Touching in Psychological Practice

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Abstract

This summarises some core research on touching in human development. Rules of touching are discussed, in Pakeha, Maori and professional psychology cultures. Examples are given of touch gone wrong in terms of these rules. Possible rationales for touching and not touching are offered, followed by some fairly conservative guidelines. It is assumed some of these would be mutable over time.

"... a patient was unable to bring herself to touch a chair which she regarded as contaminated. The therapist and a nurse who was assisting modelled touching the chair, but the patient was unable to do so. The therapist asked whether the patient knew of a children's game, in which people put their hands, one after another, on top of the previous hand; the bottom hand is then pulled out and put on top, and so on. The game was played on the contaminated chair (with a great deal of laughter); the patient had touched the chair several times, and the programme was begun."

(Salkovskis & Kirk, 1993).

Touch as Crucial to Human Development

Two great bodies of research have established that touch is a requisite of primate and human development.

The first was by Harlow over 35 years from 1931, demonstrating the importance of clinging and holding in young primates. During the same period Bowlby and others demonstrated the catastrophic effects of touch-deprivation and separation from parents upon infant children. There is a need for continual interaction with one or a few adults during infancy.

Anna Freud (1965) proposed that the skin as a sensory organ facilitates the embodiment of the child, a theme elaborated at length by Montagu (1971), Fisher (1986), and Pruzinsky (1990).

Infants held, handled, fondled, cleaned and rocked thrive better than those without such experiences. There is of course interplay with taste, smell, proprioception, hearing and vision.

Weaning initiates a series of withdrawals of intimate touch; exploration and social training initiate children into culture-bound patterns of interaction, including touching. Self-touching behaviours appear.

Touching is sanctioned along age, gender, power and local culture lines, e.g., sand and mud play, handshakes, hongi, applying facial makeup, ritually-patterned in contact sports.

In preschool years the number of adults touching the child may increase, then taper off in the years from 6-12. These children may resist or avoid adult touching. During these years physical contact among children increases.

In middle and late adolescence there is emergence of bonding behaviours among other and same-sex peers.

Rules of Touching

Spatial and Temporal Expectations

Social stimuli connoting intimate interaction have a bearing on expectation of touch. Middle class Pakeha have fairly clear expectations about the conditions of one-to-one therapy, acquired from reading, media, cartoons and discussion with other clients. Other Pakeha, Maori, Polynesian and immigrant groups may not be familiar with the conditions of psychological therapy.

Small interview rooms may create expectation of intimacy. Among Pakeha 1-2 metres of personal space is usual in a casual or business meetings; 75-120 cm is a natural distance to discuss personal issues as friends; 45-60 cm implies a close bond, as between spouses, or parents and children. (Hall, 1966). In the long run propinquity and privacy will raise expectancy of greater intimacy, and possibly greater touch. It is therefore common for therapists and clients to state the conditions of intimacy early on.

When two or more people set aside 40-50 minutes for private discussion without an obvious agenda there will be a strong connotation of intimacy. When they withdraw to a small room and close the door for that long (the therapist being aware of the conventions and the client maybe not) some mismatch of experience and expectation is possible.

Are There Norms Of Touching?

There may well be generally accepted rules of touching, but they are often unstated, and certainly depend on context. Friends or relatives who have not

seen each other for some time may embrace, then spend much time together and hardly touch at all.

Individuals vary widely in their use of their own and others' personal space. Psychologists, too, will vary.

In Aotearoa/New Zealand little work has been done on prevalence of touch in ordinary social interaction. There has for example been no replication of the work of Jourard (1966) or his successors.

Jourard's exploratory study of body-accessibility presented young unmarried students with front and rear views of an asexual body and asked them to show on which of a number of different body regions they had touched, or been touched, by various designated persons (see Fig 1) - namely Mother, Father, Same-sex Best Friend, Opposite-sex Best Friend.

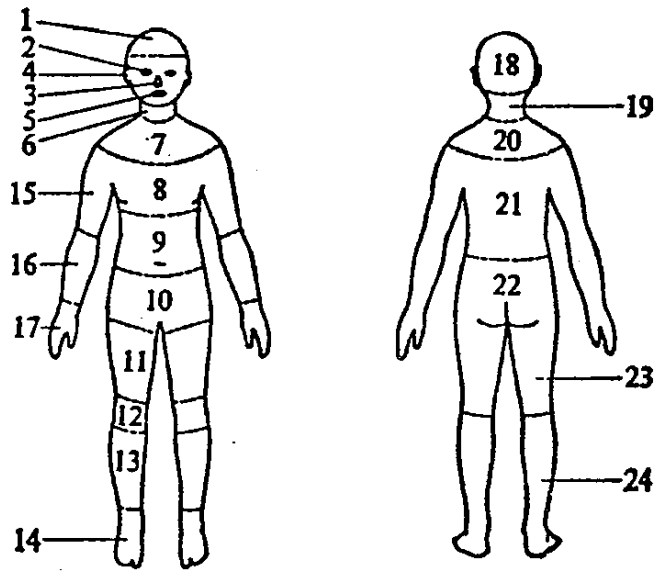

Figure 1 - The front and rear view of the body as demarcated for the Body-Accessibility Questionnaire. (Jourard, 1966)

For that group, touching was most frequent between opposite-sex friends, followed by same-sex friends and parents.

Jourard's article should be read, and followed up by reading Henley (1977) who replicated the work in the US, focusing on the politics of power and sexuality in nonverbal communication, including touch. She concludes that

> In this male-dominated society touching is one more tool to keep women in their place, another reminder that women's bodies are free property for

> everyone's use. We can further project a picture of the way touch, in combination with other nonverbal behaviour, must work to perpetuate the social structure in other status areas though we have fewer data showing the details of this function. (p.123).

The writer finds an ethological stance useful for increasing sensitivity to patterned touching behaviour. One can for example observe age and gender variations on touching behaviour in or outside coffee shops.

Aversive and Variant Touching Histories

Many clients of psychologists, and at least some psychologists, will have such touching histories.

Sexual Abuse

Writers on sexual abuse offer figures of 10-50% for women clients and 5-20% for men clients, at some stage in their development. (Colgan & McGregor, 1981). People who have had their need or powerlessness exploited will tend to scan powerful others for cues that will help them identify, estimate risk from, avoid, placate or challenge the risky other.

Therapists are merely a special group of risky others, and must respond with sensitivity to their own and clients' motives, recognising the inequality built into the therapeutic encounter.

Violence and Intimidation

It is safe to assume that every person has been physically and verbally attacked by a parent or peer, at some time.

As with sexual abuse psychologists should be aware of the research on spatial norms (Argyle 1988, Henley 1977). Clients with histories of abuse by violence, observation of violence, intimidation and terrorisation should be asked about their preferred distance.

Some present with anger problems, and seem fairly confident about proximity until invited to breathe less deeply, or adopt a vulnerable position to relax. Those who have experienced assaults as life-threatening, or whose fears are continuously re-aroused, will require an available personal space of 2-6 metres, i.e., a large room, even though they may be able to sit through a meeting at 12 metres distance.

Neglect And Avoidance

Clients with histories of neglect may have suffered interruption to bonding with caregivers in infancy and childhood (Bowlby, 1969; Karen, 1994).

Others may have been touched seldom, and have little recollection of observing adults' touching behaviours during their development. Disabled clients may simply lack opportunities to touch or be touched as they would like.

Such people come to psychologists with a wide variety of physical contact needs. They may express those needs without being aware enough of the aversive or attractive effect this has on others.

Conditions for Which Touch is a Primary Issue

We began with an intervention with a patient suffering from Obsessive-Compulsive Disorder, a condition in which patients often show unusual patterning of touching behaviours, many involving notions that the touch of others is contaminating to person or object.

Child psychologists will be familiar with children who are distressed by touch, and distress others if touched as in autistic and near-autistic disorders. Frequent sexualised touching by children is a strong cue to consider possibility of sexual abuse by an adult.

Psychologists' Cultures of Touch

Most Aotearoa/New Zealand psychologists are Pakeha or come from other North European tauiwi backgrounds. These groups are seen as infrequent touchers compared with, say, Argentinian, Greek, or Spanish nationals. Indeed visitors from the USA and South Africa comment on our relatively inhibited touching behaviour in casual social situations. (Older, 1982).

It may be that local psychologists are relatively inexperienced in this area. Nuances of proximity, intimacy and touch known by tauiwi may be inaccessible to us without training.

Professional Touch Culture

At the onset of work psychologists offer clients a package of conditions.

There are rules about duration and frequency of sessions; about privacy and confidentiality; about informed consent.

The relationship will be respectful, dispassionate, and holding. The psychologist will try to do no harm.

There will be a proposed plan of treatment. The psychologist will use interventions and practices which are validated by scientific knowledge and backed by clinical experience.

Absence of touching is usually a part of the package.

Psychologists asked whether they touch their clients will usually say they do not. They will then usually offer an exception. Men will mention handshakes; women will speak of a spontaneous arm or shoulder stroke with clients in extreme distress.

Psychologists working with disabled people may need to guide a hand or arm. Psychologists using biofeedback methods may touch or handle clients, as when attaching electromyograph pads.

It is probable that most psychologists touch their clients from time to time. As far as we know most avoid touching clients or students most of the time.

There is a folk belief that touching by female psychologists may be less risky than touching by a male psychologist. True or not, this misses the point.

Clinical psychologists advise against touching most clients. Their rationale is that clients may misconstrue the therapist's intention, or construe touch in terms of their own previous experience. Some clients may not be aware of such experience if preverbal; some dissociate to modify awareness; acutely anxious clients may be unable to dispassionately review it.

New knowledge of the prevalence of sexual and physical abuse, and some widely-reported criminal, civil and disciplinary actions (Loates, 1991; NZPsS, 1997) sensitise us to the potential harmfulness of touch to clients, and the risk to our reputation and livelihoods.

Touching and Children

Psychologists who work with children can make use of play, and displacement activities, using sand, water, paint, pencils, solid toys and soft toys. They can also observe children with caregivers and form an impression of touch repertoires and styles which has some ecological validity.

An educational psychologist comments that testing very young children may require sitting the child on her knee, to reduce stress, maintain task focus and enable access to a table surface. Another psychologist comments that this would be risky for a male psychologist to do. The writer asks, from whose point of view?

Again, anxiety about risk to our reputation may override debate about utility, professional technique, and the effect of such touching given the experience of child *and* caregiver.

At all events, child psychologists also tend to work from a principle of keeping touch to a necessary minimum.

Touch Gone Wrong

From time to time psychologists who shake their client s hand, pat a shoulder or move as if to, will notice lack of participation, a startle reaction, recoil, o change of facial expression.

At such a moment it may be timely to respond with

- 'I noticed when I did that you did not seem comfortable'
- (followed by) an enquiry about client experience
- a reassurance about respect for boundaries
- an apology if that is seen as necessary.

The psychologist can then or later reflect on the incident, and discuss it with a colleague if it poses issues for worker or relationship.

Responding promptly and reviewing such issues early is one of our best safeguards. Loates (1991) in her account of the Davidson case, describes a sequence of interactions, rests from contact, and shaping encounters spanning eight years before actual sexual exploitation began.

When touch goes wrong the psychologist can take the initiative to clarify goals, boundaries, and to review with colleagues. The earlier this is done the better.

Space does not permit review of cases but the reader is referred to Loates (1991). In May 1997 *Connections* reported the outcome of charges of professional misconduct by Pierre Beautrais. To that report are appended useful comments on psychological practice.

Beyond the Fringe

Many healers use touch as a matter of course. GP's, physiotherapists, osteopaths, chiropractors, bodywork therapists, and gestalt therapists do use touch and appear to have conventions that enable them to use touch safely. Older (1982) presents persuasive arguments for wider use of touch in psychological therapy.

Psychologists sometimes argue that it is avoidance of touch that differentiates them from GP's, forgetting that many GP's are excellent listeners who get the diagnosis more or less right, and have some advantages in formulation because they may be the family doctor.

Stroking and handling can be soothing to people; even the hoariest bedside manner may be moderated by unexpectedly non-aversive, or healing touch (Heylings, 1973).

Avoidance of proximity does limit our awareness of the variety of body behaviour, texture and odour. It can also make us poorer observers of the repertoire of self-touch in our clients and ourselves. Such activities as finger tapping, hair-play, rhythmic kicking, twiddling, chin-stroking, minimal rocking, self-hugging, adam's apple tugging, arm-folding and preening are seldom found in our notes.

Summary

Psychologists work in a variant culture of non-touch when they address issues of behaviour, affect, cognition, fantasy, interpersonal issues, and sensory experience.

This culture of non-touch is not immutable and may be modified to some extent by personal preference and experience, technique, necessity, conceptual framework and the behaviour of the client.

And the contextual culture(s) of touching.

Touching and Maori

Pakeha probably cannot be Maori in the heart. Very ordinary Maori values may be in conflict with academic and professional psychology style. For example aroha may imply more readiness to touch than would be socially comfortable for a Pakeha, let alone a Pakeha psychologist.

We can however use opportunities to experience Maori values of touch in Maori context. It is relatively easy to participate in a powhiri as manuhiri.

Essential to Maori mana and identity is the concept of tapu. In tapu are included elements of godlikeness, perfect essence, being set apart, and contamination. Some beings and some entities may not be touched.

Manuhiri are tapu as they come on to the marae.

The karanga affirms the common destiny and fate of tangata whenua and manuhiri alike. More links are made through invocation of the spirits of the dead, and the whakapapa links are explained. Speakers are each followed by a waiata led by women, which removes the tapu from his oration while standing, and allows him to resume his seat on the paepae (Walker, 1992).

Only after the ritual alternation of speeches do manuhiri cross the marae to shake hands and hongi with tangata whenua. In this ritual a Pakeha is confronted with the extraordinary variety of personal styles of ritual touching in a very short time.

This raises issues about local replication of Jourard's study of body accessibility. Perhaps use of the terms tapu and noa would provide a vocabulary at once respectful and precise, since we often deal not only with cultural values but also individual histories of non-respectful touch.

Some touch is non-negotiable, as in Maori treatment of the crown of the head as tapu (you don't touch the head of a child either); some touch is negotiable, as in exploring the stages of intimacy; psychologists may always choose to declare certain body areas tapu in dealing with their clients.

For some areas and purposes, touch may be negotiable, even in psychological practice.

Rationales

For Not Touching

Intimate touching, enjoyed or not, has no place in psychological interventions. In the context of therapy it is an abuse of power.

Unsolicited touching may be highly aversive for the clients.

It is hard to elicit comprehensive information on a client's touch history, regardless of the duration or depth of the work. Our knowledge of the meaning of touch for any client will always be incomplete. (Courtois, 1996, APA 1997). Touch may signify bonding, reassurance, invitation, intimidation or chaos.

If 'psychologist' is substituted for 'client' in the paragraph above, that is true too.

Exploration of reasons for seeking or avoiding touch will result in a different type of learning about it. Exploring *meaning* in a context of non-touch may give clients more access to implicit memory than would gratification of touch-hunger, or avoidance of the matter altogether. (Langs, 1975).

For Touching

Some touching is noa, or ordinary, with a substantial number of clients. An example would be a handshake with a client who appears to have no discomfort with it. Such rituals may be experienced as safe by some social groups, e.g., business people.

In acute distress, refusal to touch may be experienced by a client as rejection. This does not imply the psychologist must touch, but that the want, and the meaning of refusal to meet it, should be dealt with in some way.

Some conditions may require an extension of touching repertoire (Salkovskis & Kirk, 1993, quoted at the start of this chapter).

Further, some touching may be required as part of intervention supported and validated by research, e.g., clients who self-harm continuously and habitually; clients who cannot complete a necessary movement without guidance.

A psychologist who has moved closer to a client, asking, 'What might help you just now?' will sooner or later be told, 'Hold me'. This answer does not commit the psychologist to doing so, but requires at least a follow up question such as, 'How would that help you just now?'

Some Guidelines

- Other than ritual behaviours (e.g., handshake if that is your ritual) and necessary behaviours (touch without which treatment could not proceed) do not initiate touch as a matter of course.
- The setting in which you work may not always respect your client's comfort zones about propinquity and privacy. Talk and ask about client's preferred personal space. Be sensitive to nonverbal cues.
- Learn the touch history of your client as far as you can. With children, much can be learned from direct observation in interview. Helping caregivers discuss and modify touching behaviour can be highly effective.
- Learn and review your own touch history and behaviour, including self-touch, as far as you can.
- If clients seek physical contact it is helpful to discuss with them what benefit they think would result. This can initiate useful work on awareness of need, and ways this might be met. Issues of dependence, neediness, resentment or sensuality can be worked on without therapist use of touch.
- Should any intervention requiring touch seem indicated, work out your rationale for this, and review it with a colleague. Be sure the client understands the rationale. Negotiate permission to touch, if necessary session by session.

- Do not initiate any touch with a client that you would not be prepared to discuss in senior or peer supervision.
- Record touch interventions in session notes, outlining your rationales.
- You can make provision for an auxiliary therapist to join you; as in the extract which begins this chapter.

If your touching manoeuvre is brilliantly innovative, remember, there's nothing new under the skin. It is easy for us to fantasy about receptivity, tractability, accessibility and improvement in your client (Brock, 1985).

Take your own needs seriously and provide for them in other settings. We are trained to address issues of suffering and joy rationally. The most rational of us is susceptible to an unexpected lapse of self-awareness.

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