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## Touch in Psychotherapy

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# Touch in Psychotherapy

Pauline Rose Clance  
Earl C. Brown

**SUMMARY.** This article is an edited transcript of several experienced psychotherapists participating in an open dialogue on their personal experiences and thoughts regarding the use of touch in psychotherapy. They discuss the decision-making process in whether to apply or withhold touch, which includes several contextual variables such as timing, self-awareness of the therapist, countertransference, and the congruency between the appropriateness of the request for touch by the patient during the session and his or her own historical background. The usefulness of touch in psychotherapy is addressed. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2001 by The Haworth Press, Inc. All rights reserved.]

**KEYWORDS.** Touch, body, psychotherapy, contact, healing, Satir

We, as psychotherapists, think it is important to discuss the issue of touch in psychotherapy as a result of the varied experiences that confront the therapist. There are some theoreticians and clinicians who state and believe one should never touch a client and there are others of us who think touch may be powerful in the healing process. We believe touch can be wisely and judiciously applied during the course of therapy to the benefit of our clients.

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The therapist's decision-making process in whether to apply or withhold touch in psychotherapy is a complex one where contextual variables, as well as the client and therapist as people, are critical. When experienced within an ethical context, touch may be used in a manner that minimizes its potential abuses and maximizes its potential benefits.

In the following discussion, several psychotherapists have joined together to share and discuss their personal experiences and views of with whom, when, and how touch may be used in the healing process and when touch may not be helpful. This transcript is an audio recording of an ongoing dialogue that has been transcribed and edited for written form.

**Pauline Rose Clance, PhD, Interviewer:** I am writing a chapter in a book on the decision-making process of the therapist in regard to touch. How do you decide who to touch or who not to touch? What kind of process, either at the more conscious or unconscious level, do you think is going on in this decision? And then I was interested in the differences, as you think about it, between patients you touch and patients you do not touch. Is that choice based on certain characteristics in the patient or not? Or more in general, what do you know about that decision in yourself. How do you decide with each person sitting there in front of you whether to touch or to not touch?

**Earl C. Brown, PhD:** There's one thing I know: It's not a question of touch to me; it's a question of what is good psychotherapy. It seems to me that touch has to be part of good psychotherapy, particularly if it's being done in a way that is described by words like humanistic, existential, experiential, gestalt, transactional, interpersonal, and broadly psychodynamic.

As far as I'm concerned, it's a patient-driven phenomenon. When a new person comes in, I'm acutely aware of them. I notice how close they walk to me, or how they pick out where they sit, or how they are in terms of posture. I recall one guy who startled me. The first time I saw him, he wanted to give me a great big hug. Then I learned, quite a bit later, that he did that because he heard I was a humanistic therapist, and he thought they did that a lot.

But the kinds of signs I'm looking for are how tense somebody is with me, or how relaxed they are. How much they seem to trust me versus how much they don't. Or how much there's a civility, which is pretty superficial, or cordiality, which goes some deeper. I do not make the first move or the first touch. I wait for that. If the patient sticks out their hand to shake, I shake hands. If a patient, maybe later on, wants a hug on the way out, fine. Sometimes (more often with men than women), I'll join in an arm around the shoulder or something like that.

And then there are people I've seen for a long time, and we're just cuddly-burns. One patient, for instance, reported that a friend asked her about seeing me and wondered why she came to see me. And the patient replied, "I wanna

get held!" It was reparative of early trauma, but that was the reason she was coming, and I held her, at her request. I am comfortable holding someone who needs more than talk. Usually, I sit in the corner of my couch and place a pillow in my lap. If the patient stirs, I open my arms so they are free to shift, or to get up, and to move to another place.

There are some signs that will warn me off. One is if the person seems somewhat schizophrenic or paranoid or dissociated or something in the direction of multiple personality. I'm very slow to touch them, if at all, because I cannot expect a cohesive response; one part might be gratified while another is outraged.

Something else deserves to be mentioned here. I'm pretty good about getting touched elsewhere than in therapy sessions. So when I come to work, I'm not craving touch. While I thrill at touch, and I like the touch that I have with you-all, I don't look to a patient for touch. I'm usually pretty well satisfied on body contact.

There's another kind of patient who, as we go along in psychotherapy, allows their self to become dependent. And that to me is a good sign during the course of therapy; if they will allow themselves to depend upon me. The very conditions of psychotherapy, that is, exclusive attention, careful listening, empathetic understanding, and judicious responding, altogether, have a regressive inclination and attraction to them. If the patient feels safe enough to yield to this attraction, their dependency permits touching in a parent/child sort of way, figuratively bringing the child out to their skin. This contrasts with, and is corrective of, the real-life hurting events, which drove them further inside their body. The evidence is now clear: If kids are not touched in a loving way, they do not thrive; rather, they manifest a wasting away, a moroseness.

If a patient is dealing with something that is very difficult for them and they pat the couch beside them, I will move to sit beside them. The extent of physicality varies with my patient. Given certain circumstances, I have arm-wrestled with a patient; I have physically restrained a patient from leaving my office in a deranged state; I required one patient to wear a motorcycle helmet because he would lunge at the wall as a way of punishing himself for bad thoughts.

Also, if I surmise that a patient is accustomed to having a "sucker parent," or wants to make me into Dr. Feelgood, I would rather not physically comfort or console them at that time. It's better that I help them to become aware of their resistance to whatever is in the offing.

It is important that—if I touch a patient in an extraordinary way—it has to be clear that this is *not* sex. And it also has to be clear that we can talk about it. For instance, if somebody asks me to hold them (and I do hold them), at the next session I will go back to that holding and talk about it to find out how

that felt to them, or what followed upon that, or if they have any concerns or worries, or if it brought up anything in particular. So, we process that. A lot of body stuff is silent. A lot of feelings and movements don't have words, especially if somebody was messed up very early in life. What I want to do is to get that conscious and one way of getting it conscious is to refer to it, reflect upon it, and to talk about it.

There are times when it *is* sex. Times when I feel myself being seduced. The patient's agenda is not the same as my own. Far from touch, all I want to do is take notice. Why does this man gaze intently into my eyes; why does this woman come dressed and comport herself in this manner? I suppose that it is already conscious on their part. I need to get equally conscious on my part. Without blame or shame, we need to get to the place where we can talk about it and fit it into the pattern of their life. Often, it turns out, seduction is an effort to turn therapy into something other than therapy; a turning-of-a-table that was encountered earlier in their life when a caretaker turned into an abuser. If the therapist colludes in the seduction, and both act out their fantasies, then therapy is at an end. The therapist is disgraced and the patient goes on as before, without trust, perhaps some revenge, but no resolution.

Touch is too valuable at connecting to be severed from practice and its value is preserved when the therapist can discern the trauma of disrupted relationships and not add another link to the chain.

**Debbara J. Dingman, PhD:** I had two reactions, Earl: one was to your statement about the patient who allows himself or herself to become dependent in the course of psychotherapy, and how that is a good sign. The current Zeitgeist is shaming about that aspect of psychotherapy. Managed care companies look at the bottom line, symptom reduction, and short-term treatment. From within that paradigm, to say that the therapist is fostering dependency is to pronounce the ultimate shaming dismissal of the therapeutic relationship. So our discussion is healing to me. Those who categorically declare that dependency and physical contact have no place in psychotherapy propose that we are born dependent and that our goal in life is to become independent, or not dependent. This is not true. In contrast, our discussion reflects our understanding that one develops over time and, in psychotherapy, from infantile dependency to mature, adult dependency. One could also call it mutuality or interdependency or something like that.

I was thinking about an appointment that I had this morning. The man asked me to hold him, and I did not want to. I'm wondering if it's about the issue of dependency. He does not want to be dependent on me. There is also something very hostile in our interaction. He was very controlling and particular throughout the session, insisting that I not speak. Then he said, "Will you please come hold me and comfort me?" I suggested that we talk about it instead.

So we did that, and I did not touch him in the session. It intuitively felt wrong to have physical contact when our emotional contact was so jagged and unexplored. Previously with this man, I had made a clear decision to have physical contact with him in a group setting, but not alone in my office. I do not know quite how to explain that clinically.

**Dr. Brown:** You don't need to. What is happening in me is how you as a person feel about this want. And I would take that seriously—how you feel—like I don't want to. Not to violate your kid, because probably your kid is saying I don't want to.

**Interviewer:** Earl, in response to your statement that touch must be patient-driven and that the therapist must also be self-aware, I recall that one of our former graduate students reported the following:

I remember an important lesson I learned (it only took once) about timing with a patient of mine. In the first session I held her, comforted her. My supervisor very kindly said, "You may have to deal with that later on," and boy was she right. It created a dynamic that was premature and not workable. It was really tough to move out of that kind of good-mother pose that was driven by me, not by the patient.

It created an unhealthy dependency where the work was blocked, effectively, for quite some time. Then with my trying to extricate (you know, having to do my own work), it just botched it for a long time. I mean one horrible experience that was not fun or pleasant—or more importantly, not necessarily therapeutic all the way around. The patient got the early impression that I was going to do it for them. Now one of my big parameters is taking time to know the person, because even after three months sometimes I'm not sure what the signals are about.

**Dan Mermin, PhD:** Here's the crux of what I think. I certainly find that, overall, I touch patients less than I did 15 years ago. That partly comes out of the climate and partly it comes out of my own experience. In general, I wait for a patient's cues. I'm also clear that with some clients I immediately put my hand out when I first meet them in the waiting room and at the end of that first session. And it seems fine. But there are some times I don't; I wait. I feel like that is kind of instinctive. So far, I'm trusting that. I haven't violated anyone or set up some kind of dynamic by doing that, which says to me I'm processing pretty well what I'm getting. I do have people with whom I have not even shaken hands. Somehow I pick up on a cue about that. I'm sure that on certain days it has more to do with how I am that day, but I think I'm also responsive to what they're putting out.

I think that my views about touch have been very much influenced by my training in psychomotor—kind of in both directions in the sense that psychomotor gave me a structure for making touch safer for people (in group setting,

in particular), so that I'm quite comfortable with it. I know that part of the procedure is that I'll be checking with them at every step. You know, do you want contact or not? And how does that touch feel and do you want that hand on your hand or not, etc.?

That guides me to a degree with individual clients, in a sense, that I may do a piece of what you call a psychomotor structure. It's what you call a one-on-one with a client, usually with a cushion, an object, or occasionally using the cushion as an ideal figure, a negative figure, but then I'll be an extension of that figure in some way. For example, someone's working with a different kind or a positive kind of father and mother. We may use a cushion for that figure, and then I'll be an extension of that. So sometimes I will be holding someone, once removed with the big pillow between us, where I'm just supplying the backup work.

I've also been a containment figure for people's rage or aggression, again using a cushion as a kind of buffer. I have people push into a cushion and try to push it through the wall with me standing behind it. Just push with their fist or push with their shoulder in such a way that they feel the solidity of containment. So psychomotor has kind of given me some techniques for doing touch in a way that feels clearly defined.

**Dr. Brown:** Symbolic.

**Dr. Mermin:** Right, exactly.

**Interviewer:** In a group setting.

**Dr. Mermin:** Yes, but what I was describing was one-on-one. In a group setting I use other group members. Then I'm much more comfortable, say, about having a positive parent hold someone directly. In general, I do that in sessions. I hug people sometimes at the end of the session, and I have sat with people with my arm around them at times, but it's pretty infrequent. Some of the time there is deep grief or falling apart, and, in some instances, I may provide that with their permission. I probably do that less than I used to. Or, I'm more inclined to extend a hand or something—a hand to hold if they want it rather than sitting beside them. Probably the only exceptions to that in the last few years have been with a very severely dissociative client who moved into flashbacks and was thrashing about in the room, banging her head against the wall, stuff like that. I have physically restrained a client and held her, but then with a lot of processing afterwards.

I want to share with you that I also wrote to an insurance company about touch. It probably was not as thorough as the statement I just made (Note: an insurance company had asked, "Do you touch clients" and Dr. Mermin had written a statement about touch to them).

**Dr. Brown:** You know I put out that one-sentence thing on consent to touch. All it said was: "I consent to being touched—in a nonsexual way—by my therapist during our sessions." And I got some feedback, particularly from Pauline. I'm going to lengthen that; I'm going to add some more stuff. Perhaps I can pick up something from what you had to say that would help me in adding to my consent form.

**Dr. Mermin:** I found it was very interesting. I know I must be very comfortable with it because I was irritated about writing the statement, but I also felt very clear that I was going to own what I did. I didn't feel apologetic.

And then the feedback I got from the insurance company was: "yes, we agree with you for this year." And I didn't submit a release form, but the company said: "we think you would be safer if you had your client sign a release form." But they didn't say you have to do this.

**Interviewer:** That is one of the things I was thinking might be helpful, that is, that we come up with some kind of consent form regarding touch. And it's also part of a way of educating clients. So that's something I've been thinking about a lot as I'm getting feedback from therapists and clients. One of the interesting things is that people who are very much identified as body psychotherapists indicate that in some ways they feel less struggle about touching and when to touch and how to touch because they think that people come to them with this clear notion that they're going to work with their body. I began to wonder if, in part, gaining an informed consent from clients, or educating them in some kind of consent form, about touch might be helpful—something like, "From time to time, I may find that touch is an important therapeutic tool" and "With your consent" or "With your request." The wording would be very important, I think. But it's interesting that the body therapists don't have a specific consent form, but they indicate that they think they have an implicit contract because they label themselves body therapists.

**Bruce Pemberton, PhD:** Well, I think they do. Increasingly, I find myself referring people who I feel would benefit from a lot of touch to body therapists or massage therapists. I've done that about four times in the last year in conjunction with what we're doing in our therapy. I have gone from touching a lot in the early work I did 15 or 20 years ago to hardly touching at all now. Any touch I do is clearly patient-driven, and usually a handshake or a hug, although I haven't hugged a patient in a long time.

**Ruth Hepler, PhD:** Even at the end of a session?

**Dr. Pemberton:** Right. What I found over time is that the patient who wanted a hug would ask for it on rare occasions after I stopped offering it. I used to do it for me as much as for the patient and over time got all supervised out of



that. As I got more in tune with the patient's needs, I found I didn't want as much hugging. I don't know if I want it or don't want it now, but I just don't hug as much anymore. What I didn't like before in both groups and individual psychotherapy was that once people hug it becomes an expectation and, therefore, an obligation. When we talked about that in groups, some people always expressed this sense of obligation to hug or touch and relief at opening up the subject. In recent years in group, I look at when people touch and ask people to talk about their touching in the group. I ask people to put in words what they were trying to express by their touch.

In couples group there is a lot of touching which is really important to find an expression in words. One person might be saying something and continue to go on and on, and the other partner will put their hand out and touch their arm. Or one person might come in late and somebody will say something to them, and they'll reach out and grab their partner's hand. There is always valuable information behind the touch, and I want the group to discover the meaning behind the touch.

I don't shake hands much anymore, because if it's not extended I don't want to initiate. Yet I notice I do sometimes stick out my hand, which I just realized is almost always with a couple. It's usually a male, and it's usually a certain kind of male, and I feel quite comfortable. But not shaking is usually my pattern because, after that initial time, at the end of the session, I will wait for the extended hand. And most people don't offer then.

I wonder what the cues are for me to initiate the handshake. I know I wait for his approach. How a person gets up from a chair in the waiting room and how quickly they come forward tells me if they are expecting a handshake. There is a cue there. Even if the hand is not extended, the quality is partly in the rate and it's partly in the eye contact.

So I think more and more of asking patients to put their touch into words, and, when I feel someone needs holding, I don't do the work of holding. I love referring folks either for a period of time or for simultaneous therapy to people I've come to trust and appreciate to do that. It's just like anything else. I'll refer when others do something better than I do. There are things that I don't do that well, and I will refer patients to people who are more comfortable or used to touching, and whom I feel know their boundaries perhaps better than I know mine. That's been an evolutionary thing.

I don't think it has to do as much with the times; I think it has to do with my own personal therapeutic work. Almost all my own therapy work in my life right now has to do with body therapy. It's interesting that I do less touching as I get touched more. When I think of doing body work, and I have considered this, I think of doing it more formally and getting trained in it. I appreciate people who are well trained. And when I make a referral to a

body therapist, the patient has set to be touched. And when I go to a body therapist I expect a contract to be touched.

I also realize that in my own therapy I didn't get a lot of touching. So I think that sticks in my expectation.

And I think the thing I learned most about responding to the client's need or checking for permission to touch came from Virginia Satir. I just love watching the way she would enter somebody's personal spaces. She would say, "My hand is on the edge of your chair here. I have an urge to touch your arm. Would that be alright with you?" She would always say, "I really have the urge to touch your throat or to pinch your toes. What do you think of that?" She would always announce and receive permission.<sup>1</sup> If she did not receive permission, she was very lovely, staying right there. She didn't withdraw. It wasn't like, "Oh, well, you don't want me to touch you there." She would say, "This is probably the right distance for now." Just constantly communicating her urge to initiate or responding to the other person's request or urge.

I think I touch less now than I used to, because I think I'm less sure of always announcing my intention or getting permission at this point. So when you circulated the consent form, I realize now I will probably read it again. I like what you're doing, and I'm thinking: Do I want to add that back in? Most of the touching I have done in my work with clients was either holding or touching the chest, the throat, or the face.

**Interviewer:** Sort of a way to help a person release?

**Dr. Pemberton:** Right. But I do that seldom now. For a while, I found people less and less expressive. Now I don't see that much difference. I see people feeling safe and coming to real sobbing and crying, through silence, or from just a word or an observation about how they are holding themselves or not breathing. I often have them touch their own chest. When I have an urge to touch their chest now, I might ask them to watch their hands and follow their hand to their chest and put a little more pressure on their chest, or throat, and see what happens.

**Interviewer:** That's a good tip.

**Dr. Pemberton:** I was thinking if I see some symptoms, I might say, "I'm wondering if you want someone there beside you" or "I'm wondering if there is a yearning about having or inviting someone to be there to hold you." I might personalize it and check to see if they would like me to be there. And almost always now it comes to either a gestalt or some kind of self-work on their past. I guess I don't ask them for permission to touch—I don't want to initiate. I take my impulses and try to look for what this involves, put it out there for them to activate.

**Dr. Mermin:** What struck me with Pesso (founder of psychomotor psychotherapy) is noticing the part I call self-touching where the person is doing his or her own self-soothing.<sup>2</sup> He always uses that, as a cue for introducing the outside figure.

**Dr. Pemberton:** That's right.

**Dr. Mermin:** And you're saying you can go the other way.

**Dr. Pemberton:** Um hum.

**Dr. Mermin:** You can do it with cues, too, or actively self-sooth.

**Dr. Pemberton:** Or I'll find the figure . . .

**Dr. Mermin:** That you want. And then, in effect, you're still the symbolic, outside figure just observing. It's interesting. It's their hand, you know. I often use my urge to touch as information. I have the tendency towards what Virginia might do, but really I hardly ever touch any more.

**Dr. Dingman:** In a recent session, a client was crying and patting herself. The motion of her hands was unusual for her, and I was intrigued by it. I asked if she could tell me what her hand was saying. At the time, I thought she ignored my question and I let it go. My fantasy was that her hand was expressing her request for contact.

She started the next session saying, "I want to talk about my hand." Terrific. She said, "I couldn't answer your question last week but I wanted you to hold my hand." This opened up new areas in her psychotherapy. We spoke for the next few sessions about her not being able to ask me, about her not being able to answer my question, about her wish for me to hold her hand, about her fantasies about why I didn't, and what all of that means in the context of her life.

At the end of the period of processing all of that, she made the following request: "I want to make this explicit that the next time you see my body communicating something that I cannot put into words and you have a hunch about what I'm saying to you, will you please act on your hunch. I promise we'll hang in there to process it through completely and to a positive outcome later." I agreed to take that risk with her. So that's where we are in her therapy, because she is asking for that right now.

**Interviewer:** Sounds like a great contract.

**Dr. Dingman:** We'll see where we go.

**Dr. Hepler:** Except I would probably (even with that) tell her what my fantasy was. Instead of acting on it I think. I would probably negotiate my

part and say, “Well I think I’d rather say something” when she would say, “No, I want you to act on it.”

**Dr. Dingman:** Well, what I’ve said is, I will verbally mediate it, as I did, and our contract is now if she is still not verbally responding, I will move toward. I will take some risk. And then in our contract, we will process this after that. Fine tune until we get it.

**Dr. Hepler:** It makes me think about how we haven’t used this word yet, but we’ve all alluded to it: about how we use *countertransference* in our work around touch. We’ve used the term *patient-driven* a lot, but I am almost equally aware of my own countertransference. I know when I’ve had patients and have been aware of some sexual excitement on my part. That’s a real clear sign for me to be very careful about any kind of touch.

When you talked about Virginia Satir, that’s the way I work. I don’t know that I got it from her, but if I feel that countertransference, I make it conscious by saying, “I’m aware that I’m feeling like coming and sitting beside you.” I just make it a statement. Not “May I,” or “Should I?” And they’ll usually say, “That would feel good,” or “That would be scary.”

And also at the end of sessions sometimes, when a person has been real hostile and there’s been negative energy in a session and they want a hug, I will say, “I don’t think our energy today really supports that, and we’ll talk about it next week because what it feels like is an old aggressive, unhealthy dynamic of ‘let’s kiss and make up’ and it never works.” So I’ve been really aware of how important my feelings are about touch, and then processing afterwards.

Another thing I’ve been aware of with patients is how *they* make touch an issue. There’s a person I’m working with right now who, in times past, earlier in her work, I did some much-needed holding with her. She’s moved along really quite beautifully in her process and doesn’t require that now. Not that getting away from touch means health, but for her it was progressive. We had a session recently where she had really been through a bad time. And she said in the session, “I was aware that at some point today I wanted to have you just come over here and just hold me.” And I thought to myself, “That would not be the best thing for me right now.” And that just felt like . . .

**Dr. Brown:** . . . that she could get to that.

**Dr. Hepler:** Absolutely, and that she put the break on it herself.

**Interviewer:** I thank each of you for discussing this issue and for your thoughts about touch in psychotherapy.

The use of touch in psychotherapy is an important and relevant therapeutic modality that can contribute to positive therapeutic change and growth when applied appropriately. One common viewpoint held by these psychotherapists is that touch is a patient-driven phenomenon. Careful observations of the client's own physical behavior toward the therapist is assessed as a cue, which reflects the receptivity or inclination for therapeutic touch. More often than not, it is a client's verbal request for touch which initiates the use of touch by the therapist. When touch occurs, it is important to constantly "check-in," discuss, and process the experience. However, if a therapist thinks touch can benefit a client, for instance, to help facilitate getting in touch with his or her feelings, the therapist asks permission and then explains the procedure. The creation of a consent form for a client's permission for touch may be helpful for therapists who use touch as an integral part of their therapy work.

Whether touch is client or patient-driven, several contextual variables influence the therapist's decision-making process. Some considerations are timing, the presence or lack of congruency between the appropriateness of the request for touch in relation to the client's dynamic background or the emotional milieu of the session, and the therapist's self-knowledge of his or her own boundaries. Despite theoretical criticisms, it is the discussants' belief that touch may be appropriate and beneficial for a client's development of a healthy, adult dependency in the therapeutic relationship. In some instances, however, touch may be counterproductive, especially when the expectation for touch has been established early in the relationship and later, inadvertently, evolves into an ungrounded obligation. At other times, for example, when the client's expression for touch appears to be sexual in nature, it is the responsibility of the therapist to discern and deal with the client's possible acting out behavior of previous abuse situations and *definitely not touch the client*. Processing what is happening seems much more crucial.

Overall, the general attitude by the psychotherapists is that touch may be important within good psychotherapy. The beneficial effects of touch may also be achieved through indirect means. This may include a therapist's guidance and observation of client self-soothing and affective self-reflection or the client's verbal interpretation of his/her desire for touch. Whether touch is utilized or not, it is important for both the client and therapist to process such issues in the therapy.

A call for further research and ongoing inter-dialogue among licensed professionals is needed to help therapists further address questions, resolve ambiguity, guide, and demystify the use of touch by therapists in the therapeutic context. In *Touch in Psychotherapy*<sup>3</sup> these issues are discussed in several different chapters.

NOTES

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