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## A survey of clinicians' use of touch and body awareness in psychotherapy

Anastasia D. McRae  
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Anastasia D. McRae  
A Survey of Clinicians' Use  
of Touch and Body  
Awareness in Psychotherapy

#### ABSTRACT

A national purposive expert convenience sample of approximately 164 licensed, practicing mental health professionals responded to an anonymous online survey regarding the use of touch and body awareness in their treatment with clients. This study sought to answer the question of the effects of training, whether during the course of study to become a mental health professional or in a specific formalized body-oriented modality, on the attitudes and behavior of clinicians towards their use of touch and body awareness in psychotherapy treatment. The findings showed that training in the use of touch or body awareness does influence positive attitudes toward both. It was also found that training is an indicator of increased use of touch and body awareness by those clinicians surveyed.

A SURVEY OF CLINICIANS' USE OF TOUCH AND BODY AWARENESS IN  
PSYCHOTHERAPY

A project based on independent investigation,  
submitted in partial fulfillment of the requirements  
for the degree of Master of Social Work.

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2008

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## CHAPTER 1

### INTRODUCTION

Just as a controversy existed regarding whether it would ever be appropriate for the therapist to use self-disclosure in therapy many years ago (Jourard & Friedman, 1970) a controversy continues among clinicians as to whether the use of touch and body awareness is or ever can be appropriate in psychotherapy. Touch is perhaps the most powerful way animals communicate. It is only logical that humans have used it for centuries as a way to help each other heal.

Though it is still thought of by many as a taboo, use of touch and body awareness is a branch of psychotherapy with roots going back to and beyond Freud. Unfortunately, the power of touch brings with it both positive and negative possibilities. As one writer notes, the body and the touching of it are difficult and confusing subjects culture-wide:

Many of the difficulties in integrating bodymind psychotherapy into psychotherapy as a whole are reflecting of general cultural problems around bodies and touch. Body-centered therapy rubs—literally—on some of society's sorest spots. It brings to light all the ways in which themes and experiences of embodiment become traumatizing aspects of individual history, through our culture's deep sickness in relation to sexuality... Working through the body, and with and through the feeling and thoughts that this work mobilizes, necessarily uncovers our trauma of socialization: a trauma which cannot fully be repaired or undone. To fantasize such an undoing is to fantasize a state outside culture (Totton, 2003, p. 147).

Although Freud once wrote that “the ego is first and foremost a body-ego,” (as cited in Smith, 1998b, p. 5), the person existing with bodily deprivations and needs is something of a pink elephant in the treatment room since Freud ceased touching his own

clients and ordered all other analysts in his early psychoanalytic circle to do the same (Totton, 2003). Much, if not all, training of psychotherapists is curiously lacking in knowledge relative to seeing the person living within and as a body, other than, perhaps, courses on pharmacological issues and physical trauma.

The field of neurobiology has expanded contemporary conversations concerning the nature of the body in relation to mental and emotional processes. This is especially the case in the area of trauma where it is argued that the brain and physical development of a person are greatly impacted by emotional distress and that the body in turn remembers that emotional distress as physical symptoms, as stated earlier, that may have no purely physical antecedents (van der Kolk, 1994; Ogden, 2000; Solomon & Siegel, 2003).

In recent years studies show the increased use of complementary and alternative therapies by populations engaged in psychotherapy, including touch therapies like massage, acupuncture, and Reiki (Field, 1998a, 1998b; Mamtani, R. & Cimino, A., 2002). Many clinicians in the mental and physical health arenas, quite possibly users of alternative modalities themselves, have turned to what is today termed *holistic medicine* in an effort to span what has become the chasm between treatment of the mind and body. Some of these clinicians have sought out formal training in or dialogue on the use of touch or body awareness and use one of both in their psychotherapy practice. Even still, most psychotherapists continue to think of touch in the treatment room as contraindicated for their patients, and legally and ethically risky, if not outright dangerous for the patient and therapist.



The current study investigates the influence of training in the use of body awareness or touch on the attitudes and use of both among surveyed mental health professionals. The sample includes clinicians both with and without training in the use of touch and body awareness as well as those with formal training in a bodywork modality or body-oriented psychotherapy. The term *bodywork* refers to the intentional use of systematic touch to therapeutically assist clients in the integration of body awareness in the release of stored habitual tension patterns. *Body awareness* is defined as a means of perception as experienced through movement, gesture, illness, or sensation.

The following review of the literature will address the current state of understanding about both the power of touch and body awareness as a healing tools along with the risks and ethical concerns attendant on the use of touch.

## CHAPTER 2

### LITERATURE REVIEW

As if in an echo of their often conflicted predecessors, writers and researchers involved in the dialogue about the use of touch in psychotherapy are divided. In both theory and empirical research, we find, on the one hand, a focus on past and possible future abuses of touch -- ranging from sexual misconduct and other inappropriate boundary violations to situations where touch would be clinically contraindicated. On the other hand, we have recognition of the crucial place of touch in human development. Research through much of the twentieth and early twenty-first centuries shows conclusively that the absence of touch or its negative use affects the emotional-mental maturation --even survival-- of infants, and that appropriate physical contact has a significant role to play in helping trauma survivors recover (see, for example, Harlow, 1959; Spitz, 1945).

While there is much theoretical work written on the use of touch in psychotherapy, within the body of limited empirical research there is no consensus for or against the use of touch, though it is obvious that touch in the treatment room continues. The pages that follow constitute a review of pertinent clinical literature about touch and body awareness used as therapeutic tools in psychotherapy. This review will explore the reverberations of the taboo on touch use in psychotherapy through a brief look at its history, in addition to a look at past and current arguments for the use of touch and body awareness, including body psychotherapy.

The first section below deals with the touch taboo's history and its present day ramifications. The second section covers the thinking that evolved parallel to that of the taboo, one that presents a case for the use of touch and body awareness. The third section deals with mental health professionals who incorporate touch and/or body awareness into their work with clients, looking specifically at their attitudes towards training and ethical issues. The review is organized in this manner in order to provide a framework to the current study's investigation of attitudes towards and incorporation of the use of touch and body awareness in psychotherapy as reported in a survey of licensed, experienced clinicians who volunteered to respond to an anonymous Internet questionnaire.

### *The Touch Taboo*

Though the history of the proscription of touch in psychotherapy is easily traced back to Sigmund Freud and the early days of psychoanalysis (Kertay & Reviere, 1993), it would be remiss to overlook the much longer and influential history of mind-body duality in Western thinking and culture in general. This dichotomous way of thinking about the human being had its beginning in antiquity and has been the topic of much philosophical and theological debate since then. In the writings of Augustine, Aquinas, Newton, and Descartes we find the most well known of the roots of this debate, though they are but a very few of the voices that contributed to the current state of affairs (Kelsey, 1973; Smith, 1998b). Freud's stance against touch in psychoanalysis was very much a part of his contemporary culture and of the larger cultural history wherein the religious authorities had, it is suggested, forfeited the body to science and claimed the spirit as its dominion during the Enlightenment (Kelsey, 1973). By abandoning touch, Freud effectively left the body to medicine while carving out a different space for his fledgling

science in the realm of the mind, thereby continuing the tradition of thinking of the human in terms of spirit-mind-body separation (Smith, 1998b).

Freud did not start out condemning touch. Quite the contrary, as is noted in most writing on the subject, he used touch early in his work with patients to explore whether pressing the patient's head during hypnosis could help the patient "abreact" trauma (Greene, 2001; Geib, 1982; Kertay & Reviere, 1993; Ventling, 2002). Freud came to conclude that the patient's ability to adequately use the transference in treatment was impeded if touch were a component. He reasoned that touch would gratify the patient's infantile need for the parental figure, now activated by the therapeutic transference, and take away the frustration the patient must experience in order to heal from earlier disruptions to the psyche (Greene, 2001). Freud was also concerned about ethical violations by some of his contemporaries who carried their use of touch into the realm of sexual and romantic relationships with their patients (Geib, 1982; Ventling, 2002). In an attempt to minimize possible harm to patients, to solidify the therapeutic boundaries of, and to remove any obstacles to, his burgeoning discipline, Freud banned touch within all legitimate psychoanalysis, the precursor of psychotherapy (Totton, 2003; Ventling, 2002).

#### *The Touch Taboo Today*

Freud's ban against touch in psychoanalysis spread to all branches of psychotherapy and continues to affect the practices of many psychotherapists. For some mental health professionals, continued adherence to the ban translates into no touch whatsoever; for others, minimal touch is appropriate. Gutheil and Gabbard (1993) recommend that handshakes be the extent of touch allowed in therapy, partially because

of the litigious nature of our society and partially because of very real sexual misconduct and other boundary violations by some therapists (Gutheil & Gabbard, 1993; Hetherington, 1998; Holroyd & Brodsky, 1977; Pope, 1990; Stake & Oliver, 1991). In response to these boundary violations, the American Psychological Association (APA) and the National Association of Social Workers (NASW), both prohibit sexual relationships between therapist and client along with any physical contact that would potentially harm the client. Neither organization explicitly prohibits touch altogether, however. Unlike the APA, the NASW ethics code does include a specific section on physical contact. In section 1.10 of the social workers' code of ethics, the organization states that: Social workers who engage in appropriate physical contact with clients are responsible for setting clear, appropriate, and culturally sensitive boundaries that govern such physical contact (NASW, 2006, p. 13).

The dialogue surrounding touch in psychotherapy has focused to a great extent on sexual misconduct and risk management precautions; though, while the cautions are important, they “seem to reinforce a view of all touch as sexual in nature and create an atmosphere of suspicion surrounding the use of touch” (Stenzel & Rupert, 2004, p. 332). As a result, meaningful conversation or research about non-erotic touch is hindered, or inadvertently suppressed (Stenzel & Rupert, 2004). On the issue of touch leading to sexual acting out, there is no empirical correlation between the use of touch and sexualized misconduct (Holroyd & Brodsky, 1980), though research has found that opposite-sex dyads present more possibility for misunderstanding touch incidents (Gutheil & Gabbard, 1993; Holroyd & Brodsky, 1977; Stake & Oliver, 1991).

Another consideration to factor into possible misunderstandings and boundary violations is the power dynamic involved in the use of touch with specific reference to who is allowed to touch whom. In the general American culture, men, adults, medical professionals, and those in higher social standing are allowed more touch freedom than those considered in some way inferior to those listed. Although research shows that women touch others more, it is necessary to note that in the data gathered women are generally touching other women, not men (Holroyd & Brodsky, 1977; Strozier, Krizek, & Sale, 2003; Stenzel & Rupert, 2004). Therefore, in terms of power differentials, women, children, the elderly, and people considered in lower social standing (perhaps economic, racial, bodily, or for reason of sexual orientation) are granted less freedom to touch (Alyn, 1988). Some suggest that touch in psychotherapy may be detrimental in the context of the hierarchically structured therapeutic relationship because the client may not feel he or she has the possibility to deny touch initiated by the therapist, thereby locking the client into unclear and harmful exchanges (Alyn, 1988). Therapists who advocate touch with clients recommend that the client initiate the touch or that the therapist ask permission prior to the touch, thereby eliminating some of the tension of the power dynamic and curtailing negative effects of the touch (Durana, 1998; Gelb, 1982; Greene, 2001; Horton, Clance, Sterk-Elifson, & Emshoff, 1995; Torracco, 1998).

Perhaps it is for some of the above reasons that in their recent study, Stenzel and Rupert (2004) found in a national sample of 470 practicing psychologists that almost ninety percent reported never or rarely touching clients during sessions and eighty percent only shook hands with their clients sometimes. Confirming the prevalent research, the study found that therapists claiming humanistic, Gestalt, and existential

theoretical backgrounds touched more than those with psychodynamic training. Though most ask permission to touch, fifty percent report never or rarely explaining touch with clients. Seventy-three percent reported some type of discussion with supervisors or teachers that presented touch as harmful, while fifty-six percent were involved in discussions with supervisors in which touch was presented as beneficial. Stenzel and Rupert concluded that handshakes are the most common form of touching, saying that the attitude among those responding to their survey was cautious (Stenzel & Rupert, 2004).

### *Use of Touch*

Freud's was not the only opinion about the use of touch in psychoanalysis during his time. Among his close circle of friends and colleagues Freud encountered disagreement with his views, most notably from Wilhelm Reich and Sandor Ferenczi who both continued to use touch in their work with patients after Freud's pronouncement against it (Fosshage, 2000; Kertay & Reviere, 1993; Tune, 2001; Ventling, 2002). Reich suggested that the body was an important factor in psychological healing because of what he came to call "body armoring," a process that occurred as a result of bodily accidents and illness, emotional stress, and trauma. The body, as Reich saw it, was a holding vessel for experiences; if negative effects of experiences were not dispelled in a healthy fashion, they became part of a rigidified physical defense system that caused both maladaptive emotional and physical responses to new situations. The idea of body armoring is the basis of some current ways of working with the body in psychotherapy (Totton, 2003; Ventling, 2002).

More recent shifts in thinking about the use of touch in psychotherapy have been occasioned by a myriad of converging ideas in the past few decades, not the least of

which has been the changing in psychotherapy itself from a positivistic to relativistic science, from an exclusively intrapsychic to a relational and interpersonal model (Fosshage, 2000). Among the ideas affecting the shifts in perspective include the findings and questions from research into the nature of the mother-infant attachment (Bowlby, 1958; Winnicott, 1963), what contributes to healthy child development (Ainsworth & Bowlby, 1991; Erickson, 1950; Piaget, 2002), neurological research on normal development (Damasio, 1994; Schore, 2003; Siegel, 2001) as well as how development is affected by trauma at various life stages (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006; Schore, 2003; van der Kolk, 1994).

In normally developing humans, the sense of touch is the first to develop. As the skin is the largest human organ, touch is integral to the growth and development of the individual (Montagu, 1971). Research by Spitz (1945) and Harlow (1959) pointed to the importance of human touch in both psychological and physical development. Harlow's experiments with infant monkeys and surrogate mother monkeys, some made of wire-mesh and others with cloth, showed that touch is perhaps as crucial to human infant survival as food (Harlow, 1959). Spitz's (1945) work with infants and their imprisoned mothers came to similar conclusions about the need for adequate touch. Both experiments demonstrated that without adequate touch the subjects failed to thrive.

Touch is an important element in human development, not only in the lives of infants but throughout the life cycle (Bar-Levav, 1993; Orbach, 2003a; Turp, 2000). Human contact plays a major assisting role in the growth of movement patterns and a sense of self in the world by allowing for the evolution of a "secure base" from which the infant, child, then adult, can orient oneself (Turp, 2000). Bowlby's (1958) attachment



theory, though it does not mention touch as such as an important vehicle, seems based on the notion that enough of a certain kind of touch and touching by the primary caregiver creates lifelong effects on the child and the manner in which he or she will interact in relationship with others. Like Harlow's monkeys who were unable to mate successfully once matured (Harlow, 1959), children who receive not enough or confusing contact, expressly physical in this instance, develop maladaptive ways of connection. In *Language of the Body*, the basis for what later became Bioenergetics, Lowen (1971) suggests that one maladaptive pattern exerts itself in the condition of schizophrenia wherein the patient is unaware of himself as a body-self in relation to other body-selves.

#### *Use of Touch Today*

Smith (1998a) designed a taxonomy that offers some clarity of definition as it regards touch in psychotherapy. He identified seven types of touch, five of which he labeled as acceptable: inadvertent or unintentional touch, as in bumping into someone by mistake; touch as a conversational marker like placing a hand on a shoulder for emphasis; socially ritualized touch like handshakes at greeting or parting; as an expression of comfort or care, as in holding the hand of a grief-stricken person; or touch as technique, as in conducting physical contact in a specified theoretically informed manner in which the practitioner has received training (Smith, 1998a).

It is evident that therapists do indeed touch their clients in non-erotic ways, if only in the formal greeting of handshakes (Gutheil & Gabbard, 1993; Holroyd & Brodsky, 1977; Milakovich, 1998; Stenzel & Rupert, 2004; Stake & Oliver, 1991). Therapists using touch with patients cite a variety of therapeutic benefits for doing so, including facilitating greater client self-disclosure and bond with therapist (Clance & Petras, 1998;

Durana, 1998; Jourard & Friedman, 1970); reparation of human contact-attachment disorders (Liss, 1977; Wilson, 1982); grounding a client in the present moment (Clance & Petras, 1998; Geib, 1982; Leijssen, 2006); to access pre-verbal material (Bar-Levav, 1998; Liss, 1977); provide an emotionally corrective experience (Durana, 1998; Kupfermann & Smaldino, 1987), along with calming or consoling the client in times of distress (Mandelbaum, 1998; Torracco, 1998).

Goodman and Teicher (1988) suggest that if the rationale in talk therapy is to develop new neuronal pathways in the brain, then the definition of therapy could widen to include other ways of exploring these new pathways, like the use of touch and body awareness, specifically for the patient who suffers from arrested development:

"The development of neuronal circuitry runs parallel to the psychotherapeutic definition of rehabilitation: small graduated steps of learning under the guidance of a psychotherapist. Touching for the undeveloped personality may serve the same purpose" (p. 498).

Like many others, Goodman and Teicher make a distinction between which patients will benefit from the use of touch in treatment and which patients will not (see Durana, 1998 for a detailed discussion).

Though it is generally agreed that touch should not be used with all patients, with some populations, such as children – especially quite young children—it is very difficult not to involve some level of touch (Cowen, Weissberg, & Lotyczewski, 1983; McNeil-Haber, 2004). In those instances decisions about the touch needs of the child should be of the highest consideration (Aquino & Lee, 2000; McNeil-Haber, 2004). One nationwide

study with ninety-one licensed clinical social workers, eighty-three percent of whom were women, found that ninety-five percent of the respondents used touch at least some of the time with clients, most often shaking hands or touching a client's shoulder, arm or, back (Strozier et al., 2003). Respondents reported touching children and the elderly more than adults and adolescents (Strozier et al., 2003); and were more likely to touch physically ill clients and those of their own gender. Respondents in this study were least likely to use touch with clients diagnosed with borderline personality disorder (34%), the opposite sex (25%), clients with boundary issues (13%), or those diagnosed with schizophrenia (12%) (Strozier et al., 2003). Eighty-two of the 91 social workers in their study reported receiving inadequate training from classes or placements to deal with issues of touch with clients (Strozier et al., 2003). While the results of this study cannot be generalized to a larger population of mental health professionals, it does highlight the decisions clinicians make regarding touch with adults and the levels of training available to them surrounding the use of touch.

In phone interviews conducted with eighty-four respondents using a non-random sample, Milakovich (1998) reported ten areas of difference between therapists who touch and those who do not, four of which point to the importance of both personal and professional experience with touch as indicators of the respondents' use of touch in psychotherapy treatment with patients. Milakovich (1998) found that those who reported touching had experienced touch from their own therapists; had supervisors and teachers who validated touch in treatment; had experienced body therapies and body-oriented psychotherapies; and had training in therapeutic modalities using touch (more than fifty hours). These results coincide with other findings (Geib, 1982; Stenzel & Rupert, 2004)

and theory (Durana, 1998) asserting that touch experiences of therapists and the type of training and supervision encountered professionally each have a direct impact on their use of touch in the therapy room.

While there is no research on the efficacy of touch as a modality within psychotherapy, per se, there are data on patients' experience of touch in psychotherapy. Geib (1982) surveyed ten female patients who had been in treatment with male therapists for at least ten months. She focused on the patient response to clearly non-sexual physical contact (Geib, 1982). From the data, Geib (1982) formulated four factors relating to positive client response to touch in verbal psychotherapy: therapist gave client a sense of control of touch; therapist responded to client's need; encouraged discussion about the touch; and made sure touch was congruent with state of the relationship, i.e., the touch employed responded to appropriate intimacy established in the relationship (Geib, 1982). The four respondents who found touch in therapy problematic, though overall they rated the therapy as favorable, listed reluctance to jeopardize positive feelings by revealing negative ones engendered by touch (feeling unable to express anger, guilt about anger); perception of therapists as needy and vulnerable; and a return to family of origin dynamics (Geib, 1982).

Horton, Clance, Sterk-Elifson, and Emshoff (1995) expanded and tested Geib's four factors in their research with 231 patients. Positive perception of touch in therapy correlated with three of Geib's factors: patients felt touch was congruent with their issues; that the therapist was sensitive to their reaction to the touch; and the patients felt they could be open with the therapist about the touch incident (Horton et al., 1995). Respondents also reported that touch communicated acceptance (47%) and created a

feeling of closeness (69%). Horton et al. (1995) found that the therapeutic alliance was positively affected by the use of touch, though thirteen percent of the sample did report negative effects. The study found that patients dealing with isolation, depression, intimacy issues, and abuse were helped by touch. They also reported that respondents felt affirmed, respected, and more bonded to the therapist because of the touch offered in the therapy.

### *Ethics*

Touch is an undeniably powerful communication modality with many possibilities for both healing and misinterpretation in the context of psychotherapy. Though there is potential for misunderstanding or misuse of touch in clinical work, many writers have said that touch is not, however, a topic to be avoided. “The matter of touch is so important and pervasive that the question may not be whether or not therapists *should* touch their patients, but rather *how* touch is utilized and processed in therapy” (emphasis in original) (Kertay & Reviere, 1993, p. 39). Pope, Sonne, and Greene (2006) suggest that not talking about touch in classrooms, supervision, and consultation is harmful to both therapists and patients alike. The absence of dialogue hampers mental health professionals and students in their ability to develop professional ethics and self-understanding that could help guide the clinician when a touch event occurs in their practice and perhaps lessen the likelihood of unethical or confusing contact for patients (Pope, Sonne, & Greene, 2006).

Kertay and Reviere (1993) offer a three-tiered ethical approach to the use of touch: once both client and therapist have concluded that the touch is not harmful and is part of the necessary therapeutic relationship, then concerns of theoretical soundness

come into question. Durana (1998) adds that the therapist's understanding of her or his own responses, motivations, and attitudes to touch, along with the dynamics of power, gender, and how boundaries play in the use of touch are also ethical concerns. While Durana (1998) points out the need for proper training in his clinical guidelines for the use of touch, Smith (1998) goes further in his taxonomy of ethics by positioning training as the first ethical consideration, saying that if the training has been inadequate in terms of theory or supervision then the therapist should not use touch with patients. Additionally, Smith (1998a) asserts that touch should be in the best interest of the patient and ego-syntonic for the therapist.

#### *Body awareness as technique*

Touch is but one method on a continuum of modalities in psychotherapy treatment from verbal to non-verbal, (Leijssen, 2006). Body awareness as a technique utilized in psychotherapy does not necessarily include actual touching. In fact, many proponents of body awareness do not advocate touch as a technique *they* use professionally (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006, 2006; Rothschild, 2000; Orbach, 2003b). Various techniques designed to bring attention to bodily sensations, unconscious movements, and feeling states in the body are positioned along the continuum between verbal treatment with no allowance for the body and treatment wherein touch is a component (Leijssen, 2006).

"...Body psychotherapy does not necessarily involve touching. It can be, and often is, carried out with no physical contact between client and therapist. Sometimes therapists will tell clients what they observe about their body posture, movements, expressions and so on. Sometimes they will suggest ways in which clients can amplify or otherwise explore what is happening in their body. Sometimes they will talk clients through exercises and positions intended to develop their bodily freedom, to increase their breathing, or to facilitate the flow

of energy. Sometimes they will mirror clients' movements or posture, and this can develop into an active dialogue. And sometimes they will simply consult their own embodied experience as a source of information about the client's process (Totton, 2003, pp. 117-118).

The incorporation of body awareness in psychotherapy can serve as one barometer of the state of the client's transference and any countertransference on the part of the therapist thereby allowing for a richer, though not flawless, attunement to non-verbal or preverbal cues (Field, 1989; Orbach, 2003a; Shaw, 1996; Totton, 2003).

Allowing a place for the body in psychotherapy treatment, body awareness here is defined as making use of both the therapist and patient's physical reality, more precisely,

“...the *expressions* of the body of the patient in the form of anatomical shape, gestures, looks, e.g., eye contact, physical contractions/relaxation, and of the *sensations* of the body as felt and expressed by the patient in various forms like feeling hot/cold, pain, nervousness, sadness, anger, fear, joy, emptiness, etc.” (emphasis in original) (Ventling, 2002, p.4).

Bodies in their own right, not only as symbolic registers, can serve as a pathway to greater here-and-now responses to patients as well as invite more clarity into ways patients respond to the therapist's physical presentation (Orbach, 2003b; Petrucelli, 2007). This can be especially the case when working with clients with eating disorders, self-harming behaviors, physical trauma of any kind, life-threatening illnesses, and otherwise somatically presented concerns (Ogden, 2006; Orbach, 2003b; Petrucelli, 2007).

One area of recent interest is the call for heightened use of body awareness in trauma therapies. Van der Kolk writes:

“Physiological arousal in general can trigger trauma-related memories, while, conversely, trauma-related memories precipitate generalized physiological arousal. It is likely that the frequent re-living of a traumatic event in flashbacks or

nightmares cause a re-release of stress hormones which further kindle the strength of the memory trace. (van der Kolk, 1994, p. 9).

Spearheaded by advances in neurobiology, researchers like Bessel van der Kolk, Alan Schore, and others have written, revisiting Reich's theory regarding body armoring to some extent, that the body stores emotional trauma (Ogden, Minton, & Pain, 2006; Schore, 2003; van der Kolk, 1994). These researchers call attention to the necessity of treating the client's body and mind as interwoven aspects of the person in pursuit of health and wholeness of the individual.

Orbach (2003a) believes therapists must bring conscious awareness of how their bodies are in fact already an integral part of the therapeutic relationship, writing that "our patients are already using our bodies just as they are using our psyches" (p. 13). She further suggests that the process of engaging in embodied practice also offers therapists an opportunity for greater self-care and knowledge through mindful attention to themselves, physically and emotionally (Orbach, 2003a).

Totton further suggests one unique quality of body-centered or body-oriented psychotherapists is their ability "to feel comfortable with their own embodiment, and comfortable with physical contact—relaxed and undeprived enough to trust their own ability to hold appropriate boundaries without refraining from touch altogether" (Totton, 2003, p. 118).

### *Body-Oriented Psychotherapy*

Bodywork, as defined earlier, is very different from general touch. Of the seven categories outlined by Smith, touch as technique is unique in that it involves extensive training on the part of the clinician. Although we have little research involving bodywork



and psychotherapy, we do have information on the use of alternative therapies by the general population. In the past two decades there has been a huge increase in use of body therapies, herbal therapies, spiritual modalities, and special diets among Americans, with estimates that more than one third use these avenues (Elkins et al., 2005). With this large a number of the population turning away from the standard medical community, or at the very least seeking different methods as added components to their care, it is hard to imagine that more research on the combination of bodywork and psychotherapy is not available. Elkins et al. (2005) notes that only thirty-four percent of the respondents told their psychotherapists about their use of an alternative therapy (Elkins et al., 2005).

While the history of touch use in psychotherapy is as long as the history of psychotherapy itself, it is necessary at this point to briefly highlight some of the developments in the former in order to clarify some points of the current research. What is now known variously as body psychotherapy, body-oriented psychotherapy, Hakomi, Rubenfeld Synergy Method, the Rosen Method, Rolfing, somatics, or bio-energetics, to name a few, all have, in some way, their beginnings in the work of Wilhelm Reich and Sandor Ferenczi. From Reich emerged students in various parts of Europe who founded the Neo-Reichian Body Psychotherapy Institutes in Norway, Sweden, Germany, and the United States. Alexander Lowen and John Pierrakos formed bioenergetic analysis while those opposed to this way of working, David Boadella and George Downing, created biosynthesis and body psychotherapy, respectively (Ventling, 2002). There was also Fritz Perls, founder of Gestalt therapy and Peter Geissler in Austria, founder of psychoanalytic body-oriented psychotherapy (Ventling, 2002). All the schools address the body through techniques including body awareness, mindfulness, and touch (Ventling, 2002).

### *Summary*

The taboo regarding touch in psychotherapy is still very much a part of the ethical concerns of the mental health profession though it is no longer as strictly adhered to as it once was. Due to a number of strands of thinking throughout the history of psychotherapy along with findings from various other disciplines, attitudes about the use of touch, the body, and body awareness in treatment are changing (Anderson, 2007; Fosshage, 2000). Unfortunately, with the change in attitude, there may not have been a corresponding increase in dialogue and training needed to enhance the ethical use of touch and body awareness.

In general, therapists are better prepared to handle situations competently when they have been prepared to deal with an issue before it appears in their clinical practice. Education about touch is especially important since an unexamined practice of touch can so easily lead a therapist into serious difficulty (Sanderson, 1995, quoted in Tune, 2001).

While findings show, and opinions point to, a need for adequate training and increased self-awareness on the part of the therapist in relation to the use of touch and body awareness (Durana 1998; Horton, et al., 1995; Ketray & Reviere, 1993; Smith, 1998a; Strozier et al., 2003) the bulk of the literature to date neglects to include the voices of those mental health professionals who have engaged in additional training in these areas. Quantitative research involving clinicians who are professionally trained to use touch and body awareness is particularly absent from the literature. The purpose of this study is to survey the differences in reported practices and attitudes of mental health professionals who use touch and body awareness with and without additional training.

## CHAPTER III

### METHODOLOGY

#### *Formulation*

The purpose of this study is to answer the following question: “Do clinicians with training regarding the use of touch and body awareness report using these modalities more often and report more positive attitudes towards them than do clinicians who report no training in the area?” This research question incorporates two hypotheses of difference: 1) that training in the use of touch and body awareness engenders more use of both among mental health professionals; and 2) that training is also a significant predictor of a clinician’s attitudes and beliefs about the use of touch and body awareness.

This study was conducted using a mixed method, relational design, in an effort, as Anastas writes, "...to describe whether or not a phenomenon or a characteristic of it is systematically associated with another phenomenon and, if so, how” (Anastas, 1993, p. 150). The study used primarily quantitative survey questions with a limited number of qualitative questions. The participants were comprised of mental health professionals, including clinical social workers, psychoanalysts, and otherwise licensed professional counselors.

The mixed method design was appropriate for this study in two ways: it allowed for the quantification of responses as well as some possibility for deeper narrative response. One weakness of the quantitative portion of the study is that during data analysis it is difficult to ask all the necessary questions to account for the multitude of

variables present thereby forcing the researcher to ask and answer only a small selection of questions that will undoubtedly leave many more questions unanswered. A weakness of the qualitative sections is again during data analysis, as the complete richness of the coded data may not come through due to the difficulty in finding similarities in every answer. "No study can presume to isolate, measure, and discuss every variable of possible interest" (Anastas, 1993, p. 157). With that in mind, the vision of this study is to serve as a preliminary effort that may lead to future research.

### *Sample*

A purposive expert convenience sample of one hundred sixty-four mental health professionals took part in this study. Clinicians were able to participate if they were licensed mental health professionals—either as psychotherapist, psychoanalyst, professional counselor, or clinical social worker—with at least five years clinical experience. If the clinicians currently used a specific touch modality, they needed licensure or certification to practice that particular modality to participate in the study.

Those excluded from the sample were clinicians not licensed and those who without at least five years experience in their respective field. Participants also needed to read and write in English and have use of a computer with internet access. Diversity of race, class, gender, sexual orientation, and clinical modality is present as much as possible through the choice of organizations used as entry points.

### *Ethics and Safeguards*

Emotional risks of participating in this study proved minimal, as the respondents were experienced mental health professionals with access to clinical resources and knowledge of ample coping skills for processing emotional impacts. For this reason, no

resource list of mental health referrals was distributed. As this study took place entirely over the internet, even those with busy schedules had the opportunity to complete the fifteen-minute survey when it was best for their schedules. Conducting this survey over the internet also eliminated any stress a participant might have had about possible identification as a respondent.

Participants may have benefited from their involvement in this research by the opportunity given to share their experience and to influence other clinicians' ideas about the nature of integrating touch and body awareness into psychotherapy. Questions might have invited new ways of working in the mental health field and suggested areas for further training. There was no compensation or material benefit to respondents from participation in this study.

Participation in this study was completely anonymous and no specific answer is traceable to any particular respondent due to the use of encrypted software, via Survey Monkey.com. Participants were asked at the beginning of the on-line survey to acknowledge consent or refusal to participate in the survey by clicking on a "yes" button at the end of an informed consent letter. If they chose to participate, they were taken to the first question of the survey. If they declined to participate, they were directed to the exit page, without seeing or completing the survey, but thanked for their interest in the study.

All research data will be kept secure in a locked location for three years, as mandated by federal law. After three years, the researcher will continue to keep the materials secure or destroy them if they are no longer needed.

### *Data Collection*

Participants were asked to complete a fifteen-minute thirty-six question anonymous online survey about their use of body awareness and touch in sessions with clients, about their training and familiarity with touch and body awareness as a component of their practice, as well as about their attitudes about touch and body awareness. There was also a series of demographic questions for participants to answer (see survey in Appendix D).

Quantitative data was collected because of its concreteness and the opportunity of doing correlational analyses, while qualitative data was collected for the richness of more individualized, in-depth and personal responses that numbered responses to survey items might not capture. The design of one question in the survey instrument (#17) replicates Smith's taxonomy of touch (Smith, 1998a). Smith's taxonomy allowed for the inclusion of a recognized, accepted, and clear categorization of touch (Durana, 1998; Stenzel & Rupert, 2004).

Licensed mental health professionals were recruited through the Smith College School for Social Work alumni association (graduates from 2005 or earlier to ensure at least five years in practice), the National Association of Social Workers, the American Psychological Association—Divisions 29 and 39, and the Illinois Association of Clinical Social Workers. Clinicians who might have more formal training in the use of touch and body awareness were recruited through national organizations, schools, and training facilities including the California Institute of Integral Studies, the Naropa School, the United States Body Psychotherapy Association, and the training institutes for Hakomi, the Rosen Method, and the Rubenfeld Synergy Method. Participants were also identified

through association or a snowball sampling method by which participants were encouraged to pass along the survey to colleagues they identified as having interest in the study.

Recruitment began with phone calls and emails to the above listed organizations after receipt of approval from the Smith College School for Social Work's Human Subjects Review (Appendix A). Once initial contact was complete, a recruitment letter (Appendix B) was sent electronically to the identified person who had agreed to send it along to the organization's list-serve. The recruitment email included information about the intent and description of my study, participation requirements, and the risks involved in participation.

Once possible participants received the letter and agreed to take part in the study, they received instruction, in the body of the letter, to click on a link that took them to the online survey. The first page available to participants was the informed consent (Appendix C) to which they answered YES or NO prior to proceeding to the instrument. If they answered YES, they went to the first question of the survey. If they answered NO, they went to a "thank-you" page and directed out of the survey.

Limitations of the study include the use of a survey for data collection. While an online survey reaches larger numbers of respondents at a relatively low cost to the researcher and can guarantee the anonymity that may make candid responses to a sensitive topic much more likely, recipients needed Internet access in order to participate. Even with the larger number of respondents, the study's findings will not be generalizable to a wider population given the survey's sampling limitations. Recipients can also easily dismiss a survey without attending to it when not approached directly by

an individual researcher. Conveying complex ideas in readily measurable survey questions may result in failure to capture some nuances of the subject matter or recipients' responses such as is possible in an interview.

Participants were also asked to supply demographic information demographics pertaining to age; sex; years in practice; state of licensure; type of mental health licensure; theoretical framework from in which they work; type of arena in which they practice; and how they identify racially or ethnically.

#### *Data Analysis*

Once the data were collected, statistical tests were run to ascertain any relationships among variables using descriptive statistics, including frequencies and cross-tabulations. Descriptive statistics were further utilize to view the data based on which respondents reported some level of training and which did not and to ascertain whether chi-square tests for difference were possible. Chi-square tests were run for gender, use of touch and body awareness, and training variables on a series of questions highlighted as those most salient in regards to use of touch and body awareness and the therapist attitude toward both.

Data collected from open-ended, narrative questions was coded for themes and identified according to therapists reporting training in the use of touch or body awareness and those who did not. Representative quotes appear in the findings section to substantiate themes or ideas found among the quantitative data.



## CHAPTER FOUR

### FINDINGS

The absence of training and dialogue about the use of touch and body awareness in psychotherapy has been cited as one plausible reason for ethical misconduct vis-à-vis physical contact in the treatment room. This research project focused on a small facet of this debate by asking whether training in the use of body awareness and the use of touch among licensed mental health professionals was a predictor of more and different, non-erotic, use of physical contact. The major finding of this research is that training does have an effect on both use of and attitudes about touch and body awareness in the psychotherapy practice of those surveyed.

#### *Characteristics of Respondents*

Online surveys were started by 164 respondents between November 2007 and February 2008. 103 surveys were complete and useable. Surveys were eliminated due to missing consent or demographic information; out of country mental health licensure; and listing a non-recognized mental health licensure or theoretical background. The following demographic information is for the remaining sample (N=103). Respondents to the survey were a diverse group across sex, age, practice setting, years in practice, and location (see Table 1).

#### *Overall Sample Characteristics*

The median age of the respondents in the sample was 51 with the maximum age at 86 and the minimum at 29. Ninety-one (88.3%) of the respondents were female and

TABLE 1

**Demographic Characteristics of Respondents**

	Frequency	Percent			
<b>Sex</b>					
Female	91	88.3			
Male	12	11.7			
<b>Race or Ethnicity</b>					
Caucasian or White	82	79.6			
African American or Black	2	1.9			
Jewish	9	8.7			
Latina or Hispanic	2	1.9			
Arab or Lebanese American	3	2.9			
Native American	2	1.9			
Other	3	2.9			
<b>Mental Health Licensure</b>					
Clinical Social Worker	76	73.8			
Marriage and Family Therapist	8	7.8			
Professional Counselor	10	9.7			
Psychiatrist	2	1.9			
Psychologist	6	5.8			
Other	1	1.0			
<b>Practice Settings</b>					
Private Practice	56	54.4			
Community Mental Health	21	20.4			
Adult or Child Inpatient	2	1.9			
Hospital Adult or Child Outpatient	3	2.9			
Other	21	20.4			
<b>States Represented by Licensure and Distribution of Respondents</b>					
Arkansas	1	Massachusetts	21	Oregon	2
California	12	Maine	4	Pennsylvania	3
Colorado	6	Maryland	4	Rhode Island	1
Connecticut	10	Minnesota	1	South Carolina	1
Delaware	1	North Carolina	2	Texas	1
Florida	1	New Hampshire	1	Virginia	1
Georgia	2	New Mexico	4	Washington	2
Hawaii	2	New York	10	West Virginia	1
Illinois	4	Ohio	1		

twelve (11.7%) were male. Respondents answered variously to an open-ended question about race or ethnicity with 79.6% answering “Caucasian or White;” 8.7% “Jewish;” 2.9% “Arab-American or Lebanese American;” 1.9% each for “African American or Black,” “Latina or Hispanic,” and “Native American;” and 2.9% answered “Other” (see Table 1).

The median time for years in practice among the respondents is 17. More than half of the respondents (54%) reported working in private practice settings (see Table 1). Twenty-six states are represented in the sample as counted by licensure, including Arizona, Connecticut, California, Illinois, Massachusetts, Washington, and West Virginia (see Table 1). The bulk of the sample (73.8%) reported having mental health licensure as clinical social workers though there were others represented (see Table 1).

The reported theoretical framework of responding clinicians varied a great deal. The largest grouping was of psychodynamic therapists (N=37), followed by those claiming an eclectic background (N=19). Other frameworks reported were psychoanalytic (N=6), Body Oriented or Centered Psychotherapy (N=7), Jungian (N=5), CBT (N=5), Somatic Psychotherapy and Integrative (N=4, each), Gestalt, Object Relations, and Narrative (N=2, each), and Other (N=10).

#### *Characteristics of Those Reporting Some Level of Training in the Use of Touch or Body Awareness*

The sample was further broken down according to those who reported some level of training in the use of touch or body awareness. Of the total sample, 59.2% reported

having some training in touch and body awareness and their use in the treatment room either through coursework, in supervision, or for a bodywork modality (see Table 2). Fifty-three women (58.2%) reported some training in the use of touch or body awareness and eight men (66.7%) had some training. By mental health licensure, the majority (83.3%) of the psychologists, half of the psychiatrists, 47.4% of the clinical social workers, and 100% of both the marriage and family therapists and the professional counselors reported some level of training in this area. The mean age for this group was 51.70 and the mean number of years in practice was 18.97 (see Table 2).

TABLE 2

**Characteristics of Those Reporting Training in Body Awareness or Use of Touch**

	Frequency	Mean	Percent
Female	53	--	58.2
Male	8	--	66.7
Years in Practice	--	18.97	--
Age	--	51.70	--
<b>Mental Health Licensure</b>			
	Frequency	Percent	
Clinical Social Workers	36	47.4	
Marriage and Family Therapists	8	100	
Professional Counselors	10	100	
Psychiatrists	1	50	
Psychologists	5	83.3	
<b>Type of Training in Body Awareness Or Use of Touch</b>			
	Frequency	Percent	
Classroom Discussion	27	26.2	
Seminar or course	41	39.8	
Supervision	42	40.8	
Formal Training	41	39.8	

Clinicians involved in a particular body centered psychotherapy reported training that had lasted, for most (77.4%), more than one academic term, included personal treatment as part of the training (82.1%), involved information on professional ethics (86%), and included methods to help in the integration of the modality into their mental health practice (71.9%). Clinicians trained in a formal bodywork modality or particular

branch of body centered psychotherapy reported practicing from many schools of thought including Reichian therapy, Somatic Experiencing, Radix, Rubenfeld Synergy Method, the WaveWork, Hakomi, Cranial Sacral therapy, Bodydynamics, Polarity therapy, Reiki, Sensorimotor Experiencing, and Rosen Method Bodywork.

### *General Findings*

The findings are grouped below in two primary areas: attitudes and beliefs about and the actual use of touch and body awareness in mental health practice with a focus on the differences between those who reported some training in the use of touch or body awareness and those who did not.

#### *Attitudes and Beliefs*

Attitudes and beliefs were assessed through a subset of questions designed to get an impression of how clinicians in this study thought about the physical body as a clinical component of the psychotherapy process. Likert scaled questions and an open-ended question focused on the respondents' emotions, thoughts, or concerns about their participation in the study.

A majority (91.8%) of those reporting some level of training said they view tending to the physical as equally important as tending to the emotional while over half (65.9%) of those who reported no specific training in the use of touch or body awareness agreed that the physical is equally important. A similar trend is apparent in ideas about memories stored in the body and a clinician's use of both her and the client's physical reactions during treatment. Some part of the work of many clinicians (91.8% of those with training, 85.7% of those without) in this study is informed by a belief that memories are stored in the body and have an effect on the health and well-being of the client.

TABLE 3

**Comparison of Attitudes and Beliefs of Therapists by Report of Training in the Use of Touch or Body Awareness in Psychotherapy**

	N	With Training	Without Training
<b>Tending to the physical in psychotherapy is as important as tending to the emotional and mental processes.</b>			
Yes	83	91.8%	65.9%
No	19	8.2	34.1
<b>A belief that memories are stored in the body and affect the health and well being of clients informs some part of my work.</b>			
Strongly Agree	53	75.4	16.7
Agree	39	16.4	69.0
Neutral /Not sure	7	4.9	9.5
Disagree	3	1.6	4.8
Strongly Disagree	1	1.6	0
<b>My bodily reactions and those of the client are important indicators for me in the course of clinical treatment.</b>			
Strongly Agree	50	71.7	16.7
Agree	38	23.3	57.1
Neutral /Not sure	11	3.3	21.4
Disagree	2	0	4.8
Strongly Disagree	1	1.7	0
<b>I am unclear about the validity and use of touch in therapy.</b>			
Strongly Agree	5	0	11.9
Agree	17	6.7	31.0
Neutral / Not sure	21	8.3	38.1
Disagree	26	31.7	16.7
Strongly Disagree	33	53.3	2.4
<b>When I have used touch I have a sense that I am doing something wrong or will face ethical or legal repercussions.</b>			
Always	0	0	0
Almost Always	0	0	0
Sometimes	16	10.7	25.0
Rarely	35	28.6	47.5
Never	45	60.7	27.5

Two respondents, both reporting some level of training, voiced their opinion about the importance of training in these areas:

My... training was NEVER to touch clients. I do a lot of supervision of interns and discuss touch with my students regularly. I do believe therapists should think before using touch and should understand why they do it. It should never be for the therapist's comfort or benefit. Body awareness and discussion of body experiences are a critical part of my work in a family trauma clinic. It is helpful for me that touch is openly discussed in my workplace and a topic of clinical team meetings as well as trainings. [Respondent reported training in the form of classroom discussions, seminars, and supervision.]

I've worked in the mental health field for many years and the profession has given me mix messages when it comes to "touch," "feel" so I have had to rely on my own personal professional opinion. The majority of cases that I carry are either latino/a or african-american (ethnic/culture. I try to accommodate & respect the individual's culture and rituals). [Respondent reported training in the form of seminars.]

Another respondent who reported no training in the use of touch or body awareness stated his or her concern a little differently: "[I] now have a fuller appreciation of what use of touch can mean, and I now see that I use it and think about it more often than I realized." [Respondent reported no training.]

A respondent who reported formal training in a bodywork modality wrote in: "For me in general touch belongs to human being. We all learned in an essential way through being touched, so using touch in psychotherapy is an important tool for learning about oneself and for communication."

Respondents saw the bodily reactions of the clinician along with those of the client as important indicators in the course of treatment. Ninety-five percent of those with training and 73.8% of those without training strongly agreed or agreed that their bodily reactions and those of the client are important information. It is salient in each of the three instances mentioned that even those without training, more than half from that

group, think of the body, both theirs and the client's, as important and are influenced by their awareness of physicality in the room. Some, however, voiced concerns about scope of practice:

I think that touch is not really the role of a psychotherapist, unless one wants to pursue a specialization, such as Reiki, and offer services concurrently. I see this as both a therapeutic and legal issue. We should be professionally qualified for the things we do. That said, I think that discussion of sensations in the body, body memory, and physical experience should occur more. This allows a clinician to reach more clinical topics with quiet individuals, cultures who may be more likely to experience feelings somatically, and of course, people experiencing illnesses. I think that clinicians are sometimes concerned that they are not qualified to discuss physical or medical experiences not having gone to medical school. I think that this is a shame. We are not providing medical interventions. We are opening new dialogues. Mind and body do not stand juxtaposed to each other. [Respondent reported no training on the use of touch or body awareness.]

There are basic ethical principles that must be followed whether one uses touch or not. Therapists must be educated in the modality and experience total comfort when employing touch in therapy. [Respondent reported formal training in a bodywork modality.]

In terms of their clarity about the validity and use of touch in the psychotherapy there was a sharp divide between the groups. While eighty-five percent of those with training strongly disagreed or disagreed that they were unclear about the use of touch and its validity, 42.9% of those without training strongly agreed or agreed that they were unclear on this point, and 38.1% of those without training were not sure or neutral about touch's use and validity. Some respondents explained it in the following manner:

Taking this survey reminds me of how split I am about touch. I believe it can be helpful, but I'm also committed to practicing w/in the limits of my professional license. [Respondent reported formal training in a bodywork modality.]

When I consider touch, and we in Hakomi do a lot, I am again aware of my own ambivalence of using it and not because I think there is anything wrong with it, but I always worry about how it is interpreted by a client. [Respondent reported formal training in a bodywork modality.]



I tend to have a negative response to the use of touch in therapy, except occasionally with older people, so I felt a little old fashioned/rigid in my responses. However, I do believe that, with the exception of people trained in specific body-based techniques, one has to be very cautious about the impact that touch can have on a client and the therapists' needs that may be involved. [Respondent reported no training in the use of touch or body awareness.]

Though participants from neither group said they always or almost always had a sense of doing something wrong or feared facing ethical or legal ramifications for using touch, 16.7% (N=16) did sometimes have this concern, 36.5% (N=35) had it rarely, and a little less than half (46.9%, N=45) never had a sense of ethical or legal repercussions. The majority of those with training, 60.7%, never had the sense of wrong doing while the majority of those without training, 47.5%, rarely had that sense.

Table 3 shows a larger percent of clinicians who had received training in use of touch or body awareness answered positively when asked about their attitudes and beliefs. Chi-square analyses were run to determine if these differences were significant. There was a significant difference in "Tending," "Body Reactions," and "Touch as Valid" (see Table 4). There was no significant difference in the variables "Body Memory" and training. The results of this analysis partially support the hypothesis that there is a significant relationship between training and attitudes and beliefs.

TABLE 4

**Chi-Square Results 1: Training and Attitude**

Variable	df	N	Value	p
Tending	1	102	9.248	.002
Body memory	-	---	----	-----
Body reactions	1	102	7.664	.006
Touch as Valid	1	102	17.049	.000

## *Use*

Just over half (51.4%) of the entire sample reported rarely or never using touch in their psychotherapy practice. The other 48.6% reported using it at least some of the time. A portion (22.1%) of those respondents without training experienced using touch almost always or sometimes. Though many (70.5%) of those with training in the use of touch and body awareness reported using touch in their psychotherapy practice almost always or sometimes, some reported rarely (11.5%) or never (13.1%) doing so (see Table 5).

Respondents shared a range of opinions about their clinical experiences in specific instances with the use of touch:

One long-time client, not particularly psychologically sophisticated and very sensitive, used to ask me regularly for a hug at the end of her session. For a long time, I acquiesced. Eventually, I began to feel less and less comfortable with the "routine" and tried to talk with her about ceasing the practice, mumbling something inchoate about "feelings need to be talked about, not acted on..." She was understandably devastated, had little comprehension of what I was talking about, and felt primarily rejected and confused. Today, I'd have done the whole thing quite differently, but I wouldn't have necessarily ceased the practice -- just processed it better! [Respondent reported no training in body awareness or the use of touch.]

I practice both psychotherapy and Rosen Method Bodywork. Touch is never used in psychotherapy. Touch is only used when the client has contracted to participate in Rosen Method Bodywork with this practitioner. [Respondent reported formal training in body awareness or the use of touch.]

There are times in a client's process that I use touch to support an already happening process. ie: a client in a fetal position, touching (with permission), a foot so she knows she is not alone in her deep process. I rarely use touch, even though I was trained to, and always ask permission. I use touch less with men and gay women in my practice. [Respondent reported formal training in body awareness or the use of touch.]

My theoretical stance is that touch IS appropriate in some cases, and I have used touch with some of my clients. Social work ethics (NASW) include the use of appropriate touch. [Respondent reported no training in body awareness or the use of touch.]

TABLE 5

**Comparison of Use Tendencies of Therapists by Report of Training in the Use of Touch or Body Awareness in Psychotherapy**

	N	With Training	Without Training
<b>I incorporate body awareness into my clinical practice.</b>			
Always	28	45.9%	0
Almost Always	34	39.3	23.8
Sometimes	31	13.1	54.8
Rarely	6	1.6	11.9
Never	4	0	9.5
<b>In my clinical practice, I am aware of and utilize my own body sensations to inform my approach with clients.</b>			
Always	36	50.8	11.9
Almost Always	32	32.8	28.6
Sometimes	28	14.8	45.2
Rarely	6	1.6	11.9
Never	1	0	2.4
<b>In my clinical work I notice and talk with clients about their physical realities---</b>			
Always	16	23.0	4.8
Almost Always	40	49.2	23.8
Sometimes	38	23.0	57.1
Rarely	8	4.9	11.9
Never	1	0	2.4
<b>I have had the experience of using touch as an element in my clinical practice.</b>			
Always	3	3	0
Almost Always	13	21.3	12.6
Sometimes	34	49.2	9.5
Rarely	19	11.5	28.6
Never	34	13.1	61.9

I have only used touch w/ clients in a setting that structures the use of touch in the therapy, such as Hakomi training. In my "office" practice as an LPC I do NOT use touch. [Respondent reported formal training in body awareness or the use of touch.]

One client who was pregnant and emotionally rejecting. The client was able to realize her emotional conflict through the use of touch. As she became aware she was completely numb to the sensations of the baby inside her, she was able to access her fears and sadness about being pregnant. By the following session she was letting her husband feel the baby move and genuinely bonding with the baby. [Respondent reported no training in body awareness or the use of touch.]

A majority (85.2%) of respondents reporting some level of training always or almost always incorporated body awareness into their clinical practice while three-quarters (78.6%) of the respondents without training reported doing so almost always or sometimes. Of those respondents without training, 21.4% rarely or never incorporated body awareness into their psychotherapy treatment (see Table 5).

Examples from respondents of their use of body awareness in treatment with clients:

I was meeting with a 9 year old girl who was very angry about her foster care situation and had started having anger outbursts in school which were very uncharacteristic of her. She expressed frustration at not being able to feel the anger coming on. We acted out feeling angry and once she was able to recognize the feeling of anger in her body she could address it before it became an outburst. [Respondent reported no training in body awareness or the use of touch.]

I have a counter dependent client who uses a certain gesture to indicate that she is fine, and I pointed out this gesture to her, so that she can be aware of moments of pushing away feelings of need. [Respondent reported no training in body awareness or the use of touch.]

Therapists surveyed about use of their body sensations to inform their approach with clients showed similar results, with 83.6% of those with training almost always or always doing so, 73.8% without training almost always or sometimes doing so, and 14.3% of those without training doing so rarely or never (see Table 5).

Helping clients to examine their physical reactions in the treatment room was reported by 72.2% of those with training always or almost always with the largest percent (49.2%) reporting almost always doing so. A majority (80.9%) of therapists without training reported incorporating client physical responses almost always or sometimes with the highest number (57.1%) reporting sometimes. Only 7.8% of the entire sample reported rarely doing this and 1% never doing so (see Table 5). One therapist who reported some training in body awareness and use of touch wrote in of his or her process:

I have worked in inpatient and outpatient settings with trauma survivors. I encourage my clients to find the place in their bodies where they feel a particular feeling the most and, when appropriate or requested, I will sit next to a client and, with their permission, put my hand on their hand that holds the feelings to help them feel like they are sharing the feelings with me.

Table 7 shows the type of touch used by therapists in the sample, according to gender and training. Socially ritualized touch, as in handshakes, is the most used type of touch by both therapists with training in use of touch and body awareness and those therapists without training. Those with training chose touch as technique as the second most used form of touch. Therapists without training were much more likely to touch inadvertently (54.7%) than were those with training (14.7%). Interestingly, only 57.3% of those with training said they use touch as technique (see Table 7).

Table 6 displays results of when sample respondents offered touch. Reports of when touch occurred during treatment were similar for both groups in all but three areas. Therapists with training were more likely to use touch when they thought it would help with client self-disclosure (41.1%) than those without training (0%). Therapists without

TABLE 6

**When Touch Offered by Training and Gender**

	Female N=91	Male N=12	With Training N=61	Without Training N=42
			Total Checked (%)	
End or beginning of session	44.0%	50.0%	27 (44.3%)	19 (45.2%)
End of treatment, at termination	56.0	41.7	26 (42.6%)	30 (71.4%)
When client sad/anxious	30.8	8.3	17 (27.9%)	12 (28.6%)
For client self-disclosure	24.2	25.0	25 (41%)	0 (0%)
When client requests	50.5	41.7	33 (54.1%)	18 (42.9%)

training indicated that they used touch most often at the end of treatment (71.4%) than those with training (42.6%). Therapists with training rated using touch with clients at the clients' request higher (54.1%) than those without training. Both groups were just as likely to use touch at the end or beginning of a session and when a client is sad or anxious.

TABLE 7

**Touch Category by Training and Gender**

	Female N=91	Male N=12	With Training N=61	Without Training N=42
			Total Checked (%)	
Inadvertent-- not intentional	31.9%	25%	9 (14.7%)	23 (54.7%)
Conversation marker	38.5	33.3	22 (36%)	17 (40.4%)
Socially ritualized	75.8	83.3	48 (78.6%)	31 (73.8%)
As an expression of comfort	42.9	33.3	28 (75.9%)	15 (35.7%)
Touch as technique	31.9	50.0	35 (57.3%)	0 (0%)

Some clinicians expressed their positions on when they offer touch as follows:

I never use touch other than a greeting hand shake, or termination hand shake or hug. Physical sensations are more a conversation topic. I believe strongly in discussion of physical sensations as being relevant to psychiatric state. I just do

not believe that touch is my role. [Respondent reported no training in the use of body awareness or touch.]

I do NOT use touch as regular part of my clinical work. For me, touch is part of the "social framework" such as handshakes, guiding people down a hallway (holding child's hand), etc. My theoretical framework does not incorporate touch so when I do touch a client, I do have to consider if it is clinically appropriate - most of the time, I don't feel it is clinically appropriate. [Respondent reported no training in the use of body awareness or touch.]

Working a lot with female traumatised clients I have often used touch with the outcome that clients became more relaxed and in some cases could speak about difficult experiences why they were touched. At the same time they were able to put their body awareness into words. [Respondent reported formal training in the use of body awareness or touch.]

Table 4 shows a larger percent of clinicians who had received training in use of touch or body awareness answered positively when asked about their use of touch and body awareness. Chi-square analyses were run to determine if these differences were significant. There was a significant difference in "Body Awareness," "Use of Client Body," and "Actual Touch" (see Table 8). A chi-square analysis could not be run to determine if there was a difference in "Use of Own Body" since more than 20% of cells had expected value of less than 5, which violates an assumption necessary for the use of chi square. The second major hypothesis, that training in the use of touch and body awareness engenders more use of both among mental health professionals, was partially supported by the results of this analysis.

#### *Gender Differences*

Women (N=91) and men (N=12) reported mostly comparable answers in attitude and actual use of body awareness and touch except in three broad areas. The subset of questions on attitude revealed no major differences between men and women in the

sample. Women were more likely to use body awareness (61.5%). Fifty percent of the male respondents reported using touch as technique as opposed to the 31.9% of female

TABLE 8

**Chi-Square Results 2: Training and Use**

Variable	df	N	Value	p
Body awareness	2	103	39.96	.000
Use of own body	-	---	----	-----
Use of client body	2	103	19.06	.000
Actual Touch	2	103	43.85	.000

respondents. The time at which touch was offered showed the most contrast between women and men. Women reported offering touch more during termination (F=56%, M=41.7%), and when client is sad or anxious (F=30.8%, M=8.3%) than their male counterparts.

*Narrative Data*

The general narrative themes that surfaced in the answers from clinicians in the study when asked in what kind of situation did touch occur are as follows: when offering specific bodywork, in situations of trauma and grieving, at termination, when client asked for a hug, with young children, at the beginning of a session, in culturally specific context. Some answered that they do not touch or that touch is not appropriate. Most answering this question stated that they used touch in their general practice. Some who do use touch reported not doing so in a psychotherapy context and some acknowledged that touch is feasible under certain conditions according to NASW guidelines. Some of these comments are distributed throughout this chapter.



For the particular touch incident described in earlier statements, therapists were asked to describe what they attributed to either the negative or positive outcome of the incident. General themes were: unsure if the incident were positive, that clients felt connected; it was a planned touch; clients connected to a physiological sense of themselves; it was a corrective emotional experience; it enhanced and clarified the client's self awareness; and the healing intention of the incident. Others described their experiences this way:

#### Negative outcomes

I believe I was too rule-bound in how I explained not wanting to hug. I wish I had been more reflective about my own personal comfort or discomfort and then disclosed a version of that. The clinical moment might have been useful had I been able to do so. [Reported no training.]

The negative outcome (her hurt and confusion) was directly attributable to my inept processing, largely, in turn, due to the rather doctrinaire nature of my psychodynamic training conflicting with my own better instincts and preventing my effective internalization of the role of physical contact in an authentic treatment moment. [Reported no training.]

The first client laughed about the gesture, and felt more comfortable admitting to certain needs. When I did hold the second client's hand for a moment, she became calmer because she felt more accepted, and we talked about it during her next appointment, as well as discussion of her waiting for me, etc. The whole thing was a crisis in the therapy. [Reported no training.]

#### Positive outcomes

People become aware of their body as having memory and history and are able to connect, heal, and release traumatic events and/or patterns that are no longer working with them in their highest good. [Reported no training.]

Clear patient therapist boundaries, clear exploration re: potential meaning of hug. Ability to process effects of hug in next treatment session. [Reported formal training.]

Every traumatic experience seems to involve mental, emotional, spiritual, "energetic" and physical components and memories, and to the extent that all are

released, the healing is more or less thorough and permanent. [Reported formal training.]

Only a few therapists (26.6%) who reported using touch also reported using outcome measures to assess the effectiveness of their use of touch. Of those still fewer elaborated on the type of measure used. The general themes from the narrative data of this question focus on changes in client self-perception, changes in the therapeutic alliance, client feedback, and checking in with the client.

### *Overview of Results*

The results of this study reveal a relationship between training in the use of touch and body awareness and attitudes and use among mental health professionals surveyed. It was found that those with training were more likely than those reporting no training in this area to have more affirming beliefs about the use of touch and body awareness and to use both more often in their psychotherapy practice. These results surfaced even though the majority of those without training used body awareness at least some of the time and held mostly similar attitudes about the use of touch and body awareness. Distinct divisions emerged concerning actual use of touch and clarity about touch's validity in the treatment room.

Overall, more respondents used body awareness than touch. Most (51.4%) answered that they rarely or never used touch in their psychotherapy practice. The most used type of touch was socially ritualized touch, as in handshakes or pats on the back. The majority of respondents offered touch at the end of treatment, during termination. These results are congruent with previous studies on the use of touch in psychotherapy.

## CHAPTER FIVE

### DISCUSSION

A review of the literature revealed that the use of touch in psychotherapy is still very much addressed in terms of stark contrasts of positives and negatives and often met with ambivalence. Yet the literature also reflects a change over time in attitude among mental health professionals about the body and body awareness -- a change that may have led some mental health professionals to seek out training in or dialogue about the use of touch and body awareness in psychotherapy. Although literature is beginning to appear that stresses training as an important element when incorporating touch or body awareness in psychotherapy, there is a lack of empirical data concerning those mental health professionals who do have training in the use of touch or body awareness.

The question guiding the current research investigated the effects of training in the use of touch and body awareness on clinicians' attitudes toward, and use of, both touch and body awareness in psychotherapy treatment. This question incorporated two hypotheses: 1) that training in the use of touch and body awareness engenders more use of both among mental health professionals; and 2) that training is also a significant predictor of a clinician's attitudes and beliefs about the use of touch and body awareness. This mixed-method study sought to understand any relationship between training in the use of touch and body awareness and the attitudes and behavior among those mental health professionals surveyed.

### *Current Findings and Previous Literature*

The findings show that training in the use of touch and body awareness does affect how mental health professionals think about and use body awareness and touch in psychotherapy. The results of this research show a relationship between training in the use of touch and body awareness and positive attitudes about touch and body awareness as well as increased use of both in psychotherapy. Chi-square analyses found significant difference in three of the four questions in both subsets targeting actual use of touch and body awareness ( $p > .000$  for each question) and attitudes and beliefs ( $p > .000$ ,  $p > .002$ ,  $p > .006$ ) about both, thereby partially supporting both of this study's hypotheses.

Those mental health professionals surveyed who reported some level of training in the use of touch and body awareness were more likely to have used both body awareness and touch in psychotherapy, have more comfort and clarity about the validity of touch in psychotherapy, and less worry that the use of touch and body awareness is inappropriate. Training seems to produce a more thoughtful consideration of use of touch and body awareness and an allowance for touch as part of a treatment continuum as echoed by a number of writers on this topic (Greene, 2001; Leijssen, 2006; Milakovich, 1998; Petrucelli, 2007; Shaw, 2003; Smith, 1998a; Totton, 2003).

It is not surprising, then, that a larger percentage of clinicians who had received training in use of touch or body awareness answered positively when asked about their attitudes and beliefs and were also more likely to use touch and body awareness in their psychotherapy practice. Several authors and researchers (Durana, 1998; Kertay & Reviere, 1993; Smith, 1998a; Stenzel & Rupert, 2004) link training in some type of body-oriented modality, access to other mental health professionals with whom to process

touch related incidents, or involvement in a theoretical framework that allows for touch or body awareness as valid treatment modalities leading to more informed and less ethically questionable usages of touch.

Interestingly, with over half (59.2%) of the sample reporting some level of training in the use of touch and body awareness, a little less than half (48.6%) of the sample reported using touch in their psychotherapy practice. Of the remaining 51.4% who reported never or rarely using touch, 14.6% of that number reported receiving some form of training in touch and body awareness. The original hypothesis that training would tend to make therapists more likely to use actual touch was only partially supported. It may be that anxiety about risks still constrains many from use of the modality that they have sought training in. Some of the narrative comments seem to suggest that being able to dialogue about touch and body awareness may increase the self-reflection that could lead to ambivalence and wariness due to more focused consideration of the issues related to the body in psychotherapy. The ambivalence among therapists who reported training in a formal body work modality was also salient in the narrative data, and is consistent with clinicians who are very keen on the use of body awareness treatment, but who do not advocate touch (Ogden & Minton, 2000; Ogden, Minton, & Pain, 2006; Rothschild, 2000).

Those who reported no training in use of touch or body awareness were slightly less likely to use body awareness, much less likely to use touch, and when they did use touch seemed unclear about why they used it, were unsure if it had been a positive experience for the patient, and did not know whether touch could be a valid modality. These clinicians do use touch but with higher levels of ambivalence and added confusion

about why and whether it is appropriate. The results of this study partially support the thinking that body awareness is a murky reality for most therapists not trained in a body-oriented modality and who have not had the opportunity to discuss these issues in a professional setting (Orbach, 2003b; Totton, 2003) and that therapists are not as comfortable with their own bodies as they are with the client's body as informational tools in treatment (Leijssen, 2006; Ventling, 2002). Strozier, Krizek, and Sale (2003) report similar findings on touch use among clinical social workers in terms of their sample's inability to clarify why they chose to use touch as well as their overall lack of exposure, through formal training or supervision, to the use of touch or body awareness concerns.

While training is a powerful influence on the use of and attitude about touch and body awareness in psychotherapy, it is not a predictor of whether or not touch will be used. In her study of the differences between therapists who touch and those who do not, Milakovich pointed to other aspects that influence therapists' use of touch, in addition to training in a body-oriented modality. Most notably, she highlighted the significance of therapists' personal and professional experience with touch (Milakovich, 1998). Though the current research did not ask about personal and professional experiences of touch and body awareness directly as did other research (Clance & Petras, 1998; Milakovich, 1998; Strozier, Krizek, & Sale, 2003), this researcher is aware that factors other than training affect how mental health professionals will work with touch and body awareness. In fact, it is reasonable to assume that there was possibly a predisposition among those who chose to participate in this study towards more positive interest in body awareness, the body, and the use of touch by the very fact that they volunteered to take part.

Self-awareness and professional dialogue are both thought to be crucial components in the ethical use of touch and body awareness (Durana, 1998; Kertay & Reviere, 1993; Smith, 1998a; Wilson, 1992). The current research found that 86% of those with training in a formal body-oriented modality answered that they had received ethics information as part of their training and were less likely to fear legal repercussions due to use of touch in their practice. It is encouraging that those with formal bodywork training do feel ethically prepared to make use of that training in practice, even if some of them, as seen in the narrative statements, choose not to use touch for reasons related to ethics and the currently received wisdom about the proper scope of practice boundaries.

The type of touch most often offered is indicative of the influence of training in the use of touch and body awareness. Even with the noted ambivalence of those with training toward touch in practice, they did not report using inadvertent touch as a method, where clinicians without training choose it as the second most used form of touch.

#### *Strengths of Study*

This study consisted of a thirty-six question survey conducted online after this researcher made contact with various organizations to obtain permission to have the survey made available to their list-serves. Quantitative and qualitative data were collected over a three-month period. Collecting this type of data allowed for the quantification of responses as well as narrative responses that added depth to the purely numerical answers, thereby offering sufficient nuance to address the complexity of the issue and the respondents' thoughts about it.

The self-designed survey worked well with the research question to solicit the type of information expected from the sample group. The construction of the survey

hinged on five subsets of questions: demographic information; a series of questions focusing on attitudes towards body awareness and use of touch specifically; training; clinical interactions; and experience of the survey itself. This approach was appropriate in that it allowed for information gathering from various perspectives. It may well also have sparked participant reflection about how individual participants do and do not use touch or body awareness (a few respondents actually mentioned this in write-in comments, in fact).

Use of an online survey significantly increased the number of respondents for the sample, much more so than a mailing to the same organizations would have produced. The ease of making contact with organization representatives by telephone, sending them a request letter with a live email link that they could then forward to their list-serves made this process tremendously successful. If time had permitted, the sample could have been far greater. Being able to assure anonymity through SurveyMonkey.com's encrypted software was a very helpful asset, especially when working with a classically controversial topic. Lastly, an online survey was a cost-effective tool to gather data over such a short period from so many different places.

The strength of the sample was in its number, diversity of training, and variety of locations. Though the response rate versus rejection rate is impossible to calculate because once the request letter left this researcher there was no way of knowing how many people may have simply deleted the email, 164 people started the survey and from that group, 103 were used in the research analysis. As discussed in earlier chapters, some respondents left out crucial information or failed to answer questions, so that 61 of the 164 responses could not be used. The inability to cue or prompt participants about



missing data is one disadvantage to a quantitative survey that might not have been problematic in a qualitative, face-to-face interview.

Apparently, based on the number of respondents in the short time that the survey was available online, there is enough interest in the topic to warrant further research. This study may have only tapped a very small vein possible of informants who may be accessible using online survey instruments. With this in mind, the sample seems to adequately represent the sought after groups: mental health professionals and mental health professionals who have training in the use of touch or body awareness. Due in part to the recruitment process, these numbers included an even range of diverse levels of training in use of touch and body awareness. That twenty-six out of fifty states -- including Washington, Georgia, California, Massachusetts, and Texas -- were represented, is another strength of the sample. Though heavily weighted on the east coast, the geographic diversity of the sample offers some sense that results could apply nationally.

Although minimized in this study, researcher bias was an interesting component of note. On the one hand, it was clear because of full disclosure and researcher accountability that this researcher has a strong interest in the incorporation of body awareness, including touch, into the psychotherapy treatment room. It is also of note because some of the write-in comments suggested that an actual positive researcher bias was perceived in a contrary way, for example, one respondent wrote: "[I] wondered how questions seemed biased towards touch being considered a negative while I've always seen it as a useful therapeutic tool." Perhaps this response is also a positive -- in that the

instrument was mistaken for leaning in the opposite direction from the one in which the researcher positions herself.

### *Limitations of Study*

Even though there are many strengths of the study, it is also limited. Most notable is the sample's imbalance in ethnicity and gender. Caucasian women were by far the majority of the sample. This is due in part to the researcher's focus on the recruitment of therapists trained in the use of touch and body awareness for the sample. It was assumed that recruitment of general therapists would produce some level of ethnic diversity; unfortunately, this was a faulty assumption. Only 19 out of the 103 participants did not report being Caucasian. Similarly, only twelve out of the 103 respondents were male.

Additionally, the use of the internet survey offered some drawbacks, the major one being the limitation addressed above with regard to unanswered questions. An internet survey question can only be asked once, and if it is not clear or acceptably phrased, there is a risk that the respondent will not answer it or will provide an answer the question did not intend. Unlike the situation in qualitative research, the researcher does not have the freedom of explaining the question or of clarifying an answer, or simply reminding a respondent that an answer is still needed. Another drawback is that some recipients possibly dismissed the survey without attending to it because it was an electronic transmission without a researcher to give it a human appeal.

Another limitation of the survey is possible researcher bias. Prior interest in the subject matter and training and licensure as a massage therapist may have influenced the way in which the research reported here was conducted. A core assumption, based on personal and professional knowledge, was that there existed psychotherapists who have

received training in use of touch and body awareness to make up a portion of the sample. To that end, sampling methods sought to contact those clinicians as well as general practitioners.

### *Implications for Future Research*

The results of this research support Strozier, Krizek, and Sale's (2003) observation that: "given the potential of touch in psychodynamic treatment, it would seem wise to address the intervention of touch in open dialogue within the educational, supervisory and/or training setting" (p. 58). Training in the use of touch and body awareness, whether in classroom discussions, in supervision during placement, in seminars, or through formal training in a body-oriented modality, is the best line of defense against ethical violations concerning touch. It allows students as well as practicing clinicians to, at the very least, become clear on why they do or do not incorporate touch or body awareness into their practice protocol.

The findings of this study suggest two perspectives of interest: that of clients of clinicians experienced and trained in the use of touch and body awareness and that of the mental health professional student in training. It could prove interesting to investigate the experience and outcome of clients diagnosed with Post-Traumatic Stress Disorder or Generalized Anxiety Disorder through the course of a year-long treatment with clinicians trained in the use of body awareness and touch. The clients would be split into two groups: one receiving talk therapy only and the other body-oriented psychotherapy. Pre- and post-treatment measurements would be made of changes in brain structure and function, cardiovascular indicators such as cortisol levels and blood pressure measurements by way of neuro-imaging or stress level tests. The measurements could

compare symptom and health indicator changes as a function of each type condition's treatment.

Another fruitful study revolves around the needs of mental health professionals in training regarding touch and body awareness. This study could involve an assessment of attitudes and behaviors of students prior to any training in the use of touch and body awareness and after a year-long period wherein students were afforded the opportunity to experience personal treatment in a body-oriented modality, whether primarily hands-on or a body-oriented psychotherapy, and professional training in the form of lectures and seminars taught from a variety of perspectives in the area of mind-body-spirit. The sample would be split into three groups: one receiving regular training and only personal treatment; another receiving regular training and only professional training in touch and body awareness; and the last receiving regular training along with personal treatment and professional training in touch and body awareness. This research could compare the affects of training in the use of body awareness and touch on self-awareness, clinical sophistication, ethics, as well as offer an idea of whether including some level of training in this area would prove beneficial to new generations of mental health professionals.

The use of touch and body awareness in psychotherapy is not an easily dismissed topic. In fact, as the public continues to influence the profession with ideas from other cultures and disciplines, as it demands more from us as a profession each day, it is only self-awareness on the part of clinicians and knowledge of the needs of clients that will afford us the tools for professional discretion, ethical conduct, and healing of the whole person in this highly technological age of disembodied reality.

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Appendix A

Human Subjects Review Approval Letter



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Smith College  
Northampton, Massachusetts 01063  
T (413) 585-7050  
F (413) 585-7054

November 30, 2007

Anastasia McRae

Dear Anastasia,

Your revised materials have been reviewed and all is now in order. We are therefore happy to give final approval to your interesting study.

*Please note the following requirements:*

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

**Maintaining Data:** You must retain signed consent 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,

A handwritten signature in black ink that reads "Ann Hartman".

Ann Hartman, D.S.W.  
Chair, Human Subjects Review Committee

CC: Gael McCarthy, Research Advisor

Appendix B  
Recruitment Letter

Dear Mental Health Professional,

I am writing to you as a second year student at the Smith College School for Social Work to request your participation in a brief but important online survey regarding the use of touch and body awareness as techniques in clinical psychotherapy practice with a wide range of clients. "Body awareness" here is defined broadly as recognition of the importance of the physicality of self and other and its role in healing. The bulk of the survey asks questions about your clinical experiences using touch and body awareness as an element of your practice.

In order to participate in this study, you must be a licensed mental health professional—either a psychotherapist, psychoanalyst, professional counselor, or clinical social worker and have at least five years clinical experience. If you currently use a touch modality (e.g, Hakomi, Rosen, Alexander Technique, Polarity, Healing Touch, the Rubenfeld Synergy Method, or a body psychotherapy method not mentioned here) in your practice, you must also be licensed and/or certified in that modality.

Access to your individual submissions will be limited to this researcher, my research advisor, and the Smith College School of Social Work statistical analyst. I hope to incorporate your anonymous contributions, in aggregate, into my master's thesis and in future research and presentations. The survey is brief and should not take more than 15-20 minutes of your time. You may skip any question you prefer not to answer. The survey will remain open until March 30th; you can access it via the link below.

<http://www.surveymonkey.com/----->

Your responses will help to fill a gap in the empirical research available on the numbers of mental health professionals integrating touch and body awareness into their practice as well as contribute to the on-going dialogue about both modalities as techniques in our profession. I hope you decide to take part in the survey. Thank you in advance for your input. Please feel free to contact me with questions or concerns you may have at the email listed below.

Thank you,

Anastasia D. McRae  
amcrae@email.smith.edu

Appendix C  
Informed Consent Letter

# Use of touch in psychotherapy

## Consent Form

Dear Participant,

My name is Anastasia McRae and I am a master's level student at the Smith College School for Social Work. I am conducting a research study to gather data for my master's thesis and for possible presentations and publications. I am investigating clinical attitudes and activities involving body awareness and touch in psychotherapy treatment.

I am interested in the use of touch and the use of body awareness as therapeutic techniques by mental health professionals. In order to participate in this study, you must be a licensed mental health professional—either a psychotherapist, psychoanalyst, professional counselor, or clinical social worker and have at least five years clinical experience. If you currently use a touch modality (ex. Hakomi, Rosen, Alexander Technique, Polarity, Healing Touch, the Rubenfeld Synergy Method, or a body psychotherapy method not mentioned here) in your practice, you must also be licensed and/or certified in that modality. The survey takes approximately 15-20 minutes to complete and includes demographic questions such as your age, race or ethnicity, gender and educational level. The survey requires that participants read and write in English. The bulk of the survey asks questions about your clinical experiences using touch and body awareness as an element of your practice.

While there is no foreseeable emotional risk to you from participating in this study, it is possible that you will find certain questions in the survey thought provoking. It is assumed that as a seasoned mental health professional you probably have access to resources should you find the need to process your participation in this study.

You may benefit from being part of a study that offers the possibility to influence other clinicians' ideas about the nature of integrating body awareness into psychotherapy; suggesting ways of embracing a new way of working in the mental health field; and contributing to an area of clinical research that has been neglected. Compensation will not be provided for participation in this study. As this survey is being conducted completely online with encrypted software designed to protect the identity of the participants, your participation is completely anonymous and no specific answer can be traced back to any particular respondent. The link to the survey does not retain email addresses or ask that you give your name. The software program collects and initially compiles the data for further research and the researcher is given this controlled data in aggregate form. Only my research advisor, the Smith College School of Social Work statistical analyst and this researcher will have access to these materials. All research data will be kept secure in a locked location for three years, as mandated by federal law. After three years, I will continue to keep the materials secure and destroy them when they are no longer needed.

Your participation in this study is voluntary and you may decline to be involved in this study without repercussion. You may withdraw from the survey at any time simply by exiting the survey or closing the browser. I can be reached by email at [amcrae@emell.smith.edu](mailto:amcrae@emell.smith.edu). I welcome your questions and comments. If you have any concerns about your rights or any aspect of this study, please contact me at the above email or contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974. I hope you will decide to participate in this study.

You must read and electronically sign this informed consent form by clicking on the "yes" option below before being able to proceed with the survey. If you choose to consent, please print off this page and keep it in your records. If you click on the "no" option below, you will immediately be exited from the survey. During the survey, you may decline to answer any questions you do not feel comfortable answering. You have the right to exit this study at anytime prior to pressing the "DONE" option at the end of the survey. Once you have submitted your completed questionnaire, you will not be able to withdraw from this study since there is no identifying information on the surveys that would connect a particular survey to your responses and permit the information to be selectively deleted.

**YOUR CLICKING THE "YES" BUTTON INDICATES THAT YOU HAVE READ AND UNDERSTOOD THE ABOVE INFORMATION; THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.**

Please print a copy of this page for your records by going to FILE at the top of this browser page then selecting the PRINT option so you can contact me later or use the referral numbers.

### 1. I consent to participation in this survey

Yes  
 No

Appendix D  
Survey Instrument



# Use of touch in psychotherapy

**2. Tending to the physical in psychotherapy is as important as tending to the emotional and mental processes.**

- Yes  
 No

**3. A belief that memories are stored in the body and affect the health and well being of clients informs some part of my work.**

- Strongly agree  
 Agree  
 Neutral/Not sure  
 Disagree  
 Strongly disagree

**4. I incorporate body awareness into my clinical practice.**

- Always  
 Almost Always  
 Sometimes  
 Rarely  
 Never

**5. In my clinical practice, I am aware of and utilize my own body sensations to inform my approach with clients.**

- Always  
 Almost Always  
 Sometimes  
 Rarely  
 Never

**6. My bodily reactions and those of the client are important indicators for me in the course of clinical treatment.**

- Strongly agree  
 Agree  
 Neutral/Not sure  
 Disagree  
 Strongly disagree

# Use of touch in psychotherapy

**7. In my clinical work I notice and talk with clients about their physical realities--for example, the way they may hold their bodies; an irregular gait not due to illness or accident; particular gestures when any one subject is mentioned.**

- Always
- Almost always
- Sometimes
- Rarely
- Never

**8. I have received training in body awareness and its use in the treatment room either through coursework for my degree as a mental health professional, in supervision, or formal training in a bodywork modality.**

- Yes
- No

**9. What kind of training did you receive? (choose all that apply)**

- Classroom discussions
- Seminar or course
- Supervision
- Formal training in a bodywork modality

**10. If formal training in a bodywork modality, please name it in the space below.**

**11. How long was the training?**

- 1 day or part of a day
- 2 or more days
- 1 week
- 2 or more weeks
- 1 academic term (quarter, semester)
- more than 1 academic term

**12. Did the training involve personal treatment as part of your completion?**

- Yes
- No

**13. Did the training include information on professional ethics?**

- Yes
- No

# Use of touch in psychotherapy

**14. Did the training include methods to help you integrate the modality into your psychotherapy practice?**

- Yes  
 No

**15. I have had the experience of using touch as an element in my clinical practice.**

- Always  
 Almost always  
 Sometimes  
 Rarely  
 Never

**16. I am unclear about the validity and use of touch in therapy.**

- Strongly agree  
 Agree  
 Neutral/Not sure  
 Disagree  
 Strongly disagree

**17. I have or currently use the following types of touch with clients (choose all that apply):**

- Inadvertent or not intentional, as in brushing against someone by mistake  
 Conversational marker, as in a touch on hand or shoulder for emphasis  
 Socially ritualized, as in handshakes or greeting hug  
 As an expression of comfort or care, as in holding a client's hand, embracing with a hug, or rocking  
 Touch as technique, as in a formal bodywork centered technique, i.e. Reichian

**18. I use touch mostly with clients who are (choose all that apply)**

- Under 5 years old  
 5-10 years old  
 10-15 years old  
 15-30 years old  
 30-50 years old  
 50-70 years old  
 70+ years old

**19. I am more likely to touch a client, with their permission (choose all that apply):**

- At the end or beginning of a session  
 At the end of treatment, during termination  
 When a client is sad or anxious  
 When I think it will help clients with self-disclosure  
 When the client requests (if it is clinically appropriate)

# Use of touch in psychotherapy

**20. I have used touch with clients and was able to process it with colleagues or supervisors.**

- Yes  
 No  
 Sometimes

**21. When I have used touch I have a sense that I am doing something wrong or will face ethical or legal repercussions.**

- Always  
 Almost Always  
 Sometimes  
 Rarely  
 Never

**22. Though I am clear about my theoretical framework's stance that touch in the context of therapy is inadvisable, I have used touch in my clinical practice.**

- Yes  
 No

**23. In what kind of situation did this touch occur? Please describe in space below.**

**24. Based on your clinical experiences, can you describe a particularly notable therapeutic intervention, either positive or negative, that occurred as a result of touch as therapy between you and a client?**

**25. To what would you attribute either the negative or positive outcome of the above interaction?**

**26. Do you use particular measures to assess the effectiveness of your use of touch?**

- Yes  
 No

**27. If so, please name them below.**

**28. How was it for you to take part in this survey? Did any particular emotions, thoughts, or concerns occur to you?**

## Demographic Information

**29. Your Age**

**30. Your Sex**

**31. How you self-identify your race or ethnicity**

**32. Mental Health Licensure**

**33. Years in Clinical Practice**

**34. Theoretical framework or orientation**

**35. State of licensure**

**36. In which of the following settings do you practice**

- Private Practice
- Community Mental Health Agency
- Hospice
- In-Patient Treatment, Adult
- In-Patient Treatment, Child and Adolescent
- Hospital Outpatient, Adult
- Hospital Outpatient, Child
- Other

## End of Survey

Thank you for your interest and participation in this research study.