



**Therapeutic Relating Embodied:
An Exploration of Psychotherapists' Experiences of Touch in Therapy**

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Table of Contents

Chapter 1: Introduction	7
1.1 Background and Context.....	7
1.2 Aims & Objectives.....	9
Chapter 2: Literature Review	10
2.1 Touch and Human Development.....	10
2.2 Psychotherapeutic Touch: Historical and Theoretical Overview.....	12
2.3 Factors Influencing Perceptions and Experiences of Touch.....	20
2.4 Ethics and Clinical Guidelines.....	22
Chapter 3: Methodology	24
3.1 Research Design.....	24
3.1.1 Reflexivity and Bias.....	25
3.2 Sample and Recruitment.....	25
3.2.1 Overview of Participants.....	26
3.2.2. Types of Psychotherapeutic touch.....	27
3.3 Data Collection.....	28
3.4 Data Analysis.....	29
3.5 Ethical Considerations.....	30
Chapter 4: Findings	31
4.1 Introduction.....	31
4.2 The Embodied, Self-Aware Therapist.....	31
4.3 The Power of Touch: Balancing Risk and Potential.....	36
4.4 Attuned Relating Embodied	41
Chapter 5: Discussion	46
5.1 Introduction.....	46
5.2 The Embodied, Self-Aware Therapist.....	48
5.3 The Power of Touch: Balancing Risk and Potential.....	52
5.4 Attuned Relating Embodied.....	58

Chapter 6: Conclusion.....	64
6.1 Strengths and Limitations	64
6.2 Suggestions for Further Research	65
6.3 Implications for Psychotherapy Practice	66
References	67
Appendices.....	76
Appendix I: Participant Information Sheet	76
Appendix II: Demographic Questionnaire	77
Appendix III: Semi-Structured Interview – Guide Questions.....	78
List of Tables	
Table 1. Demographics of Participants.....	27

Abstract

Touch has been used within psychotherapy since the origins of the profession. Research shows evidence of the therapeutic potential of touch between therapist and client, highlighting a dimension of deep healing that cannot be accessed via discursive means. Contemporary neurobiological research bolsters arguments for the healing potential of touch within psychotherapy, and even for its necessity in healing some forms of trauma. Psychotherapeutic touch has been subject to much taboo and critique, however, and its use remains controversial. The potential risks of harm to clients are well-documented, including regression and re-traumatisation. This qualitative study presents in-depth insights into working with psychotherapeutic touch, through an Interpretative Phenomenological Analysis of the accounts of three experienced psychotherapists. Three themes emerged: the embodied, self-aware therapist; the power of touch: balancing risk and potential; and attuned relating embodied. It finds that the extent of the psychotherapists' own embodied awareness is an important foundation and tool in their work, as well as bringing a deeper dimension and richness of experience to them as people. Working with psychotherapeutic touch also entails a conscious process of balancing potential and risk and working carefully and slowly within an established therapeutic relationship. The study sheds light on the refined level of attunement that can be enabled by incorporating the body and touch in intersubjective relating. Working with the somatic dimensions of transference and countertransference was seen as enhancing the psychotherapeutic process.

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A final dedication to my niece, Esperanza, whose early departure from this world on 13 April, 2016 meant I did not get the chance to hold her. She has touched me deeply nevertheless.

“...and we merge into this body which is better informed than we are about the world”

- Maurice Merleau-Ponty

Chapter 1: Introduction

1.1 Background and Context

Touch has been used within psychotherapy since the origins of the profession, and is referred to across the historical literature. It has been subject to taboo and critique, however, and its use remains controversial. Research shows evidence of the therapeutic potential of touch between therapist and client, highlighting a dimension of deep healing that cannot be accessed via discursive means. Contemporary neurobiological research bolsters arguments for the healing potential of touch within psychotherapy, and even its necessity for healing some forms of trauma. However, the potential risks of harm to clients are also well-documented, including regression, re-traumatisation, abuse including sexual abuse, and other breaches of personal boundaries.

Touch remains cautioned against on many training courses, in the literature and by regulatory bodies and psychotherapists, and the age-old psychoanalytic taboo against using touch in therapy is still present for many in the profession generally (Casement, P. 1982), and within humanistic strands (McLeod, 2008). Nevertheless, psychotherapists, particularly body psychotherapists, in Ireland and elsewhere continue to use touch in their work. The ongoing interest in body-focused psychotherapy involving touch is visible in contemporary literature and practice, and in training courses and workshops ('Body Psychotherapy', IAHIP website), and a review of accredited psychotherapists in Ireland shows a history of training in body-oriented approaches involving its use. Additionally, anecdotal evidence from

discussions with practitioners generated an awareness in the researcher of the use of touch by practitioners who are traditionally-trained and advertise as such, but have undergone subsequent training in its use and actively incorporate it in their practice.

The researcher's own experience of body-oriented exercises in a 'Stress Response' module during psychotherapy training elicited a new personal awareness of the body as a source of information on unconscious material, including patterned forms of relating to the self and others. It also created an awareness of body-oriented work as a potential way of working to explore and change these, in particular the role of bodies and touch in interpersonal regulating (Schore, 2002), and thus curiosity about its potential within therapeutic relationships. The contrasting cautioning against touch as an appropriate intervention conveyed in most other elements of the training, together with the afore-mentioned issues of taboo and ethics, further fuelled the researcher's curiosity.

In terms of existing literature specifically on touch, despite its often marginal status in psychotherapy discourse and practice, numerous studies and journal articles exist that critically examine the use of touch (including Kertay and Reviere, 1993; Hunter and Struve, 1997; Durana, 1998; Clance & Imes, 1997; Stenzel & Rupert, 2004; Phelan 2009). These focus largely on controversies and ethical and practical questions raised by using touch, including potential for harm to the client, though some offer more practical guidelines for mitigating recognised risks and supporting a positive, healing experience. While some qualitative research exists exploring clients' and therapists' experiences of touch in psychotherapy, the literature recognises a need for more research in this area (Smith, Clance, Imes, 1997). What research has been conducted

focuses primarily on the experiences of clients in relation to touch. There is a gap in the literature regarding psychotherapists' experiences of working with psychotherapeutic touch. This study therefore aims to contribute to existing research by offering a detailed exploration of practitioners' experiences of using touch in therapy, including the impact on them and the meaning they derive from it as people and as practitioners.

1.2 Aims & Objectives

This qualitative study aims to understand psychotherapists' personal experiences of using touch in therapy practice, and the meaning they derive from it. While not all who use touch are body psychotherapists, and not all body psychotherapists use touch (Rothschild, 2002), this orientation is nevertheless the most likely to advertise touch as a modality, and it is assumed that the emphasis on the body and the use of touch is of particular significance to those practitioners identifying as body psychotherapists. The research will therefore focus on acquiring insights into the particular meaning of the use of touch by body-oriented psychotherapists. Its specific objectives are to:

- examine the context and rationale for the practitioners' use of touch in psychotherapy, including perceived benefits;
- explore the nature of therapists' experiences of the process of using touch in clinical practice, and the sense they make of it;
- explore any impacts on working with touch on the participants' identities as practitioners and as people
- investigate therapists' understanding and experiences of potential risks to the client, and how these are managed within the therapeutic relationship, including ethics and clinical guidelines.

Chapter 2: Literature Review

The literature review begins with the physiology of touch and its role in human development. There follows an overview of the history of touch in psychotherapy and the differing views of the principal therapeutic orientations regarding touch. Alongside this overview, the major themes related to touch identified in the literature are discussed, including:

- its healing potential in psychotherapy and theoretical rationales underpinning its use;
- taboos and controversies including psychoanalytic critiques, potential for harm or trauma, cultural/social contexts, gender, power dynamics and litigation fears;
- differences between therapists who use touch interventions and those who do not, and suitable client types; and
- contemporary ethical considerations and clinical guidelines.

Online databases were used to review the most relevant literature to contextualise the study and inform the focus of enquiry and methodology. These are primarily books and peer-reviewed articles in academic journals of psychotherapy, psychoanalysis, neuroscience and psychology; books on touch in psychotherapy; and books outlining the theory and practice of body-orientated psychotherapy approaches using touch.

2.1 Touch and Human Development

Contemporary research highlights the essential role of touch in human survival, growth and development, as it shapes relationships between babies and their caregivers

(Siegel, 2001; Sonkin, 2005; Schore, 2002). Studies on the neurobiology of attachment reveal the inter-regulation of affect between child and primary caregiver(s), and its implications for relational patterns in later life. Pre-verbal, sensory experiences during early brain growth have a long-lasting impact on somatic and psychological development, patterning the child's sense of self, emotional development and expectations of others (Schore, 2002; Snyder, Shapiro, & Treleaven, 2012; Bretherton, 1992). Hunter and Struve's study of touch in psychotherapy (1997) highlights this central place of touch in emotional development, contextualising its implications for the psychotherapeutic dyad.

Schore (2001) describes how the infant's capacity for psychobiological affect regulation develops very early via interactions with caregivers, and how this shapes resilience and mental health into adulthood. Embodied, interpersonal neurobiology is thus fundamental to our capacity to develop and learn to regulate our emotions. This happens largely outside conscious awareness but involves a right-brain connection to body sensations, rather than left-brain cognitive functions. Damasio (1994) describes the brain seeking 'suitable survivable accommodation' between the organism's needs and its environment to achieve regulation. This can be seen as a neurobiological or somatic explanation of the core conflict which Freud (1930) articulates in 'Civilisation and its Discontents', where he describes the price paid by individuals who must repress their own personal needs to satisfy those of the group.

The neuroscience research highlights the somatic, interactive nature of emotional development within early attachment relationships, through the infant's and caregiver's mutual responses to facial expressions, body movements, tone of voice, physiological changes, and the child's developing capacities of smell, taste and touch (Schore 2002,

p. 253). Hunter and Struve (1997) highlight the central role of touch in emotional development and articulate the relevance of this for psychotherapy practice. Because developmental trauma can occur at the pre-verbal, right-brain, sensory level and is stored in implicit memory and not accessible by cognition, therapy must take into account this psycho-somato-emotional development and the non-verbal, somatic-oriented aspects of relating with clients.

2.2 Psychotherapeutic Touch: Historical and Theoretical Overview

Though touch is long associated with healing in many cultures (Durana, 1998), its use in psychotherapy remains somewhat controversial. Bonitz (2008) notes that touch was commonly used in the 18th and 19th centuries in treating hysteria, and in their early days Freud and Breuer used touch, including head or neck massage, to alleviate symptoms and facilitate emotional expression (Forer, 1969; Phelan, 2009). Indeed, Freud developed his theory around the biological foundations of the psyche, stating that the ego is first and foremost a bodily ego, derived from physical sensations (1923). However, once he had elaborated his theory of transference of aggressive and sexual drives, a theoretical rationale emerged for avoiding touch entirely, for fear of gratifying infantile sexual wishes and risking regression or infantile fixation (Bonitz, 2008). As analysis of transference became central to psychoanalytical technique, along with Freud's rule of abstinence, so did the taboo regarding touch (Forer, 1969; Bonitz, 2008; Phelan, 2009).

While the psychoanalytic taboo continues to this day (Casement, 2000), some of Freud's followers used touch in their own clinical practice. Ferenczi advocated touch,

including hugging and holding, believing it useful in repairing early damage in patients' experiences (Kertay & Reviere, 1993; Phelan, 2009). Freud criticised this, particularly as Ferenczi became romantically and sexually involved with several female patients (Bonitz, 2008). Freud outlined his concerns in a letter to Ferenczi, caustically cautioning that the latter's practice of holding patients could descend into 'pawing' and 'petting parties', drawing unfavourable attention to the budding practice of psychotherapy (Jones, in Smith, Clance, Imes, 1998, p. 110).

Though they emerged from Freud's theory of the unconscious, early object relations proponents shifted the emphasis from drive theory onto significant early, pre-Oedipal relationships, seeing human connection and nurturance as the individual's primary motivation (Gomez, L. 1997). Beginning with primary caregivers, significant others become the most important external objects shaping the individual's development, patterning their intra-psychic and interpersonal dynamics of relating within and without. Similar to attachment theory in emphasising how these significant early relationships shape the sense of self and capacity to relate to others, the early object relations theorists' insight has been confirmed by contemporary neuroscience research: we exist and develop via the other (Holmes, 2001). In this context of emphasising the role of nurturance and empathy in the client's early history and the therapeutic relationship, Geib argues, one may conceive touch as 'nonerotic' (Geib, P. in Smith, Clance, Imes, 1997, p. 112).

Goodman & Teicher distinguish such approaches as a 'deficit' model of therapeutic work, considering the client to be in childlike mode, requiring the therapist's ego support to compensate for inadequate nurturing (1988, p. 494). The relationally-oriented theorists that followed Freud challenged the dominance of his libido-based

drive theory and 'regressive-conflict model', emphasising the infant's initial total dependence on significant others as gratifiers of needs before discovering the world and developing boundaries. They believed any traumas within this early relating become split off and internalised in the psyche as part objects within the ego. The differences were not resolved, leading to a major point of contention within psychoanalysis: does frustration enable change, or does it impede healing by re-enacting earlier deprivation traumas (Bonitz, 2008, p.394)? The question divides practitioners to this day.

The deficit approach to regression work entails first surrendering to the pull of the regressed ego and allowing total dependence on the therapist, before re-engaging in the intersubjective relationship as a more well-rounded self. To facilitate this, the therapist must be supportive, reliable and well-attuned to the client's needs, while holding firm boundaries to build trust in the relationship (Gomez, L. 1997). Some object relations proponents recognised the role of the body in supporting this mode of relating: Balint (1968) mentioned use of touch in meeting the client's need for contact, emphasising the physical aspects of insights rather than seeing this as primarily cognitive as in traditional psychoanalysis. Balint named the importance of feeling, sensing and touching in facilitating the integration of new experiences in the therapeutic relationship.

Though not formally departing from Freudian drive theory, Winnicott described the importance of the early holding environment provided by the attuned mother in giving the child a vital sense of self and shaping their later relationships (Winnicott, 1971, p. 9). For Winnicott, the sense of feeling in touch with others and with one's own body and its processes was essential for living a life. He believed that responsive and

attuned 'mirroring' by the mother provides a vital sense of self, developing what he termed a 'true self' who can relate authentically to others (Winnicott, 1956).

In Winnicott's intersubjective 'potential space' between therapist and client, the client can safely play and explore new ways of being, allowing a new reality to emerge (Nolan, P. & Nolan, S. 2002, p. 17). The relationship is therefore central for Winnicott: where there is trust in the therapist's holding, and good enough attunement, the client can recover the authentic self and more freely express its needs in a relational context. While not explicitly referencing touch as a necessary part of his work in creating a holding environment, Winnicott mentions using it with a client on one occasion, holding her head in mutual, non-verbal communication via a rocking motion (1975).

The object relations theorists outline detailed conceptualisations of intra-psychic and interpersonal relating which seek to explain the nature of transference and counter-transference dynamics in therapeutic relating, via an understanding of the positions adopted by therapist and client at different times and how this may reflect their earliest relationships (Gomez, 1997). By remaining present and available to the feelings and emotions that arise as counter-transference, including somatic counter-transference, the therapist can engage with the client's present-day expressions of their internalised object relationships, letting these enter conscious awareness and be worked through. Counter-transference is thus not seen as an obstacle to therapy but rather a vehicle (Nolan & Nolan, 2002, p. 19-20). Through intersubjective relating and close attention to the feelings, sensations and experiences of both client and therapist, new and healthier ways of relating can occur.

Reich, one of Freud's better-known detractors, founded a more explicitly body-oriented tradition challenging the barriers to touch imposed by classical psychoanalysis (Hunter & Struve, 1997, p. 57). Believing neuroses and related body-tensions could be identified in musculature, posture and breathing, Reich developed a typology of 'characters' representing different body tensions or holding patterns – 'armouring' – corresponding to developmental phases (Reich, 1980). Though body-oriented approaches to healing existed prior to his work, he situated it in a psychotherapeutic context and explicitly challenged the classical psychoanalysis barriers to touch (Hunter & Struve, 1997, p. 57). The body-oriented psychotherapy tradition following Reich includes a variety of approaches that built on and revised his ideas in various directions, but most, including Bioenergetics (Lowen, 1994) and Biodynamic Psychology (Staunton, 2002) share an emphasis on experiential learning rather than transference relationships.

The Human Potential Movement and the Humanistic schools of psychotherapy that emerged from it saw touch continue as an acceptable therapeutic intervention. Emphasising authenticity, spontaneity and free expression of feelings in the therapeutic relationship, many humanists consider touch an appropriate way to convey genuine affection (Bonitz, 2008, p. 395). This has ranged from 1960s group hugs ('love baths') to Rogers' advocating physical contact to express compassion where appropriate (1970). Perls, an analysand of Reich's, emphasised integrating the body and its sensations, formalising touch within Gestalt body process (Kepner, 1997). The behaviourists including Skinner (1971, in Hunter & Struve, 1997) were unconcerned with transference and practised physical contact with those they were treating.

Several contemporary body-centered approaches build on Reich and followers, taking into account recent developments in attachment theory as informed by neuroscientific studies, and emphasising the role of developmental and other forms of trauma. These neo-Reichian approaches include Sensorimotor psychotherapy (Ogden & Fisher, 2015); Somatic Experiencing (Levine, 1997); and Hakomi body-centred psychotherapy (Kurtz, 1997), considered by some as a transpersonal or psycho-spiritual approach to psychotherapy (Staunton, 2002, p. 133). The NeuroAffective Relational Model (NARM) for working with developmental trauma, developed by Heller and LaPierre (2012) outlines a sophisticated integration between psychodynamic, cognitive, somatic and process-oriented psychotherapy approaches, including touch interventions, to regulate the nervous system and reshape the capacity for relating.

Totton (2003) synthesizes these approaches into three broad models of body psychotherapy: 'adjustment' work to release stuck energies in the body; the 'trauma/discharge' model facilitating completion of held-back physical impulses following shock; and the 'process' model which views the body's symptoms as telling a story and seeks to express the underlying repressed experiences (Totton, 2003). These approaches see touch as validating pre-verbal, biological and emotional longings for physical connection and affect regulation, providing psychosomatic connection deeper than verbal communication, capable of healing early deficits (Forer, 1969, LaPierre, 2006). Pointing to the neuroscientific research on touch as a psychobiological regulator, many of these approaches see *not* touching as a potential trauma of 'omission' in some instances, contrasting with Freud's trauma-of-commission risk (LaPierre, 2006, 45). All advocate treating the body, including touch where appropriate, as central to the therapeutic process, while recognising associated risks, particularly with sexual trauma.

These approaches contend that working gently, carefully and subtly can help regulate a client's nervous system with far less possibility of re-traumatisation (Heller, LaPierre, 2012, p. 23). The Sensorimotor approach is based on the premise of working within a client's 'window of tolerance' of the autonomic nervous system (Ogden, Minton, Pain, 2006) to avoid either the dissociation of hypoarousal on the one hand, or the 'flooding' of overwhelming body sensations that occurs in hyperarousal. Both states make it impossible for the client to process information or experiences effectively. Heller and LaPierre advocate focusing on regulating the client's nervous system as a precondition to therapeutic work, as this is the foundation to developing attachment, in our nervous systems' developmental sequence. They caution against working with transference dynamics if a basic self-regulation capacity has been impaired by early trauma (Heller, LaPierre, 2012, p. 21).

In this context, Ogden, Minton and Pain highlight the potential for sexualisation of touch and risk of trauma associated with its use, stating that touch must be used judiciously and cautiously if at all (2006, p. 200). They also name the importance of the therapist examining their own beliefs, attitudes and potential countertransference reactions to the use of touch. While touch is a potential intervention within the Sensorimotor Psychotherapy approach, the authors note that direct touch between client and therapist is not necessary to accomplish its goals. Where some kind of physical contact is desirable but touch itself contraindicated, they suggest using objects such as a pillow or ball as a buffer to avoid direct contact, or supporting the client's self-touch to increase body awareness (Ogden, Minton, Pain, 2006, p. 201).

Contemporary psychoanalyst Holmes (2001) outlines a model integrating modern attachment theory and research into a psychoanalytic framework, without mentioning

touch as an intervention. Casement (1982, 2000) describes the case of Mrs. 'B', where he declined the client's insistent requests to hold her hand as a means of overcoming an original trauma. He offers a nuanced account of considering this request and the client's breakthrough resulting from his declining it. He sees his decision to work instead through projective identification with her as having maintained analytic holding, allowing her to retrieve her personality and tolerate working through terrifying memories (Casement, 1982). Casement nevertheless recognises the occasional need for touch, though not advocating this generally (Casement, 1982).

Forer (1969) argues that, while soothing therapeutic touch risks erotic or sensual arousal for client or therapist, this is material to work with: client and therapist can learn that fantasies do not have to lead to action, allowing clients to separate nurturing touch from eroticism (Forer, 1969, p.230-231). For Nolan, working relationally is key when incorporating body awareness and working with touch (2012, p. 109). He advocates a relational body-mind perspective, which incorporates different modes of experience and expression including body sensation, emotions, cognition, imagination and motor activity (2012, p. 114). He agrees with Totton's (2013) contention that incorporating an explicit body-mind stance in understanding intersubjective meaning can make the quality of transference and countertransference rawer, more accessible to consciousness. Explicitly tending to transference related to charged body signals can also help avoid the pitfalls of a purely body-oriented stance focused on discharging a client's problems – a 'hysterical *folie à deux*,' which can either replicate the trauma endlessly or enact a 'charismatic "cure"' (Nolan, 2012, p. 132). For Nolan, the therapist staying embodied allows the physical aspects of transference to be recognised and countertransference to be worked with intersubjectively.

2.3 Factors Influencing Perceptions and Experiences of Touch

Several sources consider social and cultural influences on therapists' approaches to touch. Hunter and Struve (1997) outline the power dynamics of touch in social settings, considering gender power-dynamics and ethnic differences in comfort levels regarding types of touch. They find Americans relatively touch-deprived, as does LaPierre (2006), who sees 'illiteracy' of touch in contemporary Western society underlying many of the ethical fears and prohibitions on touch in psychotherapy. While Freud elaborated a theoretical rationale for prohibiting therapeutic touch, this cannot be divorced from the Victorian Viennese context which privileged rationalism over feeling, nor from his quest for scientific respectability for psychoanalytic theory (Phelan, 2009). Additionally, Phelan argues that many women of that era valued touch more highly as a normal aspect of healthy communication, not necessarily erotic in nature, raising the question of how the position of touch might have evolved differently had more women had prominent roles in the development of psychotherapy.

Bonitz (2008) notes that such social and cultural factors and power issues must be included in ethical considerations. Durana warns that using touch can reinforce culturally-prescribed gender-power imbalances (1998, p.270 & 274). Goodman & Teicher (1998, p. 492) cite fears of lawsuits or increased insurance premiums as a factor prohibiting touch in North America. Phelan (2009) highlights sexual abuse of clients as requiring regulation, while observing that abusive clinicians, not the technique itself, should be indicted (2009, p.100). Williams (1997) notes that the degree of self-disclosure by the therapist is a better predictor of inappropriate sexual involvement than the degree of nonsexual touching. Nolan (2012), recognises the controversies in relation to touch but echoes Hunter and Struve's (1998) contention

that bringing the question 'out of the closet' and into discussion is a more responsible way to promote ethics and quality in its use (2012, p. 108).

Given the taboos, mainstream psychotherapists under-report using touch, making quantification difficult: Phelan notes several confidential surveys showing high percentages used touch in their practice (2009, p.98) in the United States. No such data was available in relation to the Irish context. Milakovich (1997, cited in Smith, Clance & Imes, 1997) highlights factors common to therapists using touch, including: humanistic orientation, greater use by females, positive personal experiences of therapeutic touch, belief in its healing capacity, training in its use, and supervision by supportive practitioners. The research examines therapists' reporting on types of clients they have used touch with, finding not all suitable for touch interventions. Therapeutic effects are found in those with schizoid presentation, bonding/attachment deficits, primarily intellectual functioning, or shame regarding intimacy. Interviewees caution against touch with clients with poor boundary control or borderline functioning and those who act over-seductively. Its use remains controversial in cases of physical or sexual abuse. Goodman and Teicher (1988) cite Winnicott's advocating of touch to provide holding for schizoid personalities and other primitive states.

Hunter and Struve (1997) review several client-perception studies indicating favourable therapeutic outcomes. While these do not universally conclude that touch enhances therapy, respondents cite several benefits including deeper trust and greater openness with the therapist, deeper self-exploration and enhanced self-esteem (p.104-5). Goodman and Teicher (1988) outline dissertation-study findings with small numbers of clients reporting touch as impacting positively. Conditions included prior consent and discussion of touch, a sense of control by the client, a client-

led demand for touch, and congruence between the experience of touch and the overall therapeutic experience. There is a lack of literature examining therapists' own experiences of working with touch, whether it be accounts of somatic countertransference or insights into perceived impacts on practice from the practitioner's perspective.

2.4 Ethics and Clinical guidelines

Regarding ethical and clinical guidelines for touch in psychotherapy, the literature raises more questions than answers. Criteria are often vague, e.g. lists of variables for consideration (Goodman & Teicher, 1988, p. 496), or of risks therapists should be alert to (Durana 1998). Few guidelines are widely applicable, reflecting the highly subjective nature of this topic. Phelan (2009) outlines possible uses of touch including greeting, consolation, reassurance, grounding or reorienting and harm-prevention, through handshakes, hugs, a pat on the back, touching hand/arm, holding or rocking the client. Ogden, Minton and Pain (2006) note the importance of recognising any sexualisation of touch by client or therapist, highlighting pitfalls as well as benefits to its use (p. 200). They recommend seeking written consent from clients and conducting a 'touch history' to ascertain clients' past experiences with touch, with the therapist considering their own beliefs, attitudes and potential countertransferential reactions to it. They advise assessing the appropriateness of using touch on a case-by-case, session-by-session basis, and evaluating the client's ego strength, sense of boundaries and overall functioning, as well as the therapist's capacity to hold difficult transference evoked that may also exceed the working intimacy in the therapeutic relationship (p. 201).

Recognising the healing potential of touch and insufficient research on this, Hunter and Struve (1998) identify comprehensive guidelines on its clinical uses and factors a practitioner should consider before using touch. These include a typology of touch, an outline of conditions for appropriate touch, a list of instances where it is inadvisable, and specific techniques and case examples. They consider touch with specific populations, and professional standards regulating erotic touch between therapists and clients, including transference and countertransference and clinical presentations indicating emerging erotic transference. Working with bodyworkers is suggested as an adjunct where the therapist does not wish to use touch themselves. They provide no detail on touch strategies in Sensorimotor psychotherapy, Somatic Experiencing, Hakomi or Biodynamics, where resistance and more vigorous forms of touch are used.

While he acknowledges the important role of theory in establishing coherent practice and informing interventions, Totton (2003) critiques the over-emphasis on it in some of the body-oriented trainings as over-intellectualised and creating more confusion than clarity in an attempt to fend off criticism and secure professional credibility. He emphasises experience as the most important aspect of trainings in body-psychotherapy, in terms of supporting an effective and ethical practice of psychotherapeutic touch.

Chapter 3: Methodology

3.1 Research Design

This study takes a qualitative approach, exploring in detail the personal experiences of psychotherapists using touch in their practice. As identified by the literature, it is difficult to draw generalised conclusions about an area as complex, subtle and subjectively experienced as touch in psychotherapy. It is thus of interest to the researcher, and to the field of psychotherapy, to gain a more in-depth understanding of the phenomenological experiences of individual psychotherapists actively using touch in their practice, and the sense or meaning they derive from this. Interpretative Phenomenological Analysis (IPA) was therefore chosen as the preferred methodology, concerned as it is with the detailed examination of human lived experience (Smith, Flowers & Larkin, 2009).

IPA is a dynamic research process that involves exploring and making sense of subjective experiences, including the researcher's experiences and knowledge in a process of phenomenological interpretation that constitutes a 'dual hermeneutic' or dual interpretation (Harper and Thompson, 2011). Relying upon idiographic, detailed case exploration (Pietkiewicz, & Smith, 2012), IPA is particularly suitable for exploring experiences of phenomena such as touch within psychotherapy, a field primarily concerned with individuals' subjective meaning-making and their experiences in relationship with others, rather than with drawing generalised conclusions. A semi-structured interview was chosen for data collection. This created an open-ended, flexible context in which to explore the specific topic of touch as experienced by the

participants, including any areas that may not have been anticipated by the researcher.

3.1.1 Reflexivity and Bias

Reflexivity is a recognised feature of this qualitative approach, and seen as a strength in facilitating the acquisition of rich data and deep insights into participants' personal experiences. The researcher's own reflexivity is acknowledged in this study, and is distinguished from the participants in the presentation of the research findings. The researcher's hermeneutics can be characterised as two broad interpretative positions: a hermeneutics of empathy and a hermeneutics of suspicion or questioning, in relation to the research participants' own interpretation or hermeneutics of their experiences (Smith, Flowers & Larkin, 2009). In relation to the present study the researcher embodied both those positions, recognising on the one hand a personal curiosity and openness to the potential role for touch within psychotherapy, and on the other a critical questioning in relation to rationales for its use and to questions of ethics and risk of harm in a transference, therapeutic context. The researcher used the supervisory process and discussions with peers particularly in the designing of interview questions and selection of themes, to avoid tendentious questioning and to manage potential biases and remain open to all interpretations beyond any existing assumptions.

3.2 Sample and Recruitment

A sample of three psychotherapists practising from body-oriented approaches involving touch were selected, based on an assumption that the decision to train and

practise as body psychotherapists using touch was of personal significance to the participants. A minimum of five years' professional, post-accreditation practice was sought, to ensure adequate depth of experience of using touch. This was also to increase the likelihood of experience in working with clients in longer-term therapeutic relationships, with the hope of generating rich data on the relational and transference aspects of psychotherapeutic touch. A requirement that participants be in regular supervision was also a selection criterion, to ensure they adhere to good ethical practice in this field, in view of the recognised risks associated with the use of touch in therapy. Participants were identified through peer contacts and internet research, and recruited through direct email contact, with the first three to respond selected for interview once criteria had been verified. Participants were then contacted by email with information about the study, including information on anonymity, informed consent and confidentiality (see Appendix I).

3.2.1 Overview of Participants:

The participants had been in practice post-core-training for over ten years. Each had undertaken three or more different forms of body-oriented psychotherapy training specifically including the use of touch, both at core training stage and in post-qualification trainings. These included: Sensorimotor Psychotherapy, Hakomi psychotherapy, Body Harmony, Rebirther Breathwork, Gestalt therapy, Biodynamic psychotherapy and Bioenergetics. The trainings involved extensive practical experience of receiving touch, as well as on its use with others. In addition, all had trained in one or more non-psychotherapeutic modality involving touch, such as massage therapy, energy healing, yoga and chakra training, and shamanic practice,

which they felt added to their experience and understanding of the impact of interpersonal touch and its use.

3.2.2 Types of Psychotherapeutic Touch:

The participants described using different types of touch interventions with different clients and presenting issues. Those mentioned in the interviews included touching clients' hands, arms, shoulders and legs. The types of touch ranged from exploring the impact of the contact itself (e.g. fingers or hand), to touch given as support (e.g. a hand offered), touch given as resistance (hands or shoulders), or touched used in Bioenergetic massage (legs).

Table 1. Demographics of Participants

Name (pseudonym)	Maria	Liam	Eddie
Training	Rebirthing Psychotherapy (core) Sensorimotor Psychotherapy Levels 1 & 2 Body Harmony Energy Healing	Biodynamic Psychotherapy (core) Gestalt (postgraduate) Body psychotherapy (postgraduate)	Psychodynamic, Person-Centred (core) Gestalt (postgraduate) Hakomi full training (5 years) Sensorimotor Psychotherapy Level 1 Advanced Shamanic Practitioner
Years in practice	22	11	13
Specific training in psychotherapeutic touch?	Yes (core training)	Yes (core training)	Yes (post-core training)
Always used touch as an intervention?	Yes	Yes	No (only after training in its use)
Experienced touch as a psychotherapy client?	Yes	Yes	No
Experience of touch in other healing modality?	Yes	Yes	Yes

Supervised by practitioner who uses touch?	Yes	Yes	Yes
Theoretical underpinning of touch use	(see training)	(see training)	(see training)
Use of touch increased / decreased?	Decreased, but fine-tuned	Same	Low plateau (used with small % of clients)

3.3 Data Collection

Each interview lasted approximately 90 minutes, was recorded by digital Dictaphone and transcribed verbatim by the researcher. Detailed field notes were taken immediately after interview, to record initial impressions and impact of the interview material on the researcher, and to support the development of in-depth analysis. Notes also documented any impressions related to transference and countertransference during the interviews including somatic responses. The process of transcribing also promoted a deeper engagement with the data and processing of the material.

Participants were first asked to complete a demographic questionnaire (see Appendix II) to obtain information about their training backgrounds, practice and experiences in relation to touch. This also created an opportunity for the participants to begin the process of reflecting on their own history of experiences, as well as providing a context for the interview questions that followed. Exploratory, open-ended questions were asked in relation to the participants' experiences of working with touch in their psychotherapy practice, and drawing on some of the major themes identified in the literature review (see Appendix III). The semi-structured interview format was designed to elicit information specifically on the topic of psychotherapeutic touch, while remaining open enough for the participants to bring in subjective experiences and

interpretations in relation to the overall topic. Not all questions were asked during all interviews, as some of the relevant material emerged unprompted from participants' narratives.

3.4 Data Analysis

Each interview was analysed separately (Smith, Flowers & Larkin, 2009), with observations and questions noted on transcripts. Multiple readings of the transcripts were conducted at different times, to allow the researcher to integrate material (Pietkiewicz, & Smith, 2012). Salient words and distinctive phrases from each interview were written out in 'word clouds' on paper, to begin the process of reflection and association-making. Initial interpretative comments were noted also, in relation to both content and language use including elements such as metaphors, symbols, pauses and repetitions (Pietkiewicz, & Smith, 2012).

A close, line-by-line coding and analysis of transcripts was then conducted to identify theme clusters, commonalities and divergence, first within each transcript and then across all three interviews (Harper and Larkin, 2011, p.105). Themes were then checked against the available literature to avoid researcher bias, and re-checked against the participants' narratives to confirm the degree to which they were present. The process was informed by the researcher's knowledge of the field, and reflection by the researcher on their own perceptions, reactions and processes. Finally, the process of identifying themes included discussion in supervision and with peers, to mitigate researcher bias and help ensure relevance.

3.5 Ethical Considerations

One of the basic research principles identified by McLeod (2015, p.12) is the commitment to an ethic of care in producing genuine knowledge. Ethical principles of respect for autonomy, beneficence, non-maleficence and justice were upheld in the conducting of this research (Harper & Thompson, 2012, p.24). Participants were provided with background information regarding topic, context, design and goals of the research, and their rights as research participants. These include the voluntary nature of the study and the participants' freedom to choose what to disclose or not during the interview, as well as the right to withdraw from the study at any point. This information was outlined in a participant information sheet (see Appendix I) which was emailed to participants before interviews, and discussed with them at the start of their interview. Confidentiality of participants was ensured, with all recordings, transcripts and notes anonymised, coded, and stored in locked files, so that all data has been de-identified. Participants' identities are protected by the use of pseudonyms.

Chapter 4: Findings

4.1 Introduction

This chapter explores the impact of body-oriented work involving touch on the lives and psychotherapy practice of three psychotherapists. The in-depth interviews yielded rich data on their experiences. Following Interpretative Phenomenological Analysis methodology (Smith, Flowers & Larkin, 2009), the researcher used her own psychotherapeutic skills and close analysis to interpret the data and identify three themes conveying core aspects of the therapists' experiences:

1. The embodied, self-aware therapist
2. The power of touch: balancing risk and potential
3. Attuned relating embodied

The three were closely intertwined, with Themes 1 and 2 emerging as preconditions for the attuned, embodied relating described in the third, as well as outcomes or by-products thereof. They are outlined below, illustrated by verbatim extracts from the therapists' narratives.

4.2 The Embodied, Self-Aware Therapist:

“It becomes a way of being”

The extent of the therapists' embodied awareness stood out during each interview. Consistent references were made to their personal, somatic self-awareness, closely intertwined with their accounts of client work. Their training backgrounds in body-oriented work, and personal experiences of receiving therapeutic touch, highlighted

the depth of their experience and training in this orientation. Seen almost as a given, and as a vital foundation and tool in their work, their highly-developed, embodied self-awareness and experiences of touch were a salient aspect of their experiences and identities as psychotherapists.

Two participants identified their own experiences of psychotherapeutic touch as influencing their decision to train in this orientation, as well as informing their ongoing practice. Maria described how, after a personal crisis in her early thirties and attending a psychiatrist for months without effect, she was dramatically impacted by a single breath-work session:

Maria: ...it was like somebody turned on the light [...] It had a profound and immediate effect. And it was the immediacy of the effect that I was most taken with. Because I was getting to the point of hopelessness with the system I was working in. [...] The shift I got was dynamic, it was tangible. [...] In such a dramatic way, that I thought 'ok I want to know how to do this because if it can help-' I was in that place thinking 'well my goodness if it can help *me!*'

Though aware that body-oriented approaches were considered by some at the time as alternative or, 'kind of...far right of kooky!', Maria's personal experience of them working for her made her open to these modalities as an effective therapeutic route:

Maria: "It's just that there's more. There's more to us than just what's between the two ears, and there's different ways. There have to be different ways to get there."

Liam had trained as a massage therapist, and experienced bodywork, dance and authentic movement practices before training in psychotherapy. Though he himself had experienced traditional talk psychotherapy, his core training was body-focused from the start, influenced by these earlier experiences. Liam emphasised the central importance of having experienced touch as a client before using it in one's practice, conveying how important this is to him as a practitioner:

Liam: My sense is that the most important thing is to experience it yourself, first. [...] To have the experience of that type of therapy, be it that it's Gestalt, or Bioenergetic, or psychodynamic, or somatic, or Hakomi, or, you know, Sensorimotor... it's the *experience* of it for yourself. [...] To see how it impacts you, how it works. [...] You have to experience a *lot* of this stuff [...] to know how it can work, and to understand the energy, energetic part of it, yeah.

All participants named a belief in the body as an important access route to uncovering unconscious material, for those who are open to it. Their personal experiences and awareness of this were named as a factor informing their own practice orientation:

Maria: It was also knowing how much, in my own process, how much my body was involved. Recognising that, for instance if I [...] was feeling something and if I focused on where that was in my body, I could actually get more information, and I realised there's a whole *wealth* of information that hasn't been taken into account. [...] A lot of my interest has come from direct experience. [...] I started with the body. Body and breath. And came up that way.

Eddie: The *body* is the royal road to the unconscious! (*laughs*). [...] and it's *potentially*, em, a really powerful and lovely way to ehm.. make contact with unconscious stuff and, making the unconscious conscious is what we're about.

The participants consistently identified use of their own somatic awareness as an intrinsic aspect of their psychotherapy work, and something which had become automatic or second nature. This was reflected in how they spontaneously referenced their awareness of body reactions during the interviews, verbalising this to give the researcher some insight into their internal processing as it occurred:

Liam: So as you ask me that question I go *right* inside myself, I feel myself really deeply, right into my core, into the very bottom of my tummy, into the... second part of my tummy, into my solar plexus and into my heart.

Maria described how intrinsic this awareness is for her:

Maria: I'm so used to working with touch, and I'm so used to tracking what's happening in the body alongside of the narrative, and paying as much attention to that as to the narrative; I've been doing that all the time I've been working as a therapist.

In all three interviews the therapists' verbal delivery was paced quite calmly and evenly, and each regularly paused for moments of reflection before answering questions, connecting to their own internal physical awareness. This conveyed a sense of comfort within their own skin, and was experienced by the researcher as promoting a sense of calm yet engaged openness to exploration during the interviews. It also provided insights into how the practitioners used this internal body awareness as an important source of information to help them to respond in a congruent, authentic way. Asked about colleagues' attitudes to his use of touch, for example, Liam noted a body movement that betrayed his feelings on this before he verbalised them:

Liam: Mmmm... [*clasps his hands and puts them firmly on lap / in front of belly*] Yeah it's a good question, I, I think, funny as you ask it, I think – I notice now there's a part of me - and I even noticed as I went to answer it I notice what just happened with my hands! (*laughs*) – I think there's a part of me that protects it a little bit.

In the early stages of his interview, Eddie appeared careful, almost cautious answering questions, and seemed concerned with answering them in a way that accurately conveyed what he needed to say. Further into the interview, appearing increasingly grounded, there was less verbalisation of this checking-in process.

Eddie: (*After breathing deeply and with hand on belly, indicating a focus on his body*) "Yeeeahhh. Yeah. I'm just ehm.. I'm just checking in with myself around what – why – the whys and wherefores of why that might be. Ehm..."

This 'checking in with himself' physically at different times was experienced by the researcher as buying time, to recognise whether he felt comfortable to go ahead and answer a question, or if he was satisfied with his answer. It offered a window into how his internal process might play out with a client.

Finally, the therapists' experiences of embodied work including touch appeared to have a profound impact on their experiences and identities both as practitioners and as people. Eddie conveyed this with a careful, quieter tone of voice, reflecting the sense of respect and privilege he articulated:

Eddie: [...] I feel a *huge*, huge privilege [...] that somebody feels safe enough with me to do that. The *nourishing* has kind of eh, registered deeply with me and like, I don't even *know* yet how deeply it's registered with me. But [...] I think if I had stayed purely doing psychodynamic therapy, em, I'm not sure if I'd have given up before now... yeah. I certainly wouldn't be as comfortable in myself as a human *being* and as a therapist.

Liam articulated surprise at his own depth of experience, which he seemed only to become aware of consciously via the interview process, reflecting perhaps just how intrinsic this embodied awareness is to him:

Liam: So, so it's really interesting to discover that about myself [...] And it's eh... a very *interesting* thing (*said quietly, in a perplexed / marvelling tone*). Yeah... I mean what comes to mind as you ask the question *now*, is... is that I suppose what I'm really aware is, is of what I *bring* to my work, and that sort of sort of moves me a little bit as I reflect on it, because actually I realise I bring an *incredible* sense of my own embodiment.

Maria named the impact on her and her practice also, describing a deeper awareness and experience of herself in the world:

Maria: It's almost like as though I had grown up with this idea that the body was the vehicle for moving your self around, but I realised that it – gosh, it is so much more, and the more I got to *know* it, the richer the experience of living is. [...] It becomes a way of being. And also you become very aware of when you're not 100% present. And the difference that makes in a therapeutic setting.

Researcher: So has it increased your capacity for presence-?

Maria: I think it impacts on you in general, it... how y-... to live in the world, from being aware of being inside of your skin, with an awareness of your body [...] When I looked out the window this morning, and I saw that extraordinary sky, and those colours, I was aware of smiling, and I was looking at it, I was aware of the wind against my skin, on my face, I was in a dressing gown, I was aware of the wind, as I looked up, and then I was aware of the quality of light,

and I was aware of the *feeling* of the sun shining. [...] Yeah, I was experiencing it in a very... it makes life a much more sensual experience.

4.3 The Power of Touch: Balancing Risk and Potential

“The cherry on the cake”

“...can also send somebody running”

The second theme which stood out was the participants' belief in the significant power of psychotherapeutic touch to access emotions, release trauma and integrate change, and the potential for harm that it also poses. Both were discussed in tandem, and all three therapists described the importance of establishing safety and building trust as an intrinsic aspect of their work in this modality.

Liam saw this orientation as offering a significant additional dimension to therapy. In the extract below, his delivery was noticeably slowed-down and deliberate, his voice reaching almost a whisper at some points, which seemed to reflect his awe at the power of touch:

Liam: [...] it does bring a dimension to the work that can be *powerfully* transformative, you know. That sitting in the chair, four feet apart... I'm not sure fully *gets*. [...] The body work has something that is, it's like, it's like... it's *kind of like the cherry on the cake*. It's a bit of a crude way of putting it, but there's something quite eh, if it's appropriate [...] it can really be transformative, and highly repairing.

Researcher: So what is that cherry on the cake that it offers?

Liam: [...] It's something about the *energetic release* that's possible, through the intervention, that sometimes... I don't know if it's as possible (*with non-touch therapy*), yeah.

Eddie articulated a similar belief in an additional level of release or relief offered via touch, referencing his awareness of trauma theory:

Eddie: It's [...] giving our muscles and sinews those real experiences, and so they can release from some of that tension. [...] And that's the trauma bit. The trauma is that movement that didn't get to happen. And, be it a car accident [...] or somebody shouting at you, or somebody giving you a disapproving look or whatever [...] getting an *experience* of... some part of them getting freed up. Like, it'll work in *talk* therapy but it could take a long time.

Maria understood both the power and risks of touch from her own experience of inappropriate use. She recalled being touched by a facilitator in a therapeutic group context, six months after her mother's death, which had been "very dramatic and traumatic" for her:

Maria: [...] I was lying kind of out flat, and *without warning or permission* she put her hand on my stomach and pushed, and, and my instant response was to want to *hit* her! And I was really [...] in a very vulnerable place, and [...] it shut me down for the next few days. And it left me where I, I kind of withdrew, which would be a defence pattern I have myself, I'm very aware of it [...].

Researcher: So how did you experience that?

Maria: As a violation. As a *total* violation.

This experience made her aware of the risk of re-traumatising a client who had experienced any kind of violence, abuse or developmental trauma in their history. Maria, like the other participants, felt that training on touch has a vital role to play in mitigating such risks:

Maria: I find a lot of therapists very nervous about touch. [...] And it – completely understand it, touch is very powerful. Em, and I understand the nervousness, and it's – if there's no training in it, then it's great that the nervousness is there, because it will stop people doing anything that could be in any way harmful. [...] I think you *need training* before you – you go into working with touch. I really do.

Eddie referenced the importance of continued training and ongoing development of somatic-self-awareness, via personal therapy and body-oriented practices.

Eddie: Oh for anyone using it eh, training is, training is absolutely essential, 'cos you really don't know what's gonna come up with somebody. [...] It's like practising, practising your own self-awareness, [...] helps one register ehm and

track ehm those edges or risk points with particular clients. So I believe part of the ethics is keeping our own [...] self-development, going.

Liam likewise emphasised training, describing an occasion where he felt he inappropriately used touch with a fellow trainee in his early training. During a practice exercise he made a spontaneous decision to use touch with his classmate:

Liam: It's like, oh gosh, I wasn't paying *attention*, to myself, what was happening for me, I wasn't paying attention, really, to the client, I was just in perhaps some anxiety about what to do next. And I pulled a tool out inappropriately, in the moment, to do something. But that's what you learn in the training [...] that intervention has the potential in a live situation to be damaging.

Appropriate supervision was identified as another important factor in supporting safe body-oriented practice. The participants had all experienced supervision by practitioners trained in body-oriented approaches involving touch. Liam chose to have two supervisors while in training, a body-orientated one to complement his 'classical Humanistic Integrative' supervisor. He also highlighted the supervisory support offered by body psychotherapy postgraduate and CPD trainings he had attended. Maria stressed the importance of therapists exploring their own motivations for using touch via supervision:

Maria: I would spend a *lot* of time with young therapists getting them to really work with *themselves*, on what's going on with *you*, when you have that desire to touch. Where is it coming from in you? [...] Because I really think it's em.. it can be - touch can be *really*, really powerful. And it can also send somebody running if it's used incorrectly.

The importance of having a clear theoretical rationale for the use of touch was also named in relation to safety. This varied depending on their orientation and training backgrounds, as can be seen in the earlier extracts. Maria noted her use of touch had changed over the years:

Maria: It's decreased, but... it's much more fine-tuned... ehh (*reflecting*) [...] if I use touch now it's very, very fine tuned when I'm using it. [...] In Sensorimotor it's very much less is more. [...] And though touch is used, it's always very focused. [...] Yeah. There's always purpose with it. It's not like I'm reaching over and touching you- it's not that. If I'm going to reach over, we do it mi- in a state of mindfulness, we're in collaboration, mindfully.

This collaborative aspect of body-oriented work including touch came across strongly in participants' narratives. All named the therapeutic alliance as the central foundation to safety in the work, and the gradual process of building this over time:

Liam: I mean I touch therapy is [...] *all* about the development of the therapeutic alliance, so a client walks in the door for the first time I mean of course you're never going to touch the client, or even suggest an intervention that would involve touch, or exercise or contact. For some clients if it comes in, if at all, it mightn't come in for two years or three years. Occasionally you meet a client and it will come in after four sessions, but that's sometimes because the client has done a lot of previous work."

The therapeutic alliance was both a foundation for the work, and its ongoing development an inherent 'by-product' or outcome of the work itself. The participants described several key elements to developing trust in the therapeutic alliance in the context of body-oriented work incorporating touch. These included prior discussion of touch, clarification of rules and intent, clear and explicit verbalising before, during and after its use, and slowing down the pace of the work. Liam described this process of informing, discussing and verbalising:

Liam: I say, you know, there's this piece of work that I sense might, *might* be helpful right now, and I explain what that would involve, so I go into a lot of detail about what it would involve, you know, the parameters of it, you know, [...] I explain to them *exactly* what will happen, so that it's very explicit and very clear. And then I check in with them, 'how do you *feel* about that as I say that to you, what d- how, how are you, is that something that...?' You know. And then we have a dialogue about it, we s-, you know... I suppose we establish ground rules and boundaries, and all of those things.

Maria referenced the same process of checking in with the client what response they are having to the topic of touch being mentioned:

Maria: I'm offering it as an experiment, and we are mindfully studying what happens with the touch. What happens even with the *suggestion* of touch. Sometimes that's a session in itself.

Researcher: Ok, so very slowed down.

Maria: Oh it's *hugely* slowed down – bite size. Bite size. It's knowing the... how important and powerful the use of touch *is*.

Ultimately the risks associated with psychotherapeutic touch were seen as part of its potential for healing, once this is recognised and worked with. Liam recounted being told by a client at the end of his therapy that a touch intervention had been 'the most memorable and impactful' part of the work for him: ' he said it blew him away and it impa- it was so impactful and reparative.' The work with this client had involved a risk on the part of both individuals in relation to vulnerability, and this was worked through.

Finally, both Eddie and Maria named the particular importance of safety and clear boundaries being put in place with clients of the opposite sex:

Eddie: [I'm] quite aware of that safety piece. So ehmm...that I would be *very* conscious with doing any touch work, and particularly as a male with female clients.

Maria: I've found that in working with men, it's very much ehm.. you need to be really clear... On where you're going with it, what your motivations are, and that the, the client is really clear as well. [...] Clear on the boundaries. [...] Because of the, the sexuality element.

While participants identified different conditions they felt necessary for touch bodywork to be safe, ultimately there remained an element of discernment on their part, just as with any other psychotherapeutic intervention. The difference here was their referencing the use of their own body responses to inform this discernment around the use of touch, and their close tracking of clients' body responses during the moment-to-moment engagement. This is outlined further in the next section.

4.4 Attuned Relating Embodied

“To mirror that I exist”

The third theme emerging strongly from the interviews was a sense of a refined degree of attunement and depth of intersubjective relating, facilitated by the embodied dimension. The extracts below convey the different elements of: somatic awareness, verbalising, tracking, slowed pace of work, risk and collaboration as described above, along with transference and counter-transference, as they play out in this attuned and embodied relating at the touch boundary.

The participants attached importance to supporting the client’s development of greater somatic self-awareness in support of their process. There was a sense of offering an opportunity to integrate missed or unlived experiences at a deeper level. This happened by tracking body responses in the context of the therapeutic interrelating. Eddie had a sense of playing the role of an infant’s parent, containing and pacing the work and supporting the client to recognise and verbalise their experiences in a safe context:

Eddie: One of the pieces is ehm, is having that, back to the felt sense piece, but in a supported environment. [...]. It’s like they can get a sense of something that maybe as a child they didn’t have support to feel their grief, or feel their isolation, or feel their anger. [...] And, em [have] found something in themselves which they may not have known since they were babies.

He described this in relation to his work with a particular client:

Eddie: And to trust, not just trust support, but even trust the possibility of support, eh was a huge piece for [the client]. And ehm, and just – getting a kind of a – a *body* experience of what that’s like, like ok there was a huge amount of grief came up, there was also, there was grief and relief. [...] the relief that this just might be possible. Taking support just might be a possibility.

Eddie referenced his awareness of Sensorimotor theory and neuroscience in relation to the therapist's role in supporting the client to regulate their nervous system via attuned relating and somatic awareness.

Eddie: A lot of the work with Hakomi and Sensorimotor is tracking, tracking body movements. I know we do it in a lot of the other therapies as well, but there's a particular kind of focus on *very* subtle, very subtle body movements.

He described how slowly the process needs to happen for the client to truly integrate the new experience at the body level, working at the edge of the client's 'window of tolerance' (Ogden, Minton, Pain, 2006). This involves slowing down the client's process enough that clients can integrate sensations and experiences, while also avoiding either hypoarousal or hyperarousal of the nervous system.

Eddie: Yeah they're slowed down, in themselves in their own, it's like their process has slowed down so they're able to *notice* more. [...] know what their touch points are, what their trigger points are. And then there's the possibility, then, of them being able to do some kind of self-regulation. [...] [In] Sensorimotor, they call it [...] 'savouring and relishing,' but it's *staying* with that new experience, just really, really staying and really *notice* that sensation.

Before a client develops this self-awareness and capacity to self-regulate, the therapist must closely track the client and identify potential breaches of boundary or risk of trauma.

Eddie: [...] *even* if they're not able to say stop, the resistance manifests in their body (*inaudible*) see the resistance. [...] and of course it's up to me to really know where the brakes are. So even if they themselves are not saying here is my 'no', or 'this is not ok with me', their body will be shouting no, generally. There will be a rigidity, there will be ... it's like, there won't be the *curiosity*.

He described how incorporating somatic awareness enables him to identify when a client's boundaries are in danger of being breached, when they themselves might not be aware or feel able to communicate it:

Eddie: It's tracking the non-verbal responses [...] if I get a little jangle about some bit of the story, if some part of my countertransference tells me there's something [...] if I'm noticing that riskiness, em, I think I feel it about... somewhere about there, somewhere in the middle of my chest or maybe in my solar plexus [...] that's a no-go for me. [...] I'm, eh tentative enough to, to notice you know subtle, those subtle em... protections that people will have [...] 'cause frequently the verbal no is not there.

Liam described it as listening 'at a gut level,' while tracking any subtle body movements or twitches in the client that signal their real boundaries, though the client may be unaware or overriding these:

Liam: Because they're not paying attent- so in their *head*, 'oh he's such a nice person, I couldn't possibly stop', or 'I couldn't-', you know. The cognitive bit is kicking in, and overriding what's actually happening. [...] everyone's overriding the gut, with the head, you know.

Maria described working with a client whose arrival into the world had been 'unwelcoming' and who experienced a sense of not being grounded. In this session she appeared to be in a very early state of regression, and Maria worked with her at the touch boundary of their hands. Maria's close tracking and mirroring within this was described as offering the client a new sense of herself, and a corrective emotional experience that was integrated somatically:

Maria: And as her hand came forward I just followed it, and I matched it, each of her movements I matched. And on the touch, her whole expression transformed. I could see it transforming in her face, but also in her body, when she *got* the touch, she smiled, and she started to laugh, and she sat up straighter, and then she came forward and she said, 'Yess. Now I *know*, I'm *here!* [...] And then we deepened with the 'I'm welcome' –what does that feel like?

Researcher: So really it's to kind of affirm that, her felt sense.

Maria: Yeah, to get it somatically, that's the whole point of using the body, it's to get it somatically. [...] To give back what wasn't there, like... When the infant is born, part of how I know I'm here, as a little one, is I see it reflected in you – I *need* the other. [...] To mirror it, to mirror that I exist. And part of what gives an infant safety is touch. To know where I end. Where I am. This is me.

An earlier stage of Maria's work with this client involved withholding touch until her need for it had been more fully explored, somatically and verbally. This involved Maria's awareness of her somatic-countertransference in relation to the woman, and her use of it in the work. The client presented with needs reflecting 'oral' personality (Reich, 1980), described as, "without boundaries and very, very needy, [...] 'I want you and there's never enough.'" This activated Maria's own 'self-reliance' defence, and it was her incorporating and naming of somatic countertransference with the client that moved the work forward:

Maria: That would get activated. And I would find myself having a strong resistance to using touch, or to giving into that. I'd nearly - particularly in the early days I'd nearly want to go into a (motions putting arms up / pushing away) grrrrrrrr – go away! I would feel myself wanting to push! Right? And even as I'm talking I'm noticing now how (*looks at foot and smiles*).

Researcher: Your foot went up.

Maria: My foot! Yeah! Now that's the kind of thing I'd be tracking, in a session. And in – I would be trying to sit with that, and be talking to my supervisor about it. And she said but isn't that the perfect opportunity to bring it into the room, let's talk – you know why not bring it into the room?

Maria's disclosing of her somatic responses to the client, and communicating her experience of the client's demands as challenging, led to a working through of past traumas for the client via the experiences having touch withheld as well as receiving it, and exploring both. Maria noted that she does not automatically give or use touch:

Maria: Sometimes touch can be a comfort. But you know the way if you – if comfort comes sometimes too soon, the very thing that the person needs to – to clear, or is working with, it kind of goes underground again, whereas being without the comfort brings up the very issue they want to work with.

Liam similarly described the subtle discernment required by the therapist in deciding whether or not to make a particular touch intervention:

Liam: It mightn't necessarily *actually* be the right thing to do in the moment, you know, it might be to *sit* with the energy, it might be to explore it, to stay with it, breathe into it, you know.

Finally, Maria described her awareness of erotic transferences from male clients in the earlier years of her practice, which led to differences in how she worked using touch with women and men. This included an additional need for clarity on motivations around its use, as well as greater clarity around boundaries, "because of the sexuality element." She described how her tracking of erotic transference might manifest at the somatic level:

Maria: You know, the eyes changing, the... ehm the coming up –what I would call the kind of 'coming up' – the interest, the, that little frisson.

Researcher: In their overall demeanour?

Maria: In the overall demeanour, and it's in kind of micro-movements almost, in the body. [...] It's like if you were out on a first date with somebody. You know the way you're tracking interest, we'll say over dinner, or, having your drink. It would be seeing those similar kind of indicators. [...] Tracking that and noticing [...] how my own body is. When I feel that, when I feel that wanting to - put a strong boundary there. [...] I suppose a lot of my work – I know everybody does this as a therapist... but, a lot of my work is not just tracking the client but constantly tracking myself, in response to the client.

Chapter 5: Discussion

5.1 Introduction

This study set out to acquire insights into the individual experiences of psychotherapists using touch in their practice, and the meaning they derive from it. Its objective was to understand the context and rationale for their use of psychotherapeutic touch, and to explore its impact both on their practice and on their experiences of themselves as practitioners. A qualitative research approach was thus chosen, using Interpretative Phenomenological Analysis to acquire a deeper insight into the participants' interpretation of their experiences, and the complexities and subtleties involved in this form of therapeutic relating.

The participants' narratives yielded rich information on their experiences of working with psychotherapeutic touch, and among these, three salient themes emerged:

- The embodied, self-aware therapist
- The power of touch: balancing risk and potential
- Attuned relating embodied

These were strongly interlinked, and the second and third themes in particular took some time to differentiate, as they are so closely interdependent and manifest concurrently in practice. Nevertheless, they can also be conceptualised as flowing one from the other in sequence, as themes 1 and 2 were understood by the participants as foundations and prerequisites to the third.

The first theme highlights the extent of the therapists' own sense of themselves as embodied practitioners, manifesting in regular references to their use of body responses as important tools in their practice, as well as during the interviews. Their somatic awareness and sense of embodiment appeared to enable them to relate therapeutically in a confident and authentic way. It also came across as an effortless, intrinsic way of being for them, adding an extra, sensory dimension to their experiences within their clinical practice and in their wider lives.

The second theme emerging from the data was the participants' belief in the power of psychotherapeutic touch to bring awareness, healing and transformation. In particular, touch was named as helpful in facilitating energetic release, processing trauma and integrating new experiences at a deeper, non-verbal level. In tandem with this positive potential, participants named the potential for harm if touch is used inappropriately. Factors mitigating this risk included: appropriate training and supervision, the therapeutic alliance, clarity of rationale and motivation, prior clarification and discussion, slowed-down pace of work, and clear and explicit verbalising of processes involving touch.

The final theme to emerge from this study was the embodied, attuned nature of the therapeutic relating described by the participants. The therapists saw themselves as fostering the development of new self-experiences in the client via the body-oriented work including touch contact. Having first grounded and resourced their clients through supporting them to develop greater body awareness, they work at the edge of the client's 'window of tolerance' to retrieve and integrate unconscious material and release unprocessed trauma. This work involved closely tracking and mirroring their clients' body responses, while incorporating somatic countertransference, to support

the therapists' capacity for attuned relating, thus bringing an additional, embodied dimension to the therapeutic relationship.

The findings are discussed below under the three themes, in relation to the relevant theory and literature available on the topics outlined in Chapter 2. Similarities and divergences between the present study and previous research are highlighted, along with some gaps in the literature.

5.2 The Embodied, Self-Aware therapist

The findings in relation to the practitioners' own experiences of embodiedness and touch offer insights into an area which receives little consideration in most of the existing literature. In the books on body psychotherapy in general, and in the theoretical and practical manuals on specific body approaches including touch, the emphasis is on the client and the client's body (Totton, 2003; Smith, Clance & Imes, 1997; Staunton, 2002; Kepner, 1997; Ogden, 2015; Levine, 1997; Kurtz, 1997). Topics such as assessment, diagnosis, observation and techniques are covered with the spotlight firmly on client factors and presentations. Even where detailed descriptions are given of specific touch interventions involving, of course, the psychotherapist's body, this is done without the embodied experiences of the therapist being mentioned or discussed in any great detail. Though there is research on somatic countertransference, it is a difficult area to quantify due to the many different names given to the same phenomenon, including: body empathy (Jacobs, 1991), body listening (O'Shaughnessy, 1984| DaSilva, 1990), embodied countertransference (Samuels, 1985; 1989; 2000; Field, 1989; Stone, 2006), embodied attunement (Emery

1992), and somatic intersubjective dialogue (Dosamantes-Beaudry, 1997; 2003). In addition, the research primarily focuses on reactions to and from clients without elaborating in any great detail on therapists' somatic experiences of themselves as embodied.

In the literature specifically focused on touch, Smith, Clance and Imes devote a chapter to 'Therapists' recall of their decision-making process regarding the use of touch in ongoing psychotherapy' (1997, pp. 92-108). However, the extracts from therapists' responses to a questionnaire on the topic focus on the practitioners' cognitive or intellectual decision-making process in using touch, without naming their use of their own body awareness in this. While somatic awareness may in fact have played a role, it is not mentioned, while other factors such as theoretical rationales, client histories and demographics, presenting issues, and therapists' beliefs are given.

The participants in this study all conveyed a sense of being very comfortable in their own skin and displayed a natural ease in connecting to their own body sensations, as an important foundation for being comfortable with touching clients in the appropriate context. This is consistent with Hunter and Struve's work on the ethical use of touch in psychotherapy, which identifies therapist discomfort with touch as a contraindication for its use (Hunter, M., & Struve, J. 1997, p. 151). The authors encourage therapists to reflect on their personal history of being touched in childhood and adulthood, as well as clarifying personal views on the use of touch in their practice. They provide a list of questions to stimulate this reflection, and suggest the practitioner write a statement summarising their past experiences and present views of touch (Hunter, M., & Struve, J. 1997, pp. 264-267). However, they do not go into any detail on the somatic or

embodied experiences of therapists within this, nor do they explicitly encourage this aspect of reflection on the part of therapists.

Exceptions to this omission include Cameron's chapter on 'Subtle Bodywork' in Staunton (2002, p. 162-166). She names energetic self-awareness in the therapist as the first stage of helping clients to develop it, and offers a number of specific exercises to support them to develop awareness of subtle body sensations, and to identify habitual energy holding patterns in their bodies. Cameron also provides a section on using the therapist's own energetic response to help develop the client's awareness, without giving any detail on where or how this energetic response might manifest in the therapist's body. While Cameron's naming of energetic self-awareness echoes Liam's point about the importance of practitioners experiencing the energetic aspect of psychotherapeutic touch, her brief treatment of it misses the central importance he and the other participants allocate it.

Two participants named their experiences of receiving therapeutic touch as a factor in their decisions to train in this therapeutic orientation, while the third experienced it during his training. All three shared a belief in the body as an important route to accessing the unconscious, both theoretically and, for two (Maria and Liam), informed by their own experiences of this. Some of the literature offers information on demographical, personal and historical factors influencing practitioners' decision to work with touch, including their own experiences of it (Phelan, 2009, p. 98; Milakovich, 1997, cited in Smith, Clance and Imes, 1997), however most writings lack details on the nature of these experiences, or their impact on practitioners' training choices or their practice. Levine is one of the more notable exceptions to this: he includes a detailed account of his personal experiences of a traumatic accident (Levine, 1997),

and the impact this experience had on his development of a ‘Somatic Experiencing’ approach to working therapeutically with trauma.

This overall gap in the core texts on body psychotherapy and touch contrasts starkly with the accounts provided by the present study, where practitioners regularly referenced use of their own somatic awareness and embodiedness as a foundation to their work. Their consistent references to this as it occurred in the interviews conveyed how developed it was, and how intrinsic to their ways of being and relating. Liam’s own surprised recognition of the extent of his sense of embodiment could be said to reflect the assumption that such self-awareness would be a given for the body-oriented practitioner, in the same way that a classical psychotherapist would be expected to have a high degree of self-awareness of their own defences. However, while this was identified by all participants as essential, and according to their narratives was encouraged and experienced at the practical level within their trainings, embodied self-awareness in the therapist appears almost as an afterthought in the literature, occasionally named but not further explored. The present research thus begins to fill this gap, offering insights into practitioners’ internal processes in recognising and naming body sensations, and what this might mean for them in practical terms, as well as offering a flavour of how it can be used in the work.

Finally, the embodied self-awareness conveyed by the participants in this study was expressed as impacting on their sense of themselves both as practitioners and in their wider lives. Such personal, phenomenological accounts are absent from the existing literature. Through the ‘double hermeneutics’ of Interpretative Phenomenological Analysis (Smith, Flowers, Larkin, 2009), this was understood as adding an additional, embodied and sensory dimension to their identities as practitioners and to their

experiences of themselves in the world. This dimension was seen to support their professional practice, and add depth and richness to their lives. This is encapsulated in Maria's account of experiencing a sunset as not just a visual phenomenon observed at a distance, but a rich, sensual experience she was part of.

5.3 The Power of Touch: Balancing Risk and Potential

The findings of this study on the perceived power of touch are consistent with existing literature, in terms of its potential both to heal and to harm. While different body-oriented therapies conceptualise the therapeutic potential in different ways, incorporating the body including touch is broadly seen as offering an additional dimension to the therapeutic process that can promote deeper healing and transformation. Specific contributions which participants attributed to touch included energetic release, processing trauma and integrating new experiences at a deeper, somatic level. These are reflected in the writings on body psychotherapy in general (Totton, 2003; Smith, Clance & Imes, 1997; Staunton, 2002), and within manuals detailing specific body-centred approaches including Gestalt, Sensorimotor Psychotherapy, Somatic Experiencing, Hakomi and Bioenergetics (Kepner, 1997; Ogden, 2015; Levine, 1997; Kurtz, 1997; Reich 1980).

The touch interventions described by the participants can be seen as falling across the three categories of body psychotherapy defined by Totton (2003): adjustment, trauma/discharge and process, reflecting the integrationist approach of many neo-Reichian body psychotherapy practitioners as outlined in Totton (2003). In addition, Smith, Clance & Imes (1997) identify three specific functions of psychotherapeutic

touch from their research into clients' experiences of it. These are: providing a link to external reality; communicating acceptance and increasing self-esteem; and allowing the experience of new modes of relating. These outcomes of touch are reflected across the participants' accounts, for example in Liam's work on grounding clients with bioenergetics exercises, i.e. linking them to external reality, and in Maria's example of the client whose work involving touch gave her an experience of being welcomed into the world (acceptance and esteem) and the somatic experience of receiving another's support – a new mode of relating for her.

The power attributed to psychotherapeutic touch originally stemmed from theoretical elaborations dating back from Reich (1980) and Lowen (1994), who sought to reinstate a more central position for the body within psychoanalysis following on from Freud's theory of the biological foundations of the psyche (1923). More recent developments in neuroscience have bolstered many of the core concepts of these earlier approaches, elucidating the role of body interactions and non-verbal interactions in shaping personality development, and pointing to the need for body-oriented, sensory therapeutic interventions to access 'right brain', implicit memory allowing deeper integration levels not accessible by cognition (Schore, 2002; Siegel, 2001; Sonkin, 2005; Wallin, 2007). Hunter and Struve (1997) highlight the central role of touch in emotional development and articulate the relevance of this for psychotherapy practice.

The study participants identified these theoretical and scientific backdrops to their body-oriented practice, and the important role attributed to touch within these. This was evident in Eddie's emphasis on supporting clients to stay present with or 'savour' new experiences and notice sensations, in order to fully integrate these at a deeper level, or in Liam's work to amplify the felt sense of a client's new experience. It reflects

both the attachment and object relations emphasis on facilitating new experiences of self and other, and the neuroscience evidence on the role of the body in integrating these. Liam's sense of the 'crudeness' of his words in attempting to describe the subtleties of his work reflects his view of the limitations of language, and the benefits of approaches that go beyond the exclusively dialogical mode of working therapeutically.

Not all clients may be open to this, and the question of appropriateness, safety and risk in psychotherapeutic touch was raised in this study and reflected in the literature. The most obvious risk identified by participants was a breach of physical boundary, and the accompanying emotional and relational betrayal that this could entail. Smith, Clance and Imes (1997) discuss this in relation to specific client groups and presenting issues. The other most commonly identified risk was of traumatising a client who has experienced previous traumas such as physical, emotional or sexual abuse (Smith, Clance & Imes, 1997; Hunter & Struve, 1997).

While not disclosing any specific instances of touch causing harm to clients, two participants described their personal experiences of its potential for harm. Liam disclosed having used touch inappropriately with a fellow-student during his early training. Maria personally experienced a practitioner using touch on her without prior notice or discussion, which she experienced as a violation. These direct personal experiences with touch informed their awareness of the need for conditions to be in place for the safe use of psychotherapeutic touch, as well as the importance of training in its use.

The researcher was interested to note the use of the term 'nonerotic' touch in some of the North American literature (Geib, P. in Smith, Clance, Imes, 1997). This suggestion that touch is implicitly sexual unless otherwise specified can be seen to reflect the over-sexualisation of touch in a culture that has been described as 'touch-deprived' (Hunter & Struve, 1997; LaPierre, 2006). Geib notes the difficulty many North Americans have in differentiating between sexual and other types of physical contact (in Smith, Clance, Imes, 1997, p. 109). She contends that this association stems from Freud's Oedipal and drive-oriented theory which sees touch as essentially sexual. However, she states that the object relations emphasis on pre-Oedipal issues concerned with very early mother-child interactions makes it possible to use the term 'nonerotic' touch, while recognising that such touch can potentially become sexualised in any context. The participants' experiences reflect this stance, as they recognised the potential for sexualisation of touch while not assuming it in all cases, and remained open to working with this once it has been clarified.

The efforts to elaborate clinical guidelines on psychotherapeutic touch and emphasis on obtaining explicit consent in Hunter and Struve's (1997) work can be seen as emerging from a cultural landscape shaped by greater regulation and litigation than the European context. This search for definitive guidelines and clarity on the matter does not reflect the emphasis on self-awareness and discernment conveyed by participants in the present study, who made few generalisations about suitability or contraindications in relation to touch, but rather named a range of variables to be taken into account with an individual client as well as each client-therapist dyad, as outlined below. Along with these factors, they displayed a sophisticated awareness of the complexities involved in working with psychotherapeutic touch, and in particular the risk of boundary breaches including re-traumatisation or sexualised touch, which they

believed helped them to manage associated risks. Their embodied awareness and understanding of embodied countertransference dynamics were named as helping them in this discernment.

The findings in this study on factors promoting safe use of touch closely correlate with those identified in the literature. The therapeutic relationship, one of the primary factors identified by participants in relation to safety, is also named in the writings on body psychotherapy and within the specific approaches (Totton, 2003; Staunton, 2002; Kepner, 1997; Ogden, 2015; Levine, 1997; Kurtz, 1997). In the two main texts on psychotherapeutic touch, the therapeutic relationship is explored in terms of clarifying boundaries, intimacy, trust, and power dynamics (Smith, Clance & Imes, 1997; Hunter & Struve, 1997). Both explore the specific issue of the therapeutic alliance in relation to touch with survivors of sexual abuse, also named as central to safe work by the participants in the present study.

The question of informed consent clearly identified by participants is also covered in the literature. While they described an ongoing process of clarifying this verbally before and during work with clients, the books on touch present it as verbal and written contracts to be obtained as a more formal, almost administrative requirement at intake stage (Smith, Clance & Imes, 1997; Hunter & Struve, 1997). The texts outlining specific body-oriented approaches offer more nuanced, detailed descriptions of the process of introducing the question of touch, clarifying intent, discussing rules and boundaries, and reviewing the client's reactions in a way that incorporates the somatic aspect of this work, more closely reflecting the participants' narratives (Kepner, 1997; Ogden, 2015; Reich, 1980).

The emphasis on the importance of training emerging from the present study is also found in the literature. In particular, the importance of experientially-oriented training mentioned by participants is reflected in the descriptions of exercises contained in the text books outlining the practice of approaches such as Sensorimotor Psychotherapy, Hakomi and Somatic Experiencing. As observed by Eddie, the emphasis in Hakomi training is on developing a capacity to track the subtle movements in a client (Kurtz, 1997). In pondering the question of whether or not there exists a specifically body-psychotherapeutic approach to training, Totton states that the one certainty is that it must be experientially grounded (Totton, N. in Staunton, T., 2002, p. 215). This is reflected in the participants' primary emphasis on themselves and their own awareness and experience in relating to their clients as a primary tool in their practice. Their numerous references to their use of supervisory relationships to support a safe and ethical use of psychotherapeutic touch also correlates with the literature, particularly in the texts providing overviews of body psychotherapy (Staunton, 2002; Smith, 1985; Totton, 2003) and specifically on touch (Hunter & Struve, 1997), though not so explicitly named in literature specific to the different body-oriented approaches.

While the texts on psychotherapeutic touch attempt to elaborate guidelines around appropriate client populations and seeking consent (Smith, Clance & Imes, 1997; Hunter & Struve, 1997), the participants in this study appeared to have a more case-by-case approach in their decision-making process around whether or not to introduce it. This involved applying their own discernment in relation to variables including presenting issues, duration in therapy, and the development of the therapeutic relationship. It was also informed by the therapist's somatic awareness or gut feeling in relation to the client, as is explored further in the next section.

5.4 Attuned Relating Embodied

The participants in this study saw themselves as supporting the client to develop greater somatic awareness of themselves, as a necessary foundation to containing difficult emotional states. This reflects the approach of seeking to compensate for early deficits articulated in the literature (Forer, 1969, LaPierre, 2006), where a person has not received the early attunement and regulation required for them to develop a solid sense of self that is then capable of holding different affect states and healthy relating with others (Nolan, 2012).

Eddie described this deficit approach in his work to slowly and patiently support and contain clients in their gradually-developing awareness, so that they may then recognise and reconnect with disowned feelings of grief, isolation or anger in a supportive environment. Wallin describes this process of supporting clients to experience a coherent sense of self, while also being able to imagine the subjective experience of another, as 'mentalisation' (2007). Body awareness is a central aspect of mentalisation, and requires the therapist to have this capacity in order to resonate with the client and respond in an attuned manner. By attuning at the nonverbal level first, the client is supported to integrate dissociated or disowned unspoken experiences, as well as engaging in intersubjective relating as a more coherent self (Wallin, 2007, p. 134; Nolan, 2012).

The participants' accounts of their own embodiment also echoed the role of the attuned or 'good enough' parent described by Winnicott, well-enough able to manage their own internal state that they can be fully present to the child (1956). Winnicott describes the vital role of attuned and responsive relational mirroring played by the

mother in giving the baby a sense of its own self. For a client who has experienced distorted or unresponsive mirroring in their early years, the therapeutic relationship is seen as offering the potential for a new sense of self to be formed. The importance of therapists' somatic attunement emerging from the findings of this study is strongly reflected in Winnicott's writings, where he speaks in detail of the importance of the mother's/therapist's eye contact and an appropriate level of holding or touch. Consistent, attuned mirroring supports the child to develop their own sense of existing as a whole self and 'feel real' (Winnicott, 1956, p. 117). This echoes the deliberate, attuned relating that occurs over time described by the practitioners in this study.

Nolan (2012) states that therapist and client automatically co-regulate affect between them. The participants' accounts reflect Nolan's belief that becoming more conscious of how this happens somatically sharpens our understanding of clients, and 'weaving in the physical' deepens and increases containment, attunement and thus effectiveness in the work (2012, p. 106). Attachment theory also closely articulates the attuned relating conveyed by the research participants, who act as a 'secure base' for their clients to explore new experiences of themselves and how they relate to another in the context of a trusting and intimate relationship (Bowlby 1969; Ainsworth, 1970). Contemporary neuroscience research adds a further layer of detail and subtlety in relation to the somatic dimension that accurately reflects the participants' accounts. Working at a refined level of awareness and tracking micro-movements, therapists offer their attuned presence to support the clients to recognise and tolerate different affect states, slowing down the pace of work and verbalising the process as it happens in order to promote a body-level integration of these new experiences. In doing so they act as interactive 'psychobiological regulators' (Ogden, 2006, p. 214). Eddie explicitly

referenced his understanding of embodied neurobiological regulation theory in his work to support clients' regulation.

Along with the work to increase awareness in the client and support them to regulate, the findings convey the therapists' work on integrating unconscious material. The participants worked from an understanding that unconscious, dissociated or repressed experiences can be somatised in different ways. Working to reintegrate this was done with an awareness of the risk of re-traumatising, and this informed their conscious attempts to work very slowly and carefully. Working at a very subtle level of awareness and attunement was identified as supporting them in this regard. Liam described it as the client developing their capacity to listen 'at a gut level', so that warning signals about a boundary about to be breached are recognised and communicated, rather than being cognitively overridden as can become habitual. By working slowly and verbalising the somatic process, and exploring the client's experience of this, the possibility opens up for a more authentic, embodied mode of relating within therapy. By reconnecting with the body in this way, unconscious material can be recovered and traumas processed safely (Ogden, Minton, Pain, 2006).

Indeed, this approach is seen as particularly helpful in working with trauma, including developmental trauma which many clients present with. Both Eddie and Liam specifically referenced the goal of releasing held energy or trauma, which is given detailed consideration by a number of theorists and practitioners including Ogden, Minton and Pain (2006) and Levine (1997) in particular, who offer comprehensive theoretical and practical frameworks for working with trauma via the body. The Sensorimotor Psychotherapy approach conceptualises a person's capacity for modulating physical or emotional arousal as a 'Window of Tolerance' (2006),

referenced by Eddie in the present study. Levine describes concepts of ‘titration’ and ‘pendulation’ in his approach to supporting clients to gradually tip into experiencing difficult emotional and physical states, without actually re-entering a state of trauma, .i.e. remaining within the window of tolerance. The micro-detail outlined in these approaches closely reflects the practitioners’ accounts of the refined nature of their embodied awareness and somatic attunement to their clients. By attending to somatic attunement in this way, affective attunement can follow and the client can develop new awareness and tolerance of different affect states to integrate these (Totton, 2003, p. 81).

Finally, the participants’ awareness of psychodynamic theory and practice came across strongly in their narratives, along with the central importance of working intersubjectively with somatic transference and countertransference dynamics in the therapeutic relationship. Nolan (2012) describes a ‘relational body-mind therapy’ approach, which incorporates body awareness into an integrative framework that highlights the importance of situating somatic awareness firmly within a relational context. The participants’ narratives reflected Nolan’s contention that incorporating an explicit body-mind stance in understanding intersubjective meaning can make the quality of transference and countertransference rawer and more accessible to consciousness.

Object relations in particular were reflected in the accounts, with Maria, for example, referencing her awareness of the early dynamics being re-enacted by clients in terms of what position they are putting her in in their relating to her. The case example she gave outlines her use of somatic transference and countertransference in navigating

the question of optimal levels of frustration in the work, a central topic of debate and divergence within the object relations literature (Gomez, 1997).

In this context, the risk of gratification was explicitly named by two of the participants, reflecting discussions in the literature. Caldwell (1997, as Cited in Ogden, Minton & Pain, 2006) cautions against using touch to rescue either client or therapist from uncomfortable emotions. Liam and Maria both highlighted the importance of supporting a client to stay present with difficult somatic experiences, albeit at the edge of their 'window of tolerance', to experience and integrate something new. Working at the boundary of touch, Maria's introduction of her somatic response and use of it in the work allowed her the client to recognise and experience unmet needs in a safe and supportive manner, and in a way that allowed the client to learn to tolerate and integrate the somatic experience of not being met in her request for touch. This was also later contrasted with the experience of receiving supportive touch, in order to affirm the client's capacity to experience goodness in her body, as she noticed somatically the difference in her posture between receiving it and not receiving it.

Finally, Heller and LaPierre (2012) caution against the dangers of inauthenticity in the work, particularly with highly sensitive clients presenting with early developmental trauma who are very attuned to the therapist. The participants appeared to employ their experiences of somatic transference and counter-transference in a way that supported them to approach the work more congruently and confidently. The same authors also caution against a premature focus on transference dynamics when self-regulation has been strongly compromised by early trauma. Because the attachment process occurs earlier in the nervous system's development, they claim these deficits must be addressed and the foundations of nervous system regulation put in place first,

as a premature focus on transference dynamics risks causing regression. This emphasis on the importance of first developing a client's capacity to regulate reflects the participants' approach in this study. This is achieved via a somatic focus including touch, so that new self experiences and more authentic ways of relating can occur via this embodied and attuned relationship.

Chapter 6: Conclusion

This study finds that the therapists' own embodied awareness is an important foundation and tool in their work, as well as bringing a deeper dimension and richness of experience to them as people. Working with psychotherapeutic touch also entailed a conscious process of balancing potential and risk and working carefully and slowly within an established therapeutic relationship. The findings also shed light on the refined level of attunement that can be enabled by incorporating the body and touch in the intersubjective relating. Working with the somatic dimension of transference and countertransference was also seen as enhancing the psychotherapeutic process and supporting a deeper level of healing and integration.

6.1 Strengths and Limitations

Strengths

This in-depth, qualitative exploration of practitioners' experiences offers rich and valuable evidence on how they work therapeutically with touch, and the subtleties involved. It reflects the complexities involved in this modality, and vivid first-hand accounts of the main themes covered in the literature as they are experienced in practice. It addresses a gap in the existing literature by offering insights into the inner processes and embodied experiences of the psychotherapists in incorporating touch in their practices. In particular, it provides deeper insights into the more personal, phenomenological impacts of using psychotherapeutic touch on the participants, whose reported sense of embodiedness appeared to considerably enhance their

vision of themselves as practitioners and in their wider lives. It also offers a flavour of how the embodied dimension of psychotherapy can be used in the work, and its impact on the therapeutic relationship, from the perspective of the therapist.

Limitations

While the interviews offered rich data, it is not possible to generalise this to the larger population, due to the subjective and qualitative nature of the findings. In addition, the participants had all been in practice for many years and demonstrated considerable experience and knowledge about the use of psychotherapeutic touch, both in theory and practice. There was a degree of cohesion in their narratives in terms of a shared appreciation of the power, risks and practicalities involved in working with touch, as well as a similar degree of enthusiasm about its inclusion in their practice. A less experienced practitioner may have yielded different information about more negative or challenging experiences of using touch with clients.

6.2 Suggestions for Further Research

This study points to the need for further exploration of the embodied nature of therapists' self-awareness as an important foundation to working with psychotherapeutic touch.

While practitioners' experiences are examined in depth, it does not include clients' experiences of receiving touch, due to ethical limitations imposed. This is another area which requires more consideration for research, to build a more comprehensive picture of touch within the intersubjective therapeutic relationship.

A number of sub-themes emerged which could not be covered within the limited scope of this study but merit further qualitative investigation to deepen the understanding of psychotherapeutic use of touch. These include working with subtle energy dynamics, as well as the somatisation of unconscious material and how this manifests in different client presentations.

Finally, there is a need for further qualitative and quantitative research on the use of psychotherapeutic touch in an Irish context, as much of the literature available on the subject is North American or British, and there is currently no clear overview of its use among psychotherapists in Ireland.

6.3 Implications for Psychotherapy Practice

The overall sense of enhancement and meaning that working with the body using touch appeared to bring to the practitioners, and to their practice, suggests that this orientation has great potential for those practitioners and clients who are drawn to it. Incorporating a mind-body awareness in the intersubjective relating was seen as important to a holistic, integrative approach. At the same time, the participants were all keen to highlight the need for extensive experience in receiving touch and training in its use before applying it in practice, aware as they were of its potency as well as the risk of harm. Mainstream psychotherapy training courses could therefore usefully include introductory modules on working with the body as an important dimension of the therapeutic relationship, as well as exploring the use of psychotherapeutic touch within this and offering a context in which to discuss related issues of safety and ethics.

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Appendix I: Participant Information Sheet

Research exploring psychotherapists' experiences of touch in therapy



INFORMATION FORM

My name is Delphine and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my research project on the use of touch in psychotherapy. It is a qualitative study looking at psychotherapists' own personal experiences of using touch in therapy, and the sense they make of it.

I am interviewing psychotherapists with at least 5 years' practice experience post-accreditation, who are interested in talking about their experiences of touch in therapy.

What is Involved?

If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this I will ask you a series of questions relating to the research question and your own work. After the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research.

I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters) _____

Signature _____

Date / /

APPENDIX II: Demographic Questionnaire

How long have you been practicing as a psychotherapist, post-graduation? (Years / Months)	
Which accreditation body/ies are you a member of? (e.g. IAHIP / IACP / ICP, etc.)	
What kind of core training did you do? (approach / modality)	
What further training / qualifications (if any) have you done?	
Did you have specific training on using touch in psychotherapy?	Yes / No
If so, was it part of your <u>core</u> training, or <u>subsequent</u> training / professional development?	
Have you always included touch as an intervention in your work?	Yes / No
If no, at what point in your practice did you introduce touch?	
Did you have any experience of touch in psychotherapy yourself as a client?	Yes / No
... and in any other modality / healing therapy?	Yes / No
Have any of your supervisors used touch in their practice?	Yes / No
Did your supervisor(s) support the use of touch in your practice?	Yes / No
Does your use of touch sit within a particular theoretical orientation(s)? If so, which one(s)?	
Has your use of touch increased or decreased notably in your practice, over time?	

APPENDIX III: Semi-Structured Interview – Guide Questions

Background

1. I'd like to start by asking you about what brought you into psychotherapy work?
2. What led you to become interested in working with the body, and particularly with touch?

Some questions re. how you work with touch, and your experiences & thoughts on it

3. Can you talk me through how you work with clients using touch?
(including how you introduce it; process in deciding how / why client is ready...)
4. Is there a particular example of having used touch with a client that you could share?
5. Are there any ways that you work on touch with clients without touching them yourself? (E.g. developing client self-touch / or body awareness?)
6. I'd like to hear a bit more about different kinds of touch interventions you work with, and what contexts you use them in (e.g. presenting issues / types of clients?)
7. What is your sense of how these interventions impact on the work?
8. Can you describe how you feel about including touch within your psychotherapy practice?
9. Have you had any experiences of somatic counter-transference in relation to touch, that you'd like to share with me?
10. Do you feel there are differences for clients in their experiences of psychotherapy with touch, and without touch?
11. What about differences for yourself as a practitioner?
12. Can you describe any impacts that using touch has had on you as a person?
13. Can you give me a sense of what touch brings to your practice that other interventions can't?
14. Can you give me an example of a time where you found touch not to be helpful?
15. Are there any specific issues or risks you think are important to highlight in relation to using touch with clients?

16. Can you tell me any things you believe would be useful to share with a psychotherapist considering integrating touch into their practice?
17. How have psychotherapist colleagues responded to your use of touch in your practice?
18. Do you have any thoughts on the training available on using touch in psychotherapy in Ireland?
19. Is there anything else you'd like to say, or any important area I have not covered?