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TOUCH IN PSYCHOTHERAPY: A SURVEY OF PATIENTS' EXPERIENCES

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A questionnaire surveying patients' experiences of and attitudes toward physical contact in psychotherapy was used to test and extend Gelb's (1982) identification of four factors associated with patients' positive and negative evaluations of touch in psychotherapy: (1) clarity regarding boundaries of therapy; (2) congruence of touch; (3) patient's perception of being in control of the physical contact; and (4) patient's perception that touch is for his/her benefit rather than the therapist's. Two additional hypotheses tested were: (1) whether the degree of therapeutic alliance (as measured by the Working Alliance Inventory–Horvath & Greenberg, 1986) can help predict patient evaluation of touch, and (2) whether potential for sexual attraction in the therapy dyad is inversely related to positive evaluation of touch. Results supported a positive relationship between both Gelb's factors and the WAI and patients' positive evaluations of touch in therapy. No generalizations regarding negative touch can be made from the data, however, due to the small number of negative evaluations reported. Hypothesized potential for sexual attraction did not prove significant in predicting evaluation of touch. Thematized and tabulated narrative answers indicated that a large number of respondents felt touch fostered a bond, trust, and greater openness with their therapist (69%), and/or communicated acceptance and enhanced their self-esteem (47%). General theoretical and clinical implications are discussed, as well as recommendations for further research.

Touch, long associated with healing in most cultures, has been eschewed by most schools of psychotherapy that are not strictly "body-oriented." Personal, societal, and theoretical considerations led Freud, after initially experimenting with touch, to firmly reject its use in psychoanalysis (Mintz, 1969*b*; Older, 1977). Freud's prohibition against 'gratifying' patients with touch has permeated the mainstream of psychotherapy despite the more interactive and interpersonal direction taken by most psychotherapies. In spite of this widespread taboo against touch in therapy, many therapists at times do touch patients in order to express warmth and caring, or for other therapeutically motivated reasons (Holyrody & Brodsky, 1977; Kardener, Fuller, & Mensh, 1973; Milakovich, 1992). Yet little attention has been given to clinically appropriate touch in therapy, and the patient's perspective is rarely taken into account.

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Emphasis in the literature has been on the incidence and undeniably harmful effects of erotic contact between therapists and patients (Pope, 1990). Sexual acting out by therapists with patients is a violation of professional ethical standards (American Psychological Association, 1981, 1988), and in some states of legal statutes, because it is almost always destructive to the patient (Brown, 1988; Feldman-Summers & Jones, 1984; Sonne, Meyer, Borys, & Marshall, 1985; Sonne & Pope, 1991). But is all physical contact between therapist and patient (beyond a formal handshake) a "boundary crossing," as Gutheil and Gabbard (1993) suggest, which places one on a "slippery slope" from which it is all too easy to descend into countertherapeutic gratification of one's own or the patient's needs? Are there no appropriate uses of touch which further the therapeutic alliance and the patient's progress? Other than general condemnation of seductive or sexualized contact with patients, no consensus exists regarding the appropriateness or benefit of touch in therapy.

Psychoanalytic theory that gratification (touch) interferes with the patient's motivation for therapy and with the analysis of the transference partly obscures the fact that the taboo against touch in therapy is largely due to fear of stirring sexual feelings which may then be acted on. Nothing illustrates this better than the historic rift between Freud and Ferenczi (Balint, 1968). Ferenczi's (1953) assertion that nurturing touch could aid the analysis by helping patients tolerate the pain their characterological defenses avoided, thus to some extent sidestepping their defenses, was bitterly rejected by Freud who focused immediately on the danger that psychoanalysis would become the object of prurient interest (Jones, 1955).

Historically, therapists who believed the judicious use of touch with patients could be of value faced censure: physical contact with patients was emphatically declared to be "evidence of the incompetence or criminal ruthlessness of the analyst" (Menninger, 1958, p. 40). Wolberg (1967) proclaimed that "physical contact with the patient is absolutely taboo" since it may "mobilize sexual feelings in the patient and the therapist, or bring forth violent outbursts of anger" (p. 606). Given the atmosphere created by labelling all touch in psychotherapy as destructive, dangerous, or unethical, it is understandable that in one study of psychotherapists who reported touching patients, therapists were far more concerned about their use of touch being misconstrued by colleagues than by their patients (O'Hearne, 1972).

In the literature supporting the use of touch in therapy, the patient's experience of such interventions are almost always filtered through the therapist's theoretical explanation of its impact. Moreover, in writing of touch in therapy, therapists have often used terminology, such as "holding environment" or "gratification of the patient's needs," which obscures the exact nature of the contact (Balint, 1968; Little, 1966; Winnicott, 1958).

One of the first attempts to empirically study the effect of physical contact in an outpatient counseling situation was undertaken by Pattison (1973), who looked at whether touch increased patient "self-exploration" and effected perception of the relationship (from either counselor's or patient's perspective). Her results indicate that touch increased self-exploration, but fail to show that touch significantly affected perception of the relationship. Pattison makes the caveat, however, that a social desirability response set may have obscured the true effect, since client verbalizations indicated that touch was in fact noticed and meaningful in terms of rapport.

In general, empirical studies of nonerotic touch in psychotherapy have been scant, exceedingly limited and artificial in their application of the "touch" condition, or actually analogues of psychotherapy, using students as "patients" and/or "therapists" (Alagna, Whitcher, Fisher, & Wicas, 1979; Stockwell & Dye, 1980; Tyson, 1978). These studies fail to capture the *dynamic meaning of touch* in actual therapeutic encounters; their generalizability to on-going psychotherapy in which touch is sensitively timed and integral to the patient's needs and issues is therefore questionable. Little attention has been given to patients' actual experiences of touch in individual psychotherapy. Yet, research indicates that the patient's point of view is a valuable source of information in assessing therapeutic alliance and predicting therapy outcome (Gurman, 1977; Hartley & Strupp, 1983; Marziali, 1984; Salvio, Beutler, Wood, & Engle, 1992).

Gelb's (1982) phenomenological study of the meanings attributed to nonerotic touch in traditional psychotherapy is the only empirical study which directly assesses the experiences of actual patients in ongoing, individual psychotherapy. The major limitation of this study is its small, homogeneous sample—10 relatively young, white, female patients of male, traditional therapists

(psychodynamically oriented "talk" therapists not explicitly offering touch as a therapeutic technique).

Purpose of the Study

The present study tests and extends Gelb's (1982) identification of four factors associated with patients' positive and/or negative evaluations of touch in therapy. These factors are: (1) clarity regarding touch, sexual feelings, and boundaries of therapy (including the patient's sense that the boundaries, when not explicitly discussed, are extremely clear and unambiguous); (2) patient control in initiating and sustaining physical contact; (3) congruence of touch with the level of intimacy in the relationship and with patient's issues; and (4) patient perception that the physical contact is for his/her benefit, rather than the therapist's.

Another area of potential relevance in understanding patients' responses to touch in therapy is the concept of therapeutic alliance (TA). Bordin (1976) identified three components of TA: the agreement between therapist and patient about the goals and tasks of therapy, which he believed mediated the quality of the relationship or bond. TA has only recently been defined empirically and tested (Alexander & Luborsky, 1986; Horvath & Greenberg, 1986, 1989; Luborsky, Crits-Christoph, Alexander, Margolis, & Cohen, 1983; Marmor, Horowitz, Weiss, & Marziali, 1986; Marziali, 1984). TA measures have been shown to predict treatment outcome measures with the patient's perspective being especially valuable in predicting outcome (Bachelor, 1991).

Logically, therapeutic alliance would play a role in patients' evaluations of physical contact in therapy since TA is indicative of the quality of the bond between patient and therapist, and general agreement on the tasks of therapy, presumably including the use of touch. This study examines whether the quality of the therapeutic alliance can help predict the patient's evaluation of touch occurring in therapy.

The recent literature indicates that the taboo against touch in therapy is primarily about the risk of arousing sexual feelings in the therapist and/or patient, the fear of being misunderstood, and concern about seduction and sexual misconduct, which, given the nature of transference and regression phenomena, is akin to incest. Despite the fact that surveys of therapists fail to support the assumption that appropriate touch in therapy leads to inappropriate erotic touch (Pope, 1990), touch certainly has the potential to trigger sexual feelings and/or fears in either therapy partner.

The present study looks at whether a greater potential for sexual attraction in the therapy dyad, for instance, between heterosexual opposite sex or homosexual same sex therapy partners, makes touch more ambiguous and prone to misinterpretation, and thus less likely to be positively evaluated. A study of nonverbal communication (Heslin & Alper, 1983) found that females' generally positive reactions to being touched were less favorable when the toucher was a male other than their partner. It seems logical to conclude that discomfort with touch in therapy would be more likely when there is an increased potential for sexual attraction.

Procedure

An anonymous survey was the least intrusive method of reaching a large, diverse sample of psychotherapy patients. Therapists, clinics, counseling centers, and self-help groups were contacted in order to encourage distribution of the research packet containing a cover letter, the questionnaire, and WAI. A return postage paid, self-addressed envelope was included so that patients could mail the packet directly to the researcher. Volunteers were reassured of the voluntary and confidential nature of their participation in the study and instructed *not* to put their name or that of their therapist(s) on any of the materials.

Several methods of recruitment were employed to assure a diverse cross sectional sample of patients. A list of therapists in a large Southern metropolitan area was generated from state professional association and telephone directories of therapists working with adults (and upon recommendation of therapists and respondents, expanded to include therapists in other states). Over 300 therapists were contacted. Of the 900 research packets distributed, approximately 125 were mailed to cities and mid-size towns in other states in the mid-west, the north-east, and the south-east.

To maximize chances of getting negative as well as positive evaluations of therapist touch, an attempt was made to reach patients other than through their therapist. Packets were distributed through a network of free support groups for sexual abuse survivors and in a variety of non-therapy settings such as churches, bookstores, twelve-step, and support groups. Advertisements soliciting volunteers were also run in several weekly newspapers.

Eligibility Criteria

The study targeted those who have had a *significant* positive or negative experience of touch in therapy, or for whom touch is a salient issue. The patient cover letter and questionnaire both state the criteria for participation in the study: participation is restricted to adults (20 years or older) who are or have been within the last two years in individual therapy with a non-body-oriented psychotherapist for at least two months and have experienced some sort of physical contact with their therapist (beyond accidental contact or a formal handshake). Only those who returned *both* the questionnaire (specifically evaluating the valence of touch in therapy) and the WAI were included.

Description of Research Instruments

The instruments used in the study were a 39-item questionnaire designed by the researcher and Horvath and Greenberg's (1986) Working Alliance Inventory (WAI). The questionnaire gathered patient demographics and asked about the main issues or problems patients were working on in therapy. Patients' attitudes toward and receptivity to physical contact with their therapist were assessed by asking: have you ever wanted your therapist to "hug, hold, or touch" you in some way; have you ever asked (directly or indirectly) for physical contact with your therapist; and if so, were you comfortable with your therapist's response?

Patients were asked to evaluate on a 7-point Likert scale (from Very Negative to Very Positive) their overall response to the physical contact which occurred in their therapy, and whether their feelings about themselves, feelings about the therapist, or the quality of therapeutic work were positively affected by the touch. Other Likert items assessed four of the five factors Gelb (1982) identified as associated with patients' evaluations of touch occurring in therapy. (The fifth factor, whether the patient's expectations of therapy or the therapist were fulfilled by the reality of the therapist, was not included because it was considered too difficult to define in questionnaire format). The questionnaire also asked patients to evaluate touch in previous therapy if it had occurred. A number of therapist variables were gathered as well. Finally, short answer, open-ended questions allowed patients to illustrate or elaborate on their answers to scaled items.

The patient portion of the WAI, a 36-item, self-report instrument which is subdivided into the three scales measuring the degree of bond between therapist and patient, agreement on goals, and agreement on tasks of therapy was chosen because it is relatively brief, self-administered, divided into subscales comprising the conceptual components of TA suggested by Bordin (1976), and has been shown to be significantly correlated with outcome in therapy (Horvath & Greenberg, 1989).

Reliability and Validity

The Touch in Therapy questionnaire is a self-report of attitudes, experiences, and evaluations of experiences. The questionnaire asks for *global responses* which should be relatively stable over time, barring a sudden shift in therapy such as a major empathic failure. Augmenting scaled information with descriptive information provided a check of internal consistency and validity.

Reliability tests were also performed on the scaled items testing Gelb's (1982) factors and on the four dependent variable questions. Cronbach alphas from .55 to .64 on items testing Gelb's factors suggest that there is a unique portion of the variance accounted for by individual questions, so combining them into a scale or scales was not appropriate. A high degree of internal consistency (Cronbach alpha coefficient of .86) in the four dependent variable questions, however, suggested that these items be combined for purposes of analysis. These items asked patients to evaluate and rate: (1) their overall response to the touching that occurred in therapy; (2) whether feelings about their self; or (3) feelings about the therapist were positively affected by the physical contact; and (4) whether the touch positively affected the quality of their work in therapy.

Horvath and Greenberg (1986) reported subscale reliability estimates (Hoyt's values, 1941) for the patient and therapist versions of the WAI which range from .82 to .93, with a Cronbach alpha of .87 for Total scores for the patient version. Horvath and Greenberg (1989) concluded from the results of three studies investigating the WAI's reliability and validity, and the relationship between subscales, that the WAI has adequate reliability. In two of the studies examining item homogeneity indexes, the client's version of the WAI had an estimated alpha of .93. These studies also demonstrated a high degree of correlation between the Task subscale and outcome measures. In general, measures of therapeutic alliance, from both the therapist's and the patient's

point of view, have been shown to be valuable sources of information and excellent predictors of psychotherapy outcome. Furthermore, the "patient components have emerged as better predictors of positive outcome" than other measures (Bachelor, 1991).

Methods

A stepwise multiple regression procedure was used to test the hypothesis that factors Gelb (1982) found to be associated with the patient's evaluation of touch occurring in therapy will in fact predict patients' evaluations of touch in therapy as measured by the questionnaire. A multiple correlation coefficient was used to test the second hypothesis, that there is a positive relationship between the dependent measure (evaluation of touch) and total WAI score. Additionally, a stepwise regression analysis was used in order to look at the contribution of the individual subscales of the WAI. The hypothesized negative effect of increased potential for sexual attraction on the patient's evaluation of touch was tested using a *t*-test to compare groups—"high potential for attraction" and "low potential for attraction." High potential for attraction was defined as patient paired with 'object choice' (i.e., heterosexual male patient with female therapist) and low potential as the inverse.

Finally, a stepwise regression procedure was used to evaluate the constellation of independent variables, out of all the variables chosen for the study, which most parsimoniously explain the patient's evaluation of touch. A series of *t*-tests were performed in order to look for possible differences in evaluation of touch that may not have been captured by the regression equations. Qualitative information was thematized; key words and phrases such as "trust," "felt better about myself" were used to categorize responses, which were then tabulated and compared with the positive and negative themes identified by Gelb (1982). If the narrative answer did not contain key words or phrases, and its meaning was not clear, it was ignored and not counted.

Results

Characteristics of Respondents

Two hundred and fifty completed research packets were returned, of which 231 were useable. The majority of patients who responded were in therapy with private practitioners (94%), and most with doctoral level psychologists (56%) (see Table 1). The sample is predominantly white (90%), generally in their 30's or 40's, and well educated (see Table 2). Significantly more female (84%) than male (16%) patients responded. The majority of female patients see a female therapist (84%) and the majority of males see a male therapist (68%). All combinations of patient sexual orientation and gender by therapist gender were

TABLE 1. Therapist Characteristics: Gender, Setting, and Credentials

	Female Therapists		Male Therapists		Total	
	n	%	*n*	%	*n*	%
	Setting of Therapy					
College counseling center	2	<1	0	0	2	<1
Low-cost clinic	4	<2	0	0	4	<2
Private practice	164	71	52	23	216	94
Other	5	2	4	<2	9	4
	Therapist Credentials					
PhD or PsyD	101	44	29	13	130	56
MA	29	13	14	6	43	19
MD	1	<1	4	<2	5	2
MSW	29	13	5	2	34	15
Other	14	6	2	<1	16	7
Gender (Count) and Total	175	76	56	24	231	

Notes. (1) Therapist characteristics are as reported by patients. Percentages are of total sample rather than of males and females.

TABLE 2. Patient Demographics: Age, Education, Amount of Therapy

	Female Patients	Male Patients
Age		
Mean	40	38
Range	22–72	24–55
Std Dev	8.41	
Years of education		
Mean	17	17
Total years of therapy		
Mean	6.5	4.8
Std Dev	4.26	
Length of therapy*		
Mean	3.8	2.8
Std Dev	3.14	
Current or recently terminated therapy		
Current	$n = 177$	$n = 34$
Terminated	$n = 15$	$n = 4$

Note. One female patient did not indicate whether therapy was current or recently terminated.
* Current or recently terminated therapy for which the questionnaire and WAI were completed.

reported except for bisexual male and female seeing the opposite sex therapist (see Table 3).

The problem most often listed as a presenting problem or main issue of therapy was relational difficulties (48%); sexual abuse (incest, childhood sexual abuse, unspecified sexual abuse, or rape) was the second largest category, with a third of the participants reporting these issues. There were an additional 64 references to trauma-based problems or diagnoses–physical and emotional abuse or neglect, post-traumatic stress and multiple personality disorders (MPD). Depression, grief, or loss (29%) ranked third. Self issues such as low self-esteem, shame, "false self," and learn-

TABLE 3. Patient/Therapist Dyads: Percentage of Total Sample

	Female Therapists		Male Therapists		Total	
	n	%	*n*	%	*n*	%
Female patients						
Bisexual	16	7	4	2	20	9
Homosexual	63	27	2	1	65	28
Heterosexual	83	36	24	10	107	46
Total	162	70	30	13	192*	83
Male patients						
Bisexual	0	0	1	0	1	0
Homosexual	4	2	11	5	15	7
Heterosexual	7	3	14	6	22	9
Total	11	5	26	11	37*	16
Total						
Bisexual	16	7	5	2	21	9
Homosexual	67	29	13	6	80	35
Heterosexual	90	39	38	16	129	56
Total	175	76	56	24	231	

* Two individuals did not indicate sexual orientation.

ing to self-assert represented the next largest group of complaints at 28% (see Table 4).

An additional source of information regarding the symptoms or issues prompting therapy was gathered from the symptom checklist. Respondents who left the question about presenting problem(s) blank checked several problems here. The checklist indicated a considerably higher prevalence of depression, self-esteem issues, isolation or loneliness, and anxiety than was indicated in responses to Q7 (see Table 5).

Gelb's Factors

The substantive hypotheses that Gelb's (1982) four factors are positively correlated with the patient's evaluation of touch occurring in therapy was generally supported by the data. Analysis yielded 3 significant predictive or explanatory variables, which entered in the following order: congruence of touch with the patient's issues accounted for 21% of the variance; the addition of the patient's perception of therapist's sensitivity to patient's reaction to touch increased precision by 5% (to 26%); and finally, adding the patient's ability to communicate with therapist about feelings toward therapist increased precision by another 3%. Taken together, these three variables explain 29% of the variance in the overall evaluation of touch occurring in therapy (see Table 6). Whether the patient felt the touch was for his/her benefit was the only factor which did not attain significance.

Therapeutic Alliance and Evaluation of Touch

The second hypothesis tested, that therapeutic alliance is positively correlated with the patient's evaluation of touch in therapy, was supported. The total WAI score and the combined dependent variables measuring the valence and effect of touch in therapy produced a Pearson correlation coefficient of $r = .32$, $p = .0001$. The WAI's three subscales—the degree of bond, agreement on the tasks of therapy, and agreement on the goals of therapy—entered into a stepwise multiple regression procedure yielded one significant ($p < .05$) variable, Bond, which accounted for 11% of the variance in the evaluation of touch. (Note: the Bond subscale and the total WAI scores were corrected by dropping two items when it was discovered that there was a misleading typographical error in one of the questions and that the other item was consistently misread, judging from patients' margin notes and responses on similar questions).

Potential Sexual Attraction and Evaluation of Touch

The final hypothesis, whether potential sexual attraction is inversely correlated with positive evaluation of touch in therapy, was not supported. A t-test revealed no significant difference in the evaluation of touch ($t = .0035$, $df = 227$, $p = .9972$) between groups hypothesized to be high and low in potential for sexual attraction.

An optional, specific question about how openly sexual feelings between therapist and patient were addressed was answered by less than 28% of the respondents, too few to allow for its inclusion in the above analysis. Surprisingly, even patients who answered the question the most negatively ("not at all openly") nonetheless rated their overall response to touch in therapy posi-

TABLE 4. Count of Presenting Problems and Main Issues (Percent by Gender and Total)

	Female Patients		Male Patients		Total	
	n	%	*n*	%	*n*	%
Relationship issues	87	45	23	61	110	48
Sexual abuse (incest, rape)	72	37	7	18	79	34
Depression, grief, loss	60	31	6	16	66	29
History of physical abuse, neglect, or trauma (PTSD, MPD)	60	31	4	11	64	28
Low self-esteem, identity	57	30	7	18	64	28
Family of origin (ACOA, etc.)	41	21	9	24	50	22
Anxiety, panic attacks, phobias	19	10	3	8	22	10
Personal growth	19	10	2	5	21	9
Job, career, or life direction	19	10	1	3	20	9
Sexual identity issues	18	9	1	3	19	8
Pain, illness, or disability	10	5	2	5	12	5

TABLE 5. Problem or Symptom Checklist

	Females		Males		Total	
	n	%	*n*	%	*n*	%
Depression	147	76	28	74	175	76
Low self-esteem	146	76	28	74	174	75
Relationship difficulties	141	73	30	79	171	74
Isolated or lonely	132	68	25	66	157	68
Personal growth	132	68	23	61	155	67
Anxiety, panic attacks, phobias	125	65	22	58	147	64
Stress	123	64	24	63	147	64
History of sexual abuse	83	43	10	26	93	40
History of physical abuse or neglect	69	35	11	29	80	35
Sexual problems	67	35	10	26	77	33
Suicidal thoughts	63	33	11	29	74	32
Trouble managing anger	62	32	6	16	72	31
Obsessive thoughts	47	24	12	32	59	26
Fears or phobias	48	25	7	18	55	24
Abusive relationship	46	24	5	13	51	22
Eating disorder	46	24	3	8	48	21
Physical problems	43	22	4	11	47	20
Substance abuse	30	16	11	29	41	18
Sexual identity issues	28	15	3	8	31	13

tively. Of the fourteen patients who reported that sexual feelings were not addressed openly, none rated therapist touch negatively and only one rated it as neither positive nor negative.

Other Variables

A final stepwise regression analysis included all the independent variables chosen for the study: Gelb's factors; the total WAI score, representing degree of therapeutic alliance; patient age and gender; therapist age and gender; length of current therapy; total therapy; hypothesized sexual attraction; mean age difference between patient and therapist, and whether or not patients endorsed wanting therapist to hug, hold, or touch them. Analysis yielded four significant ($p < .05$) predictive or explanatory variables, entering in the following order: the congruence of touch with the patient's issues accounted for 22% of the variance; whether the patient wanted touch increased precision by 17% (to 39%); adding the patient's ability to communicate with therapist about feelings toward therapist increased precision by 4% (to 43%); and finally adding the fourth variable, the congruence of touch with the level of intimacy in the therapy relationship, raised the predictive ability another 1%. Together these four variables explain 44% of the variance in the overall evaluation of touch occurring in therapy (see Table 7).

A series of *t*-tests performed in order to search for possible differences in the evaluation of touch according to age, gender, sexual orientation, dyadic pairing, or problems checked yielded no significant differences, with the exception of three problems endorsed: sexual problems ($t = 2.64$,

TABLE 6. Hypothesis I: Relationship of Gelb's Factors to Patient's Evaluation of Touch in Psychotherapy

Prob > *F*	Variable Entered	Partial R^2	Model R^2	*F*
.0001	Q26: Touch feels congruent with patient's issues	.2088	.2088	57.274
.0001	Q25: Patient feels therapist is sensitive to his/her reaction to physical contact	.0527	.2615	15.419
.0085	Q20: Patient open with therapist about feelings toward therapist	.0234	.2850	7.045

TABLE 7. Stepwise Multiple Regression Procedure with All Independent Variables and Dependent Variable—Patient Evaluation of Touch in Therapy

Prob > *F*	Variable Entered	Partial R^2	Model R^2	*F*
.0001	Q26: Touch feels congruent with patient's issues	.2184	.2184	57.5735
.0001	Q16: Patient wanted therapist to hug, hold, or touch them	.1671	.3855	55.7394
.0002	Q20: Patient open with therapist about feelings toward therapist	.0418	.4273	14.8955
.0119	Q27: Touch feels congruent with level of intimacy in therapy relationship	.0176	.4449	6.4359

$df = 228, p = .009$); history of sexual abuse ($t = 2.35$, $df = 228$, $p = .02$); and phobias ($t = 2.10$, $df = 228$, $p = .04$). Patients who checked either sexual problems, a history of sexual abuse, or fears and phobias rated touch significantly more positively than those who did not.

Narrative Themes

The largest number of written descriptions in this study point to two important themes. One, touch creating a feeling of bond, closeness, or a sense that the therapist really cares, thereby facilitating increased trust and openness, was reported by 69% of the sample ($n = 159$). This theme was expressed in these ways: "made therapy feel personal rather than business-like"; "made me feel cared for . . . felt very connected to my therapist"; "assured me of her presence during the session, and her commitment to go through the process of healing with me." Two, touch communicating acceptance and enhancing their self-esteem was reported by 47% of the sample ($n = 109$). Following are examples of how this theme was expressed: "made me feel safe with her, important and precious to her"; "helped me learn that I was loveable"; "means validation and unconditional care." This theme was also identified in Gelb's study (see Table 8). (Note: multiple themes were identified in the narrative descriptions, so these two major themes cannot be looked at additively.)

Respectful, reassuring touch seemed to help many patients feel supported and safe enough to move into threatening material or a deeper level.

TABLE 8. Positive Themes: (Count and Percentage by Gender and Total)

	Female Patients		Male Patients		Total	
	n	%	*n*	%	*n*	%
Theme 1: Touch provided a link to external reality	3	2	0	0	3	1
Theme 2: Touch communicated concretely, "You are not alone"	20	10	2	5	22	10
Theme 3: Touch communicated acceptance, enhancing self-esteem	90	47	19	50	109	47
Theme 4: Touch helped create (model) a new mode of relating	31	16	6	16	37	16
Theme 5: Touch put the patient in better contact with bodily sensations	13	7	5	13	18	8
Theme 6: Created a bond, feeling of closeness, that therapist really cares	140	73	19	50	159	69
Theme 7: Patient feels strengthened, reassured, comforted, or healed	45	23	4	11	49	21
Theme 8: Touch facilitated a breakthrough in therapy, permitting either regression or "hard work"	20	10	2	5	22	10
Theme 9: Touch provided a sense of containment, safety, or closure	23	12	3	8	25	11
Theme 10: Touch met a current deprivation	3	2	0	0	3	1

Note. Multiple themes were identified in narrative answers.

One woman wrote, "by making me feel safe and loved [touch] allowed me to move forward at times when I didn't think the pain would allow it. . . . It has been one of the most healing parts of my therapy." Another described how her therapist "would hold me as I cried, mourned, wailed during sessions and would give strong hugs at the end of each session. I could not have done the life changing work I did were it not for the physical support of that therapist." A number of patients expressed their belief that touch was a more reliable gauge than words. One patient wrote, "The mouth can lie, but the body can't"; another that she "trusted her [therapist's] touch long before I could trust or even really listen to her words."

Sexually abused patients were more likely to attribute a corrective or educative role to touch in therapy, and to report feeling "touchable," "lovable" or generally better about themselves as a result of touch than were nonabused patients. Of the patients who reported a history of abuse: sexual abuse (n = 43), physical abuse and/or neglect (n = 30), or both sexual and physical abuse (n = 50), 71% or 87 respondents wrote that touch repaired self-esteem, trust, and a sense of their own power or agency, especially in setting limits and asking for what they needed.

It is noteworthy that only ten respondents described negative touch experiences in current therapy: four females and two males described current therapist behavior which signalled their therapist's discomfort with touch and three females and one male indicated that touch (or the kind of touch) was accepted or tolerated, but was not to meet an expressed need of theirs. These descriptions were reflective of two of Gelb's negative themes. There were no clear examples of the first three of Gelb's negative themes: feeling trapped in the gratification of being close; feeling guilty about being angry at a seemingly nurturant therapist; or feeling responsible for therapist's well-being (reversal of normal roles).

References to discomfort with touch in current therapy were often qualified by descriptions of how this had been beneficially resolved, or was an issue the patient sought to work through in therapy. References to unwelcome, intrusive, seductive, or outright sexualized touch from (usually previous) therapists were mentioned by 13% of the sample. Several patients discussed the therapist assuming a level of intimacy and familiarity with touch which was offensive to them and caused them to flee therapy. There were sixteen examples which described sexually inappropriate behavior by previous therapists, ranging from ambiguous, seemingly seductive to blatantly damaging sexual misuse of the patient. All such examples were described as either disturbing and confusing or "very destructive," even though some of these patients acknowledged valuing other aspects of the therapy relationship.

Discussion

The extensiveness of therapy, along with the diversity and seriousness of problems and symptoms reported, differentiates this study from earlier experimental studies of touch in which patients were just beginning counseling (versus intensive psychotherapy) or were actually students participating in the research for credit. The problems or issues most frequently reported were those for which interpersonal touch has been theoretically cited as potentially beneficial: abuse, isolation and loneliness, intimacy and relational difficulties, depression or grief, and self-esteem and identity issues (Hollender, 1970; Hollender & Mercer, 1976; Lowen, 1967; Mintz, 1969*a*; Robertiello, 1974*a*,*b*; Sheperd, 1979; Stein & Sanfilipo, 1985; Wilson, 1982).

Although there was considerable diversity in sample characteristics such as age, length of current and overall psychotherapy, therapist credentials, sexual orientation, and patient–therapist dyads, the sample is predominantly white, female, and highly educated. This is due, at least in part, to a reluctance in some quarters to support this research due to the controversial nature of the topic and to institutional barriers to accessing psychotherapy patients. Very few patients surveyed reported that their primary therapist was a psychiatrist, probably because psychiatric associations were not contacted, and several groups of psychiatrists declined to participate. In general, psychodynamically oriented therapists refused to participate. A number of low cost counseling centers, university counseling centers, and public mental health centers contacted also declined to participate. Unfortunately, there are no statistics available to determine how representative this sample is of the larger outpatient therapy population.

Questions remain regarding possible gender and ethnic (or cultural) differences in receptivity to touch in therapy. Is the high percent of women represented here an artifact of sampling, or does it point to actual gender differences in touch in psychotherapy? One reason more females than

males may have responded to this survey is that several low cost women's clinics and a network of sexual abuse survivors groups (which are predominantly female) distributed packets, while no comparable agencies treating males were identified.

Surveys of therapists' attitudes and behaviors (Holroyd & Brodsky, 1977; Milakovich, 1992), however, indicate that female therapists report engaging in more nurturant touch than male therapists, and more often with same sex than opposite sex patients. Male therapists were noted in Holroyd and Brodsky's survey to be more likely to perceive benefit in nonerotic touching of opposite sex patients, but to also perceive greater risk of misunderstanding of nonerotic touch by either sex patient. Women are probably more frequently touched in therapy than men, and more frequently by female than male therapists, however, incidence of touch was not accessed in this study and further research is needed to support a conclusion that women receive more nurturing touch in therapy than men do.

Despite the fact that no significant gender differences were found, potential gender differences in desire for and response to touch in therapy warrants further study. Men and women are socialized differently, especially in regards to expressive, receptive, and sexual behavior (Abbey & Melby, 1986; Nguygen, Heslin, & Nguyen, 1975). A research design which matched male and female subjects and explored factors such as who initiates touch, kind of touch, and the meanings attributed to it would be more likely to tap gender differences than the present study.

The impossibility of obtaining a random sample of patients who are touched in therapy was a major drawback of this study. The controversial nature of the topic itself made it difficult to get uniform cooperation from therapists and clinics in distributing research packets. The anonymity of the survey further prohibited selecting patients on the basis of criteria such as diagnostic category or gender for which comparisons would have been useful.

Although a large number of research packets were distributed to a variety of therapy settings, support groups, and through newspaper solicitation of volunteers, very few of the questionnaires returned contained descriptions of negative touch or unfavorable evaluations of touch in *current* therapy. This is perhaps the most serious limitation of the present study. Almost two thirds of the sample ($n = 156$) gave the highest possible score to the question, "How would you characterize your overall response to the touching that has occurred in your therapy?" Thus, the results concern *positive evaluations of touch* in therapy only; no generalizations can be made about negative evaluations of touch, other than to point to common themes mentioned by patients describing their current or previous therapy.

More study is necessary to determine what contributes to negative evaluations of touch in therapy. We know from follow-up research with patients who have been involved sexually with their therapist that these experiences are usually destructive, but other than Gelb's (1982) limited sample, there is no systematic documentation from the patient's perspective of negative touch experiences in therapy.

Gelb's Factors

Although the results support Gelb's findings that patients' positive evaluations of touch in therapy are associated with it's congruence, patient control, and patient ability to speak freely with the therapist, the narrative answers indicate that many patients have difficulty both verbally requesting physical contact and expressing negative reactions about the therapy. In this light, it seems especially important that touch be neither gratuitous nor exploitative, but a genuine response to the patient's express or manifest need for physical contact.

Perception of therapist sensitivity to their reaction to touch seems to abet many patients' sense of control by reassuring them that their nonverbal message has been "heard" and respected. Sensitivity to subtle nonverbal messages also precludes incongruent touch, in that the therapist senses when touch is unwelcome, or, when eliciting an ambivalent or negative response to touch, desists and explores the reaction.

In general, touch is likely to be perceived positively when there is sufficient intimacy in the therapy relationship to enable the patient to communicate on a deeper level about the therapy relationship. Openness is a hallmark of intimacy. Yet this ability to communicate intimate thoughts and feelings *about the therapist to the therapist* is not something one can readily expect from many patients. It is often the product of a well-established, successful therapy, or of skillful facilitation by the therapist. Ironically, touch itself may play an important role in facilitating such open-

ness. More than two thirds of the respondents wrote that touch communicated or reinforced a sense that their therapist genuinely cared, and that the safety created by this bond helped them open up, go deeper, and take risks.

Interestingly, Gelb (1982) noted that the inverse of the above, the patient's *inability* to speak openly with her therapist about the therapy relationship, was involved in negative experiences and evaluations of touch. Without facilitation by the therapist or a level of intimacy in which the patient feels free to communicate potentially uncomfortable, embarrassing, or negative thoughts and feelings about the therapy or therapist, physical contact is apt to be risky, for how can fears, concerns, and negative reactions be addressed? Gelb grouped the negative responses to therapist touch she found in her study under the umbrella of "ambivalence and silence." Often touch had been appreciated or helpful, but inability to address concerns about touch eventually led to a negative appraisal of its effect.

"Patient felt touch to be for patient's, not the therapist's benefit," was the only one of Gelb's variables which was not significant in accounting for the patient's positive evaluation of touch in this study. Gelb found the inverse of this factor to be associated with negative reactions to therapist touch. The fact that there were very few negative evaluations of current therapist touch in the present study may explain why it did not enter the equation as a highly significant variable. Patients may be more likely to evaluate touch negatively when they feel that touch *primarily* meets the needs of the therapist, but may evaluate it neutrally or positively in the absence of this impression.

Therapeutic Alliance

It is not surprising that a high WAI score was positively related to positive evaluation of touch in therapy, or that the Bond subscale was the most significant. Both the theoretical literature and studies which measure TA and therapeutic outcome stress the centrality of Bond in the conceptualization of TA (Freebury, 1989). Bachelor's (1991) study of the relationship between patient improvement (specific measures of therapeutic outcome) and three different measures of TA found that patient perception of the therapist and the degree of bond "yielded the stronger predictions and involved therapist-offered helpfulness, warmth and emotional involvement, and exploratory interventions" (p. 534). She concluded that "the therapeutically most relevant factors are therapist-provided help and demonstrated warmth, caring, and emotional involvement," which "appear to enhance the client's collaboration and commitment to the process" (p. 546).

Sexual Orientation and Gender Pairing in Therapeutic Dyads

That sexual orientation and gender pairing in the therapy dyad did not affect the patient's evaluation of touch in therapy is of interest, yet, in retrospect, these variables probably do not adequately tap the sexual tension and ambiguity of intent which they were intended to tap. Logically, many other factors bear on the issue of sexual tension in the therapy relationship: whether or not the therapist or the patient are *actually* attracted and consciously or unconsciously signalling interest; whether the patient feels threatened by this attraction; the overlapping relevance of other factors studied, such as the therapist's clarity regarding boundaries and the patient's ability to be self-revealing about potentially awkward or embarrassing sexual feelings and thoughts, and the potential for primitive longings for a merger with the therapist, regardless of gender or sexual orientation, to be confused with adult sexual feelings.

It appears that neither *potential for sexual feelings* in therapy (as indicated by gender and sexual orientation pairing of therapists and patients), nor *actual unacknowledged sexual feelings* negatively affect patients' evaluations of touch in therapy. Two factors, however, bear on the interpretation of the above: (1) the sample in this study is composed almost exclusively of those with positive experiences of touch in their current therapy, and (2) the study does not adequately explore sexual attraction and seductiveness in the therapy dyad. This study did not access whether the patient was sexually attracted to the therapist, a factor that might make touch "dangerous" or uncomfortable, even if the therapist has excellent boundaries.

Narrative Themes

The majority of patients (69%) indicated in their narrative answers that touch helped them *feel* a bond with their therapist. Words and phrases used to express this concept were: "bond," "safety," "closeness," "there for me,"

"on my side," "deepened trust," "my therapist really cares about me," and therapist is "able to handle strong feelings." For many respondents (47%) touch directly communicated, through their therapist's willingness, sincerity, or lack of hesitation, the therapist's acceptance or positive regard for them, despite their own self-doubts and self-loathing. For some, feeling "touchable" seemed to allow a parity with the therapist, for the patient to feel better about him/herself, and therefore less self-conscious or ashamed of revealing hidden or denied aspects of self.

Respectful touch directly communicated, in ways that verbal reassurances at times could not, two critical messages to those who have suffered violations of trust, personal boundaries, and sense of self. First it communicated that they are "loveable," as one woman put it, "worthy of a clean, pure touch" that does not carry "the high cost of losing myself." A mundane, but profound revelation for many abuse survivors was that they *deserved to be nurtured.* Secondly, respectful touch had the ability, as one respondent stated, to communicate or teach "on an integrated level . . . appropriate boundaries." In terms of trust or belief, experiencing is believing.

The majority of themes identified in the narrative responses have to do with the quality of the bond in therapy—the patient's sense that the therapist is emotionally involved and reliable, and the perceived benefit of enhanced self-esteem, trust, and increased ability to "open up" and more profitably use therapy. These findings seem to confirm Bachelor's (1991) assessment of the importance of therapeutic alliance from the patient's perspective, especially the bond fostered by the perception of therapist warmth, involvement, and positive regard. Damaging themes most often mentioned in reference to previous therapies were either examples of empathic failures, or actual violations of the patient's trust. Clearly, sexualized touch in therapy, like a rotten apple in a barrel of apples, spoils the good.

Conclusion

As Frank (1957) points out, language never completely supersedes the more primitive form of communication, physical contact. Touch can negate, reinforce, or otherwise alter the verbal messages. While it is impossible to separate the contribution of touch from other aspects of the therapy relationship, many patients indicated that touch reinforced their sense of the therapist's caring and involvement, which allowed them to open up and take more risks in therapy.

The results support the judicious use of touch with patients who manifest a need to be touched, or who ask for comforting or supportive contact. They also support Ferenczi's (1953) position that, contrary to orthodox opinion, "gratifying" the patient does not necessarily interfere with the patient's motivation to work in therapy, but may alleviate shame and help the patient tolerate the pain enough to face and work through issues more quickly, or on a deeper level.

Despite the overwhelmingly positive testament to the helpfulness of touch given by patients in their narrative answers, therapists need to proceed with caution when incorporating touch in their repertoire. Gelb's (1982) parameters for using touch in psychotherapy, while generally supported by the present research, are far from simple guidelines. They require astute clinical judgment, vigilant monitoring, and above all, sincerity and openness between therapy partners. It is obvious that the patient's reaction to touch can not be understood outside of its context, which in this case is the therapy relationship. Positive responses to Gelb's factors and to the WAI both bespeak a high level of constructive involvement, cooperation, and communication in the therapy relationship.

Another reason touch in therapy can not be reduced to a simple set of do's and don'ts is the variability of individuals. Our histories and innate temperamental differences affect our need-state and relational style. Therapists who are not comfortable using touch should make clear to the patient that this is a personal preference and/or a theoretical stance so that the patient is not shamed by his/her need for physical reassurance or comforting. Both the therapist's and the patient's personal style, preferences, and expectations of therapy must ultimately be negotiated.

The more cognizant therapists are of their own and their patient's needs and preferences regarding physical contact, the less likely therapy will be aborted or stalled because of a poor match between patient and therapist. Rigid rules prohibiting any physical contact, or the converse, ritualized contact, miss a rich opportunity to explore an array of feelings, self-perceptions, and interpersonal issues that are evoked by touch, touch hunger, or touch avoidance.

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