches over the last 7 days, 30 days, and year are: Range=35-0, M=2; Range=100-0, M= 4; and Range=1,200-0, M= 40, respectively. Likewise for number of clients with whom the therapists have engaged in touch in the last 7 days, 30 days, year, and the course of their career are: Range=35-0, M=2; Range=90-0, M= 4; Range=1,200-0, M=16; and Range=18,000-0, M=60, respectively. It should be noted that

the number of clients in ones career would, of course, also depend on the number of years in practice, which itself had a range of 39. Inquiring about duration of touching in therapy led to findings that touch, when it occurs lasts from between less than one second to about a minute, with the majority (50.8%) reporting touches lasting “several seconds.” In terms of who initiated touch in the therapeutic relationship most participants responded “the client mostly” (27%), followed by “the client exclusively” (19%), “the client and me equally” (15.9%), “me somewhat more than the client” (14.3%), “the client somewhat more than me” (9.5%), not applicable (4.8%), “me mostly” (3.2%), and “me exclusively” (0%). Overall 30.5% of therapist indicated the client initiated touch more while 17.5% indicated that they themselves were more often the initiators. Finally, therapists were asked about the body parts, both their own and those of their clients, involved in touch within the therapy. They were also asked about the types of touch that occurred. Therapists endorsed the following body parts and types of touch for themselves: hands (46 participants), arms (35 participants), fingers (28 participants), shoulders (26 participants), chest (23 participants), back (11 participants), abdomen (3 participants), head (3 participants), handshakes (51 participants), hugging (45 participants), holding (4 participants), kissing (1 participant), and other forms of touching (3 participants).



Figure 3: Therapists Body Parts Involved in Touch

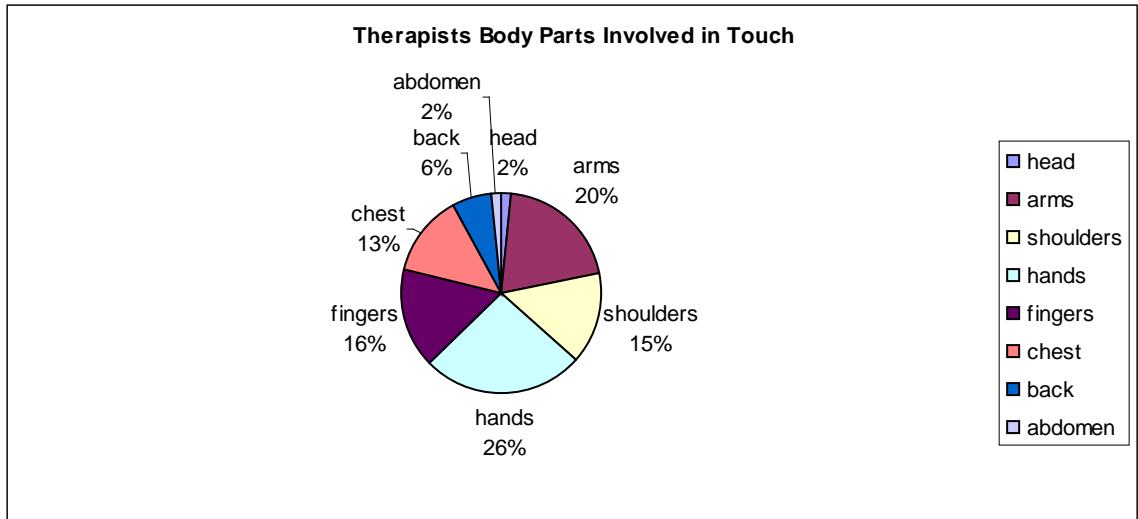
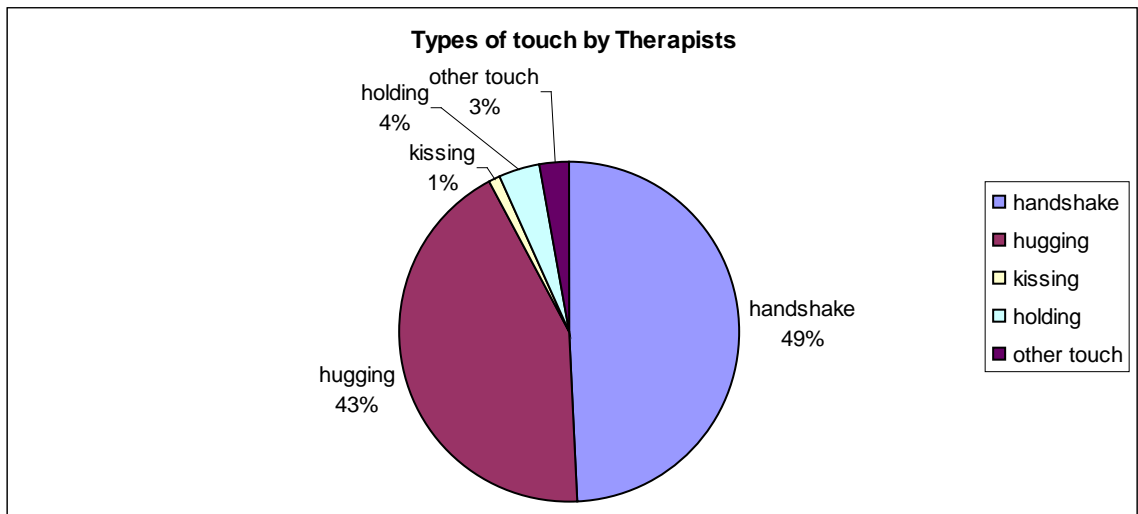


Figure 4: Types of touch by Therapists



Therapists endorsed the following body parts and types of touch for their clients: hands (46 participants), shoulders (35 participants), arms (34 participants), fingers (29 participants), chest (22 participants), back (17 participants), head (7 participants), legs (3 participants), abdomen (2 participants), feet (1 participant), handshakes (51 participants),

hugging (46 participants), holding (4 participants), and other forms of touching (4 participants).

Figure 5: Clients Body Parts Involved in Touch

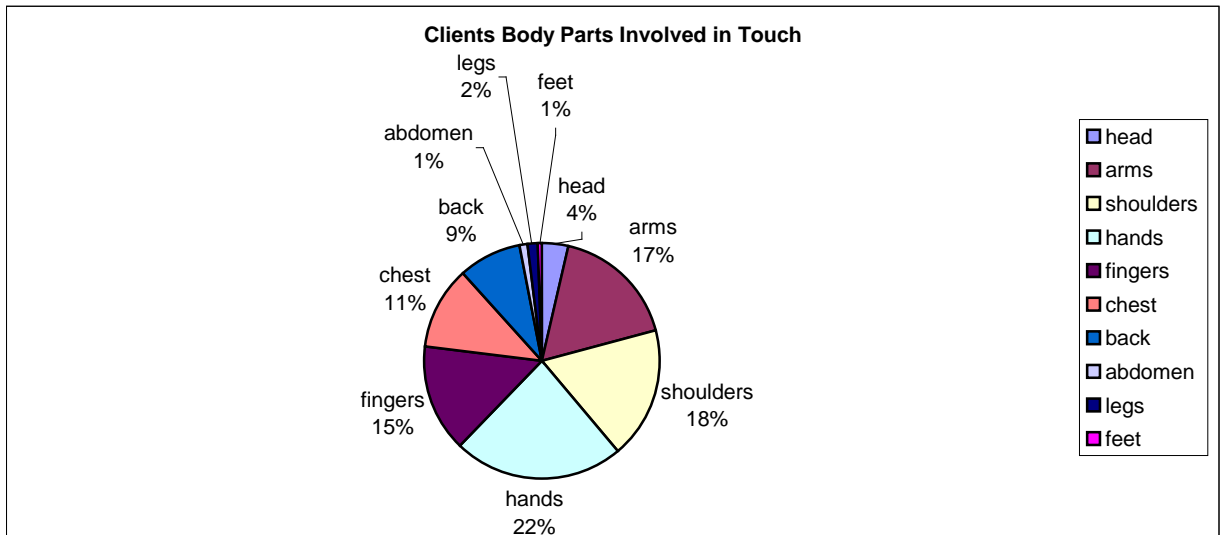
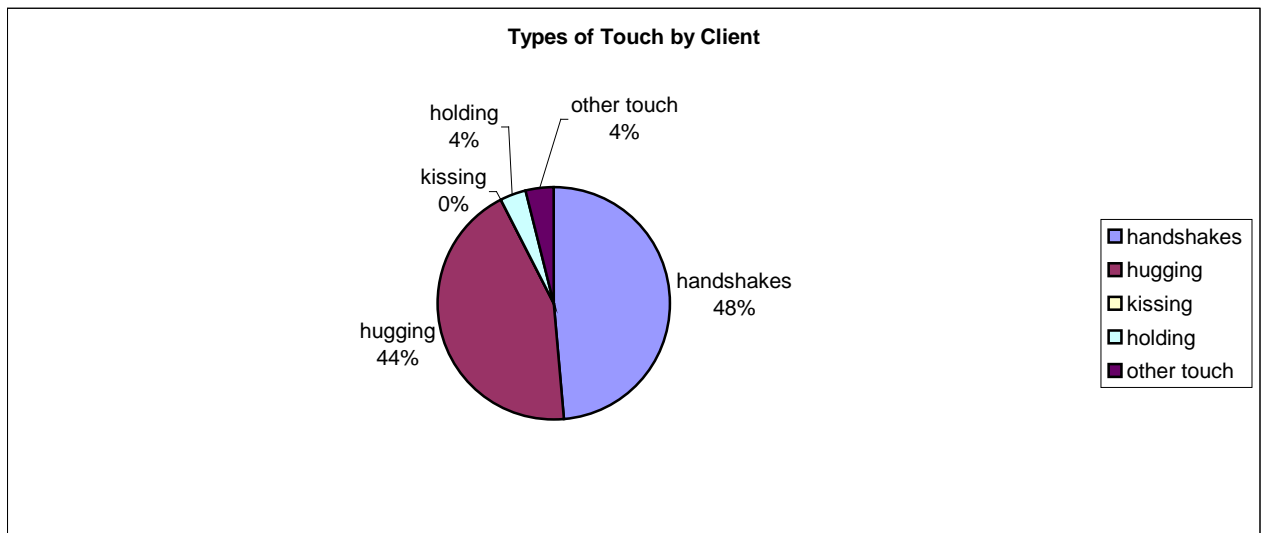


Figure 6: Types of Touch by Client



The study contained one qualitative question asking participants “Can you describe some of the types of situations in which you have or are most likely to use touch with clients?” A number of themes emerged. These themes can be divided into categories regarding the type of touch used (handshakes, hugging, pat on the back), the timing of touch (beginning of session, end of session), reasons for touching (comfort, conveying something to the client), and other factors (gender, how long the therapist has worked with the client). In general, the most common situation participants described regarding use of touch was at times the therapist and client were parting either for the end of the session or for the end of the treatment. 45 participants alluded to this in some way. Other common responses included: handshakes (29 responses), hugging (29 responses), touching upon first meeting a client (21 responses), touching for some form of comfort or support (grief and loss, reassurance, when a client is sad, upset, distressed, or crying) (23 responses), instances in which the client initiated or asked for the touch to occur (16 responses), touching the back (7 responses), touching the arm (6 responses), touching the shoulders (6 responses), touching or holding the hand (5 responses), and touch to say hello, greet the client, or at the beginning of the session (9 responses). Some responses appeared more seldomly: touching on the knee (2 responses), touch as a sign of gratitude or thanks from the client (2 responses), following a difficult session (3 responses), touching in order to ground during dissociation or flashbacks (2 responses), finalizing a decision or agreement or resolving a problem (3 responses), touch in relation to illness or impending death (3 responses), following the clients lead (4 responses), concerns about the appropriateness of touch (4 responses), knowing the client well or having seen the client long term (4 responses), discussing touch before or after or asking permission to

touch ( 4 responses), and themes involving gender (3 responses). Some responses appeared only once but seemed not to fit categorically with any of the other responses: touch on the leg, touching when running into a client in public, touch to get a client's attention, conveying understanding, conveying respect, rapport (assumed to refer to rapport), crisis stabilization, connection, solidarity, as part of technique in EMDR, and when client has experienced success. One participant noted touching under no circumstance. One participant also directly discussed attachment as the basis for their use of touch. Some of these descriptors also appeared clustered together. Most frequently participants mentioned shaking hands upon meeting a client for the first time or greeting them more generally, and hugging clients when parting. Also common were clients asking for or initiating hugs, and hugging clients to provide comfort. Other combined themes included clients asking or initiating hugs at the end of a difficult session, hugs when leaving long term clients specifically, touching the back or shoulder for comfort, hugging when leaving for comfort, or hugging when leaving to provide support specifically when a client asks or initiates. Notably no participants endorsed hugging without expressing some other theme as well.

#### *Statistical Tests and Relational Findings*

The first tests run were a series of one-way ANOVAS with the therapists grouped by attachment styles and their answers to the touch questions being the dependent variables. There were no significant differences in how regularly therapists used touch ( $p=0.773$ ), if they intended to use touch in the future ( $p=0.345$ ), whether they or the client initiate the touch ( $p=0.906$ ), or duration of touch ( $p= 0.675$ ) in relation to their attachment style. There was also no significant difference in how many clients they touched in the

last 7 days or last 30 days nor the number of occurrences of touch they had experienced in the last 7 or last 30 days ( $p=0.602$ ,  $p=0.758$ ,  $p=0.493$ , and  $p=0.383$ , respectively). The crosstabulation of whether therapists responded to having ever touched a client appears below. All three therapists who did not engage in touch were securely attached. A Chi-square test could not be run due to insufficient sample size resulting in smaller than 20% per cell.

Table 1: Crosstabulation of Therapists' Response to "Have you, at any point in our career, engaged in touch with a client?" based on Attachment Styles

	Secure	Fearful	Preoccupied	Dismissive	Total
Yes	40	7	5	3	55
No	3	0	0	0	3
Total	43	7	5	3	58

Correlational tests were run between the participants' ECR scores for avoidance and anxiety and their answers to various touch behavior questions. No significant correlations were found between these scores and the questions tested. The table below includes Pearson R's and significance ( $p$ ) values for each correlation that was run. It should be noted that there was a significant relationship found between the ECR score for Anxiety and the ECR score for Avoidance. This is an expected finding given previous literature on the roles of anxiety and avoidance in determining attachment style. The correlation is of no consequence to the study at hand.

Table 2: Correlations between ECR scores on Avoidance and Anxiety and touch behavior questions.

		avoidance	anxiety	regularly touch	touch in future	who initiates touch	# times in the last 7 days	# times in the last 30 days	# clients in the last 7 days	# clients in the last 30 days	duration of touch
avoidance	Pearson Correlation	1	.446(**)	0.158	0.008	0.029	0.038	0.060	0.091	0.087	0.237
	Sig. (2-tailed)		0.000	0.231	0.953	0.830	0.781	0.664	0.507	0.529	0.076
	N	61	61	59	59	56	57	55	56	55	57
anxiety	Pearson Correlation	.446(**)	1	-0.023	-0.138	-0.018	-0.145	-0.180	-0.102	-0.136	0.115
	Sig. (2-tailed)	0.000		0.862	0.298	0.897	0.283	0.187	0.453	0.323	0.393
	N	61	61	59	59	56	57	55	56	55	57

There was a t-test done to determine significance of the of the relationship between scores on the ECR for avoidance and anxiety and participants' answers to the question "Have you, at any point in our career, engaged in touch with a client?" These relationships were found to not be significant with avoidance yielding a p-value of 0.153 and anxiety a p-value of 0.111.

The participants in this study provided a great body of information regarding their use of touch in therapy through this survey. The relationships between their attachment styles and their answers to these questions however proved to be statistically non-significant. The meaning of these findings is expounded upon in the next chapter.

## CHAPTER V

### DISCUSSION

The purpose of this study was to address the question: In what ways is the current adult attachment style of experienced mental health professionals associated with their use of touch in practice with adult clients? The findings of this study indicate no significant relationship between the current adult attachment style of experienced mental health professionals and their use of touch with adult clients. The hypotheses of the study could be neither accepted nor rejected as no significant relationships were found between the variables.

Despite this inconclusive answer to the central study question some important data was collected from the participants in terms of their general use of touch in therapy. The findings of this study are situated in a body of similar literature, some of which is presented in Chapter II. The results found here are both congruent with and divergent from the previous literature in a number of ways. In keeping with previous literature this study found that: the most common situation in which therapist use touch is termination, touch most frequently involves the hands, arms, and shoulders, touching on the legs and holding of clients is rare (2% and 4% respectively in this study), and kissing of clients is even more rare (with only 1 occurrence reported in this study). Findings in this study regarding how frequently therapists use touch, is supported by the previous literature. Previous research has shown that about 34% of therapists ascribe to using touch occasionally or frequently. In this study about a third of the therapists endorsed using touch regularly. Most divergent from the existing literature was the difference in the number of therapist who reported engaging in handshakes with clients. In previous

literature 76-80% of therapist reported shaking hands with clients, while in this study only 48-49% did so. This study found 87.5% of therapists had touched clients during their careers. Previous studies on social workers and psychologists found that 95% and 10% of them had touch clients, respectively. The fact that this study included professionals from both of those fields amongst others may, in part, explain the difference. The sample was however overwhelmingly comprised of social workers, which may be a factor in the higher frequency of the use of touch found in this study.

Touch was relatively widely reported in this survey, with only 3 participants reporting never using touch with clients. This is contrary to much of the previous literature that shows touch to be relatively rare as well as various theoretical writings warning against the danger and taboo associated with its use. This notably high rate for touch is interesting considering the sample. Being that the participants were primarily female social workers, both of which have shown higher levels of use of touch makes the levels of touch reported in this study less surprising. On the other hand however, the sample was also primarily psychodynamic in orientation. The “rule of abstinence” and general taboo on touch in therapy comes out of the psychodynamic tradition making touch less commonly used by therapists for whom this is their primary orientation. Other previous findings include 44.5% of therapists hugging rarely and 30% hugging sometimes, whereas in this study only 43-44% of therapists in this study reported engaging in hugs with clients. Finally much of the previous literature expounds upon the importance of discussing touch with clients or letting them initiate/ control the process of touching. In this study 24 therapists reported engaging in these discussions or letting the client “take the lead.” Previous studies have not found as many therapists following these



recommendations. This could mark a turn in the field toward improved use of best practices regarding touch.

Though these findings on the use of touch in therapy add to the body of literature on this controversial and important issue in the therapeutic relationship the data were insufficient to address the question of the relationship between therapist adult attachment style and their use of touch in the therapeutic relationship with clients. Looking at the shortcomings of this study therefore becomes central to the field in terms of future practice and research. The central problem in the data was one of insufficient sample size and more specifically a lack of insecurely attached therapists. Having a distribution of 45 secure, 8 fearful, 5 preoccupied, and 3 dismissive therapists makes almost any between groups comparison non-significant. Therapists as a group tend to be more securely attached in general. This fact, in addition to the bias of a study on attachment and touch in therapy to be less appealing to those who are insecurely attached has likely resulted in the low levels of response from insecurely attached therapists in this study. This bias has been known to be an especially strong deterrent to participants with dismissive attachment styles, which explains the particularly low levels of response from this group. Several changes could have been made in terms of recruitment to increase the number of respondents in the various insecure attachment categories. Most simply collecting data for a longer time period for more participants would increase the number of insecure therapists. The inclusion criteria could be made less stringent in order to allow more people to qualify for the study, making for more participants as well. One could also do research on the types of settings those with less secure attachments and then gear recruitment toward those settings. Alternatively, since the study hypothesized no

particular pattern in regard to touch for securely attached therapists another study could be run in which the participants would first take the ECR and only insecurely attached therapists (fearful, preoccupied, and dismissive) would move on to take the touch questionnaire, essentially insecure attachment would become an additional inclusion criteria.

The data collection instrument in this study asked a number of questions on clinicians' behavior regarding touch in therapy. In addition to the types of data mentioned above, which are common in the literature on touch this study also got at some variables that have been given less attention in the research at this point. The instrument looked at therapists thoughts on the likelihood of them using touch in the future, the number of clients and occurrences of touch they had experienced in various time frames, the duration of touch, who initiates touch in therapy, what body parts (both therapists' and clients'), and some notable qualitative themes. This resulted in new information such as: most (55.6%) of therapists stated that they intend to use touch in, almost all touch lasts less than a minute, most lasting for several seconds, and most therapist endorse allowing the client to initiate touch more than they do. The issue of who initiates touch is largely unexplored in the literature as many studies define touch as only those interactions initiated by the therapist. This study indicates however that in defining touch in terms of therapist touch a large proportion of the touch that occurs in therapy is not examined.

The study questions missed some elements of the touch in therapy. Most prominently the questionnaire does not well capture the question of why therapists touch, a question that is, in a larger way, at the center of this investigation. There was one open-ended question in the survey asking in what situations participants used touch. While this

provided some more detail in the effort to understand the who, what, when, and, where of therapists use of touch it still seems insufficient to answer the why of touch. One interesting thing that came up in the open-ended question was that the act of hugging was never mentioned as a theme without the participant also mentioning another coded theme giving context such as reason or timing to the hug. One could speculate that therapists are uncomfortable admitting to using touch, hugs specifically, without caveat, because of the controversy and taboo involved in the use of touch. Additionally the study did not investigate the therapists' attitude toward touch but rather their behaviors only. Another interesting way to examine the influence of attachment on therapists touch behavior in therapy would be to ask about their attitudes toward touch, their behaviors, and their attachment style. One could then examine the correlations between attachment and attitude, attachment and behavior, attitude and behavior, and attachment and behavior in order to explore the possible relationship amongst these factors. Other elements of touch not explored by this study were ideas of whether touch was appropriate or beneficial. No questions were asked about the outcomes, effects, or reactions to touch by the clients. Touch behaviors were explored; touch effects were not. Further, the study explicitly excluded touching that was sexual or violent in nature. When does touching become exploitive or violent? Is this related to the types of touch examined in this project? These things were beyond the scope of exploration here.

The sample used in this study was overwhelmingly white, female, social workers, whose theoretical orientations are primarily psychodynamic/ psychoanalytic. This is not representative of mental health professionals more widely. There is little diversity in the sample overall. Further the sample is not random, but was collected based on

convenience and snowballing methods. These factors combined make the sample rather difficult to generalize widely to mental health professionals on the whole, as was intended in the original research question. Some conclusions could be applied to similar, rather homogeneous populations, but not significantly outside of that scope.

In terms of the distributions of therapist's attachment previous findings have shown between 67.5% and 88% of therapists to be securely attached (Ostrowski, 2001; Rozov, 2001). This is in line with the findings of this study, in which 73.77% of therapists were securely attached, despite differences in measures, samples, etc. Rozov (2001) using the Relationship Scales Questionnaire (RSQ) also found the following concerning therapist attachment: 18% fearful/ avoidant, 6.9% dismissive, and 3.8% preoccupied. This is not wholly different than the attachment styles found for therapists in this study: 13.11% fearful, 4.92% dismissive, and 8.20% preoccupied. In comparison to the Rozov (2001) study, the sample in this study was more preoccupied and secure, and less fearful and dismissive. One possible source of these differences could be actual differences in the therapists' attachment styles, though this is not statistically determined. The difference could also be resultant from biases present in the ECR measure. In the measure itself those with dismissive attachments can present as more secure and secure individuals may seem less secure (Gjerde, Onishi, & Carlson, 2004). This could explain the lower rate of therapists with dismissive attachment in the sample. This may also account for the higher level of preoccupied therapists, if therapists who would otherwise be determined to have secure attachments are appearing to be more insecurely attached, and possibly preoccupied more specifically. Further, self-selection bias elicits lower levels of response from those with dismissive attachment (Lyn & Burton, 2004),

providing further reason why there may be fewer dismissive therapists in the sample. This may be particularly true since the survey was clearly labeled as a study on attachment and touch.

The main measures in this study are the ECR and the touch questionnaire. The ECR, being an empirically validated measure is reasonably strong in terms of validity and reliability. In terms of validity there are several questions. First, is a questionnaire on the behavior patterns of adults in pair bond relationships a valid way to access adult attachment? The overwhelming body of research in attachment supports the notion of pair bonds as the main expression of adult attachment. This literature is briefly reviewed in the second chapter. Some other questions about validity include questions about the validity of assessing attachment, which is unconscious, with a conscious self report measure, and the effect of the retroactive questioning of attachment on validity (Lyn & Burton 2004, Carlson et. al. 1997; Crowell& Treboux, 1995). The assumptions are that this does not significantly disrupt validity because: self-report measures operate on the basis that can answer questions about their emotional experience and relationship behavior without overwhelming bias and that the unconscious process of attachment and the conscious process of evaluating those emotions and behaviors will yield the same, or at least reasonably similar results (Crowell, Fraley, & Shaver, 1999), and that attachment can be assessed retroactively because attachment itself is retroactive (Lyn & .Burton, 2004).

Mikulincer & Shaver (2007) assesses the validity and reliability of the ECR by looking at its use in several hundred studies since its development in 1998, and attest to its high degrees of reliability and validity. The initial chapter written for the development

of the instrument reports the reliability of the two scales of the measure to be as follows: Avoidance (alpha = .94) Anxiety (alpha = .91), N=1082 (Brennan, Clark, & Shaver, 1998). Lyn and Burton (2004) reported the same values for alpha in their study. Despite the consistently high alpha coefficients on the ECR measure it is still important to note the following sources of bias to which the measure is vulnerable including: self-serving bias, social desirability bias, acquiescence, response bias, depending on honesty in participants answers, levels of participant insight, fears and defenses presented, and the effect of meaning transparent questions (Brennan, Clark, & Shaver, 1998; Gjerde, Onishi, & Carlson, 2004).

The touch questions asked in this study were developed for the study itself by the researcher. This makes them more vulnerable in a number of ways to weaknesses in validity and reliability. In terms of face validity and content validity the questions seem reasonable. Efforts were made to focus on asking questions that directly accessed touch behaviors in therapy and covered a range of things that that concept could include. Questions were asked regarding if the therapists had ever used touch, the # of times and people they had touched in the last 7 days, 30 days, year, and in their careers, whether they regularly touched clients or planned to do so in the future, what parts have been involved in the touch, both their own and their clients, the duration of the touching, and who initiates touch. Each of these questions was designed to try to include the widest range of possible answers to increase content validity. An open-ended question was also asked prompting people to describe situations in which they have used touch. The aim of this question was to catch any elements that remained untapped by preceding questions. The measure is by no means perfect but seems to, within reason, access questions that

relate to therapists touch behavior in therapy. There is more doubt in terms of the measure's criterion and construct validity. Neither of these has been measured in any substantial way for the study. However there seems to be some evidence in the responses to different questions within the survey that raise doubts regarding the validity of the measure overall. Some examples follow. Fifty one therapists endorsed the use of handshakes, while only 46 therapists endorsed having touched clients with their hands, and only 28 said they touch clients with their fingers. Three therapists said they have never used touch with clients, yet four therapists reported that they had touched 0 clients over the course of their careers. These data sets show internal inconsistency in the measure, which signals that the measure may not have convergent validity, even within itself. This is a sign of weakness in construct validity overall.

Reliability has not been formally measured for this questionnaire. The same inconsistencies, which point to weaknesses in validity, may also represent weaknesses in reliability. As noted above such things clearly point to internal inconsistency in the measure, a major sign that the measure may have some issues with reliability. These questions may have in some way been confusing to participants causing these conflicting results. The researcher tried to word questions as clearly as possible and provided instructions including operational definitions of terms like touch and clients for the survey. However weaknesses in reliability certainly do remain. Other points of weakness in reliability include asking questions that are difficult to know the answer to or to answer accurately. Many of the questions on the survey regarding specific touch behaviors, such as how many clients, how many touches, what parts were involved in touch, etc. are

likely hard for people to recall information on and answer accurately. This represents another difficulty for reliability.

This study has some limitations due to design. First it is not a random sample. This opens the study to all kinds of unforeseen biases. There are also various biases present in the ECR measure for attachment. This is additionally compounded by the fact that the participants are mental health professions who likely bring even more bias to the measure in terms of question transparency. There is also the issue of self-selection bias for a survey about attachment and touch. A group of people who would engage in that kind of survey may be in some way different than those who chose not to. Finally the researcher brings their own bias to the study in believing that touch behavior in therapy is likely related to the attachment style of the therapist. This bias was hopefully checked in some way by the quantitative data analysis done, yet it is understood that this too can be biased by the researcher in some ways. These biases considered the study might still serve to shed some light on the factors involved in clinician's use of touch in the therapeutic relationship. The study is also limited in terms of statistical tests due to the comparatively small number of therapists reporting preoccupied, dismissive, and fearful attachment styles. This has influenced the type and number of statistical test that can be run and the findings that can be utilized.

In looking at the controversial issue of touch and the rising field of attachment the results of this study have important implications for the fields of social work and mental health more generally in areas of research, theory, and practice. In terms of research the findings here are inconclusive making it imperative that more research be done in this area. Some ideas for future research appear above in this chapter. More work must be



done to recruit participants with insecure attachment styles in order to create large enough groups for proper statistical comparisons to be made. More can also be done in comparing therapists' explicit attitudes toward touch versus the implicit influence of their attachment style on touch behavior. As touch continues to be hotly debated in the field and the literature continues to be generally inconclusive or contradictory more must be known about what therapists do in practice and how and why these decisions are made.

Theoretical stances on touch vary widely from abstinence to advocacy. This study shows however that even psychodynamically oriented therapists use touch in their practices. Three therapists did express never having used touch but it was otherwise nearly ubiquitous in this sample. It seems theory may need to continue to be rethought and reevaluated to fit with what is happening in therapists practice with clients. How can theory begin to ground and guide us forward in understand the best use of touch with clients? Attachment was not shown to be directly related to therapist use of touch in therapy in this study. However as research and theory continue it may need to be revisited as a useful framework to consider.

Finally important considerations are given to practice. Theories, prohibitions, and taboos aside the fact remains: therapists DO use touch in therapy with adult clients. Touch is not only the rare mistake of inexperienced or exploitive clinicians. It is something most therapists do at least some of the time. Just like anything else in the consulting room this action must not be ignored. Neither must it be something spoken of in dark places and whispered tones. If touch, as this research indicates, is something that therapists do in practice then it must be looked at, researched, theorized, and spoken about in supervisions, classes, trainings, and clinical work. In understanding that touch is

part of what therapists do we must therefore learn the way in which it can and will best benefit our clients. Best practices need to be determined in order to further the field of social work practice on the important and prevalent issue of touch.

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Appendix A- HSR Approval Letter

January 17, 2010

Michelle Waddell

Dear Michelle,

Your revised materials have been reviewed and all is now in order. We are glad to give final approval to your project. I doubt very much whether the Smith College School for Social Work will be willing to let you email all of the alums. The School has had to move to protect the alums from receiving so many inquiries and requests. Other professional organizations may be difficult as well. Recruitment does get to be a problem and I hope you are able to get your email out and get enough responses.

There is one other thing. Please put the statement at the end of the Consent in bold caps so it will stand out.

*Please note the following requirements:*

**Consent Forms:** All subjects should be given a copy of the consent form.

**Maintaining Data:** You must retain all data and other documents for at least three (3) years past completion of the research activity.

*In addition, these requirements may also be applicable:*

**Amendments:** If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

**Renewal:** You are required to apply for renewal of approval every year for as long as the study is active.

**Completion:** You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Good luck with your project.

Sincerely,

Ann Hartman, D.S.W.

Chair, Human Subjects Review Committee

CC: Colette Duciaume-Wright, Research Advisor

Appendix B- Consent form



**Consent to Participate in a Research Study  
Smith College • Northampton, MA**

.....  
**Title of Study: Therapists’ Attachment Style and the Use of Touch in the  
Therapeutic Relationship**

**Investigator:** Michelle Waddell, Smith College School for Social Work, (phone number removed)

.....  
Dear Participant,

You are being asked to be in a research study investigating the relationship between therapists’ adult attachment styles and their use of touch in therapy. We ask that you read this form and ask any questions that you may have before agreeing to be in the study. Ultimately, this research will be used for my M.S.W. thesis and possible publications or presentations.

Your participation in the study will involve an anonymous internet survey including: the Experiences in Close Relationships Inventory (ECRI), a measure of adult attachment style, questions about your use of touch with clients during your career, and six demographic questions. This should take only 10-20 minutes of your time.

The study has the following risks. You may find the information you are asked is personally and professionally revealing. This may cause some emotional discomfort or psychological stress.

The benefits of participation are: a chance to reflect upon yourself and your professional use of touch and furthering research that has potential to increase understanding of the role of touch in clinical practice.

You will receive the following reimbursement: entrance in a drawing for one of 4 Amazon.com gift certificates of \$25 each. Entrance into this drawing will require you to give your email address. This will mean you are no longer anonymous, however your email address will in no way be connected to your survey data, so your information will remain confidential. You can choose to enter the drawing even if you do not complete the survey.

The decision to participate in this study is entirely up to you. As the study is anonymous, you may refuse to take part in the study *at any time before clicking “Done” at the end of the survey*. Once you have clicked done you will not be able to withdraw, because the results are anonymous and it will be impossible to distinguish your responses for removal from the study data.

You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further

questions about the study, at any time feel free to contact me, Michelle Waddell at (email address removed for researcher privacy) or by telephone at (telephone number removed for researcher privacy purposes). If you like, a summary of the results of the study will be sent to you via email.

If you have any other concerns about your rights as a research participant that have not been answered by the investigator, you may contact, the Chair of the Smith College School for Social Work Human Subjects Review Board at (phone number removed). If you have any problems or concerns that occur as a result of your participation, you can report them to the Chair at the number above. Alternatively, concerns can be reported by completing a Participant Complaint Form, which can found on the IRB website at <http://www.smith.edu/irb/>

**BY CHECKING “I AGREE” BELOW YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE INFORMATION ABOVE AND THAT YOU HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE INT THE STUDY.**

.....

- I agree

## Appendix C- Screening Questions

Welcome! Thank you for your interest in my research. First there is a brief screening process to determine your eligibility for the study. Please answer the following questions.

1) Do you currently work as a mental health professional (e.g. social workers, psychologists, psychiatrists, licensed mental health counselor, marriage and family therapist, etc.)

Drop down yes and no

2) Do you hold a masters level degree or higher in that professional field?

Drop down yes and no

3) Have you been in full time clinical practice for at least five (5) years following the receipt of that degree?

Drop down yes and no

4) Do you currently have a direct service caseload consisting of predominately (at least 50%) adults (18 years of age and older)?

Drop down yes and no

5) Do you currently have Internet access and do you intend on having that internet access for the duration of this survey?

Drop down yes and no

6) Do you have a command of the written English Language?

Drop down yes and no

## Appendix D- ECR Measure and Scoring Guide

### Experiences in Close Relationships

*Instructions:* The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

Disagree Strongly		Neutral/Mixed			Agree Strongly	
1	2	3	4	5	6	7

- \_\_\_ 1. I prefer not to show a partner how I feel deep down.
- \_\_\_ 2. I worry about being abandoned.
- \_\_\_ 3. I am very comfortable being close to romantic partners.
- \_\_\_ 4. I worry a lot about my relationships.
- \_\_\_ 5. Just when my partner starts to get close to me I find myself pulling away.
- \_\_\_ 6. I worry that romantic partners won't care about me as much as I care about them.
- \_\_\_ 7. I get uncomfortable when a romantic partner wants to be very close.
- \_\_\_ 8. I worry a fair amount about losing my partner.
- \_\_\_ 9. I don't feel comfortable opening up to romantic partners.
- \_\_\_ 10. I often wish that my partner's feelings for me were as strong as my feelings for him/her.
- \_\_\_ 11. I want to get close to my partner, but I keep pulling back.
- \_\_\_ 12. I often want to merge completely with romantic partners, and this sometimes scares them away.
- \_\_\_ 13. I am nervous when partners get too close to me.
- \_\_\_ 14. I worry about being alone.

\_\_\_\_ 15. I feel comfortable sharing my private thoughts and feelings with my partner.

Use the following rating scale on every item:

Disagree Strongly

Neutral/Mixed

Agree Strongly

1

2

3

4

5

6

7

- \_\_\_ 16. My desire to be very close sometimes scares people away.
- \_\_\_ 17. I try to avoid getting too close to my partner.
- \_\_\_ 18. I need a lot of reassurance that I am loved by my partner.
- \_\_\_ 19. I find it relatively easy to get close to my partner.
- \_\_\_ 20. Sometimes I feel that I force my partners to show more feeling, more commitment.
- \_\_\_ 21. I find it difficult to allow myself to depend on romantic partners.
- \_\_\_ 22. I do not often worry about being abandoned.
- \_\_\_ 23. I prefer not to be too close to romantic partners.
- \_\_\_ 24. If I can't get my partner to show interest in me, I get upset or angry.
- \_\_\_ 25. I tell my partner just about everything.
- \_\_\_ 26. I find that my partner(s) don't want to get as close as I would like.
- \_\_\_ 27. I usually discuss my problems and concerns with my partner.
- \_\_\_ 28. When I'm not involved in a relationship, I feel somewhat anxious and insecure.
- \_\_\_ 29. I feel comfortable depending on romantic partners.
- \_\_\_ 30. I get frustrated when my partner is not around as much as I would like.
- \_\_\_ 31. I don't mind asking romantic partners for comfort, advice, or help.
- \_\_\_ 32. I get frustrated if romantic partners are not available when I need them.
- \_\_\_ 33. It helps to turn to my romantic partner in times of need.
- \_\_\_ 34. When romantic partners disapprove of me, I feel really bad about myself.
- \_\_\_ 35. I turn to my partner for many things, including comfort and reassurance.
- \_\_\_ 36. I resent it when my partner spends time away from me.



### Scoring Instructions for Attachment Measure (1998 36-item Version)

STEP 1: Recode the reversed variables, such that 1=7, 2=6, etc. You may want to create temporary variables, which can be reversed without potentially incorrectly transforming the original data. (We computed 'temp3' for item number 3, etc., for use in scoring below.)

Compute temp3 = A3.  
Compute temp15 = A15.  
Compute temp19 = A19.  
Compute temp25 = A25.  
Compute temp27 = A27.  
Compute temp29 = A29.  
Compute temp31 = A31.  
Compute temp33 = A33.  
Compute temp35 = A35.  
Compute temp22= A22.

Recode temp3 to temp22 (1=7) (2=6) (3=5) (5=3) (6=2) (7=1).

STEP 2: Compute scores for the two dimensions, avoidance and anxiety. (Questions about scoring in SPSS usually amount to asking, "why is the number '14' inserted into the equation to compute means?" Well, the reason is because the program is set up to allow people to miss up to 4 items [out of a total of 18; 18-4 = 14]. That way, a missing item won't make you throw out an entire subject.)

Compute AVOIDANC = mean.14(A1,temp3,A5,A7,A9,A11,A13,temp15,A17,temp19,A21,  
A23,temp25,temp27,temp29,temp31,temp33,temp35).  
Compute ANXIETY = mean.14(A2,A4,A6,A8,A10,A12,A14,A16,A18,A20,temp22,A24,  
A26,A28,A30,A32,A34,A36).

STEP 3: compute attachment-style categories from the classification coefficients (Fisher's discriminant functions) based on our sample of N = 1066.

Compute SEC2 = avoidanc\*3.2893296 + anxiety\*5.4725318 - 11.5307833.  
Compute FEAR2 = avoidanc\*7.2371075 + anxiety\*8.1776446 - 32.3553266.  
Compute PRE2 = avoidanc\*3.9246754 + anxiety\*9.7102446 - 28.4573220.  
Compute DIS2 = avoidanc\*7.3654621+ anxiety\*4.9392039 - 22.2281088.

#### Variable Labels

sec2 'coeff secure dimension'  
fear2 'coeff fearful dimension'  
pre2 'coeff preoccupied dimension'  
dis2 'coeff dismissing dimension'.

If (sec2 > max(fear2,pre2,dis2)) ATT2 = 1.

If (fear2 > max(sec2,pre2,dis2)) ATT2 = 2.

If (pre2 > max(sec2,fear2,dis2)) ATT2 = 3.

If (dis2 > max(sec2,fear2,pre2)) ATT2 = 4.

Variable labels

ATT2 'coefficient-based attachment category'.

Value labels

ATT2 1 'secure' 2 'fearful' 3 'preocc' 4 'dismiss'./.

Note: Basic statistics derived from the scale-development sample are as follows:

	N:	mean:	s.d.:
avoidance	1080	2.93	1.15
anxiety	1080	3.46	1.10

## APPENDIX E- TOUCH BEHAVIOR QUESTIONS

The following series of questions will ask you about your use of touch in the professional therapeutic relationship. For the purposes of this study touch is defined as intentional physical contact of any kind between yourself and the client. Touch may involve any combination of body parts and may occur for any duration of time. It may be initiated by either party and may have a variety of purposes. In this study touch does not include accidental physical contact i.e. tripping and bumping into a client or contact that is explicitly sexual or aggressive (i.e. hitting, punching, slapping, formal restraint positions, or various sex acts.) Touch includes but is not limited to: handshakes, touching arms, hands, backs, legs, heads, hugging, kissing, holding, etc. The context of the therapeutic relationship will be defined as all professional contact inside and outside of the therapy room beginning at first contact with the client and continuing through the end of termination. Clients will refer to adult clients only.

1) Have you, at any point in our career, engaged in touch with a client?  
yes, no, unsure

2) Please estimate the number of times (individual occurrences of touch) you have engaged in touch with a client:

- in the last 7 days \_\_\_\_\_
- in the last 30 days \_\_\_\_\_
- in the last year \_\_\_\_\_

3) Please estimate the number of individual clients with whom you have engaged in touch  
:

- in the last 7 days \_\_\_\_\_
- in the last 30 days \_\_\_\_\_
- in the last Year \_\_\_\_\_
- over the course of your career \_\_\_\_\_

4) Please mark your level of agreement with the following statement:

I regularly engage in touch with clients.

- 1- Totally Disagree
- 2- Disagree
- 3- Somewhat Disagree
- 4- Neither Agree nor Disagree
- 5- Somewhat Agree
- 6- Agree
- 7- Totally Agree

5) Please indicate how likely you are to touch clients in the future (any time after the completion of this survey)

- 1- Not at all likely

- 2- Very unlikely
- 3- Somewhat unlikely
- 4- Neither likely nor unlikely
- 5- Somewhat likely
- 6- Very likely
- 7- Almost certainly

6) In thinking about the instances of touch you have noted above please check off which of **your** body parts have been in direct contact with clients in those touches and what types of touches occurred. Please check all that apply.

- Head
- Arms
- Shoulders
- Hands
- Fingers
- Chest
- Back
- Abdomen
- Buttocks
- Legs
- Feet
- Handshakes
- Hugging
- Kissing
- Holding
- Other body parts
- Other forms of touching

7) In thinking about the instances of touch you have noted above please check off which of **the client's** body parts have been in direct contact with you in those touches and what types of touches occurred. Please check all that apply.

- Head
- Arms
- Shoulders
- Hands
- Fingers
- Chest
- Back
- Abdomen
- Buttocks
- Legs
- Feet
- Handshakes
- Hugging
- Kissing

Holding  
Other body parts  
Other forms of touching

8) In thinking about the instances of touch you have noted above about how long would you say they, last on average?

- 1- less then one second
- 2- one second
- 3- several seconds
- 4- about a minute
- 5- between one a two minutes
- 6- between two and 15 minute
- 7- between 16 and 30 minutes
- 8- between 31 and 45 minutes
- 9- between 46 minutes and one hour
- 10- about one hour
- 11- more than one hour
- 12- Not applicable

9) When you have engaged in touch with clients, who initiates this touch?

- 1- The client, exclusively
- 2- The client, mostly
- 3- The client, somewhat more than me
- 4- The client and me about equally
- 5- Me, somewhat more than the client
- 6- Me, mostly
- 7- Me, exclusively
- 8- Not applicable

10) Can you describe some of the types of situations in which you have or are most likely to use touch with clients?

## Appendix F- Demographic Questions

The following questions are for demographic purposes.

1) Which of the following is closest to your primary theoretical orientation?

Drop down list including:

- Adlerian
- Psychodynamic/ Psychoanalytic
- Cognitive/ Behavioral
- Existential
- Feminist
- Gestalt
- Humanistic
- Jungian
- Rogerian/ Client-centered
- Positive psychology
- Systemic/ Cultural
- None of these are close to my theoretical orientation

2) Race/ Ethnicity (check all that apply)

Checklist including:

- American Indian or Alaska Native
- Asian
- Black or African American
- Hispanic or Latino
- Native Hawaiian or Other Pacific Islander
- White
- Other

3) Gender:

- Male
- Female
- Transgender
- None of these or other

4) Profession::

- Psychologist
- Psychiatrist
- Social Worker
- Mental Health Counselor
- Marriage and Family Therapist
- Other Mental Health Professional

5) Number of years in practice in current profession: \_\_\_\_\_

6) Have you had formal training and/or supervision on the use of touch in therapy?  
Yes, No, Not certain, Not applicable

## Appendix G- Recruitment Email

Hello. My name is Michelle Waddell. I am a second-year Master's student at Smith College School for Social Work collecting data for my thesis, which asks the question: In what ways does the current adult attachment style of experienced mental health professionals relate to their use of touch in practice with adult clients?

I am currently looking for participants for my study. There are two easy ways in which you can help me further this research. The first is by taking an anonymous, confidential internet survey, and the second is by referring other people to do the same.

The survey will require 10-20 minutes of your time. You can read more about and choose to take the survey by clicking the link below

As a token of my appreciation I am offering the chance to be entered into a drawing for one of four \$25 Amazon.com gift certificates. You can also read more about this opportunity by clicking the survey link.

<https://www.surveymonkey.com/s/therapistsattachmentandtouch>

Your time, honesty, and thoughtfulness are deeply appreciated. If you have any concerns about this study, please contact me via email (email address removed for researcher privacy) or the Smith College School for Social Work Human Subjects Review Committee at (phone number removed)

To refer personal or professional contacts in the field of mental health please forward this email directly to them. Referring other mental health professionals helps with the study, by providing more participants. Your decision to refer others to the study is independent of your own study participation. Thank you for your assistance in this process.

Sincerely,

Michelle Waddell



## Appendix H- ECR Permission Letters

Dear Michelle,

Of course you can use the scale. It's attached, along with the chapter it was developed in.

Kelly Brennan-Jones

Hi. It is fine to use the scale, and you don't even need our permission. We gave blanket permission in our 1998 paper about the development of the scale. You can find it and other similar measures in the appendix of Mikulincer and my 2007 book, *Attachment in Adulthood: Structure, Dynamics, and Change* (Guilford Press; also available from Amazon.com). The book summarizes the history of measurement in the area and also all of the research findings up to 2007. Let me know if you have other questions about measures after you skim the book. --  
Phil

Phillip R. Shaver, PhD