

THE MEANING OF TOUCH IN THERAPY

Preface

The author of this thesis is responsible for developing the research question, gathering research participants, conducting the interviews and collecting data, and analysing the data material. All work has been performed under the supervision of Britt-Marie Drottz Sjöberg. The research and thesis is independent work, and not part of a larger research project.

I often think of myself as having a tactile, or touch-based, approach to my life, my surroundings, and how I communicate. I like to touch objects and surfaces, to feel their weight, temperature, and structure; and I like to touch people, hugging, comforting; and when I am at a total loss for words, I substitute them with touch, I emphasize the words I choose to use with touch, and I use touch to help out when I feel a lack of a better word. Touch is a big part of who I am in my everyday life, and reflections about how this relates to my future clinical practice lit the spark that eventually lead to writing this thesis.

I would like to express endless gratitude to my supervisor, Britt-Marie: Thank you for being a never-ending source of pepp, frustratingly relevant questions, and for not putting more stress on my shoulders than I put there myself. Thank you for finding my interests interesting.

This project would definitely not have happened without the ten clinical psychologists who responded to my e-mail, saying that they would like to participate in my research, and then agreeing to spend parts of their working hours together with my interview guide, a recorder and me. Thank you.

And to all of you who have agreed me, when I have tried convincing myself that handing in a thesis after "everyone else" finished their work, isn't such a huge problem after all: **Thank you.** I owe you wine, hugs, and speeches full of love.

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Kolbotn/Trondheim, autumn of 2017*

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Abstract

There is a lack of research exploring clinical psychologists' use of touch in therapy. The present qualitative study explored clinical psychologists' professional views and experiences with using, or abstaining from, touch. Semi-structured interviews were conducted with ten therapists working with adult clients, and the transcripts were analysed using thematic analysis. The analysis supported earlier findings showing that the decision to touch or not is complex, involving a network of several different considerations regarding the possible meaning of touch in therapy. The following six themes were identified: 1) Potential benefits of touch, 2) Concerns and perceived risks, 3) Therapist factors, 4) Individual clients and contexts, 5) The presence or absence of touch in therapy, 6) Professional discussions about touch. The results show that all therapists engage in formalized touch with their clients (i.e. handshaking at the beginning and/or end of therapy), whereas more than two thirds also have engaged in other types of physical touch (i.e. hugging during therapy, patting the back/shoulder/arm). Touch is rarely verbally negotiated with the clients. The results further indicate that uncertainty about the consequences of touch, fear for misunderstandings, in addition to the omission of the topic in education, leads to a general avoidance of touch as a topic in professional discussions about therapeutic practices. The research findings are discussed, highlighting the importance of challenging the taboo status of touch, implications for clinical education and supervision, as well as recommendations for future research.

Keywords: Touch in therapy; physical touch; clinical psychologists; thematic analysis.

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Introduction

Touch enables us to interact directly with the world around us, involving numerous communicating systems and capacities. The human skin is both the largest and oldest of our sense organs, housing a particularly complex sensory instrument; known as the first sense to develop in the womb, where the foetus responds to touch of the lips and cheeks at about eight weeks gestation. At birth, touch is reported to be the most developed sensory modality we have (Field, 2010; Fulkerson, 2014; Hunter & Struve, 1998; Montagu, 1986; Sheret, 2015). Several authors have described skin as the most important organ system in the human body (see for example Montagu, 1986), and the total loss of touch, and its physical and behavioural functions, is seen as devastating for normal human existence (Fulkerson, 2014; Montagu, 1986).

Throughout the lifespan, touch is seen as a critical contributor to the individual's socio-emotional, cognitive, biological and neurological development (Ertner, 2014; Field, 2010; Montagu, 1986; Hunter & Struve, 1998). From regulating physiological states, like when rocking and stroking a crying baby and hugging a friend to console and comfort, to sensing our surroundings and providing information about pain and pleasure (Field, 2010; Fulkerson, 2014; Montagu, 1986). Touch can initiate a decrease in stress hormones like cortisol, as well as a rise in levels of dopamine, serotonin and oxytocin, enhancing mood and possibly reducing the negative impact of everyday life stressors (Field, 2010; Sheret, 2015; Zur & Nordmarken, 2011). It is associated with physical growth in infants, reduced pain in some chronic diseases, and reduced cardiovascular disease in adults (Field, 2010).

Severe touch deprivation has been linked to abnormal social behaviour, attachment problems, antisocial and aggressive tendencies, and difficulties with emotion regulation, often referred to as an individual's "failure to thrive". Higher rates of adult violence is also apparent in cultures that are known to display little physical affection towards infants, and studies on infants in orphanages characterized by extreme lack of touch, have shown severe delays in physical growth, in addition to difficulties with developing normal interpersonal relationships (Blackwell, 2000; Field, 2010; Hunter & Struve, 1998; Montagu, 1986; Sheret, 2015).

On the other hand, affectionate touch has been seen to enhance language processing and learning, as well as to improve problem solving (Field, 2010). Being our only reciprocal sense, touch plays a significant role in communication on a different level than the verbal (Sheret,

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2015), also aiding us in establishing and building deep emotional and intimate relationship. Lastly, touch establishes our own existence: “You touch me, and I sense that I am” (Ertner, 2014:17).

Touch Throughout the Lifespan

Although infants and young babies are dependent on being guided through their first years mainly through touch (being carried, fed, comforted, restricted, and so on), as they grow and get older, the amount and quality of close physical contact seem to diminish in many cultures (Durana, 1998). According to Hunter and Struve (1998), the Western culture of touch is characterized by both female and male adult caregivers touching children at a preschool age more frequently than those who are older. School age also tends to be the time where children start to engage in self-touching behaviours and to look for touch from peers rather than adults, and as the children mature, touch between them and caregivers generally continues to decrease. When they reach junior high school, most instances where they are in physical contact are described as accidental, involving shoulders and elbows; and throughout adolescence, physical touch is mostly seen as something sexual or erotic, instead of social or nurturing (Ertner, 2014; Hunter & Struve, 1998; Zur & Nordmarken, 2011). Adults who become caregivers both give and receive nurturing and social touch to and from their children, but within the elderly population, incidents of touch other than instrumental acts are again seen as rare cases (Ertner, 2014; Hunter & Struve, 1998).

Physical Touch in Therapy

The occurrence of touch naturally varies with different individual preferences, habits, and experiences, with their cultural background and from situation to situation. Touching in different situations can have vastly different functions (Hunter & Struve, 1998; Sheret, 2015; Zur & Nordmarken, 2011). Different contexts, attitudes and people can open up a possibility for touch, or lead to an expectation and anticipation of touch, whereas other contexts, attitudes and people clearly signal that it is not considered an option: What is true for psychotherapy?

Following Hunter and Struve (1998), it does seem likely that psychotherapists are touching their clients, especially considering that touch (in therapy) can refer to a wide selection of physical behaviour, from hugging or holding a client, to a hand on a shoulder, or a handshake

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(Durana, 1998). It is emphasized that in the context of this thesis, touch refers to any physical contact occurring between a clinical psychologist and a client in the context of therapy.

During the past 20 years of research, an increasing number of publications are also discussing the possible benefits of touch specifically in clinical therapy. Although some researchers and clinicians dub it “the most controversial topic in psychotherapy today” (Smith, Clance & Imes, 1998:XI), several examples of appropriate touch have also been mentioned. Suggestions that touch can provide reassurance, support and nurturance, facilitate clients’ access to, expression and exploration of emotions, model safe touch, ground or restrain, welcome or say goodbye, and maintain or deepen therapeutic relationships, are mentioned by several (Durana, 1998; Ertner, 2014; Hunter & Struve, 1998; Sheret, 2015; Zur & Nordmarken, 2011).

However, as Durana (1998) points out, there is no general consensus about the benefits of touch in psychotherapy; nor are there any clear clinical and ethical guidelines exclusively regarding the appropriate use of touch (except that overt aggressive and sexual touch is widely accepted to be unethical in a therapeutic context). Through the course of history, the use of touch in therapy has been very variable, ranging from the complete absence and disapproval, to even boundless exploration and use of it. The following sections will present a general overview of the use of touch in therapy up until today.

Shamanic, religious and royal touch. The use of touch has for a long time played an important part in a wide range of shamanic and religious ceremonies, and in healing practices in various cultures, as well as a technique in medical treatment and therapy (Bonitz, 2008; Classen, 2005; Ertner, 2014; Hunter & Struve, 1998; Levitan & Johnson, 1986; Sheret, 2015; Williams, Clarke & Gibson, 2011). According to Constance Classen (2005:348; see also Ertner, 2014) the therapeutic use of touch historically had two separate functions: One dealt with the inherent, natural healing powers of touch in itself; while the other saw touch more as a medium of supernatural influences. The latter may also be known as “the royal touch”, or the laying of hands by kings in order to cure the sick, practiced up through the 17th century (Classen, 2005; Ertner, 2014). Lene Ertner (2014) further comments that the use of touch had been one of the cornerstones in western medicine since the time of Hippocrates, until it slowly decreased due to the increased availability of pharmaceutical medicines. Today, healing through the use of touch

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is often associated with the domain of alternative medicine (Ertner, 2014; Hunter & Struve, 1998; Sheret, 2015).

Touch in psychotherapy: Hysteria. According to Verena Bonitz (2008), touch was seen as a necessary therapeutic method also in treating mental diseases throughout the 18th and 19th centuries. One comprehensive example was the treating of hysteria, or “womb disease”, in women. First described by ancient Egyptians in the year 1900 BC, it was identified as spontaneous uterus movements within the female body, characterized by tonic-clonic seizures and paralysis, suffocation, and later, imminent death. By the 19th century, many rather vague nervous symptoms had been added to the description of the diagnosis, such as fainting, irritability, sleeplessness, the sensation of heaviness in the abdomen, and anxiety (Bonitz, 2008; Maines, 1999; Tasca, Rapetti, Carta & Fadda, 2012). The cure for hysteria was to redirect the uterus, and the cure of choice in the 19th century was marital intercourse, or a “pelvic massage” administered by the physician or a midwife. The massage was to lead to a “hysterical paroxysm”, or orgasm, resulting in the female clients experiencing relief from their symptoms (Maines, 1999).

With the invention of vibrators in the 1880s, increased knowledge about female sexuality, and Sigmund Freud redefining the origin of hysteria as stemming from childhood sexual traumas rather than a wandering uterus (sexual deprivation), the clinical practice of manual clitoral stimulation had disappeared from physicians’ offices by the 1920s (Bonitz, 2008; Maines, 1999).

Sigmund Freud and the pressure technique. As is described in the seminal work *Studies on Hysteria* (see Breuer, Freud & Strachey, 1895/2000), Sigmund Freud first applied his “pressure technique” during the 1890s, when treating clients with hysteria. When describing his therapeutic practice, he mentions stroking or massaging a client’s neck or head, as well as exerting some form of pressure on their forehead to help them retrieve repressed memories:

“I decided to start from the assumption that my patients knew everything that was of any pathogenic significance and that it was only a question of obliging them to communicate it. Thus when I reached a point at which, after asking a patient some question such as: ‘How long have you had this symptom?’ or: ‘What was its origin?’, I was met with the answer: ‘I really don’t know’, I proceeded as follows. I placed my hand on the patient’s forehead or took her head between my hands and said: ‘You will think of it under the pressure of my hand. At the moment at which I relax my pressure you will see something in front of you

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or something will come into your head. Catch hold of it. It will be what you are looking for. –Well, what have you seen or what has occurred to you?’” (Breuer, Freud & Strachey, 1895/2000:110)

He continues by stating the effectiveness and accuracy of his method:

“On the first occasions on which I made use of this procedure (...) I myself was surprised to find that it yielded me the precise results that I needed. And I can safely say that it has scarcely ever left me in the lurch since then. It has always pointed the way which the analysis should take and has enabled me to carry through every such analysis to an end without the use of somnambulism.” (Breuer, Freud & Strachey, 1895/2000:111)

However, by 1904 and through the development of psychoanalytic theory, Freud had abandoned his pressure technique, openly advocating abstinence from touch in psychotherapy. Touch was increasingly seen as a way to gratify infantile sexual wishes in a client, subsequently interfering with the “neurosis of transference” and thus the stagnation of the analysis and the therapy. Therefore, he and many other orthodox psychoanalysts after him, adopted a completely hands-off approach where touch was seen as directly anti-therapeutic, and where they refrained from any physical contact with their clients, including when greeting the client, and ending a therapeutic session (Bonitz, 2008; Hunter & Struve, 1998).

Some of Freud’s closest followers disagreed with his stance of abstinence, and chose to continue with the use of touch (Sheret, 2015). Examples include Sandor Ferenczi, who saw the restraint of touch as a counterproductive way of re-enacting the clients’ old traumas of deprivation. This resulted in him developing a “relaxation technique”, including hugging and kissing clients to gratify their demands. In addition, Wilhelm Reich saw techniques such as the expressive movement of limbs, breathing exercises and direct pressure on certain muscle groups, as a successful way to remove a client’s defensiveness in therapy (Bonitz, 2008; Hunter & Struve, 1998). Nevertheless, touch altogether remained taboo in psychotherapy (Sheret, 2015), and Bonitz (2008) describes the early psychoanalytic movement as more or less polarized in two camps up to the 1970s (see also Hunter & Struve, 1998).

The psychoanalytic counterpoint and research on erotic touch. Through the increased interest in attachment patterns between children and their caregivers in the 1960s and 70s, some therapists saw their work as analogous to that of a caregiver providing a “secure base” for their

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child (Bonitz, 2008). John Bowlby (1988) held that by responding to a client in an empathic, attentive and reliable way – functioning as a secure base – the client is enabled and encouraged to explore their inner emotions and thoughts. The application of physical touch was by many seen as an effective means of facilitating secure attachment between the therapist and the client. From the general framework of attachment-based therapy, movements encouraging the use of touch in ways ranging from the somewhat formalized to more uninhibited and spontaneous grew. Examples include humanistic traditions such as the “reparenting” movement, Gestalt therapy, and human potential movements. Within these traditions, touch was seen as a natural, spontaneous and honest expression of a genuine (and nontransferential) relationship (Bonitz, 2008; Hunter & Struve, 1998; Smith, 1998). The humanistic position on touch is generally seen as less theoretically complex: It was not formalized, no concern that it might interfere with transference and motivation (Smith, 1998).

Edward Smith (1998) reports of humanistic traditions encouraging experimentation with touch, among several other ways of relating and communicating. Many therapists pushed for more genuine person-to-person encounters, and touch was seen as having a central place in these contexts. Although it was most common with different massage techniques, group hugs and backrubs, there are accounts of group practices also leading to sexual orgies and what has later been established as highly inappropriate sexual contact both between the group members and involving the therapist (Bonitz, 2008). In 1977, Jean Holroyd and Anette Brodsky conducted a US study investigating psychotherapists’ practices and beliefs regarding physical contact with their clients. Their results were unexpected and revealed that 8.1 per cent of the male therapists and 0.9 per cent of the female therapists (their sample size was 1.000, return rate 70%) at some point had had sexual intercourse with their clients, either during therapy or within three months after the termination of therapy. In addition, 80 per cent of those who had had intercourse had repeated it (Holroyd & Brodsky, 1977). Similar numbers were produced in subsequent studies during the late 70s and early 80s, reporting that 9-10 per cent of male and 2.5-3 per cent of female therapists had acted out feelings of sexual attraction towards their clients (including erotic touch and sexual intercourse; see for example Pope, Keith-Spiegel & Tabachnick, 1986; Pope, Levenson & Schover, 1979). Pope, Levenson and Schover (1979) further pointed out that even sexual contact between educators and students in psychology training programs seemed to be

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increasing, with 25 per cent of the surveyed female graduates having experienced sexual contact, compared with 5 per cent of those 20 years earlier.

Highlighting the prevalence of erotic touch happening in therapy, elicited fiery debates, disbelief and denial, but also more collective and united research efforts on the topic of touch. The focus of the debate shifted throughout the 1980s and 90s from disagreements in technique and therapeutic modality, to ethical concerns and risk management considerations, with one of the major ethical dilemmas being what kind of touch interaction would be appropriate and ethical, and where the line was to be drawn (Bonitz, 2008; Hunter & Struve, 1998). Reviewing research findings for the past 12 years in 1990, also showed that therapist-client sexual involvement was decreasing (Pope, 1990). A survey from 2004 further showed that close to 90 per cent of their respondents rarely, or never, offered touch to clients (Stenzel & Rupert, 2004), although it is not clear whether this reported trend was due to the result of increased ethical awareness or the actual decrease of such occurrences (Bonitz, 2008).

Ethical guidelines on touch in therapy. Morris Goodman and Arthur Teicher (1988) reported that the American Psychological Association's Board of Professional Affairs did review their guidelines of professional conduct due to a rising number of complaints, lawsuits and increased focus on malpractice. The board held a meeting in November 1982, questioning what kind of client-therapist physical contact would be permissible and useful, as well as when, where and how such contact would be useful. Concluding their meeting, they adopted the following statement regarding physical contact: "Permissible physical touching is defined as the conduct which is based upon the exercise of professional judgment and which, implicitly, comports with accepted standards of professional conduct" (Goodman & Teicher, 1988:492).

In Norway, the Health Personnel Act (2002) lists no specific guidelines regarding the use of physical touch in therapy, despite seeing 7 per cent of surveyed members of the Norwegian Psychological Association reporting ethical dilemmas regarding sexual relationships with clients (Odland & Dalen, 1997). Rather, it states that "health personnel shall conduct their work in accordance with the requirements to professional responsibility and diligent care that can be expected based on their qualifications, the nature of their work and the situation in general" (retrieved from chapter 2: Requirements to professional conduct for health personnel, §4: Responsible conduct; The Health Personnel Act, 2002). In 1995, the European Federation of

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Professional Psychologists' Associations adopted a meta-code of ethics, named "Ethical Principles for Nordic Psychologists". These do not specify the use of physical touch, but have been developed to "protect clients against inexpedient and/or harmful intervention" and to "serve as support for Nordic psychologists facing ethical questions" (see Norwegian Psychological Association, n.d.). The code is constructed around four main principles, with especially three being relevant for the practice of touch: 1) Respect for the rights and dignity of the person [client] (including the individual's right to confidentiality, self-determination, autonomy and informed consent); 2) Competence (including only performing those tasks and methods the therapist is qualified to do through education, training and experience); and 3) Responsibility (including avoiding harmful and abusive practice, both professionally and scientifically) (Norwegian Psychological Association, n.d.).

Research on Clinical Psychologists and Touch

During the last two decades, it seems that the research on touch has shifted from focusing exclusively on problematic therapist-client sexual relationships, and more towards ethical practice and risk management in therapy. This has also opened up for a more open exploration of the possible use of (nonsexual and nonaggressive) touch in therapy (Bonitz, 2008; Harrison, Jones & Huws, 2012; Hunter & Struve, 1998; Sheret, 2015), importantly so focusing on the practical behaviour and experiences of psychologists: Do clinical psychologists use touch in their therapeutic practice today? How do they decide whether to touch, or not? How do the psychologists who touch differ from those who do not?

However, even though the interest in the topic might be increasing, and initial literature searches identified a range of articles and literature regarding the topic of touch, further specifying the search terms to primarily focus on the actual practice touch in psychotherapy or among clinical psychologists produced few results. There appears to be little visible debate occurring within the Norwegian psychologist community, with no studies researching the occurrence of touch in therapy among Norwegian clinical psychologists published in the *Journal of the Norwegian Psychological Association* between 2004 and 2017. Larger, international volumes (see for example Hunter & Struve, 1998; McRae, 2008; Smith, Clance & Imes, 1998) present research on touch within several health care professions, but very little concerns the attitudes and experiences of clinical psychologists specifically. In her extensive literature review,

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Sheret (2015) highlights only one study done exclusively on clinical psychologists (Harrison, Jones & Huws, 2012), in addition to her own study, based on a sample of 11 clinical psychologists in South Wales.

Summarizing previous research, findings suggest that therapist touch behaviour and decision processes are seen as very complex, and mainly are done on a case-by-case basis (Pinson, 2002; Sheret, 2015; Williams, Clarke & Gibson, 2011). All research confirm that non-erotic and non-violent touch does occur in therapy at least some of the time (Harrison, Jones & Huws, 2012; Pinson, 2002; Pope, Tabachnick, & Keith-Spiegel, 1987; Sheret, 2015; Stenzel & Rupert, 2004; Strozier, Krizek & Sale, 2003; Tune, 2001; Williams, Clarke & Gibson, 2011), and several point out a difference between what Tune (2001) labels as the “therapeutic space” and the “social space” (meaning what is outside of the therapeutic environment). Formalized touch, at the beginning and/or end of sessions and/or therapy, is seen as different and less potentially problematic than touch within therapy (Harrison, Jones & Huws, 2012; Sheret, 2015). In addition, Sheret (2015) points out that most therapists seem clear about what is unacceptable touch (erotic or violent), whereas decision-making in the grey areas is difficult.

When deciding whether to touch, or not, therapists seem to consider what they see as the value of touch, or issues regarding the reward and the cost of touch, where on the client’s body it would be appropriate or inappropriate to touch, and the influence of the specific therapeutic context (Harrison, 2012; Pinson, 2002; Sheret, 2015; Strozier, Krizek & Sale, 2003; Williams, Clarke & Gibson, 2011; Tune, 2001). Most therapists would highlight the sense of touch as a “taboo”, seen as a vicious cycle of omitting the topic from professional training, leading to therapists feeling they should abstain from touching, refusing to discuss it openly, and thus reinforcing the belief that touch does not occur (Harrison, Jones & Huws, 2012; Sheret, 2015). Pinson (2002) emphasized that the idea of touch as a taboo did not result in less touch by therapists, as could be expected due to a widespread attitude of “better safe than sorry”. Rather, it seemed to prevent those who did employ touch from seeking input and guidance from supervisors, or even discuss it with the actual client (see also Harrison, Jones & Huws; Sheret, 2015; Williams, Clarke & Gibson, 2011; Zur & Nordmarken, 2011). Linked to this, Stenzel and Rupert (2004) highlighted that a lot of therapist touch behaviour was guided by experiences from their professional training.

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Importantly, all authors suggested that further research was needed, both on the specific factors that come into play when therapists decide to use, or abstain from using, touch (see for example Bonitz, 2008), on practices regarding clients consenting to touch (see Sheret, 2015; Williams, Clarke & Gibson, 2011), and therapists' experiences from education and supervision, to raise awareness and reduce the frequency of erotic or violent touch (Bonitz, 2008; Harrison, Jones & Huws, 2012; Pinson, 2002; Sheret, 2015; Stenzel & Rupert, 2004; Strozier, Krizek & Sale, 2003; Tune, 2011; Williams, Clarke & Gibson, 2011). In addition, more research especially focusing on clinical psychologists has been requested (as in Harrison, Jones & Huws, 2012; Pinson, 2002; Sheret, 2015), as well as the perspectives of the clients themselves (Harrison, Jones & Huws, 2012; Pinson, 2002; Stenzel & Rupert, 2004; Strozier, Krizek & Sale, 2003; Williams, Clarke & Gibson, 2011). The present qualitative study is aiming to further investigate and explore how clinical psychologists in Norway view the use of touch in therapy, their own practices and what lies behind their decisions to touch their clients, or not.

Method

This study focuses on exploring clinical psychologists' professional views toward the use of touch in therapy, and to gain further insight into how, and on what basis, they decide to either touch, or not to touch, their clients. The goal is to create an accessible overview of clinical psychologists' experiences, challenges and reflections in relation to the topic of touch. Such an overview may then function as a base on which to build further conversations about the practical use of touch in therapy – rather than to test a specific theory or predict future behaviour. What the clinical psychologists' say about what they do is true for them and is based on their own practices, and might not be generalizable to all clinical psychologists.

This has implications for the choice of methodology, and a qualitative approach is considered to be best suited. Since gathering information about the practice of touch and their reflections around this is key to the study, the chosen data collection method is interviewing. The participants' responses to the researcher's questions lay the foundation for the study's data material. In order to create a diverse foundation for the analysis, the interview data were supplemented with data collected through writing and drawing on figures, as well as the recording of the researcher's personal reflections. The following chapter will briefly outline the methodological decisions that further form the basis for data collection and analysis. The process through which the participants were recruited and ethical considerations are also discussed.

Qualitative Methodology: Thematic Analysis

Thematic analysis was chosen as the methodological approach. The research focus is to describe and explain patterns across a qualitative data set (Braun & Clarke, 2006), rather than to establish a complete theory of touch in psychotherapy (as in the far more theoretically bounded grounded theory; Willig, 2013), or to focus on close examination of sensemaking of personal experience in a small number of people (as interpretative phenomenological analysis; Harrison, Jones & Huws, 2012). Thematic analysis is considered a widely used approach to qualitative data analysis (Braun & Clarke, 2006; Howitt, 2010; Williams, Clarke & Gibson, 2011; Willig, 2013). It is also recommended as an approach when the views likely to be expressed by participants are unknown beforehand to the researcher, as is the case in this project (Braun & Clarke, 2006).

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Thematic analysis is argued to be a foundational method for qualitative analysis, and is described as a flexible and accessible approach to identifying, analysing and reporting repeated patterns of meaning and behaviour within the qualitative data (Aronson, 1994; Braun & Clarke, 2006; Howitt, 2010; Willig, 2013). These patterns are interpreted and grouped together into meaningful themes, and the complete network of themes can summarize features of a large body of data, highlighting differences and similarities across the material, visualizing interpretations of social and psychological processes described in the data set (Braun & Clarke, 2006; Willig, 2013).

Lastly, a “theme” in thematic analysis is described to capture “something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set” (Braun & Clarke, 2006:82). In this study, the themes are informed by the research question, and are seen as an interpretation of psychological and social processes that underpin the participants’ accounts, behaviour and attitudes. The specific process of analysis conducted in this study, is described in detail from page 26.

Participants

A total of ten clinical psychologists were interviewed, five identifying as female and five identifying as male. Their ages ranged from 28 to 69 years, and at the time of the interviews, they were working in five different counties in Norway. The participants had between two and 21 years of experience with working as clinical psychologists, with a median of 4.5 years and a mean of 8.8 years.

Recruitment criteria and sampling. The participants were recruited using a purposive sampling method, whereby participants were approached and selected according to certain criteria that were found to be relevant to the research question (Howitt, 2010; Willig, 2013). The criteria were that all participants had to be clinical psychologists, and have at least two years experience working with adult (>18 years of age) clients. Care was also taken to ensure that an equal number of female and male therapists were interviewed, as an effort to ensure participant gender balance when obtaining therapist’s views on gendered issues and experiences.

Clinical psychologists. This criterion was included due to there being many different professions working within the Norwegian mental health care system, and the overarching goal

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that this research project should shed light on the actual practice within the profession of *psychologists*. Therefore, it was seen as necessary to specify being a clinical psychologist as a criterion for inclusion in the study.

For clarifying reasons, it is further emphasized that in Norwegian, the title “psychologist” is a protected title that requires having completed a six-year university education in clinical psychology in Norway, and/or the equivalent to this, in addition to the necessary clinical practice to qualify for working as a licensed clinical psychologist in Norway (Norwegian Psychological Association, 2016; The Health Personnel Act, 2002). Whereas the title “psychologist” outside Norway for instance can include people with a master’s degree in psychology, people with a master’s degree in Norway are not allowed to use the title “psychologist” or work doing therapy as a clinical psychologist. This is the reason why all information about this project has included the term “clinical psychologist”, to emphasize that the participants in this study all meet the criteria to work clinically as therapists in Norway. This implies that people who work in mental health care in Norway (for example psychiatrists, doctors, nurses, social workers, psychotherapists without the formal education in clinical psychology, or Norwegian master students in psychology) are not included in the study. Furthermore, be advised that throughout the thesis, the terms “clinical psychologist”, “therapist” and “psychologist” are used interchangeably to refer to the study’s participants, who are all licensed clinical psychologists.

Work experience. To ensure that the participants have had the opportunity to work professionally with clients in therapy, enabling them to have been in situations where issues of touch potentially could arise, it was decided that the second inclusion criterion was to have a minimum of two years professional practice after having finished their formal education.

Adult clients. As is mentioned by several (see for example Aquino & Lee, 2000; William, Clarke & Gibson, 2011), the use of touch in therapy with children and adolescents (below the legal age of 18) imply several developmental, ethical, clinical and legal concerns. In order to delineate the scope of this paper, a decision was made to only gather accounts from therapy with adult clients, i.e. clients above the legal age of 18.

Recruitment procedure. Recruitment of participants to the study was done in three steps: (1) Establishing contact with a selection of regional psychiatric clinics, (2) providing

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further information about the study to relevant clinics, and (3) getting in touch with individual clinical psychologists. The method of recruitment was chosen on the basis of wanting to reach therapists practicing in different areas of Norway, increasing the possibility for a diverse set of practices, educational backgrounds and clinical experiences. With the exception of two therapists (who were contacted and recruited separately), all participants were recruited to the study by following these three steps.

Establishing contact with a selection of regional psychiatric clinics. The researcher telephoned regional psychiatric clinics in all 19 counties in Norway, presenting herself and her research topic. The initial goal was to be allowed to provide the clinics with further information about the study, by getting the contact details of a manager who could further pass on the information to their colleagues.

Providing further information about the study. This step consisted of following up the telephone conversations and providing the relevant clinics with the study's information sheet and initial literature list (see Appendix A, B C and D for the relevant documents), asking it to be forwarded to all clinical psychologists working at the clinic. A follow-up e-mail was sent out to eventual non-responding clinics within a month after the first e-mail (see Appendix E).

Getting in touch with individual clinical psychologists. Guided by the three inclusion criteria described above, and with information about the study, interested potential participants were asked to contact the researcher in order to receive any requested extra information, clarifications or agreeing to participate in the study. A total of 11 clinical psychologists were in the end contacted and asked to participate in the study. Out of the 11, ten of them were able to find a time they were available for an interview (the one dropout was due to practical issues such as travelling distance and available time).

The Interview Guide

The interview guide consisted of 14 questions, separated into different categories believed to influence clinical psychologists' decision to use, or not to use, physical touch in therapy (see Appendix F for the complete interview guide). The questions were all based on themes identified in previous literature on touch in therapy, with topics ranging from the

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therapists' actual experiences with touch in their own practice and education, to their personal and professional attitudes and beliefs. The structure of the interview guide was to open with questions regarding their own immediate attitudes toward touch in therapy, followed by exploring their own personal experiences with touch, and what they themselves saw as determining whether they would touch or not. This order of questions were decided on to ensure that the interview would start as close to their everyday practice as possible, being open and curious about their answers. Considering that touch potentially could be seen as a taboo by the participants, it was important to create a feeling that their own, personal reflections were valid and uttered in an accommodating environment, before asking more concrete questions about specific situations and evaluations. This was also one of the purposes of using a semi-structured interview, encouraging the participants to account as freely as possible about their experiences and views on the subject, in order to gather a rich data material for the analysis (Howitt, 2010; Willig, 2013).

One specific question about areas of the body that would be acceptable to touch was added, with the addition of a figure of a male and female body, where the participants were asked to mark the areas they found appropriate. The figure was added as an attempt to facilitate more concrete exploration and reasoning around the client bodies, and also if there were any clear differences between the genders. Lastly, there were three questions around their own, professional discussions and education about touch in therapy, and one question specifically asking about the actual interview situation and how they felt about reflecting openly around touch together with an unknown researcher. This was done as an attempt to associate their general thoughts and experiences with the experience of being interviewed about it by someone unknown, and to see whether this was a topic they were well familiarized with or not.

The interviews. Ten semi-structured interviews were conducted, one interview with each clinical psychologist. All interviews were carried out by the researcher, during the period of October 2016 - March 2017. The length of the interviews varied from 36 minutes to 1 hour 4 minutes, with an average length of 46 minutes. They were all carried out using the interview guide, with additional follow-up and clarifying questions where it was necessary in order to get a comprehensive understanding of the data material. Unless some of the more open-ended answers had already covered other questions in the interview guide, the questions were always asked in

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the same order. Efforts were made by the researcher to appear as a “naïve enquirer” (Williams, Clarke & Gibson, 2011), for instance by asking “why, or how, is that?” and asking for specific examples, to encourage them to be the experts of their own clinical practices.

Considering that the themes that emerged as important for the different participants varied among the interviews, not all of the same follow-up questions were used in every interview. This was a conscious decision, made to ensure that the direction of the interview was chosen based on the participants’ reflections, rather than the researcher’s preconceptions and assumptions.

Transcription of data. All ten interviews were recorded, and together with any written notes taken during the interviews, they constitute the data set used in the analysis. The interviews were transcribed by the researcher, after all interviews had been conducted. Following the recommendation of Braun and Clarke (2006) and Willig (2013), the interviews were not transcribed to a high level of detail (such as for example the Jefferson system, described in Howitt, 2010), but they were transcribed in full, to enable the researcher to familiarize herself with the whole data set. Great effort was also made to ensure that all transcripts contain a verbatim account of the interviews, including some nonverbal utterances (such as pauses longer than four seconds, laughs and gestures) (Braun & Clarke, 2006).

Ethical Considerations

All participants received an information sheet delineating the goal of the research, the implications of participating in the study and information about storage and access to the data material both at the time of initial contact, and right before the interview took place. This was done in order to ensure informed consent, and that the participants felt safe knowing what they were participating in. No rewards or inducements were offered to the participants to take part in the study, as an attempt to ensure that they would not feel “obliged” to participate, but did so freely. The briefing before the interview included information on researcher confidentiality, anonymity, and their right to pause, cancel or withdraw from the interview and/or study at any point. Considering the possible sensitivity of the topic of touch, a question about how they felt discussing it during the interview (safety) was included in the interview guide. In addition, they were given the opportunity to debrief and ask questions also after the recorder was turned off. All participants were also given the opportunity to read through and comment on the analysis

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before the full paper was finished, and the researcher explicitly made herself available for any discussions about the topic of touch and/or the interview both before and after the interviews.

To ensure anonymity, each therapist has been assigned an alphabetical identifier, under which all tapes and transcripts have been labelled. This includes the researcher's own reflections and recordings immediately after every interview. Names of participants, towns, universities and workplaces have been removed from all transcripts.

The project is reported to and approved by the Norwegian Centre for Research Data, as they have concluded that the processing of research data and personal information satisfy the demands regulated by the Personal Data Act (see for example Datatilsynet, 2017; NSD, n.d.). Specific measures were taken to ensure that sensitive client information that may contribute to the identification of individuals would not be revealed during the interview, as it was explicitly stated both in the information sheet and in the briefing, as well as during some of the interviews.

Data Analysis

Indicating how active the researcher has been in identifying themes, as well as the overarching framework, is an important prerequisite for conducting a thematic analysis, and should be made obvious for the readers (Howitt, 2010; Willig, 2013). In the current analysis, a bottom-up method (Braun & Clarke, 2006; Willig, 2013) was used. Also referred to as a data-driven analysis, it implies that the coding of the data is done without a theoretically informed coding frame (Willig, 2013), but rather by the researcher *identifying* patterns and themes in the data material (Braun & Clarke, 2006). The analysis was conducted in line with the six phases of thematic analysis, as described in Braun and Clarke (2006:87), including using their terminology of “themes” and “sub-themes”. The process consisted of the following phases: Familiarization with data, generation of initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report.

To familiarize herself with the data, each tape was listened to and transcribed by the researcher. The transcripts were then checked with the recordings, and read through in detail. Throughout this process, initial ideas, points considered worth highlighting and potential connections within the data were noted down in the margins of the transcribed interviews. All interview transcribing, typing, data analysis and writing was undertaken by the researcher alone, as an effort to ensure that emerging themes would be apparent and identified more readily.

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When generating initial codes, individual questions were read throughout all interviews, noting down trends and tendencies in the separate answers on post-it-notes. In other words, the interviews were not analysed one-by-one, but rather question-by-question, shifting between interviews. Having the codes on post-it-notes enable more easy gathering of codes into broader themes across interviews and reviewing codes and themes at a later stage in the analysis. It was also done due to the analysis not being a strictly linear process, and thus to accommodate more constant movement back and forth between the different phases, and between the different coded extracts and complete data material. The codes were generated based on short sequences of text that were meaningful to analyse as a whole, like the example in Table 1.

Table 1
An example of the initial generation of codes.

Sequence of text	Initial codes
“It never crosses my mind to do it, actually, because it seems very unnatural to do it during the session, because of the sitting position. If we were standing, and [the client] would be crying in front of me, standing, then I would do it. Then it would be more natural to give a person a hug.”	- Physical surroundings. - Movement required to touch. - Position in the room: Sitting, standing.

After the initial coding, possible combinations of codes into overarching themes were explored (Braun & Clarke, 2006). This phase of the analysis led to the creation of a collection of potential, “candidate”, themes and sub-themes: Different sub-themes were grouped together, constituting a more general, overarching theme, as is done in a bottom-up analysis (Braun & Clarke, 2006; see the example in Table 2). Further, the different themes were constantly reviewed, both to ensure that they reflected the coded data extracts, and the entire data set (across the different transcriptions), as well as to ensure that there were clear distinctions between the themes, while the data within a theme is meaningful and coherent (Braun & Clarke, 2006).

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Table 2

An example of the generation of candidate themes, from initial codes and different sub-themes.

Initial codes	Sub-themes	Theme
<ul style="list-style-type: none"> - Physical surroundings. - Position in the room: Sitting, standing. - Table in-between. - Movement required to touch. 	Workplace and surroundings.	Individual clients and contexts.
<ul style="list-style-type: none"> - Sexual abuse. - Acting out. - Dependent. - Physical abuse/violence. - Difficulties setting boundaries. - History of bad experiences with touching. 	Client history.	

Changes to the composition of themes were made, some themes were separated into individual themes, whereas others were merged, or split into sub-themes. For example, the initial code “dependent” (see Table 2) was later moved to the sub-theme “client dependency”, underlying the theme “concerns and perceived risks” together with other related, but distinct, sub-themes. Consistent with the thematic analysis approach, the themes were not necessarily selected because of their prevalence in the data material, but rather because of their assessed relation to the richness of the data and their relevance to the research question (Braun & Clarke, 2006; Harrison, Jones & Huws, 2012).

When the themes and sub-themes were seen to precisely reflect the complete data material in a coherent way, the themes were named in a manner that should frame the essence of the data they capture. Further, quotes and extracts from the transcribed interviews were selected, to illustrate and exemplify the content of the themes and sub-themes. This was also done to ensure that the themes add something “new” to the understanding of the data, and that they are not solely a copy or a plain description of the data material, but that they include some interpretation done by the researcher, being structured and understood in relation to each other, across interviews, and in line with the research question. The researchers active role in identifying themes is highlighted, as opposed to a more passive stance where the themes

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“emerge” from the data (Braun & Clarke, 2006). Measures have also been made to make sure that the final themes do not only reflect the topics included in the researcher’s interview guide, as is highlighted by Willig (2013).

Because thematic analysis is known as a theoretically flexible method, certain critics have claimed that it is a method where “anything goes”, where the work done with the data material is unstructured, unaccounted for, and done in a more random manner than in other methods (Braun & Clarke, 2006). Braun and Clarke (2006) emphasize that several measures can be made to ensure the quality of a thematic analysis, and that the method has several advantages to offer to psychologists. They have created a 15-point checklist of criteria for a good thematic analysis (Braun & Clarke, 2006:95-96), and great efforts have been made to ensure that these criteria have been met in a satisfying manner, through repeatedly and thoroughly checking and reviewing the transcription, codes, themes and sub-themes against each other and with the complete data material. In addition, the structure of the analysis is also reflected in the results and at the level of the interview guide, to ensure a comprehensive and consistent fit between the described method and the reported analysis.

Results

What factors influence whether a sample of Norwegian clinical psychologists decide to touch their clients, or not? The analysis revealed an intricate decision-making process, where a network of several themes and experiences related to touch in therapy were considered. All identified themes and sub-themes summarize what the therapists know about touching in therapy, what they think about the use of touch, their previous experience with using touch, their training, and how they consider each case and assess consent. The main structure of the results is visualized in Table 3, showing all themes and their relating sub-themes.

The main themes identified were potential benefits of touch, concerns and perceived risks, therapist factors, individual clients and contexts, the presence or absence of touch in therapy, and professional discussions about touch. The following sections will present the different main themes and sub-themes, emphasized with quotes and examples from the interviews. All quotes have been translated by the author, striving to retain a wording and sentence structure as close to the original as possible (all original quotes included in the following section, can be found in Appendix K). Sounds have been removed from the transcription, laughs and pauses are indicated in parentheses, and italicized words indicate emphasis by the participant (unless otherwise noted). The symbol “(…)” is used where short a passage of text has been removed, due to being considered superfluous to illustrate the point of the analysis, and clarifying words or short phrases are added in brackets “[]” where necessary.

Table 3
An overview of all identified themes and their related sub-themes.

Themes	Sub-themes			
Potential benefits of touch.	Touch as empathy.	Touch as a catalyst.	Strengthening the therapeutic alliance.	Specific therapeutic techniques and interventions that utilize touch.
Concerns and perceived risks.	Touch and taboo (touch as suspect).	Misunderstandings in the interpretation of touch.	Fear for professional status.	Client dependency.
Therapist factors.	Reliance on intuition and professional assessment.	Therapeutic orientation/modality.	Client-therapist power dynamics.	Negotiating touch.
Individual clients and contexts.	Client age.	Cultural differences.	Gender and (expectations about) sexuality.	Client history. Duration of therapy. Workplace and surroundings.
The presence or absence of touch in therapy.	Actual use of touch.	Areas of the body considered appropriate to touch.	Therapist and client initiative.	Rejection of touch.
Professional discussions about touch.	Experiences of discussions in education, supervision and the workplace.	Touch as a “private” subject (risk of disclosure).	Need for more nuanced knowledge.	

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Potential Benefits of Touch

This theme encompasses several distinct, but also closely related sub-themes describing the participants' views on different potential benefits of using touch in therapy. Its use can work as a catalyst in therapy, it can strengthen the therapeutic alliance, be an expression of empathy, and certain specific therapeutic techniques and interventions that utilize touch that already exist are seen as an argument to use touch (see Figure 1).

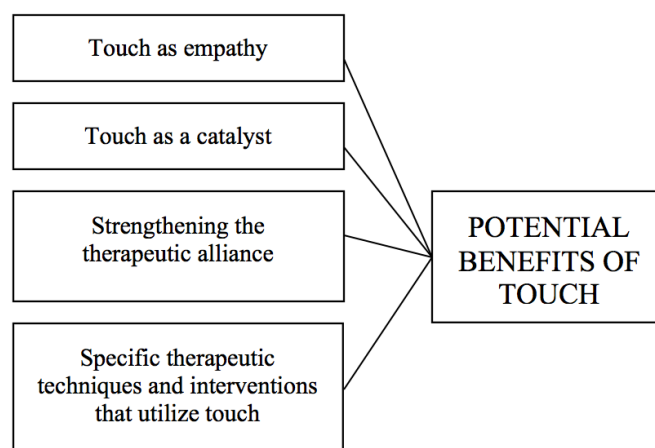


Figure 1. The theme 'potential benefits of touch', and its related sub-themes.

Touch as empathy. Most of the clinical psychologists described potential benefits of touching in relation to empathy, showing the clients understanding and acknowledgment, providing them with comfort and reassurance in actions as well as (or instead of) words. One participant specifically pointed out the nurturing function touch and physical closeness has in human development and interaction, and how touch can be seen as a way to show care and comfort, also in therapy. Other accounts showed the use of empathic touch to reassure, saying “everything’s going to be alright”, “I believe in you, I care about you”, and “I understand that you are going through some things now”. Reassurance through touch is further exemplified in this quote:

“[Touch is a way to, nonverbally, acknowledge what was talked about] – ‘there it was, and it is ok, I can handle it and you haven’t crossed any borders. There is nothing wrong in what you came forth with.’ Because many patients go there, that they tell you something, and between that session and the next, they have been thinking ‘oh, did I go too far?’ and then (...) they have need for knowing that what they did was ok, ‘it is ok, you are ok, I have seen all of this, and I can still put my hand here on your shoulder. You haven’t repelled me from you by being open, by reaching out for this contact.’”

Touch as a catalyst in therapy. Over half of the clinical psychologists emphasized the physical qualities of touching, characterizing it as a non-verbal (or possibly para-verbal) form of communication (together with other qualities such as voice pitch, facial expressions and mimicry, and word emphasis). Some referred to touch as a potentially strong communication

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method in situations where words felt inadequate or inaccurate, others as a more spontaneous, intuitive, playful way of communication. Underlying these accounts was the experience that touch in a way seemed to “avoid the language filter (...), being a more direct means of communication, speaking to the primitive areas of the brain, our emotional lives”, and that this contributes to making the message stronger and more genuine.

When asked how the physicality and potential genuineness of touch can be seen as beneficial in therapy, therapists said touch could enable them to communicate both in words, actions and with their body, that it could serve as a technique whenever they experienced that using words fell short, as exemplified by these quotes from two of the therapists:

“(...) and I felt that he needed something more than words, a kind of deeper and more genuine form of contact (...)”, and “(...) I believe that it was because it was so incredibly difficult to get in contact with her, and I wanted to try finding another communication channel than language.”

“Instead of just working with using my words – as they sometimes are insufficient (short laugh)... Well, words might not be insufficient, but sometimes I do feel that the therapy progresses more rapidly once I introduce the body and touch into the mix. That it takes less time before they [the clients] get much better. I haven’t exactly... researched this systematically, but it’s my clinical impression.”

In addition, some of the participants said that the use of touch could make the client feel more comfortable, and that an increased experience of being comfortable and safe in therapy could lead to the clients “opening up” and sharing more of themselves in therapy:

“I must be someone that they must allow to get closer, not physically, but in general, in order to feel comfortable and talk about things that they can not even feel comfortable talking about with their own [partners]. And in order to do that, you must make them feel comfortable. And how do you make them feel comfortable (...)? It is touching.”

Some therapists also described how touching could serve as a possible catalyst in therapy, when experiencing that something is pent up, or obstructed:

“I think I’ve often had that experience if something [in therapy] has been obstructed, if I feel that the patient is holding something back. I don’t think it’s about bad chemistry or anything like that, but I think

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that maybe... the patient is afraid to show some of their own, afraid to talk about things, and therefore I can feel that something is being pent up. It is almost as if we are not entirely in contact, I can't get to them. Then I may have this idea towards the end of the session, to, as they are leaving the room, to put a hand on their shoulder. Maybe I feel an urge for us to meet (...), and then I guess I've had an experience myself that it can be a very strong experience, just to get a hand on the shoulder. (...) I want to communicate that I am here. I can see you."

In summary, touch is by over half of the therapists experienced as one way to help the client feel more comfortable in the presence of the therapist, and as a potential catalyst due to being a physical form of communication – both allowing the therapist to emphasize what has already been said verbally by means of actions, and working as both a playful and spontaneous, but also genuine, alternative to words.

Strengthening the therapeutic alliance. Half of the participants gave accounts of experiencing how touch could help strengthening the therapeutic alliance between the therapist and the client. One therapist described touching (such as giving a hug, or touching the hand or shoulder of a client) as a gesture that becomes “an extension of the psychological and emotional contract” that is established between a therapist and a client, a “physical manifestation of their [emotional] contact”. He saw touch as a sign of trust, and joint acknowledgment of client-therapist contact, for instance:

“(...) after having reached a topic that I can see is very meaningful for the patient, a topic that might have been seen as very private until that moment, (...) that it has been some kind of breakthrough, being in contact with emotions they haven't been in contact with when talking about this topic, (...) and they feel seen, heard and taken care of by the therapist.”

Some therapists emphasized that more formalized ways of touching (i.e. shaking hands when meeting for the first time) can build trust and therefore also contribute to strengthening the alliance. Several saw handshaking both before and after, and hugging at the end of a full course, is a good indicator of professionalism and a way to frame their joint therapeutic relationship.

“I would say that it [shaking hands] is a different kind of, it is still physical touch, but I would say it's also different. Because it... initiates a known framework, when they [the clients] arrive here [the office]. I start

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and end every therapeutic course with shaking their hands. (...) I see this as a way to frame the therapy, being polite, (...) and a more expected kind of physical touch.”

“In those instances I see it as natural, because the patient is *leaving* the therapeutic relationship, and there is something personal there. ‘I am no longer your therapist, so you can get a hug from me now, if you wish to.’”

Another point was the experience that one gets emotionally closer and more invested in someone you have touched:

“I think it [physical touch] can strengthen an alliance, a working alliance. That they [the patients] trust the therapist more, that the therapist will be there to catch them in any way or another, that they won’t be rejected. (...) And I guess it can reduce, in a way, the perceived distance between the therapist and the patient. The therapist is in another position [of power], so it might even it out a bit, that the power relationship gets better, in a way. For the patient.”

It was pointed out, however, that although touch was seen as a way to strengthen the alliance, it is also necessary with a stable and healthy therapeutic alliance before engaging in touch outside formalized handshaking. A couple of the therapists also highlighted how being allowed to touch the therapist, by initiating a hug or a handshake, can give the client a feeling of *reciprocity* in the therapeutic relationship, of also being able to express e.g. thankfulness in other ways than verbally:

“(...) one patient who gives me a hug every time she leaves a therapy session, which is not something I would have taken the initiative to do. So this is something she wants to do, and I can see that she has a need to thank me in that way, giving me a hug when we end the session. That way, she gets to say goodbye in a way that she prefers, and it is ok by me”.

It seems as touch and the therapeutic, or working, alliance between client and therapist is seen as having a two-way relationship, where each has the potential to benefit the other.

Specific therapeutic techniques and interventions that utilize touch. This sub-theme is a comprehensive summary of all the different possible therapeutic techniques mentioned by the participants when asked about potential positive functions of touch in therapy. Not all of the

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techniques are techniques or methods they used themselves, as some of them were quite restrictive about touch during sessions, but were techniques they had heard about or could imagine would be effective.

The therapeutic function of touch mentioned most often by the therapists, was to see it as regulation of emotion. Some emotion regulating consequences of touch have been mentioned above (such as comforting, showing care and compassion), but most participants also gave more concrete examples. Assisting to regulate anxiety and panic attacks were mentioned by many, exemplified by the two following quotes:

“I think that if I had a patient who *completely* broke down or had a severe panic attack, I would have... then I guess I could have touched the patient, to help regulating their emotions. Maybe held both their hands, right, squatting down besides them, (...) held them to, in a way, contain them. (...) because one knows that this is a good way to handle a severe anxiety or panic attack.”

“(...) but sometimes they have violent anxiety attacks, and then it has felt natural to move over and sit down next to them, and say ‘is it ok if I stroke your back like this to help you calm down?’, and so on.”

Some therapists highlighted the possibility to touch clients to physically contain them, to show the client that the therapist was present, and to get contact when verbal communication is difficult, for instance during panic attacks or dissociation:

“And there are times, when I have patients that dissociate, I think that – I don’t use touch, but we can throw things to make them realize that they are here – that if we’d touch them, they would be grounded here and now, like a way to regulate emotion.”

None of the clinical psychologists interviewed claimed to use EMDR (Eye Movement Desensitization and Reprocessing) as a therapeutic intervention, but several mentioned it as a formalized and known way to use touch in therapy, where touching was integral to the method. One of the participants disclosed that while he did not have much experience and knowledge about the effect of bilateral stimulation, he intuitively found the touching in itself potentially valuable and therapeutic for the client:

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“There are more methods I have heard of, for example, I don’t do that, but there are therapists that work with EMDR, with tapping on the patients’ hands or shoulders. In those cases, I have thought that yes, I guess one thing is the bilateral stimulation and a theory about what that does, and I’m sure there’s a lot to say about that, but I also think that the touch in itself is meaningful. No matter if it leads to bilateral stimulation, or if it’s simply a matter of ‘here I am, I’m being touched.’”

One third of the clinical psychologists mentioned touching and being in physical contact with a client, for example through handshaking, could be done as an agreed-on exercise in exposure training. Another therapist mentioned that clients also could be guided in touching themselves, to explore their own boundaries:

“It is important, among others these techniques where the patients are close to themselves [in physical contact with, touching, themselves], and they somehow also learn to handle themselves and their bodies.”

Two therapists highlighted the possible value of using touch in a group therapy setting, where the intervention is two-fold: Both to i.e. help regulating a client, while at the same time modelling social behaviour to the other clients in the group.

“Sometimes, in group therapy, you want to model behaviour, right, that you show them things, by doing it yourself, you show them that it is ok. And I wanted that effect, wanted to encourage that kind of (...) communication on several levels.”

Finally, some of the participants pointed out that formalized touch, i.e. shaking hands, already is a central part of considering the mental state of the client:

“Well, you do get information about their formal state of mind [when shaking hands] (...), their eye contact and how they shake your hands (...), those are some of the aspects we [as therapists] assess in relation to the patient’s state of mind.”

This way, information given through formalized touch can give the therapist clues about the client’s present state.

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Concerns and Perceived Risks

All of the participants in the study expressed several fears and concerns in relation to the possible use of touch in therapy, either for the clients, the therapists, or both: Touch and taboo (touch as suspect), misunderstandings in the interpretation of touch, fear for professional status, and an increased risk for a negative spiral of client dependency (see Figure 2).

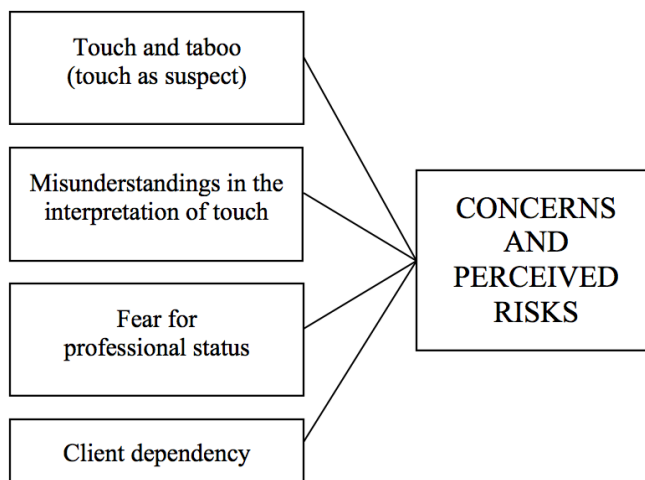


Figure 2. The theme ‘concerns and perceived risks’, and its related sub-themes.

Touch and taboo (touch as suspect). One of the sub-themes that emerged in almost every interview, was the sense that touch in itself is assumed to be questionable, or suspect, often regardless of the actual therapeutic situation. Following quotes like “My immediate thought is that it [touch] is something one should be careful with, and that it often doesn’t belong in an individual course of therapy”, “(...) it [touch] is risky business”, and something you should “be on guard about”, and “(...) it [touch] can destroy everything!”, often lead to participants expressing concerns about touch as a taboo.

One concern is that other professionals and colleagues will interpret the touch as in some way having sexual or inappropriate overtones, regard it as not well enough thought through, or see the use of touch as unprofessional. One therapist highlighted the ethical principle of not engaging in inappropriately intimate relationships with clients, saying “touching would be a less helpful factor for us in order to not get attached to that person”. When discussing the physical body of the client and where it potentially could be appropriate to touch, the therapists’ answers were in almost all of the cases guided by what would seem “too intimate”. What the therapists mentioned most often in relation to touch and taboo, was that the boundaries between touch, intimacy and sexualized behaviour are important, and that knowing these boundaries is a prerequisite for working as a clinical psychologist:

“I think it [touch in therapy] is a taboo, in a way. And I think that it often is a well-founded taboo, (...) in that it adds to a general intimacy taboo, (...) [and] intimacy has to have some boundaries, some boundaries

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that are absolute, in order for it to be safe for the client to be in therapy, especially considering sexualisation of the therapeutic relationship.”

At the same time, especially one of the therapists expressed ambivalence, saying that avoiding the concept of intimacy entirely would not be beneficial either, considering that a lot of the work that is done in clinical psychology is building intimacy and strengthening the alliance between the therapist and the client:

“(…) touch is something that often creates intimacy, I guess that is the point of it, it is also the point of talking and the point of eye contact is also to create intimacy.”

It does appear that stories about incidents of inappropriate touch in therapy, in addition to what seems to be the dominant discourse in most of the therapists education and supervision (the theme *professional discussions about touch*) have contributed to create a general fear, and apprehensiveness toward the use, of touch in therapy.

“(…) there is a little bit of paranoia [in Scandinavia], and you want to be careful with it.”

“I think it also has scared me, stories about patients who have been touched inappropriately!”

Many of the clinical psychologists point to the intimacy taboo as being the elephant in the room: A related topic that permeate the discourse on touch, while still surviving as a taboo due to rarely being talked about.

“At the same time, this is the kind of issue you have to face when talking about intimacy, how it is for the client. But this is almost like a non-topic, I’d say. (…) Among psychologists, and also in therapy.”

“Physical touch is something that… I don’t know what to say, whether it is taboo or it is something that doesn’t receive enough focus, but I think one of the reasons is that you immediately open up for topics such as sexuality and intimacy, and that… I think that’s the reason why it is difficult to talk about, too. That it is difficult to relate to, that it makes it complicated.”

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One possible reason why the intimacy taboo is seen as so stable among the therapists was seen as the fact that touch in itself is not necessarily intimate. The interpretation of the meaning and intention behind touch depends heavily on contextual factors, and as was pointed out by some of the therapists, there are several ways to create intimacy that does not include any touching.

“We do work in a setting where you can get very intimate with the client, at least on a psychological level. If you then touch, in addition, you easily get very physically intimate, and the boundaries can get even more unclear.”

“The boundary between talk and physical touch, I don’t think it is that final. I mean, it is possible to talk about topics, or just to look at people or behave in ways that are extremely intimate, without actually touching them at all. Just like it’s possible to touch people quite much without it actually feeling intimate at all.”

Thus, in order to break an intimacy taboo, the therapists pointed to the need for a negotiation of the boundaries, and of the intention and motivation behind the touch.

“(…) if the taboo is to be exceeded, if you are going to touch, (…) it *has to be safe*, (…) it has to be certain that there is nothing sexual in it. And it has to be certain for both parts; it’s not enough if only one of you feels that it is ok, if the other part doesn’t. That would be wrong.”

“So, if you are going to set up boundaries (…) for what kind of touch it is, there is of course a clear difference between the receiver and the giver of the touch. That what is seen as ok for one part, is not necessarily ok for the other. So my thought is that if we just don’t touch, you don’t have to engage in the discussion [of boundaries] at all.”

On the other hand, considering the possible risks associated with bringing up the topic of touch among colleagues and in the therapy room, these concerns lead most of the clinical psychologists to adopt a “better safe than sorry”-attitude, as highlighted by the above quote. Consequently, some of the participants had limited experiences with touching clients in general, as is discussed more thoroughly as a separate theme (*the presence or absence of touch in therapy*). Choosing to set the boundary between touching and talk therapy right after formalized handshaking was seen by these therapists as a way to protect oneself from possible negative

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repercussions, as well as a way to not engage in a very complicated discussion of where the boundary otherwise should be set.

“(…) so I get unsure, if I’m going to start touching my patients, I don’t know when I should touch, in what way, when is it enough, what does each and every patient feel is enough touch? Thus, it’s a lot easier for me just to say ‘there is no touch’.”

“Not taking initiative is probably also to protect myself.”

“And that if you *know* you *never* touch your patients, you don’t have to be afraid that they’ve ever experienced it as offending to be touched by me. Then I can feel safe that I know that I never touch them, I talk with them, and I can shake their hands, and if they give me a hug at the end, I can reciprocate the hug, but no more than that. I think it makes me feel safe.”

Misunderstandings in the interpretation of touch. The awareness among the participants of the dominant discourse about touch being seen as suspect, seemingly also drive a fear of touch being misinterpreted by the client. They do not express fear that their initiative or decision to touch will be intentionally harmful, but rather about the potential risk of touch being misinterpreted by the client, seen as being sexual, offensive, or otherwise ill-intentioned.

“We have learnt that, both during the studies and at work, that people experience things vastly different.”

“That’s what’s difficult – knowing what the function of the touch is for the client.”

Several of the participants talk about how misinterpreted touch can change the relation between the therapist and the client, sometimes even beyond possible repair, harm their professional reputation as therapists, in addition to it being shameful having unintentionally overstepped boundaries, and difficult to regulate and calibrate intention and interpretation of the intention.

Importantly, there is an unstated assumption in this analysis that the potential ways to use touch in therapy that are being discussed with the participants, and their reflections around the use of touch, is dealing with the kind of touch that is *meant* to be beneficial for the client. In other words, it excludes touch that is intentionally meant to be harmful or transgressing the clients’ boundaries, unless otherwise is explicitly stated.

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Most of the participants point to it being difficult not knowing how their client would interpret the touch, expressing the most doubt when talking about issues of sexually offensive touch, transference and counter-transference:

“If I would take the [client’s] hand like this, during therapy, I wouldn’t know what they would think about it, and that could make me a bit insecure about how that intention would be registered, and taken as an empathic expression of support, or... anything else.”

When talking about the misinterpretation of touch, over half of the participants mentioned issues of transference and counter-transference. They highlighted how difficult it can be to know what kind of meaning will be added to non-verbal communication strategies, as they by nature are ambiguous, both for therapists and clients.

“(...) it [touching] has probably opened up for misunderstandings from clients who might have felt that it has been sexually motivated, or motivated by more unacceptable drives from the therapist (...).”

Misinterpretation seemed to be particularly relevant whenever the participants had clients with what they described as a “flirtatious interpersonal style”.

“Some [clients] have an interpersonal behaviour where they become quite flirtatious towards the therapists, they are like that with everyone, and then I get a bit like, where do the boundaries go, what is the limit for what can be perceived as more sexually motivated, and not?”

In those cases, both male and female participants would express caution and restricted their own use of touch, to minimize behaviour that could be understood as sexually motivated or offensive by the client.

Fear for professional status. Over half of the psychologists talked about what is understood as societal myths and expectations about their profession, and how these expectations both lay the groundwork for their practice. While acknowledging the history of their work, they also discussed how it could be limiting, in terms of being less flexible due to lack of training in other methods than “verbal therapy”.

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“Our profession is verbal.”

One participant particularly talked about how we perceive touch and the use of touch lies implicitly in the unconscious or hidden norms in society, and that it controls what we are expected to learn about when studying psychology, for example how therapists act in front of, or together with, the client, and what feels “natural” or “unnatural”. One myth that was discussed, was the idea of the separation between the body and the mind (mind-body dualism), especially how it consciously might be perceived as an artificial separation, while unconsciously permeating the society the clinical psychologists operate in.

“(…) there are these myths that definitely exist in the society around us, this separation between body and mind, right. Psyche and soma. And then we are taught that it is an artificial boundary, that in reality there is no such separation, but at the same time, when going out working as a clinical psychologist, you find that it [the separation] nevertheless is reflected throughout society. The myths are alive and kicking out there, among people, and it is very much reflected on how the society as a whole, how all of the health care system is built.”

Many worried that using other methods than talking, such as touch, would be seen as unprofessional and ill advised both by other colleagues and by clients. This could be due to people not expecting to be physically touched during an appointment with a clinical psychologist, some mentioned, as well as the Norwegian society in general being seen as wary of physical touch and closeness. In other words, they were afraid that touching could damage their professional reputation and status.

Client dependency. About half of the therapists expressed worry that touching clients during therapy would cause the client growing dependent on getting touched by the therapist. One fear that was mentioned by several, was that a client in distress would be unable to regulate their own emotions without therapist touch. Thus, if the clients rather were helped to regulate themselves through instruction or verbal comfort, they would be less dependent on therapist touch. The reason why client dependency was seen as a possible risk was due to therapy being a temporary relation. The main aim of therapy for many participants was seen as making themselves excessive, and that the clients, through therapy, would be able to explore how they could get their needs for physical closeness met from their social network outside therapy. Some

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participants were afraid that the clients would be less motivated to actively practice being “independent”:

“They need to work out how they can find and get what they need back home. In a way I guess that’s what therapy is about, how to help people function better in their homes, in the lives they live. Because we are just temporary aid, helping them to be equipped to stand on their own feet again, in a way.”

“(…) for most talk therapies, what you [the therapist] want is for your patient not to need you any longer, and that the relational help they get from you, is something they will be able to get elsewhere. And if they get dependent on you, on getting it from you, it is unfortunate, because it might lead to them having less incentive to seek it out in their other relations, too.”

The other side of this was, however, expressed by one therapist (in relation to showing support and care for the client):

“So they have the opportunity to carry that [the feeling of care and support] with them, that they can internalize the function I have for them as a therapist, so they can become their own therapist. It is about showing them the kind of care they should show themselves when they live on, (…) a sort of… closeness to themselves. A closeness that you can show and help them to see through your body as well, as a therapist.”

Some participants mentioned the need to keep a personal distance to the client, and described touch as a kind of self-disclosure they wanted to be careful with. Just as they were hesitant about giving their private phone numbers or e-mail addresses to clients, they would be hesitant about touching them. Through keeping their distance, they saw it as easier for the client to detach when finishing therapy.

“And it’s not only for the patient that I avoid being physically close, that I don’t touch a lot (…), it is also for my own sake. Because I don’t want them [the clients] to get too close to me [emotionally]. I wish to have some distance to my work. I need to have that distance. (…) So, I can be somewhat personal, reveal things about myself for instance, but I’m rarely very private in therapy. (…) There is a boundary there, where… where I can’t get too private. Where I am put in a position, in a role, to help, not become the best friend or a friend they are dependent on.”

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Several mentioned the need for distance between the therapist and the clients' lives, saying that touch could make the separation between the two more difficult. The responsibility for delineating the roles, i.e. the therapist as a therapist, and not as a friend or a close caregiver, was seen as the therapist's. The delineation often involved the practicalities of the therapy, such as the time and date of sessions, as well as the contents of the therapy and drawing a boundary in terms of how easy it would be to contact the therapist outside hours.

“There are some patients who find it difficult with boundaries and role delineation, and then it is important to make it clear what our role is – I am here as a counsellor, as someone you can *talk* to and someone who can help you in understanding yourself to a better degree. I'm not a caregiver in that sense.”

“(…) I am in a professional role as a clinical psychologist, and I think that is important to protect, or rather important to maintain some boundaries. For example that this is not a private relation, it has a beginning and an ending, and our sessions are reserved to these days of the week or this and that time of the day, and outside of that I cannot be anything else for you.”

One of the therapists challenged the otherwise commonly held view of self-protection or protecting what is private:

“Like now, we are sitting in my home, as I am one of those therapists who finds it ok to have therapy sessions at home. I have patients here every now and then, which many therapists avoid. Both because they find it too private, they feel that the patient is entering a part of their lives, sort of, and someone finds it too private for the patient, that the patient then suddenly has to deal with something that is very much the therapist's area, with the therapist's things and so on. But I don't think of it exactly like that. (...) I just think it's ok, in a way. But I guess it has something to do with me not finding that boundary between what's personal and what is private to be so absolute. I don't find it that easy to establish, and I think that we... as psychologists, we do sometimes exaggerate the significance of such a thing. (...) [and with physical touch] it's the same thing.”

But apart from this one account, the rest of the therapists wished for some sort of distance in the work they do, between themselves and the client, between what is professional, personal and private.

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“I don’t want to be a clinical psychologist in my spare time, with my friends, and I don’t want to be too friendly or friend-like with my patients. I want to be professional with my patients. (...) [it is highlighted in] the language I use, as in the words and concepts I use in the sessions (...) I haven’t thought too much about touching, but I guess that of course also is a delineation I use.”

Therapist Factors

All participants described different qualities and experiences related to touch and their clinical practice, as well as factors they themselves viewed as either central to, or incompatible with the use of touch: Reliance on intuition and professional assessment, therapeutic orientation/modality, client-therapist power dynamics, and ways to negotiate touch (see Figure 3).

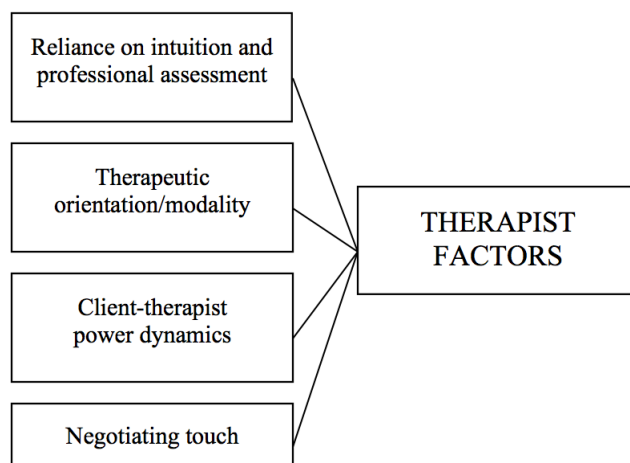


Figure 3. The theme ‘therapist factors’, and its related sub-themes.

Reliance on intuition and professional assessment. One trend in the interviews was that the therapists described personality traits or characteristics they felt were critical when using touch. They had to be sensitive to the timing and context, be understanding, confident and not to misuse physical touch for their own sake.

“[working physically] requires alertness and gentle, fine detail, and timing, and so on. But, I guess that is required of all kinds of therapy.”

In addition, the ability to be aware of what touch could signify for a client, was highlighted; especially not limiting it to only be a set of physical movements, but also as something with a psychological and an emotional element attached to it. This was seen as important especially in relation to the fact that almost none of the participants spoke about possible touching with their clients, or negotiated the use of touch in therapy. In this sense, fine-tuned social cognition skills were needed. When not talking about touch, how the clients reacted to it had to be understood reading the clients’ signals.

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“We touch [or not] based on indication, and I’d say you need to be *quite* competent at judging those possible indications.”

“I judge what they need when we end the therapy, either one single session or the whole course of therapy. What they need. Because not everyone need to shake hands and say goodbye, maybe they just need to walk out of the room really quickly because they find it hard to end things.”

Most of the therapists were more or less wary about assessing possible situations of touch, and adopted the “better safe than sorry”-position where they would rather abstain from touching, than to misread client signals. They also found it hard describing exactly *what* could be possible signals or indications from the client, and relied more on intuition, their clinical impression, on a case-by-case basis.

“It’s not that easy to explain, because it has something to do with body language and posture, right, (...) and exactly what it is, I think it’s more of the concept of general social perception than being very easy to explain in detail. (...) You just get a feeling, you get a feeling of where people have their boundaries.”

Another explicit strategy mentioned by a couple of the therapists, was using themselves as a benchmark, or assessing how they would feel about touch in a specific situation:

“I know it would make *me* comfortable, if I was in their position.”

“Yes, I do that, I base a lot of my assessments on myself [what I would be comfortable with].”

Therapeutic orientation/modality. Most of the therapists did not mention their therapeutic framework, or modality, as a factor mediating their use of touch. They would rather point out the lack of guidelines on the use of touch in their therapeutic manuals, and that they understood it as touch not being part of the therapeutic toolset within their modality. On the other hand, about half of the therapists point out that it would be equally difficult to explain the lack of touch:

“So why *don’t* we touch? If I was to justify that, then [I wouldn’t know why]...”

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“I mean, I don’t know if I can remember having read anywhere in the literature, as far as I have seen, that you really *shouldn’t* touch, for example.”

“In the manuals I use, the approaches I take in therapy, touch is not an included method. Nowhere is it described to use touch, and therefore I’m not doing it, either.”

There was one exception, as one therapist in particular was very clear that touching “within” therapy (i.e. not at the beginning or the end of therapy) would be wrong, describing it as unhealthy gratification of the client’s wishes, and the kind of therapist action that would hinder working through the unconscious drives of the client. Processing the drive and fantasising about realizing an input was seen as more therapeutic than acting it out, and this perspective was clearly given due to the therapists’ modality and training.

“I would say it [touch] is non-therapeutic. (...) It is harmful. Anti-therapeutic. (...) if you [the therapist] give in, if you give the patient what the patient wants, when the patient wants it, it is the same as giving in to their defences, their acting out. We call this defence acting out.”

Other therapists also saw touch as gratification, without necessarily drawing the conclusion that it would be anti-therapeutic. Those valued validating the clients’ emotions and propose possible ways to work through their reactions more than gratification:

“I can confirm and validate, ‘I can see that you are crying, do you want a tissue, this was hard for you’, and contain their emotions, without touching.”

Client-therapist power dynamics. Some of the participants point out that since most clients have sought out a therapist because of their assumed professional knowledge and ability to assist the client, it is impossible to talk about touch and therapy without talking about concerns regarding the dynamics, and the inherent power imbalance, between the client and therapist.

“I think that touch can never happen independent of the relationship between the people involved. So the relationship will always have some kind of meaning and consequence for how the touch is experienced and interpreted.”

“You have to be conscious that you are in a position of power.”

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It was seen as important to be aware how touch could influence the power hierarchy and dynamics within the therapist-client-relationship; and how the inherent hierarchy of therapy influences the use, navigation, and interpretation, of touch. Whereas some of the participants viewed touch as a way to lessen the distance and create a feeling of being more equal, other participants emphasized that touch could create an even bigger distance (for example by making the client feel as a more passive agent in relation to the therapist). In addition, many highlighted how the already inherent power hierarchy could create situations where the client agrees to try out techniques, or, in this specific case, to be touched, without actually wanting to, but not daring to say no to the professional.

“(…) if you [the therapist] touch another person [client] somewhere that person is uncomfortable with, it can lead to an uncertainty about the relationship. Which (…) can lead to the patient feeling submissive, or… like the weak part in the relation, in a way.”

Not being aware of the power dynamics in the therapeutic relationship was seen as potentially damaging by almost every therapist, and they would mention several factors regarding the individual clients and contexts that they tried taking into account when considering touch and their consent.

Negotiating touch. In order to explore how (or whether, and to what degree) the clinical psychologists actively sought out their clients’ consent to be touched, they were asked about consent, expectation management and calibration of the meaning and interpretation of touch. Whether “touch” was a topic that in general would arise in therapy at all was also explored, and this sub-theme thus includes both possible instances.

Only one third of the participants confirmed that they would explain and/or ask to their clients whether they could touch them. This seemed to be especially true regarding touch that would happen mid-therapy, i.e. outside the formalized framework of handshaking and possible hugging.

“‘Is it ok if I try this?’, ‘Could we try another exercise?’, ‘What is this like for you?’”

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“Kind of like ‘Is it ok if I touch you?’”

For these therapists, the idea of giving a rationale or an explanation of why they would consider touching the client, was a way of empowering the client. There was also an idea that knowing the rationale behind the request to touch, they would level their expectations and maybe even be more open to try out new techniques in therapy. In addition, it was seen as a possible measure to ensure that the client could make an informed decision of whether they wanted to consent to the touching, or not.

“(…) and you would also, you would spend some time explaining to the patient, right, it’s about their expectations. That the patient gets a rationale for the eventual use of touch, and has an expectation that it is part of the treatment, and that it may occur.”

“But I think it’s like with any other kind of intervention that we do; ‘I’m asking you this now because I think it might be helpful for you to do this and that’, right. To me, educating the patients is super important, in order for the patient to find meaning in what is happening, none the least understand more of why they get the kind of help they get! That leads them to gaining more ownership to their own therapeutic process too, and they can learn to become their own therapists too, in the future.”

When asking to touch, they rarely experience clients saying no, and most agree that it does happen, but very seldom. As mentioned earlier, client-therapist power dynamics could make it difficult to know whether clients answering “yes” to a touch inquiry are genuine, or if they are answering what they think the therapist want them to say, or if they, for any reason, are afraid to say no.

“Because, if I had asked (…), I can’t guarantee that they [the clients] would dare to say no! There’s something about the fact that I’m a psychologist, I might come across as scary, health professionals can be scary, the patients can have bad experiences with authorities from before, resulting in them having a much harder time saying no.”

One of the therapists emphasized that this risk can be minimized by both giving a clear rationale for the touch, but also by practicing and “training” the client to become comfortable with saying no or rejecting suggestions from the therapist, learning that setting clear boundaries for

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themselves does not lead to the therapist rejecting them. In addition, another therapist made it clear that a question to touch would never be asked unless there were relatively clear indications that the client's answer would be reflecting their true attitude:

“[Do you experience that the answers you get are genuine?] Yes, I do. Because the question has to arise in a context, right, it's not a question you can ask whenever, it has to be... You have to have a relational foundation, that is able to carry the question, and then you are unsure if the social foundation can carry being in touch, but you have an idea yourself that it would be the right thing to do, you just need to [verbally] check. And in those cases, I do believe that the answer you get is quite precise.”

When asked why they might not actively seek verbal consent, some participants highlighted the continuous interpretation of non-verbal communication during therapy, and that they would never initiate touch if a client was unequivocally avoiding any kind of physical contact. This aspect of consent will be explored further in the next section.

“I can't remember to ever have asked [whether it was ok to touch]. There is so much non-verbal at play.”

However, over half of the participants reported that “touch” (in general) was a topic that could be raised during therapy, both by the therapist and by the client. A couple of therapists said that it rarely was relevant for their client groups, but that they would not reject it as a topic if brought up by a client.

“(...) I do talk to many about the need to be physically close to others, to be touched.”

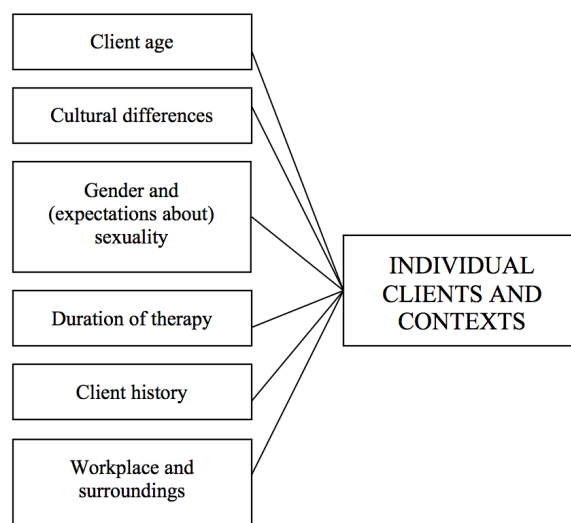
“There are patients who bring it up, the need for proximity to others, not necessarily to me, but with their partner or someone close that they wish they could get more care, or hugs, or attention, from. Physical touch and closeness.”

One therapist also mentioned actively bringing in touch as a topic in group therapy, as a way to signal to group members that there was room to talk about it if needed, both individually and in the group.

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Individual Clients and Contexts

All participants highlighted different factors linked to the individual clients and therapeutic contexts, that would also impact their decision to use, or not to use, touch: Client age, cultural differences, the client's gender and (the expectation about) their sexuality, duration of therapy, client history, and workplace and surroundings (see Figure 4).



“I mean, it depends on each and every patient.”

Figure 4. The theme ‘individual clients and contexts’, and its related sub-themes.

Client age. Although not included as a question in itself in the interview guide (it was actually used as a criteria for exclusion from the study, if participants had only worked with clients below the age of 18, unlike for example Williams, Clarke & Gibson, 2011), client age was spontaneously mentioned by several (both male and female) therapists. Therefore, it is found relevant to include briefly here as over half of the participants meant that this is something that would directly impact the inclination to touch. It seems that working with children implies some different dynamics and interactions than when working with adult clients, and that there are differences to what is generally seen as more acceptable and expected behaviour:

“(…) I would feel like, with a child, I would be more able to express my own feelings through hugging, or stroking the head or the cheeks, or anything. If the alliance with the child had been established. But with adults... it has been *very rare*.”

“At the same time, I’m thinking that it might be feel more natural to touch children than adults, if you make a separation between working in child psychiatry, then the topic of touching, giving a hug and ruffle their hair and so on, it would be more culturally acceptable.”

Specific uses of touch mentioned included leading a child by hand into the room where the therapy took place, having a child on their lap, lifting a child (from the floor), stroking their head, cheeks, and backs, being physically close and in contact during play (incidental touch), and ruffling their hair.

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Cultural differences. One third of the participants mentioned culture and potential cultural differences between the client and therapist as factors influencing the use of touch. It was most thoroughly put forward by one of the clinical psychologists. That person was not born or trained in psychology in Norway, but had worked here for many years, growing increasingly aware of the cultural differences in terms of expectations and the meaning of physical touch in Norway and in other cultures.

“I refrain from touching also because I know that people here in Scandinavia, both male and female, are less ‘touchy’ than in my culture. So I never know how they would feel about it.”

This clinical psychologist felt more hesitant about touching Norwegian/Scandinavian clients, because the interpretation of touch felt even more unsure when the client and therapist did not share the same cultural background and understanding.

Gender and (expectations about) sexuality. Out of the ten participants, over half (equal distribution of men and women) claimed that the gender of the client didn’t make any difference in terms of whether or how they would touch. At the same time, both the female and the male therapists appeared to be aware of gender issues in the relationship between the client and the therapist. Those stating that they would refrain from touching due to gender, were vary about touch being perceived differently depending on the gender of the client and the therapist. They often made assumptions about the client’s sexuality, and linked the avoidance of touch to steer clear of misinterpretations (i.e. that the touch is sexual and/or flirtatious), and possible issues of transference.

“I think that, especially if a male did it [touched] to a female, it could send sexual signals.”

“I guess you would be slightly more cautious [about touching] when the client is of the opposite gender. That you are more careful if that’s the case. That misunderstandings can occur more easily, or that something could get wrong in any way. In addition, of course, there is more easily confusion in regards to what my motive is and what the client’s motive is, right, because I myself can get attracted to women and not men, and therefore I have to check to see if there is the slightest element of attraction there.”

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Interestingly, the issue of gender (and sexuality) also played a part in relation to what behaviours were initiated by the clients. One therapist (male) remarked that male clients much more rarely initiated hugs with him than female clients, whereas another therapist commented that the frequency of hugging is embedded in the social expectations of the female gender:

“I think it is sort of embedded in certain cultures, yes. That you for instance more easily get hugs from women. Not always of course, but in general, on a group level.”

Duration of therapy. Around half of the participants highlighted the duration of therapy, or how well they knew their clients, as an important factor in the decision making process. This usually was not the case in terms of handshaking, but rather the frequency of other forms of touching such as hugging and so on.

“And also how well you have gotten to know each other, I mean I have had patients (...) that I know very well. It is different with those that are completely new, or those that I have follow-up sessions with towards the end of therapy.”

Client history. Each client’s own history, and what themes and issues that surfaced before and during therapy, were seen as important markers of the use of touch. The type of issues that were mentioned most frequently, were clients who had been sexually abused, and/or had been traumatized (both emotionally and physically), clients who had difficulties trusting others, those who were seen as “boundless”, having great difficulties setting boundaries and maybe also of understanding the delineation of roles in therapy, clients with borderline-like traits, and clients that are in deep psychosis.

“(...) there are many patients that are in therapy because they have experienced that their boundaries have been, haven’t been respected, and I don’t want to offend anyone or to re-traumatize anyone.”

“Touch is mostly not dangerous, no. Unless it is experienced as transgressing any boundaries, or as a, for someone it’s possible that touching has been traumatic at some point, and that you in a way or the other sort of... connect to an already existing trauma. And of course, if you haven’t sorted that out or don’t have control over it, it’s unfortunate. Touch can become a trigger, in a way.”

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Interestingly, whereas many of the participants would mention the same kind of issues as something you would be particularly aware of, there was no complete agreement on how to handle it in regards to touch. The same issue could make one clinical psychologist refrain completely from the use of touch, and make another psychologist see touch as especially beneficial. This was especially true when talking about traumatized clients, or clients who had had little experience with safe and positive touch. Some of the therapists viewed this as a risk factor that would best be dealt with by avoiding touch (and possible re-traumatization), whereas others saw therapy including touch as a way they could learn to navigate a field of “safe” and empathic touch:

“(…) patients who are traumatized, or who are very troubled with anxiety and tensions (….) that learning to handle the intimacy and just the plain touch in itself (….) can be positive for them”

“(…) we were thinking that for her, [it could be an experience with] physical contact that was different from sexualized or violent touch, because that was the only touch she had experienced. That touch can be anything else than that, was unknown to her. The safe care, the nurturing touch.”

Workplace and surroundings. In certain cases, factors such as the placement of the chairs in the room and the actual design of the room where the therapy sessions take place, would be decisive. Because it felt artificial or insincere, to rise from one chair and walk around the table, before bending down over the client, some participants said they would rather refrain from touching.

“But because of the situation [seating arrangement], the most natural thing that crosses my mind to do, is this: Give them a tissue.”

“We have, like we are seated now, even a table between us. (….) It’s like there’s always something in-between.”

In addition, meeting once a week at a regional psychiatric clinic (as opposed to being an in-patient) was seen to invite less touching by around half of the therapists.

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“There is a difference between working in an outpatient clinic and inpatient, as the latter might entail a slightly more ‘unstructured’ role, where you follow the patients more closely, have less structured meetings, you might meet the patients anywhere on the area, maybe in the patient’s room, so there’s... there’s much closer contact.”

The Presence or Absence of Touch in Therapy

When analyzing the actual use of touch among the interviewed clinical psychologists, it became apparent that touch does happen in therapy, and that it follows certain assumptions about appropriate places of the body to touch, the placement of responsibility to initiate touch, and navigation of consent or eventual rejection of touch. This theme summarizes the findings related to the actual use of touch in therapy, through the sub-themes actual use of touch, areas of the body considered appropriate to touch, therapist and client initiative, and rejection of touch (see Figure 5).

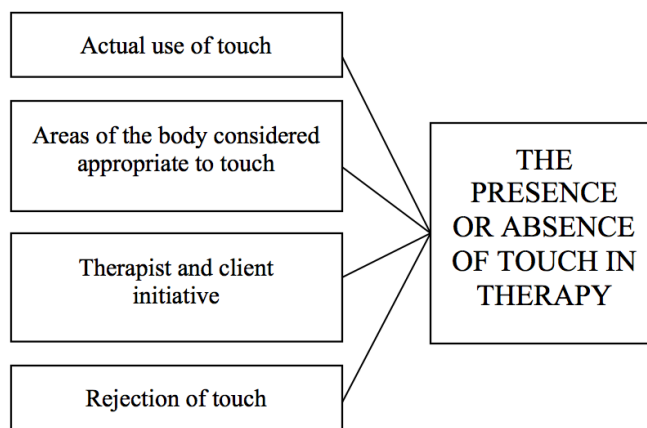


Figure 5. The theme ‘the presence or absence of touch in therapy’, and its related sub-themes.

Actual use of touch. During the questions about actual experiences of touching, and discussions following the drawing on the provided figures on paper, the following results emerge (summarized in Table 4): All ten therapists confirm shaking hands with their clients at the first session of therapy (formalized touch), unless they receive what they consider clear indications that the clients do not want to be touched. The same is true at the very last session, where shaking hands was seen as a way to say goodbye, and/or to say thank you.

“People rarely have a problem with handshaking.”

All but one of the therapists confirm reciprocating a hug, if initiated by the client, at the end of therapy, about half could initiate a hug themselves, whereas the other half would only hug if they meant that the client was clearly signalling, or going for, it.

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“A hug is not just a hug, meaning that a hug can be lots of different things.”

Three of the participants (two male, one female) were clear about no touching except formalized handshaking and/or hugging at the beginning and/or end of therapy, whereas four participants (one male, three female) confirmed that they had experienced hugging also mid-therapy. In total, five therapists (two female, three male) would engage in other types of touch than handshaking or hugging, including patting the shoulder/arm of a client, holding around the shoulders, stroking the upper back, and holding both hands on a client’s hand. Most of the therapists who described themselves as “restrictive” when it came to touch in therapy, justified their position with wanting to stay on the “safer side”, and not to do anything hastily or perform an action that could be misinterpreted. In those cases, other ways to show support or empathy was encouraged:

“Maybe you are sweet, soft and calm, good with words, supporting and encouraging, with a very good empathic facial expression that almost shows you tearing up, right, I think that could be a very good replacement for touch.”

Table 4

An overview of the different types of touch confirmed by the ten therapists.

	A (m)	B (m)	C (m)	D (f)	E (f)	F (f)	G (m)	H (m)	I (f)	J (f)
Shaking hands at the beginning/end of therapy.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Hugging at the end of therapy.	Y	Y	Y	Y	Y	N	Y	Y	Y	Y
Hugging during therapy.	N	N	Y	N	Y	N	N	N	Y	Y
Other kinds of touch.	Y	Y	Y	N	N	Y	N	N	N	Y

Note. The individual clinical psychologists are coded with letters A-J, with their gender in parentheses (m=male, f=female).

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Areas of the body considered appropriate to touch. In order to collect information about touch not only through dialogue and questions, each participant was given a sheet of paper with two figures on each side (see Appendix G and H). On one side of the paper, the outline of the front and back of a female body was pictured, on the other side, the outline of the front and back of a male body. Each therapist was given the paper with the page matching their gender facing upwards, and asked if they could mark the areas of the body where they found it ok to touch. Importantly, they were asked not where *they* necessarily touched during their practice, but rather which areas that could potentially be ok. After having marked on one side of the paper, they were asked if it would be any different if the client were of a different gender. A compilation of all the figures can be seen in Appendix I (female) and J (male).

The results show that every participant marked the hands, and most marked areas associated with a hug (usually the head and chest area); one participant marked both the back and front of the legs (beneath the knees); three participants marked upper arms, four marked lower arms; five marked the clients' shoulders, and three marked the back (except the lower back area). As mentioned earlier, around half of the therapists said they would refrain from touch due to the gender of a client, while interestingly, if touching, there were no recorded differences between the genders in terms of what areas would be appropriate or inappropriate to touch.

However, not only the areas that could be touched were discussed during the interviews, also the quality, or type, of the touch: Stroking or steady hand, light or heavier pressure. It was emphasized by almost all of the participants that different qualities of touch could signal different meanings to the client, like in this quote by one of the therapists:

“Yes, and like pressure, movement and so on, you know, there's a big difference between touching someone like this [demonstrating a still pressure] and like this [demonstrating stroking]. (...) Because I think that a hand that is held still is more... factual, in a way. While a hand that is moving easily is more empathic and intimate. Because it is stimulating in a different way. And there is a difference between holding around someone's shoulder, and to stroke someone's back, those are two very different things.”

Those who mentioned touch quality, were all mostly agreeing that they would avoid stroking a client, as it could signal more intimate, or even inappropriate, touch than a still pressure. They were also wary of the duration of touching, especially when hugging:

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“The longer the hug, the more intimate it is.”

“(…) no, I never linger.”

Therapist and client initiative. When touch happens, who usually initiates it? All of the clinical psychologists were clear that they would not “force” touch upon a client, and that they would either await their clear initiative, or initiate touch themselves unless the client very clearly refused to be touch. It seems that handshaking is something the therapists themselves initiate relatively often (but not everyone), while initiating hugging at the end of therapy is less common (occurs among half of the participants). Although four reported experiencing hugging mid-therapy, only two (one male, one female) of them would initiate these hugs themselves; the other two saw it as dependent on client initiative. For those five therapists confirming other kinds of touching than handshaking and hugging, they all initiate it themselves.

Those psychologists who do not ask their clients if it is ok to touch, rely heavily on their instincts and interpretation of client behaviour that is seen as initiating, or at least inviting, touch. When asking them what signals they would look for, most had a difficult time answering the question, and several commented that it was unusual for them to verbally describe the non-verbal cues they register in therapy. Most mentioned body language that could either invite, or reject touch, like this example:

“They don’t stretch their hand forward, or they avoid looking at me, they sort of look straight to the chair where they are supposed to sit and go directly to it (…) and if they are busy with other things, then I won’t force a handshake to happen.”

Other signals to touch would be clients leaning forward, bending over, or towards, the therapist; reaching their hand out; having eye-contact and/or looking at the hand of the therapist; in addition to their degree of vitality and movement in the room.

“I can see it in the way they lean a bit forward, give a signal that, maybe they even say it, that this has been nice and it has felt important to them, and they would like to thank me for the sessions, and then I see that they might lean forward, and I follow up. That they wish for something more than a handshake. The might wish for something more than that, to end it all. To get closure.”

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When relying on non-verbal signals, some therapists pointed out that it is difficult to know whether they made the “correct decision” to touch, or not, because it is rarely “debriefed” or talked about after the matter. This way, they mostly rely on their instinctive assessment of the situation both before, during and after the potential use of touch.

“And that was because I felt, and it’s not really like I can justify why in a very solid way, but at that moment I felt that for this patient, it wouldn’t be ok to be touched in that way. I had a suspicion that it could be uncomfortable. But I don’t really know if it was correct or not, I don’t know that.”

Rejection of touch. One thing is for the clients to regulate touch initiated by the therapist, another is for therapists to regulate touch initiated by clients. Through most of the interviews, this seemed like a difficult topic for many of the participants, especially as they were weary of rejecting their clients. Only one therapist was very clear on giving verbal correction and refusing to meet any initiative of physical touch from a client that came outside the formalized handshake, or a hug at the end.

Apart from this one account, most of the participants said they had never rejected physical touch initiated by the client.

”Well, I guess I try to, I think it’s difficult to reject the hug, because that will quickly be experienced as a general rejection. And you often reject in a non-verbal manner, which makes it hard to have a verbal conversation about what is going on and what I think about it myself.”

This is an interesting point, as it could lead to further discussing whether some therapists are too afraid to reject, or hurt, their clients, that they agree (also without clear consent) to perform actions where they don’t feel comfortable. In addition, participants very rarely report rejections from their clients in cases where they have initiated touch, with only two therapists explicitly mentioning specific accounts. Whether this is due to most touch being sufficiently and adequately calibrated, or if it is a signal that people in general are too uncomfortable and unsure about rejecting touch, is yet to be seen.

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Professional Discussions About Touch

The analysis revealed that most of the clinical psychologists' saw their own previous experiences of having learnt about and discussed touch as influencing how comfortable they felt about trying out touch in therapy (see Figure 6). Importantly, it also had implications for how willing they felt about discussing touch with colleagues and co-workers.

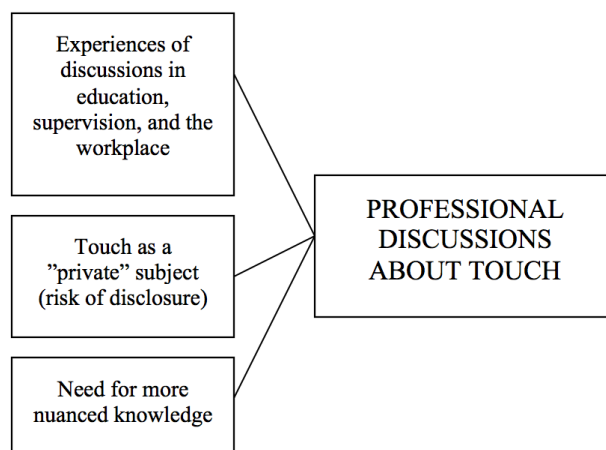


Figure 6. The theme 'professional discussions about touch', and its related sub-themes.

"I was sort of trained to... you know, that touch doesn't belong in therapy, that it isn't necessary, shouldn't be done, and then, I have just... found a rationale for this in my head, and then I've just run with it."

Experiences of discussions in education, supervision, and the workplace. Asking the participants to describe whether they had experienced any kind of reflection around the topic of touch during their education or in their professional careers, revealed a scarcity of relevant occasions. Close to all of the participants said that they felt they did not learn enough about touch during their education, to feel safe enough to experiment with it in therapy:

"Our profession is kind of verbal. We use language in many different ways, and thus we might not have learnt to use our *bodies* in that many ways, or having physical contact in that manner. So it might be due to lack of having *learnt* how to have that kind of contact?"

Their accounts show that whereas almost none had experienced touch as being a topic during their education, except from when talking about clear breaches of boundaries, such as sexually motivated misconduct with clients, more had experiences of it as a topic when under supervision. However, the frequency of discussing touch in therapy with colleagues was lower, with over half of the participants rarely doing it. The occurrence of training in, and discussions about touch in, respectively, education, supervision and their workplaces, is discussed further in the following paragraphs.

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Education. Almost all of the participants said that the topic of touch was not raised during the course of their studies, or that they cannot remember it being discussed. “In our education, touch was seen as something more unusual than usual.” One therapist mentioned student initiatives to raise awareness around touching and body-oriented therapeutic methods. Among those remembering touch as being a topic during their education, one said it had been mentioned in ethics class, in conjunction with discussing sexual harassment and abuse during the 1970s, and in doing boundary exercises to visualize how close one is comfortable with being another person, one while also discussing other ways of self-disclosure in therapy, such as whether crying together with, or in front of, the client in therapy was ok, two said they remember being taught that it was advised to avoid any kind of touch, that it was outside of what was expected from a clinical psychologist, one remembered having discussions about where to draw the line in relation to when, how and why touching could be used; and one mentioned being given an example of inappropriate sexual touch, and generalizing this experience to all kinds of touch outside the formalized handshake.

Supervision. Almost all of the clinical psychologists confirm that they have discussed the topic of touch in therapy with a supervisor. Most of the accounts are regarding the therapists themselves having brought it up as a topic, in relation to specific cases (“would it be/was it ok to do it like this?”), possible issues of misunderstanding the motivation behind the touch, and so on. One therapist especially mentioned how it would be seen as a loud warning bell if psychologists were doing things they felt unable to discuss with a supervisor:

“I mean, I think it’s an excellent way to check in, on its own, if you think that ‘no, I’d rather not tell my supervisor about this’, then... if you can’t ask your supervisor about it, it is probably wise not to do it at all. (...) If you think something should be a secret – that would be fishy.”

Workplace. Over half of the participants said that touch in therapy rarely was a topic of discussion between colleagues at their place of work. When questioned why, most answered that it was seen as private, that there seemed to be a silent agreement that touch was not a part of therapy, or that touch as a topic was reserved certain professions, such as doctors or physiotherapists. A few therapists said that they had very limited experience discussing touch

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with colleagues, and the accounts they had were always about discussing specific cases, and whether something would be seen as ok to do, or not. It seems that in situations where therapists are unsure about the safety of their practice, in addition to manuals specifically mentioning touch being hard to find, and the topic of touch is seen as taboo, it is very difficult for therapists to approach their colleagues.

A couple of participants however brought to attention that observation in some cases could be an alternative to discussion. In cases where discussion is missing, seeing how other therapists behaved could also be used as a starting point for their own reflection. One example of this was how observation alone could assist in legitimizing touch, maybe also giving a window of opportunity to bring it up as a topic later:

“People who are like role models to me, like chief physicians and so on, who might say things like ‘I’ll just give you a hug!’ to a patient, and that becomes some sort of legitimization of touching to me. (...) When someone with a higher rank at my work do it, someone with more experience than I have, it sort of makes it [touching] more harmless for me, too.”

The same therapist noted that observing other clinicians was a way to demonstrate how someone else’s clinical practice visibly differed from the participant’s own:

“[and then I noticed the therapist] touching the patient multiple times. And this is something I notice, because it’s strange. (...) It’s not part of my own therapeutic repertoire. (...) Then I quickly think ‘oh well, then that therapist is one of them who finds it ok [to touch], but I’m not.’”

Touch as a “private” subject (risk of disclosure). When asked why engaging in discussions about touch could be seen as difficult, all of the participants agreed that it had to do with touch being seen as a more private subject. This is seen as related to touch as a taboo, as something that could be seen, or misinterpreted as, something suspect. The risk of bringing it up, would thus potentially outweigh the potential benefits of discussing the topic. Around half of the therapists emphasize that they usually carefully select the ones they talk to about touch, and that if they had an assumption that their colleagues weren’t “of the touching kind”, they would rather not bring it up.

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“I guess it has something to do with it being a somewhat ‘private’ topic, that it is difficult, maybe you even are a bit scared that if you bring it up, the person you talk about it with will misunderstand your intention. (...) It was good to talk to my supervisor about it, but I wouldn’t have spoken with just anyone about it.”

“(...) it’s like you can sense that some people just aren’t of the hugging kind, and then you just don’t talk about it with them. (...) Because I have such a strong expectation about touch not being something they practice anyway.”

Other therapists explained that the private nature of the topic made them feel that they revealed something about themselves when participating in the interview: That their lack of words or little experience made them insecure, and made them hesitant to speak about it.

“It’s ok to talk about [touch] (...) I just feel like I have very few words to talk about it, but that might as well have to do with it not being a very prevalent part of my own therapeutic practice.”

Interestingly, the same feedback would come from therapists for whom touch was a much larger part of their own practice, where they were afraid they would be misunderstood and discredited if they didn’t carefully choose how to word their opinions.

“I find it a bit demanding to talk about, especially because I really care about this topic. Yes. That I have to be careful about the words I choose, and so on.”

Need for more nuanced knowledge. What was revealed through most of the interviews, was the participants’ feeling that the reflections and discussions they had about touch usually were unbalanced or lacked nuance. Some described it as not having a “conscious relationship” with the concept of touch, and said that although they in a general sense had certain beliefs of when to touch or not, they had experienced that a “one size fits all”-solution was insufficient.

“I mean there are situations where... situations in therapy where it is more... less evident that no touching should occur at all.”

Other participants also highlighted the possible benefit of discussions and knowledge about touch as leading to increased flexibility in therapy, and as a way to expand their own

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“therapeutic toolbox”. Thus, missing out on chances to properly evaluate the use of touch, was by some seen as being an obstacle in therapy:

“After all, we are not always sitting like this with a table between us, one might be outside and do exposure therapy, or meeting the patient somewhere else.”

“We intervene in a thousand different ways to give them [our clients] support and care, and to regulate their emotions. So maybe, in some cases, maybe touch could be an intervention like that. To support them, ‘come on, you can do it’ (...) That we can expand our own therapeutic toolbox, use ourselves in that manner, too.”

A few of the participants expressed frustration about the lack of nuance in collegial discussions about touch, saying they often felt that engaging in discussions rarely left them with any new knowledge or insight about touch. Many viewed “others” as having inflexible or rigid views about touch, and were hesitant bringing it up as a topic. Interestingly, not all of the therapists expressing this view had actually tried bringing it up for discussion, possibly due to reasons also mentioned in a previous sub-theme (*risk of disclosure*) and the fear of being misunderstood or misinterpreted (*touch as suspect*), damaging their professional reputation. A couple of therapists specifically mentioned efforts to talk about touch being rejected on a categorical basis, noting how refusing to discuss it, or lack of nuance, will not help moving the field of therapy forward. In other words, the perceived silence in the participants’ professional circles regarding the use of touch in therapy was seen as giving the topic an increased level of dangerousness, which was seen as unjustifiable:

“(...) but I don’t think it will get any better from not talking about it, not discussing it more, not bringing it with us as a relevant topic. Because they do arise, those almost unavoidable situations where I find that physical contact is... natural (...)”

“There are people who, if I had mentioned it [touch in therapy] to them, they would’ve responded ‘no, you must never do that!’, and just end the discussion there. And I mean, that’s not what I need. I *know* that, I know that you shouldn’t do it, what I wonder is when are there exceptions? Is my exception ok, are the reflections I have about it ok? (...) What I *need* is a real discussion about the topic. And I find that this *real* discussion is rather hard to find. (...) Of course, it obviously won’t do to get ‘yes of course, just do it’ as an answer, either. What you need is the *discussion*.”

Summarizing the results

The present study was conducted due to a desire to better understand how clinical psychologists relate to touch in therapy today, whether they find it potentially damaging or useful, and to which extent those interviewed today draw on the use of touch in their daily work. The results of the analysis suggest that their professional attitudes and decisions about the use of touch are complex. Although it seems that touch is rather rarely spoken about, the topic does occur in therapy every now and then, both at times where therapists seem to almost not even recognize that it is there, and at other times where it has an almost overwhelming presence. The meaning, and use, of touch vary not only at an individual level, but there are also seemingly large numbers of influences at a collegial and societal level too, that will affect their behaviour and attitudes.

As is eloquently summed up by Sheret (2015), there seems to be a grey area of touch in-between the kind of touch that is almost universally acceptable (for example formalized handshakes), and touch that is unacceptable in therapy (for example aggressive or sexual touch). Whether to refrain from the use of touch or not within the grey area is settled through an individual assessment of several central themes. The potential benefits of using touch in therapy are weighed against the possible risks, including both those for the client and those that can affect their (future) career, and the individual client and context is taken into account. There is also the therapist's reliance on their own intuition, how they navigate consent, and the dynamics between the therapist and the client, in addition to their own knowledge about the topic and any possible supervision. In reaching a decision as to whether to use or not to use touch, as a general approach or given specific circumstances, they also consider what form the touch may take. What kind of touch, and where, would be appropriate?

The different themes and sub-themes that were identified during the course of the analysis illustrate the decision making process of how, and on what basis, therapists decide to use, or refrain from, touch (see also Figure 7 on the following page). In the following section, key results of the study will be discussed in light of recent research on touch among therapists. Although many of the present results mirror previous research on clinical psychologists (see for example Harrison, Jones & Huws, 2012; McRae, 2008; Sheret, 2015; Williams, Clarke & Gibson, 2011), some differences are highlighted and certain distinctions are made. Clinical implications, as well as indicators for future research, are discussed.

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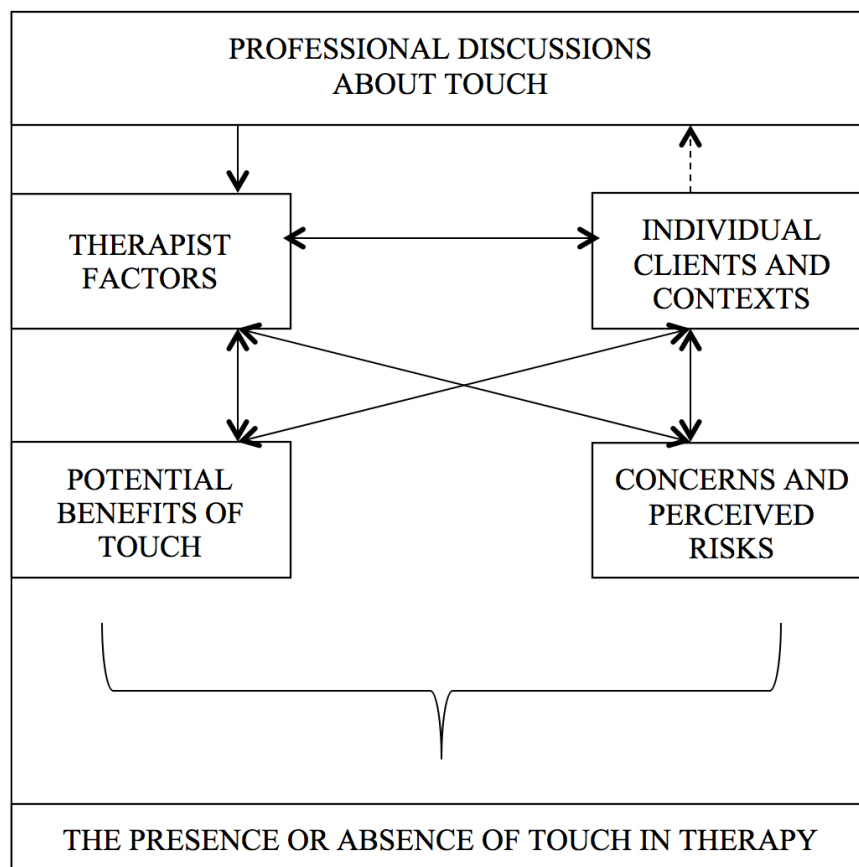


Figure 7. This thematic diagram is visualizing a theoretical overview of the different paths and relationships between the themes identified in the analysis. The decision to touch is influenced by the therapists themselves, and by their previous experiences of being trained in touch during their education, and/or engaging in professional discussions around the topic. The decision seems to be made mostly on a case-by-case-basis, with a few exceptions mostly by the therapists who emphasize that they do not engage in any kind of touch except for the formalized handshake. The individual client and the context of the therapy, such as the client’s history and demography, is assessed and considered. The analysis also shows that some specific clients and the therapeutic context could instigate further professional discussions about touch, although mainly in the context of supervision (most often when therapists were unsure whether the touch they decided to use in therapy was legitimate and appropriate in a therapeutic context, and wanted an evaluation and input from their supervisor).

What is considered potential benefits of touching, such as providing a specific therapeutic intervention, showing a gesture of empathy and understanding, strengthening the alliance between the client and the therapist, and/or touch being something additional to talk therapy, working as a catalyst; is weighed against what the therapist experiences as concerns and perceived risks of touching. Touch is seen as a topic of ‘taboo’, and many therapists fear for their professional status, that they will risk the therapeutic alliance if the client should misunderstand the motivation of the touch, or that it will lead to increased client dependency and an unwillingness to separate from the therapist. These factors influence the presence or absence of touch in therapy, including the parts of the body considered appropriate to touch, in addition to the (responsibility of the) mediation of touch. The analysis also shows that the potential concerns and risks of touch influence the degree to which the clinical psychologists’ discuss touch with their colleagues and in other professional environments.

Discussion

The Occurrence of Touch in Therapy

Mirroring earlier studies, the results from this study showed that all clinical psychologists confirmed handshaking by the beginning and/or end of therapy, and 90 per cent confirmed hugging at the end of therapy. Previous estimates on the percentage of therapists touching their clients is seen to range from around 10 per cent, up close to 100 per cent (see for example Harrison, Jones & Huws, 2012; Milakovich, 1998; Pope, Tabachnick & Keith-Spiegel, 1987; Stenzel & Rupert, 2004; Strozier, Krizek & Sale, 2003; Williams, Clarke & Gibson, 2011). According to Bonitz (2008), the inconsistent findings can be accounted for due to variations in the therapist population being studied (ranging from social workers to clinical therapists), different definitions of what types of touch were included, and sampling techniques. When explicitly reporting the frequency of different types of touch, nearly all therapists asked would accept or offer a handshake, whereas the percentage of those that would hug their clients was lower. As in the present study, even fewer report hugging their clients during therapy, and other forms of touch such as holding both hands, patting a shoulder or stroking a back.

Usually, handshaking and hugging are the most commonly described types of touch, followed by touch on the back, shoulder or lower arm (see for example Stenzel & Rupert, 2004). This is also shown in the current study, with five therapists marking back, shoulder and arm as places on the body that could be touched. Except for a hug, touch to the head was seen as unacceptable by all therapists, as well as any part of the chest and stomach, lower back, genitals, buttocks and thighs/upper legs.

Formalized touching. Especially interesting is the result that although over half of the clinical psychologists that were interviewed initially claimed they did not touch their clients at all, 100% confirmed touching when made aware that shaking hands also was included as a type of touch. While interviewing, many of the participants seemed to express surprise and contemplated openly the fact that many did not initially think of handshaking as a type of touch that occurred in therapy. This trend can also be found in studies by Stenzel and Rupert (2004), Harrison, Jones and Huws (2012) and Sheret (2015), who all found that touch at the *beginning* and *termination* of therapy is perceived as symbolically different from touch *within* the duration

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of therapy. This was earlier referred to as the separation between touch happening in the “therapeutic space” and the “social space” by Tune (2001).

One possible explanation could be that as the professional relationship between the therapist and the client ceases, the perceived professional boundaries are lessened, and the therapists are more willing to reciprocate the clients’ initiative to hug. All the participants in this study were also clear that shaking the hand of the client the first time they meet, as well as at the end of the last session, was seen as something expected and consistent with general societal norms. This indicates that it might even be seen as more deviant *not* to engage in any kind of physical contact, than to do so, quite possibly due to social norms, training experiences or theoretical considerations.

These results show that although the visible narrative within the practice of clinical psychology is one of abstinence from touch, it is indeed highly present in therapy, although not always in a conscious way. It might be that as consciousness about touch is raised, and therapists are made aware that they most likely are, in fact, already touching their clients, could lead to more openness, as well as nuanced discussions about clinical practice.

Touch, gender and sexuality. Earlier studies have shown a tendency that male therapists speak more of using touch than female therapists, and that female therapists in general are more wary than males about using touch with the opposite gender, leaving male therapists more likely to touch female clients, while female therapists are more likely to touch other females (see for example Bonitz, 2008; Hunter & Struve, 1998; Milakovich, 1998; Williams, Clarke & Gibson, 2011). The present results show little indication of an overall difference between the genders. Rather, there is a small tendency to a difference between the female and male therapists interviewed when asking for different types of touch. Whereas only one male therapist confirmed hugging during therapy, three female therapists said it occurred. But when asking about other types of touch, such as holding both of their own hands on a client’s hand, patting the back or shoulder, and so on, more males (3) than females (2) reported this. Thus, the difference between the genders when it comes to touch seems, at least in part, to be dependent on the kind of touch.

It is interesting to note that several therapists mention issues related to transference and counter-transference when discussing touch in therapy in general, whereas almost all (8 out of 10, 80%) of the therapists denied touching differently in practice if the client was of the opposite

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gender, than of the same gender. Whether this is a result of not wanting to discuss sexuality in relation to touch, or whether issues like transference and counter-transference, historically seen as central in more psychoanalytically oriented therapeutic modalities, are not seen as relevant for most of the participants' therapeutic practice today, is unknown. It could also be seen as an indication that there is a clear discrepancy between Norwegian clinical psychologists and therapists from the US (Hunter & Struve, 1998; Milakovich, 1998) or New Zealand (Williams, Clarke & Gibson, 2011), and it could be an interesting topic to explore further.

It is acknowledged that by asking the question of whether they would change their style of touching after the gender of the client, one is potentially assuming the sexuality of both the client and the therapist. Surprisingly, the possible interpretation of touch as a sexualized action was more a topic when discussing touch in therapy in general, whereas when asking more in-depth about the participants' clinical practice, the interviews revealed little differences among touching clients of the same or different gender.

The Worries of Touch

When asking the participants about possible negative outcomes of the use of touch, their responses mirror previous studies. Most therapists express worry about the risk of touch being misinterpreted, which could lead to negative consequences for the therapeutic relationship (i.e. the dynamics of power in the relationship), the client's condition, and/or for the therapists themselves. In addition, the importance of therapists' self-awareness of their own motivation regarding touch, and the societal expectations to what is "supposed to" happen in clinical therapy, seem to impose further uncertainty on their decisions to touch, or not (Harrison, Jones & Huws, 2012; Sheret, 2015; Strozier, Krizek & Sale, 2003; Williams, Clarke & Gibson, 2011). Harrison, Jones and Huws (2012; and Geib, 1998) further note that even the slightest association between touch and any risk of damage to the client, their relationship or the therapists' professional reputation, might contribute to the reluctance to even *speaking* about touch due to feeling guilty, and fear of suspicion.

Further, there was an apparent worry about touch contributing to an unhealthy degree of client dependency. This tendency has also been reported by Sheret (2015) and Bonitz (2008), and interpreted as a precautionary measure to avoid any such boundary crossing, by keeping therapist

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self-disclosure and the use of touch to an absolute minimum, regardless of any potential therapeutic benefits of such interventions (see also Ertner, 2014).

Useful Client Touch

Just as the participants in this study had reflections on possible risks regarding touch, most therapists, also those who refrained from other touch than the formalized, confirmed several potential benefits with the use of touch. The analysis revealed aspects that would be of benefit to the client, such as touch being a catalyst in therapy, and that it may offer something “more”, something in addition to words alone. In addition, it was mentioned as an expression of empathy, that it could model appropriate touch behaviour, and bring benefits to the therapeutic relationship. Similar themes are apparent in other research on the practice of touch in therapy (for a thorough review of research on the therapeutic benefits of touch, see for example Bonitz, 2008; Durana, 2008; Sheret, 2015; Zur & Nordmarken, 2011). An interesting comment by Hunter and Struve (1998), indicates that even the mere availability of touch, if the client should wish for it, may actually have greater significance as an act of support and empathy, than actually making physical contact.

In her research on non-erotic physical contact, Pamela Geib (1998) interviewed clients, and asked them about their own experiences with touch in therapy. Her analysis revealed four recurrent themes, highly decisive in the clients’ perception of touch being beneficial and therapeutic: 1) When the environment made the clients feel that they were in control of the touching (for example when a therapist asks for permission to touch); 2) When the touch clearly came as a response to the clients’ needs, rather than the therapist’s own; 3) When the therapist encouraged open discussion and verbal processing of the touch afterwards; and 4) When the levels of physical and emotional intimacy developed at the same pace in their therapeutic relationship.

Geib’s results mirrored previous research by Horton, Clance, Sterk-Elifson and Emshoff (1995), where almost all surveyed clients said their experiences with touch in therapy were positive. Interestingly, clients who reported either a history of sexual abuse, sexual problems, or fears and phobias, rated touch significantly more positively than those who did not. It seemed that experience with touch had the potential to create a feeling of closeness and being cared for, further enabling the clients to feel safe and to explore deeper and more emotionally “threatening”

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themes (Bonitz, 2008; Geib, 1998). This is seen as especially noteworthy in this context, considering that several of the interviewed therapists would consider touch inappropriate when working with clients with a history of sexual abuse or physically and/or emotionally traumatized.

Talking About Touch

What the results from this study show, is that the use of touch was typically not discussed, clarified or negotiated with clients when it occurred. Only about one third of the clinical psychologists who were interviewed confirmed asking their clients for consent when touching them, or accounted for why they thought touching (such as for comfort, support, modelling safe touch, and so on) would benefit the therapy. One reason for this could be that therapists are wary that clients may find it hard to decline a suggestion about touch (Hunter & Struve, 1998). The risk would be seeing the therapist as more powerful and someone the clients seek to accommodate, to gain approval (Williams, Clarke & Gibson, 2011). Some expressed worry that the clients' answer wouldn't be genuine or truthful. Thus, a common theme was that the therapists would rather rely on their own intuition when identifying potential appropriate times to touch.

As described by Sheret (2015), this intuition was neither easy to articulate nor often consciously thought about, but most often illustrated with non-verbal cues and the "feeling that it is right" (see also Harrison, Jones & Huws, 2012; Strozier, Krizek & Sale, 2003). An interesting difference between this study and the study by Milakovich (1998) is that, although both samples show that the therapists who touched their clients tended to trust their own instinct, the present study does not show that they were any less concerned about potential risks of touching their clients.

The lack of actively seeking consent and calibrating the expectation and interpretation of touch, and rather relying on intuition, comes across as a slightly surprising finding, and one that deserves further attention. It is seen as especially relevant to investigate further when considering that previous research (Geib, 1998; Horton, 1998; Horton, Clance, Sterk-Elifson, & Emshoff, 1995) specifically highlights verbal exploration, contextualization and explanation as critical factors for clients experiencing touch as beneficial.

Lack of words and confidence to talk about touch. Another important outcome from this study is the indication that touch is in fact more present than what is apparent when looking

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at what is being talked about among colleagues, during training and in supervision. This discrepancy is important to highlight, because what happens when therapists refrain to talk about, ask for input, or discuss what is relevant for their practice? Williams, Clarke and Gibson (2011) show that when therapists feel unsure about the safety of their practices, or find it hard to judge the professional appropriateness of therapy, in addition to discover that the topic is considered taboo, and that literature on the subject is hard to find – they find it extremely difficult to approach colleagues and ask for input or guidance.

This is also clearly shown throughout this analysis, that their own lack of knowledge regarding touch, and the potential for other therapists viewing their practice as suspect or unprofessional, leave them alone in their decisions more often than not. Several expressed that they lacked knowledge or insight into what other therapists did, and were unsure about what the therapeutic modalities they identified with actually permitted. This uncertainty was cited as one of the reasons why some of the therapists would not engage in other types of touch than the formalized handshake or hug, even though some said they were wondering whether it might have been beneficial.

The absence of touch as a topic for discussion in education and in clinical training has earlier been identified as a barrier to better understanding the appropriateness of touch, especially considering that the topic is mostly raised only when experienced negatively (Hunter & Struve, 1998; Sheret, 2015). Importantly, as is also evident in this study, the touch taboo does not necessarily preclude therapists from touching. An important difference between these results and the studies by Sheret (2015) and Williams, Clarke and Gibson (2011), is that almost all of the clinical psychologists in this study actually confirmed that they have discussed instances of touch in therapy. Most brought the topic up themselves, and also mainly had good experiences discussing it. This was, however, *only* apparent in the context of supervision, whereas almost none talked about touch at their workplace or could remember having discussed it during their education.

This lack of reference to touch during education and training has been pointed to as a key contributor to the taboo of touch in therapy (Sheret, 2015; Strozier, Krizek & Sale, 2003), and it is considered notable that clinical psychologists, when approaching a taboo (such as touch) in their therapeutic practice, react with apprehension and secrecy toward their colleagues. Especially considering that much of their clinical training and practice concerns topics that might

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be considered taboo and how to treat vulnerability and insecurities in interpersonal relationships. Several of the participants expressed that their fear was to be misunderstood by their professional colleagues, and that their own therapeutic practice would be questioned if they brought up the topic of touch in a discussion.

Lack of experience with talking about touch was also apparent during interviews, where both reactions and direct questions indicated that more than half of the participants found it difficult to talk about touch. Some would spend time searching for the right words, even commenting that they were actively choosing their words with care. Navigating the grey zone of touch seemed to spark the worry of what if they were, unwittingly, doing something wrong, that would be apparent through the interviews? This interpreted uneasiness was, however, not presented to such an extent as in the interviews conducted by Williams, Clarke and Gibson (2011), where several participants came prepared with written sheets of statements prior to the interviews.

Possible Limitations of the Present Study

When discussing the results of this study, it is acknowledged that the accounts provided by the clinical psychologists may have been censored due to the common notion that touch within therapy is a taboo, seen as something risky. Measures were made to try keeping possible censoring to a minimum, such as describe the ethical rules of this research, and explicitly asking the participants to reflect over how they felt talking about touch with a researcher they did not personally know from beforehand. The researcher's intention and goal with the study was clearly stated before the interview was conducted, and the researcher was available for questions and input, in addition to offering to distribute the analysis to the participants for further commenting before presenting the thesis. None of the participants did ask to receive and comment on the analysis. In the end, while a potential limitation like this will inevitably be a factor in all studies where the goal is to explore possibly controversial issues, it should not keep research on these topics from happening (Harrison, Jones & Huws, 2012).

On another hand, clinical psychologists have an education that explores emotions, reactions and behaviour. One could argue that they therefore are well prepared to reflect on touch. There is also a possibility that the clinical psychologists that agreed to participate in the study had more interest in the topic of touch in therapy, and had developed strategies in their

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work. Stenzel and Rupert (2004) write that awareness about touch and increased knowledge about the topic can affect their own use of touch in therapy. Most of the participants confirmed being curious about the topic, although several claimed that they mostly refrained from touching.

Sheret (2015) points out that the studies on clinical psychologists used in her own research contained an over-representation of experienced therapists. In this study, over half of the participants did not have more than seven years of clinical practice, and may thus be seen as an interesting addition to the already existing literature on touch. In addition, Milakovich (1998) pointed out that the gender of the researcher might influence the responses given by the participants, and evoke different reflections if the researcher was male or female. To test such an assertion has not been possible within the resources of the current thesis.

In order to increase the degree of self-reflexivity and transparency in this study, the researcher has kept recordings taken immediately after each interview, and actively used them throughout the analysis to ensure that the last interviews do not influence the interpretation and analysis of the first interviews to a large degree (see Appendix L for an example excerpt from the recorded personal diary). This way, both initial thoughts and later reflections are included in the data material, in addition to the transcribed material and the figures used during the interviews.

A note on generalizability. The aim of this research is not to produce new theory, or to evaluate already existing theory on the topic of touch in therapy. Rather, it is to identify and provide a comprehensive overview of how clinical psychologists view touch, and the meaning of touch in therapy, in addition to what factors influence their own use, or rejection, of touch.

The researcher acknowledges that while conducting the interviews and analysing the data material, she is influenced both by her own culture and experiences, and by the participants themselves. Rather than claiming a completely “objective” stance, efforts have been made to minimise any bias in the acquisition and analysis of the data. Due to the framework and resources available for the present thesis and research, it has not been possible to provide a second analysis by another researcher, or do any measures of inter-rater reliability (except from comments and annotations from the supervisor). Therefore, the process of analysis is described in detail, and no data has been left out from any interview when conducting the analysis, in an effort to ensure transparent research, and thus increased trustworthiness, sensitivity and integrity of the results (Golafshani, 2003; Whitemore, Chase & Mandle, 2001).

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The degree of generalizability of the results of this research to the practice of other clinical psychologists is mostly unknown. The results that have been presented are based on answers and reflections that are true for at least the ten interviewed therapists. Such an overview is hoped to function as a base on which to build further conversations about the practical use of touch in therapy, rather than to test a specific theory or predict future behaviour through generalization. The efforts made to include a heterogeneous sample of participants have been described in the section on recruitment criteria and procedure, and the researcher does not consider the sample of participants to be particularly “unusual” or to differ in any evident ways from samples included in the previous research mentioned throughout the thesis.

Conclusion

The present study shows that over half of the clinical psychologists (seven out of ten) touch their clients in *other ways* than formalized handshaking and possibly hugging. All participants confirm handshaking, and 90 per cent confirm formalized hugging at the end of therapy. The decision to touch or not involves a network of several considerations regarding the possible meaning of touch in therapy. The participants have several views on the possible benefits of touch, such as the possible contribution of something “more” to the traditional talk therapy, that touch can be an expression of empathy, support and understanding, and thus also help strengthening the therapeutic alliance between a therapist and a client. On the other hand, the possible benefits are weighed against perceived risks and concerns they have regarding misunderstandings of the intention to touch, that touch is seen as a taboo and something that might risk their professional status, and that it may lead to an unhealthy degree of client dependency.

In addition to general views on benefits and concerns regarding touch, each therapist seem to rely on their intuition and clinical assessment of the situation, the individual client, and their clinical context. The analysis shows that touch rarely is verbally negotiated with the client, with the exception of separate accounts from three participants. Touch is also rarely discussed with colleagues, and brought up as a topic during education, despite research showing that it occurs in therapy more often than not. Several of the participants articulate a desire to talk more openly about their uncertainty regarding touch, as well as having discussions about when touch could be appropriate and beneficial for their clients.

Ideas and Recommendations for Future Research and Clinical Practice

One primary recommendation for future research on touch in therapy among clinical psychologists, would be to ensure further exploration throughout the discipline, so the topic becomes recognized as an issue during training, related to therapy sessions at work and among colleagues. A goal is that this, in turn, would lead to professionals feeling more able to be open about the issue and to navigate the grey zone, both in their own practice, in theory, and as valuable support to others. It is believed that an increased degree of preparation and discussion

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will ensure that the therapists are better prepared to handle different situations in competent ways, and will possibly reduce a reliance on “blind confidence” or intuition.

In addition, as was expressed during two interviews in particular, some participants were noticeably curious about the clients themselves and their own attitudes towards touch: How do they feel about it, and what do they think about touch in therapy? Increased focus on client views on touch has been put forth by other researchers focusing on clinical psychologists (such as Harrison, Jones & Huws, 2012; Williams, Clarke & Gibson, 2011), as well as several of the participants in the current study:

“(…) and maybe we could ask the patients themselves, that would be very interesting. Maybe their experience is, and we don’t know that, in the name of user participation, maybe the patients find it weird to sit and talk to someone [a therapist] for two years, someone who has never touched them, never show any signs of physical touch? Maybe *that* is the problem, rather than us touching too much? That our idea is that we can’t touch, while our patients feel that we should have done it more?”

The studies on clients’ experiences with touch that have been mentioned in this thesis have either been interviews conducted exclusively on female clients with male therapists (Geib, 1998), or quantitative surveys including a few more open-ended, narrative questions (Horton, 1998; Horton, Clance, Sterk-Elifson & Emshoff, 1995), performed over 20 years ago and on a sample of American clients (Geib, 1998; Horton, 1998; Horton, Clance, Sterk-Elifson & Emshoff, 1995). Both the current study and previous research have highlighted several aspects of touch that is believed to be beneficial or anti-therapeutic for the clients (from the point of view of the therapists), and could serve as a foundation to build research focusing on client perceptions of touch in therapy. Conducting a qualitative study, interviewing clients about their potential experiences with touch, could provide a growing body of research on touch with richer descriptions on specific situations and attitudes toward touch also from a client point of view. Based on previous research findings regarding touch that is experienced as beneficial for clients (Geib, 1998; Horton, 1998; Horton, Clance, Sterk-Elifson & Emshoff, 1995), more therapists could be encouraged to actively talk about touch during therapy, as a means to seek their clients consent and active understanding of the purpose of their touch.

Further studies separating client from therapist-initiated touch have also been suggested as useful (Stenzel & Rupert, 2004). This study focused primarily on where the therapists

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reasoned it would be appropriate to touch their clients. Another research focus could be to explore where the therapists saw it as appropriate for the client to touch, and to see whether investigating client-initiated touch would yield different results.

Lastly, as is highlighted by Williams, Clarke and Gibson (2011:56); “it is perhaps questionable whether it is *touch* that is unsafe, or the fact that it is difficult to be open, curious, and talk about it without concerns for one’s reputation”. It is hoped that this study communicates that clinical psychologists are not alone in their ethical dilemmas. In addition, the results will hopefully lead to a climate for discussing touch that is perceived as more open, nuanced and inviting both among colleagues who touch more and those who touch less (or not at all), and less characterized by worries of simplistic dismissals and misunderstood reactions. Instead of treating the topic of touch as taboo, it would be considered useful and healthy with more open dialogue within the profession.

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Appendix A: Participant Information Sheet

Translated to English by the researcher

Request for participation in a research project

”Exploring clinical psychologists’ professional views toward the use of touch techniques in therapy: How, and on what basis, do they decide to touch, or not to touch, their clients?”

What the study is about

Physical touch plays a central part in our development, identity, regulation, communication, and in our interpersonal relations. Throughout its upbringing, a child is touched by its parents and other caretakers, by being held, lifted, hugged, and stroked. Despite its relevance, the topic in itself is sensitive, and there are few professional discussions and literature available.

The goal of this research project is to shed light on different aspects of clinical psychologists’ professional attitudes toward the use of physical touch in therapy. What does the decision process behind the application or rejection of touch in therapy, look like? Is it true that clinical psychologists belong to a group of health personnel that just does not touch their clients? If so, why is that? What processes, assessments and thoughts lie behind the decision to touch, or not to touch? What consequences can clinical psychologists attitudes toward physical touch have for the course of therapy, for education and supervision of new psychologists, and for the exchange of relevant experiences and information?

This study is comprised exclusively of clinical psychologists, with at least two years experience in clinical practice, and with clients above the age of 18. Information about the study has been distributed to a random sample of regional psychiatric clinics, with a request to contact the researcher if interested in participating in the study, or need for further information.

The project is a part of the researcher’s main thesis, conducted during the 10th and 11th semester at the clinical programme in psychology, at the Norwegian University of Science and Technology (NTNU). The thesis is supervised by Britt-Marie Drott Sjöberg, professor at the Department of Psychology.

It is emphasized that the aim of the interview is to gather information about your professional attitudes toward physical touch. Related to this, questions about potential situation where the use of touch could occur, will be asked. Please note that no information that in any way can lead to the identification of individual clients should be given, and discretion is advised when giving specific examples, in accordance with the principles of confidentiality in research.

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What does it entail to participate in this study?

If you wish to participate in this research project, you will be asked to participate in a qualitative interview during 2016. The questions will regard your attitudes to physical touch in therapy, any personal experiences and processes comprising the decision to touch, or abstain from touching, a client, in addition to any possible implications touch can have for the therapeutic alliance, supervision and education. The length of the interview is estimated to be about 30-45 minutes, and will take part at a time and place that fits well with your daily life.

The interview will be recorded using a voice recorder, and any additional hand-written notes taken by the researcher. There will not be any gathering of information from other sources than the interview itself. The interview will be conducted in Norwegian.

What will happen to the results of the study?

All personal information will be anonymised, and is treated confidentially. Only the researcher herself and her supervisor will have access to the data material. The recordings and the transcribed interviews will be stored separated from other data materials.

In the final thesis, the participants will be anonymised, and only indirect data (for example anonymised quotes) will be included. The participant will not be identifiable in the final publication.

The project is scheduled to end during the spring of 2017. When the project is finished, all data material will be deleted.

Voluntary participation

The participation in this research project is voluntary, and you have the right to withdraw your consent at any time, without stating any reason. If you decide to withdraw from the study, all information about you will be anonymised.

If you wish to participate, or have any questions regarding the project, please contact project manager **Karete Jacobsen Meland**, either on [phone number] or through [e-mail address]. The project supervisor, **Britt-Marie Drottz Sjöberg** (NTNU), can be reached on [phone number].

The research project has been reported to the Data Protection Centre, NSD, Norwegian Centre for Research Data (Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS).

Appendix A: Participant Information Sheet

Original (Norwegian)

Forespørsel om deltakelse i forskningsprosjekt

”Exploring clinical psychologists’ professional views toward the use of touch techniques in therapy: How, and on what basis, do they decide to touch, or not to touch, their clients?”

Bakgrunn og formål

Fysisk berøring er helt sentralt for vår utvikling, identitet, regulering, kommunikasjon og våre interpersonlige relasjoner. Gjennom oppveksten vil et barn berøres av foreldre og andre omsorgspersoner, ved at det blir holdt, løftet, klemmt og strøket på. Likevel er temaet sensitivt, det er eksisterer få faglige diskusjoner og lite forskningslitteratur på området.

Dette prosjektet har som overordnet formål å belyse ulike sider ved kliniske psykologers profesjonelle holdninger til bruk av fysisk berøring i terapi. Hvordan ser beslutningsprosessen bak bevisst bruk (eller fravær) av fysisk berøring i terapi, ut? Er det slik at psykologer er helsepersonell som ikke berører? Hvis det er slik, hvorfor er det sånn? Hvilke prosesser, vurderinger, tanker og avgjørelser ligger bak avgjørelsen om å berøre, eller ikke å berøre? Hvilke konsekvenser kan kliniske psykologers holdninger til fysisk berøring ha for et terapiløp, for opplæring og veiledning av nye psykologer, og for utveksling av faglig relevante erfaringer og informasjon?

Studiens utvalg består utelukkende av kliniske psykologer, med minst to år klinisk praksis og pasienter over 18 år. Informasjon om studien er sendt ut via Norsk Psykologforening og/eller til et tilfeldig utvalg Distriktpsikiatriske Sentre, med forespørsel om å ta kontakt med meg igjen ved interesse for deltakelse eller ved behov for mer informasjon.

Prosjektet er en del av en hovedoppgave som gjennomføres i løpet av 10. og 11. semester ved profesjonsstudiet i psykologi, Norges Teknisk-Naturvitenskapelige Universitet (NTNU). Oppgaven veiledes av Britt-Marie Drottz Sjöberg, professor ved Psykologisk Institutt.

Det poengteres at formålet med intervjuet er å samle inn informasjon om dine profesjonelle holdninger til berøring, og i den forbindelse vil det stilles spørsmål om situasjoner der berøring kunne være aktuelt. Det gjøres oppmerksom på at det ikke skal utleveres personidentifiserende pasientopplysninger, og i tråd med taushetsplikten må det utvises varsomhet ved bruk av konkrete eksempler.

Hva innebærer deltakelse i studien?

Dersom du ønsker å delta i studien, vil det foretas et kvalitativt intervju i løpet av 2016. Spørsmålene vil omhandle dine holdninger til fysisk berøring i terapi, eventuelle egne erfaringer og prosesser som ligger bak beslutningen om enten å berøre, eller avstå fra å berøre, en pasient,

THE MEANING OF TOUCH IN THERAPY

samt mulige implikasjoner berøring kan ha for terapeutisk allianse, veiledning og opplæring. Intervjuets varighet beregnes til cirka 30-45 minutter, og vil foregå på et sted og til et tidspunkt som passer din hverdag best mulig.

Intervjuet vil registreres med lydopptaker, og eventuelle håndskrevne notater som tas ved siden av. Det vil ikke foretas innsamling av opplysninger fra andre kilder enn selve intervjuet. Intervjuet gjennomføres på norsk.

Hva skjer med informasjonen om deg?

Alle personopplysninger vil anonymiseres, og behandles konfidensielt. Det vil kun være student og veileder som har tilgang til datamaterialet. Lydopptak og transkriberte intervjuer lagres adskilt fra annet datamateriale.

I den ferdige artikkelen vil informantene anonymiseres, og det er kun indirekte opplysninger (som anonymiserte sitater) som inkluderes i publikasjonen. Informanten vil ikke kunne gjenkjennes i publikasjonen.

Prosjektet skal etter planen avsluttes i løpet av våren 2017. Da vil alt datamaterialet slettes fullstendig.

Frivillig deltakelse

Det er frivillig å delta i studien, og du kan når som helst trekke ditt samtykke uten å oppgi noen grunn. Dersom du trekker deg, vil alle opplysninger om deg bli anonymisert.

Dersom du ønsker å delta eller har spørsmål til studien, ta kontakt med prosjektleder **Karete Jacobsen Meland**, på [telefonnummer] eller [e-post]. Veileder **Britt-Marie Drottz Sjöberg** (NTNU) kan nås på [telefonnummer].

Studien er meldt til Personvernombudet for forskning, NSD - Norsk senter for forskningsdata AS.

Appendix B: Participant Consent Form

Translated to English by the researcher

Participant Consent Form

I confirm that I have received information about the study, and that I consent to participate in the following research project: *"Exploring clinical psychologists' professional views toward the use of touch techniques in therapy."*

(name, date)

Appendix B: Participant Consent Form

Original (Norwegian)

Samtykke til deltakelse i studien

Jeg har mottatt informasjon om studien, og er villig til å delta i forskningsprosjektet:
"Exploring clinical psychologists' professional views toward the use of touch techniques in therapy."

(navn, dato)

Appendix C: Initial Literature List

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Appendix D: Research Invitation Sent to Participants

Translated to English by the researcher

The following texts are the invitations sent out (e-mailed) to the regional psychiatric clinics who responded positively when contacted by phone:

“Are you a clinical psychologist with a minimum of two years clinical experience, working with adult patients (> 18 years of age)? Would you like to help me conducting my main thesis research project at the Norwegian University of Science and Technology?”

I wish to contact clinical psychologists who would like to participate in a qualitative interview (estimated duration is 30-45 minutes) about their professional attitudes and experiences related to the use of physical touch in therapy. Please see the attached participant information sheet for further information about the topic, participant sample, interview and implications of participation. An initial literature list is also available.

Due to this being a student project, I have very limited funds, and thus have no possibility to offer any financial remuneration for your participation. Therefore, I hope that the value of participating in research in a field where we know very little about the Norwegian conditions will be significant enough. As a participant you will receive the complete thesis when it is finished, and I will of course be available for further discussions on the topic also after the finished interview. My goal is to increase consciousness around the topic of physical touch in therapy, and I sincerely hope you would like to join in.

Do you find this interesting? If you would like to participate in an interview, or have questions or other contributions, I hope you will get in touch with me as soon as possible. You can reach me on [e-mail address], or [phone number].

Thanks a lot in advance!

Best regards,
Karete Jacobsen Meland,
stud.psychol, NTNU (class of 2011)”

Appendix D: Research Invitation Sent to Participants

Original (Norwegian)

The following texts are the invitations sent out (e-mailed) to the regional psychiatric clinics who responded positively when contacted by phone:

“Er du psykolog med minst to års erfaring fra klinisk arbeid med voksne pasienter (> 18 år)? Kunne du tenke deg å hjelpe meg med min studie i forbindelse med hovedoppgaven min ved NTNU?

Til min hovedoppgave ønsker jeg å komme i kontakt med psykologer som ønsker å stille opp på et kvalitativt intervju (cirka 30-45 minutter) om profesjonelle holdninger og erfaringer knyttet til bruk av fysisk berøring i terapirommet. Se gjerne det vedlagte informasjonskrivet for ytterligere informasjon om tematikken, utvalg, intervju og deltakelse. En foreløpig litteraturliste kan også sendes over dersom dette er ønskelig.

På grunn av at dette er et studentprosjekt har jeg dessverre begrenset med midler for gjennomføring, og har derfor ingen mulighet til å tilby noen økonomisk godtgjørelse for deltakelse. Jeg håper derfor at verdien i å bidra til forskning på et felt der vi vet svært lite om norsk praksis veier opp. Som informant vil du også få tilsendt studien når den er ferdig, og jeg vil selvfølgelig også stille meg til disposisjon for videre diskusjon også etter at intervjuet er fullført, dersom det er ønskelig. Jeg jobber ut fra et mål om økt bevissthet rundt nettopp fysisk berøring i terapirommet, og håper dette er noe du vil være med på.

Virker det interessant? Dersom du har lyst til å bidra med et intervju, eller har spørsmål og andre innspill, så håper jeg du vil ta kontakt med meg så snart som mulig. Jeg kan nås på [e-post], eller over [telefonnummer].

På forhånd tusen takk!

Med vennlig hilsen,
Karete Jacobsen Meland
stud.psychol, NTNU (kull 35)”

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Appendix E: Follow-Up E-Mail

Translated to English by the researcher

The following text is the follow-up e-mail sent out to the regional psychiatric clinics who first got the research invitation, but had not provided a response within a month after the first e-mail:

”I would like to follow up on my inquiry regarding participants to my main thesis. I am still looking for clinical psychologists with at least two years of clinical experience from working with adult clients (> 18 years of age), who would like to participate in a qualitative interview (approximate duration is 30-45 minutes) about their professional attitudes and experiences regarding the use of physical touch in therapy. See the attached participant information sheet for further information about the topic, participant sample, interview and implications of participation. An initial literature list is also available.

When I last contacted you [date for last contact], I was notified that you might be able to assist in recruiting psychologists who could participate in an interview. I would like to know if you have gotten any feedback, if there are anyone I could contact further?

Thanks a lot in advance!

Best regards,
Karete Jacobsen Meland.”

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Appendix E: Follow-Up E-Mail

Original (Norwegian)

The following text is the follow-up e-mail sent out to the regional psychiatric clinics who first got the research invitation, but had not provided a response within a month after the first e-mail:

”Jeg ønsker å følge opp min henvendelse vedr. informanter til hovedoppgaven min. Jeg er fortsatt på utkikk etter psykologer med minst to års klinisk erfaring fra arbeid med voksne pasienter (> 18 år), som ønsker å stille opp på et kvalitativt intervju (cirka 30-45 minutter) om profesjonelle holdninger og erfaringer knyttet til bruk av fysisk berøring i terapirommet. Se gjerne det vedlagte informasjonsskrivet for ytterligere informasjon om tematikken, utvalg, intervju og deltakelse. En foreløpig litteraturliste kan også sendes over dersom dette er ønskelig. Da jeg sist var i kontakt med dere [dato for siste kontakt] fikk jeg beskjed om at det kanskje kunne være mulig for dere å bistå meg i å finne noen psykologer som kunne delta på intervju. Jeg vil gjerne høre om dere har fått positiv respons fra noen, eventuelt om det er noen jeg kan kontakte?

På forhånd, tusen takk for all hjelp!

Med vennlig hilsen,
Karete Jacobsen Meland.”

THE MEANING OF TOUCH IN THERAPY

Appendix F: Interview Guide

Translated to English by the researcher

Briefing:

- Hand out a copy of the participant information sheet, giving the participant time to read through it again. Repeat the following main pieces of information:
 - Define the situation for the participant, and the aim of the interview.
 - Explain the voice recorder, let them know when you turn it on, and ask the participant for any questions before the interview begins.
 - All data is treated confidentially, and neither private persons nor employers will be recognizable in the transcribed material.
 - In cases of difficult questions, or questions the participant rather would refrain from answering, let the researcher know.
 - The participant can choose to withdraw from the interview at any point.
 - Remind the participant not to disclose any sensitive information about clients during the interview. What you are interested in, is the participant's experiences in situations that have led to the use, or the refusal to use, of touch.
- The structure of the interview is as follows: First, some questions about demography, followed by attitudes to touch, personal experiences with physical touch in therapy, consent and calibration of touch, and lastly, professional discussions around the topic of touch.
- (start the voice recorder.)

Questions about demography

(be advised that answers to these questions will be categorized/grouped together, to avoid the possibility of identification)

- Age
- Gender
- Years of active clinical practice

Attitudes toward physical touch in therapy

1. What is your view on / your immediate thoughts on the topic of touch in therapy?

→ Why?

2. What positive functions do you see touch having in therapy?

a. Under what circumstances would you find it appropriate to touch a client?

3. What negative functions do you see touch having in therapy?

a. Under what circumstances would you find it inappropriate to touch a client?

4. What does touch in therapy signify/mean to you, compared to your everyday life (outside therapy)?

THE MEANING OF TOUCH IN THERAPY

- a. What is the difference between touch happening in therapy, and in other, normal social situations?

Personal experiences of physical touch in therapy

5. Have you ever been in a situation in therapy where you decided to touch the client?
 - a. Why?
6. Have you ever been in a situation in therapy where you decided not to touch the client?
 - a. Why?
7. What decides whether you touch a client, or not?
8. What areas of a client's body do you find appropriate to touch?
(includes a figure of a female and a male body, for the participant to mark.)

→ Why?

Consent, information, and therapeutic alliance

9. How do you act to search for the client's consent to touch? (before, during?)
10. What kind of responsibility do you think you have, as a clinical psychologist, when it comes to touch in therapy?

Professional discussions around the topic of touch

11. Do you discuss the topic of touch in therapy with your colleagues? Your supervisor?

→ Why?
12. Was physical touch in therapy a topic that was present during your education?
13. What consequences do you think it might have, how/whether one discusses touch in therapy, or not? (what can be done to avoid misunderstandings in touch?)
14. What has it been like for you to participate in this interview, sharing your professional views/experiences/reflections on touch?

Debriefing:

- Does the participant wish to add anything?
- A reminder that the participation is **voluntary**, that the interview and results will be **anonymised**, and that they can **withdraw** at any point (confirm that you have their correct e-mail address).

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- Does the participant wish to receive a copy of the results when it is finished, to comment on?
- Thank you so much for participating in this study!

Appendix F: Interview Guide

Original (Norwegian)

Briefing:

- Gi ut informasjonsskriv, og la informanten lese gjennom. Gå deretter gjennom hovedpunktene:
 - Definerer av situasjonen for informanten; formålet med intervjuet.
 - Forklar lydopptakeren, når den slås på; og spør om informanten har noen spørsmål før intervjuet begynner.
 - Alt behandles konfidensielt, verken privatpersoner eller arbeidsgiver vil bli gjenkjent i det ferdige, transkriberte materialet.
 - Dersom det er spørsmål som er vanskelige, eller informanten ikke ønsker å svare på, så er det bare å si det.
 - Informanten kan velge å bryte intervjuet når som helst.
 - Jeg vil gjerne minne om at det ikke skal utleveres sensitive pasientopplysninger i dette intervjuet. Det jeg er interessert i, er informantens opplevelser i situasjoner som har ført til berøring, eller ikke.
- Gangen i intervjuet: Først vil vi gjennomgå noen enkle bakgrunnsspørsmål, deretter holdninger til berøring, personlige erfaringer med fysisk berøring i terapi, samtykke og kalibrering av berøring, og, til slutt, faglige diskusjoner rundt berøring som tema.
- (sette i gang lydopptaker.)

Demografiske spørsmål

(obs: svarene kategoriseres/grupperes, for å unngå personidentifisering)

- Alder
- Kjønn
- Tid som arbeidsaktiv (antall år)

Holdninger til fysisk berøring i terapi

1. Hva er ditt syn på / dine umiddelbare tanker rundt fysisk berøring i terapi?
→ Hvorfor?
2. Hvilke positive funksjoner kan berøring ha i terapi?
 - a. I hvilke omstendigheter er det greit/forsvarlig å berøre en pasient?
3. Hvilke negative funksjoner kan berøring ha i terapi?
 - a. I hvilke omstendigheter er det ikke greit/forsvarlig å berøre en pasient?
4. Hvilken betydning har berøring i terapi for deg, sammenliknet med i din hverdag (utenfor terapisisituasjoner)?
 - a. Hva er forskjellen mellom berøring i en terapisisituasjon, og i andre, normale sosiale situasjoner?

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Egen erfaring med fysisk berøring i terapi

5. Har du vært i en terapisisituasjon der du valgte å berøre pasienten?
→ Hvorfor?
6. Har du vært i en terapisisituasjon der du valgte å ikke berøre pasienten?
→ Hvorfor?
7. Hva avgjør hvorvidt du berører en pasient, eller ikke?
8. Hvilke områder på pasientens kropp mener du det er greit/forsvarlig å berøre?
(inkluderer figur av kvinne- og mannskropper, som kan markeres.) å
→ Hvorfor?

Samtykke, informering og terapeutisk allianse

9. Hvordan går du frem når det gjelder pasientens samtykke til berøring? (før, under?)
10. Hvilke(t) ansvar tenker du at du har som klinisk psykolog, når det gjelder berøring i terapi?

Faglige samtaler rundt temaet berøring

11. Diskuterer du temaet berøring i terapi med dine kollegaer? Veileder?
→ Hvorfor?
12. Var fysisk berøring i terapien et tema i løpet av utdannelsen din?
13. Hvilke konsekvenser tenker du det kan ha, hvordan/om man diskuterer berøring i terapi, eller ikke? (hva kan gjøres for å unngå misforståelser vedr. berøring?)
14. Hvordan har det vært å delta i dette intervjuet og dele dine profesjonelle holdninger/erfaringer/refleksjoner rundt berøring?

Debriefing:

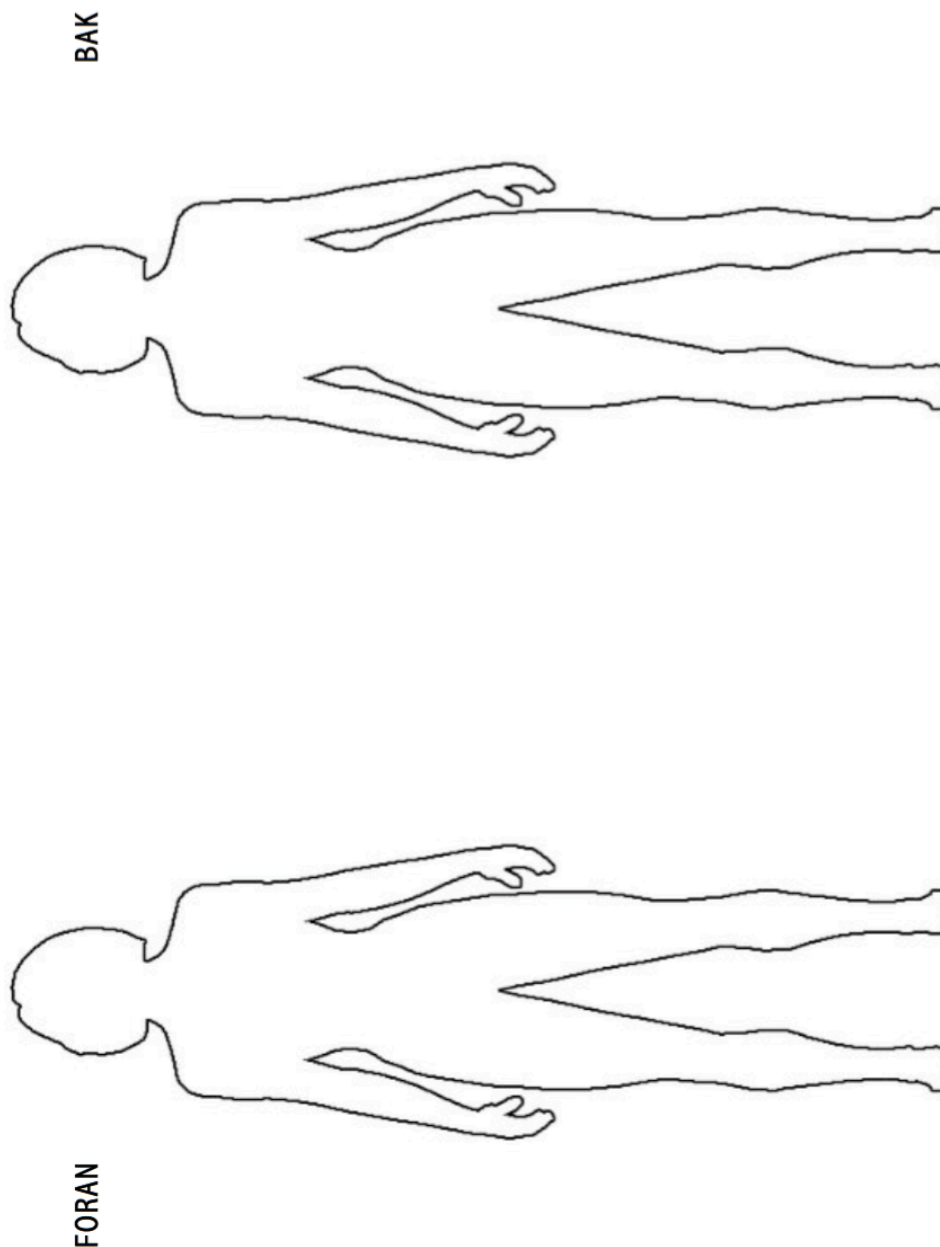
- Er det noe informanten ønsker å tilføye?
- Deltakelsen er altså **frivillig**, intervjuet og resultatene **anonymiseres**, og de kan **trekke seg** når de vil (bekrefte at e-postadressen er riktig).
- Ønsker informanten å få tilsendt et utkast av oppgavens resultatdel når den er ferdigbearbeidet, for kommentarer? Takk for deltakelsen!

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Appendix G: Female figure

(clean, as it was handed out to the participants, without any markings.)

The participants were handed the figure with the gender corresponding to their own, marking this figure first, before being handed the figure with the opposite gendered figure.

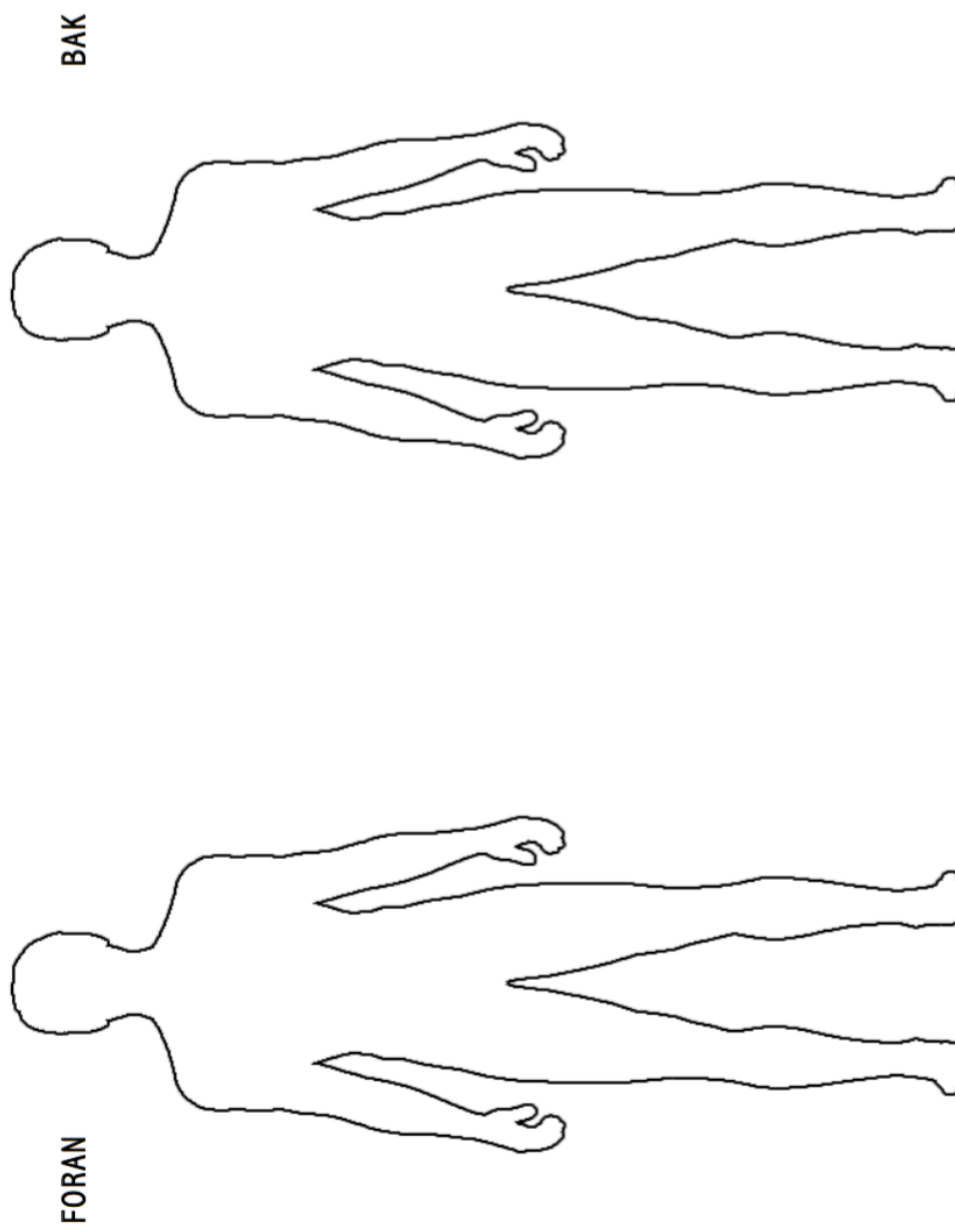


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Appendix H: Male figure

(clean, as it was handed out to the participants, without any markings.)

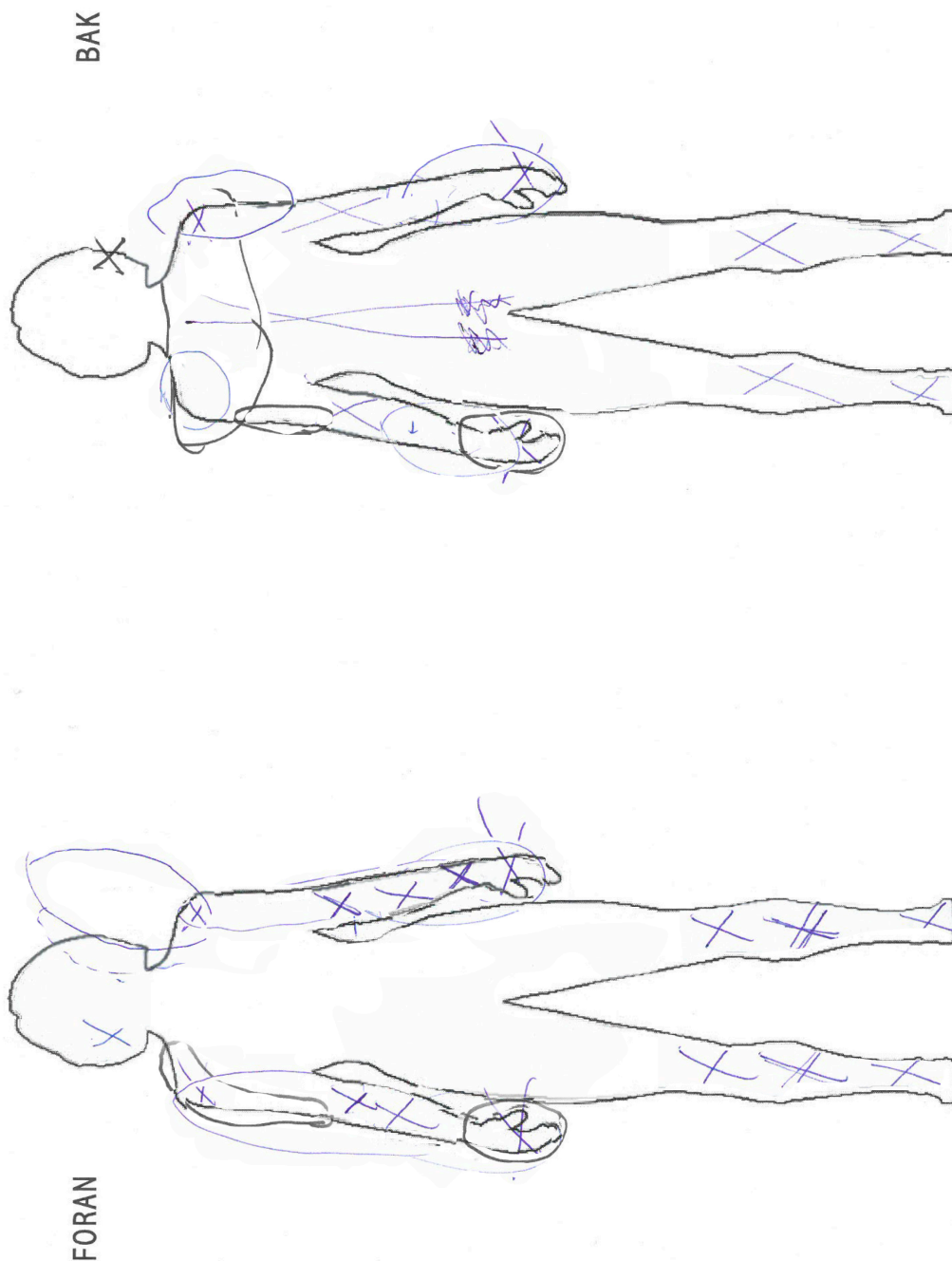
The participants were handed the figure with the gender corresponding to their own, marking this figure first, before being handed the figure with the opposite gendered figure.



THE MEANING OF TOUCH IN THERAPY

Appendix I: Female figure

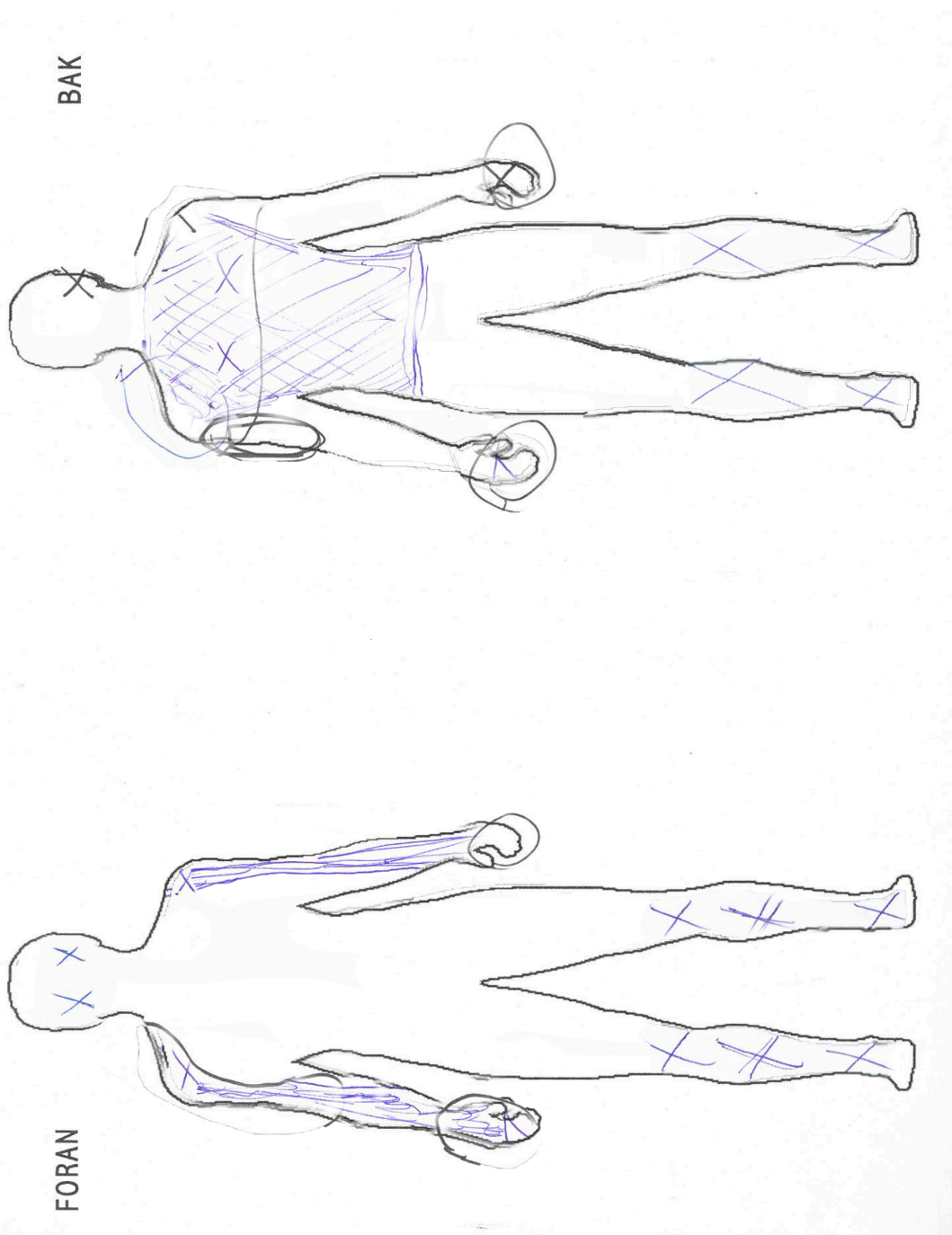
This figure is a combined figure, comprised of the total markings from all ten interviews. The reason why markings are different is because the participants marked differently: By circling areas, crossing them out, or shading. It is also highlighted that all markings in the region of the head/face are the marks of hugging, *not* for other types of touch.



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Appendix J: Male figure

This figure is a combined figure, comprised of the total markings from all ten interviews. The reason why markings are different is because the participants marked differently: By circling areas, crossing them out, or shading. It is also highlighted that all markings in the region of the head/face are the marks of hugging, *not* for other types of touch.



Appendix K: Original quotes

(An overview of the quotes that were translated from Norwegian to English, with corresponding page numbers.)

Page 32: “(...) nå kom det frem, og det er helt greit, jeg tåler det og du har ikke gått over en grense som... det har ikke vært noe feil i det. For der havner jo mange, at de forteller om noe, også til neste time har de tenkt ”oi, gikk jeg litt for langt?”, også (...) har de behov for å få en bekreftelse på at det her har vært greit, det er okei, du er okei, jeg har sett alt det her, og likevel så kan jeg gi deg den hånda på skulderen. Du har ikke frastøtt deg noe ved å være åpen, ved å ta den kontakten der.”

Page 33: “ (...) og der så følte jeg at han trengte noe mer enn bare ord, liksom, det trengtes en slags sånn på en måte dypere eller mer genuin form for kontakt”, and “jeg tror jo det var fordi det var så utrolig vrient å komme i kontakt med henne, og jeg kunne tenke meg å prøve og finne en annen kanal enn språk, da.”

Page 33: “I stedet for å bare jobbe med ordene, det holder jo ikke alltid mål [kort latter]... Nei, det kommer ikke til kort heller, men noen ganger føler jeg at det blir mye mer fart på sakene når man trekker inn kroppen. At det tar kortere tid å bli bedre. Jeg har ikke noe sånn.. undersøkt systematisk, det er bare mitt kliniske inntrykk.”

Page 33: “Jeg tror ofte jeg har fått den opplevelsen hvis det har vært noe sånn uforløst [i terapien], at jeg merker at det er som om pasienten holder igjen. Jeg tror ikke det handler om at det er en dårlig kjemi eller noe sånt, men at det kan kanskje.. pasienten er redd for å komme ut med sitt, redd for å snakke om ting, også merker jeg at det er noe sånn uforløst. Det er som om vi ikke helt kommer i kontakt, jeg kommer ikke helt innpå dem. Så jeg har en sånn innskyttelse sånn mot slutten av timen da, om å, i det man går liksom, å legge en hånd på skulderen til. Kanskje jeg har et ønske om kontakt, liksom, (...) også har jeg vel hatt en opplevelse selv om at det kan være en ganske sånn sterk ting, å bare få en hånd på skuldra (...) jeg ønsker jo å kommunisere at her er jeg. Jeg ser deg.”

Page 34: “(...) etter at vi har kommet inn på et område som jeg merker er veldig meningsfullt for pasienten, at du har kommet inn på et område som kanskje har vært veldig privat inntil da (...) at det har vært et slags gjennombrudd, at her har jeg sagt noe og samtidig vært i kontakt med noen følelser som jeg ikke har vært i kontakt med før, (...) og de føler seg sett, de føler seg hørt, og ivaretatt.”

Page 34: “(...) det med håndtrykk [vil jeg si at] en annen, det er jo fortsatt berøring, men det vil jeg si er litt annerledes. Fordi det... det starter en ramme, når de kommer hit. Jeg starter hvert løp, og avslutter hvert løp, med å håndhilse. (...) Jeg tenker det er for å ramme inn, det er sånn høflighetsopplegg, (...) en mer sosialt forventa form for berøring.”

Page 35: “Da tenker jeg det er naturlig, for pasienten er på vei ut av terapirelasjonen, og det er noe personlig i det. Nå er ikke jeg lenger din behandler, så da kan du få en klem, hvis du ønsker det.”

Page 35: “Jeg tenker det [fysisk berøring] kan nok styrke en allianse, en arbeidsallianse. At de kanskje får mer tillit til behandler, at behandler tar i mot på en eller annen måte, eller ikke avviser de. (...) Så kan det vel redusere, på en måte, avstand mellom behandler og pasient. Med tanke på at behandler på en måte står i en annen posisjon, så kan det gjøre at man står litt mer likt, eller at maktforholdet blir bedre, på en måte. For pasienten.”

Page 35: “(...) en pasient som gir meg en klem hver gang hun går, og det er ikke noe jeg ville tatt initiativ til. Så det har hun tatt initiativ til, også ser jeg at hun har behov for å takke meg på den måten, at hun gir meg en klem når vi avslutter timen. Da får hun sagt hade på en måte hun synes er fin, og det er helt greit for meg.”

Page 36: “Jeg tror at hvis en pasient som virkelig hadde knekt sammen eller fått et angstanfall eller sånn, så ville jeg nok... da kunne jeg nok tatt på, for å roe ned. Kanskje holdt i begge hendene, ikke sant, satt meg på huk ved siden av (...) og holdt i de for å liksom samle de. (...) for det vet man jo at er god håndtering av et angst, eller panikkanfall.”

Page 36: “(...) men av og til er det voldsomme angstreaksjoner som kommer og sånn, og da har det vært naturlig å gå bort og sette seg ved siden av og.. ”er det greit at jeg stryker deg på ryggen for å hjelpe deg med å roe deg ned”, eller sånne ting.”

Page 36: “Og det er jo noen ganger, når jeg har de som dissosierer og sånt, så tenker jeg at – jeg bruker ikke berøring, men vi hiver ting og, for å få dem til å skjønne at de er her og nå – at hvis vi tar på dem, så er de liksom forankra her og nå, som en emosjonsregulering.”

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Page 37: “Det er mer sånn som jeg har hørt om, for eksempel, nå driver ikke jeg med det, men det er noen som driver med EMDR-behandling, med sånn tapping på hendene eller på skuldrene. Så der har jeg tenkt at ja, en ting er jo den bilaterale stimuleringen og teori om hva det gjør, og det kan man sikkert si mye om, men at bare den berøringen i seg selv tenker jeg at er betydningsfull. Enten at den fører til bilateral stimulering, eller om det bare er det at her er det en, jeg blir tatt på.”

Page 37: “Det er viktig, blant annet med disse teknikkene hvor pasienten er nær seg selv, og lærer å på en eller annen måte tåle seg og sin kropp.”

Page 37: “Noen ganger i gruppeterapi så modellerer du jo ting, ikke sant, at du viser ting som du gjerne vil, på en eller annen måte ved at du gjør det, så viser du at det er okei, ikke sant. Og den effekten hadde jeg også litt lyst på, da. Oppmuntre til en sånn form for (...) kommunikasjon på flere kanaler.”

Page 37: “Ehm, man henter jo informasjon om den formelle kontaktevnen [ved håndhilsing], (...) dette med blikkontakt og det her håndtrykket, (...) det er jo noe av det vi vurderer også, pasientens evne til formell kontakt, da.”

Page 38: “Jeg tenker jo at det [berøring i terapi] er et tabu, på en måte. Også tenker jeg at det er et ofte ganske godt begrunnet tabu, (...) det føyer seg jo til det generelle intimitetstabuets (...) [og] den intimiteten må jo ha noen grenser som er, som skal være absolutte for at det skal være trygt for klienten å gå i terapi, og spesielt i forhold til, ehm, sånn seksualisering av relasjonen, da.”

Page 39: “(...) berøring er jo noe som oftest skaper en intimitet, og det er jo meningen med det også, og meningen med å prate og meningen med blikkontakt og sånn er jo å lage en intimitet.”

Page 39: “Jeg tror jo også at det har skremt meg litt, sånne fortellinger om at pasienter har blitt, liksom, kladd på!”

Page 39: “Samtidig er det jo hele tiden en problemstilling man står ovenfor i forhold til det her med intimsfære, hvordan det oppleves for pasienten. Men det er jo et ikke- tema, nesten. (...) Blant psykologer, og også i terapien.

Page 39: “Fysisk berøring er en ting som... jeg vet ikke hva man kan si, om det er tabu eller om det er noe som ikke er så mye fokusert på, men jeg tenker at en av grunnene til det er at det er med en gang du

åpner opp for det her med seksualitet, intimitet, og at... jeg tror jo det er det som er grunnen til at det er vanskelig å snakke om det. At det er vanskelig å forholde seg til det, at det gjør det komplisert.”

Page 40: “Vi jobber jo i en sånn setting der man blir veldig intim med pasienten, i hvert fall da på et psykologisk plan. Hvis man da innfører berøring og, så blir man plutselig intim fysisk og, og der blir grenseoppgangen mer utydelig.”

Page 40: “Jeg tenker at den er heller ikke så veldig, den er ikke så absolutt, liksom. Det går jo an å snakke om ting, eller bare å se på folk eller oppføre seg på måter som er ekstremt intimiserende, uten at du egentlig berører dem. På samme måte som at du egentlig kan berøre folk nokså mye uten at det egentlig er intimt i det hele tatt.”

Page 40: “(...) hvis det skal overskrides, hvis det skal være en berøring, (...) da må det være helt sikkert, (...) da må det være helt sikkert at det ikke ligger noe seksuelt i det. Og det må være sikkert for begge parter, det holder ikke at bare den ene parten føler det sånn, hvis den andre parten ikke føler det sånn. Da er det feil.”

Page 40: “Også er det klart, hvis man skal sette en grense for (...) hvordan *type* berøring er det, så blir det forskjell på mottaker og avsender og, da. At det kan oppfattes som greit for den ene parten og ikke greit for den andre part. Så jeg tenker at, hvis du bare ikke har noe berøring, så slipper du å gå i den debatten.”

Page 41: “(...) så blir jeg usikker på, hvis jeg skal begynne å berøre så vet ikke jeg helt når skal jeg berøre, på hvilken måte, når er det nok, hva synes den enkelte pasient er nok berøring? Så da er det lettere for meg å heller bare si at ”det er ingen berøring”.”

Page 41: “Så det at jeg ikke tar initiativ kan jo være en litt sånn selvbeskyttende...”

Page 41: “Og at hvis man *vet* at man aldri tar på pasienter, så trenger man ikke være redd for at noen noen gang har opplevd det som krenkende å ha blitt tatt på av meg. At da kan jeg føle meg trygg på at jamen jeg tar jo aldri på pasientene mine, jeg snakker med de, og jeg kan ta de i hånda, og hvis de gir meg en klem ved avslutning så kan jeg gjengjelde det, men utover det, så har jeg ikke tatt på noen. Jeg tror det gir meg litt trygghet, også.”

Page 41: “Mm, fordi vi har jo lært så mye, både på studiet og med erfaring i jobb, at folk opplever jo ting

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så ulikt.”

Page 41: “Også er det jo det som kan være vanskelig, det er jo det å vite hva er funksjonen fra pasientens side.”

Page 42: “(...) det [berøring] har sikkert har åpna opp for misforståelser fra pasienter som har kanskje følt at det har vært seksuelt motivert eller, motivert av mer sånn uakseptable ting fra terapeuten (...)”

Page 42: “Enkelte [pasienter] har jo en interpersonlig stil der de blir veldig flørtende med terapeutene og, de er sånn med alle sammen, og da blir det litt sånn hvor, hva er grensene, hvor er grensa hen for hva som kan oppfattes mer som seksuelt motivert da, og ikke?”

Page 43: “Yrket er verbalt, da.”

Page 43: “(...) det er jo de her mytene som i aller høyeste grad eksisterer i samfunnet ellers, dette skillet mellom kropp og psyke, ikke sant. Psyke og soma. Det er i hvert fall vi flaska opp på, at det er jo et kunstig skille, det er i realiteten ikke noe skille, men samtidig så, når man går ut der og skal jobbe som psykolog, så er det på en måte reflektert i hele samfunnet likevel, de mytene lever i beste velgående der ute, blant folk, og det reflekteres også veldig i stor grad på hvordan hele samfunnsstrukturen, hvordan hele helsevesenet er bygget opp.”

Page 44: “At de må finne ut av hvordan de kan finne det hjemme. Og det handler vel egentlig terapi litt om det, hvordan få folk til å fungere bedre hjemme i det livet de lever, da. For vi er bare midlertidig hjelp, sånn at vi må ruste de til å stå alene igjen, på en måte.”

Page 44: “(...) for de fleste sånne samtaleterapiformer så er det jo meninga at du [terapeuten] skal bidra til at klienten ikke trenger deg lenger, ikke sant, og at det relasjonelle som de får av deg, det skal de egentlig få andre steder. Og hvis de blir veldig avhengige av å få det fra deg, så er jo det veldig uheldig, fordi at det da fører til at de kanskje da har mindre insentiv til å oppsøke det i andre relasjoner ikke sant.”

Page 44: “Sånn at de har med den [følelsen av omsorg og støtte], at de kan internalisere meg som terapeut i seg selv da, at de blir sin egen terapeut på en måte. Og da er det noe med å vise den omsorgen som de selv skal vise overfor seg selv når de lever videre, skjønner du, at de skal leve videre, (...) en sånn.. nærhet til seg selv, da. Som man kan være med

på å vise gjennom kroppen sin også, som terapeut.”

Page 44: “Og jeg tror ikke det bare er for pasienten at jeg ikke er nær, ikke tar så mye på, (...) det er nok for min egen del, også. For jeg ønsker ikke at de skal komme for nær. Jeg ønsker å ha litt den avstanden i jobben, jeg trenger den avstanden (...) Jeg kan være litt personlig, si noe om meg selv for eksempel, men sjelden være veldig privat. (...) Det går en grense der, hvor.. hvor jeg ikke skal bli for privat. Hvor jeg er satt i en rolle, en posisjon, for å hjelpe, og.. ikke for å bli bestevenn eller venn, en venn de blir avhengige av å ha.”

Page 45: “Det er enkelte pasienter som sliter med dette her med grenser og rolleforståelse, og at det blir veldig [viktig å være] tydelig [på] hva som blir *vår* rolle – jeg er her som en veileder, en samtaleveileder og en som kan hjelpe deg med å forstå deg selv bedre. Jeg er ikke noen omsorgsperson i så måte.”

Page 45: “(...) jeg er i en profesjonell terapeutrolle, der det er veldig viktig å verne om, eller viktig å opprettholde noen grenser. For eksempel som at dette her er ikke en privat relasjon, det har en start og det har en slutt, og de her timene er forbeholdt de her dagene eller det og det tidsrommet, og utover det så kan ikke jeg være noe mer for deg.

Page 45: “Vi er jo hjemme hos meg, jeg er jo en av de terapeutene som synes det er greit å ha terapitimer hjemme, jeg har jo klienter her av og til, og det er det jo også mange psykologer som ikke vil ha, ikke sant. Både fordi de synes det blir for privat, de synes klienten kommer inn i deres, liksom, og noen synes at det blir for privat for klienten, at klienten blir da nødt til å forholde seg veldig til meg og mitt og mine ting og sånn, da. Men jeg tenker ikke helt sånn, da. (...) jeg synes liksom bare det er greit – men det er vel noe med at jeg på et eller annet vis kanskje ikke tenker at den der personlig og privat-grensen, jeg tenker vel ikke at den er så absolutt, da. Jeg tenker at den ikke er så lett å trekke, og jeg tenker vel også at vi... som psykologer kanskje noen ganger overdriver betydningen av en sånn ting, da. (...) [og med fysisk berøring] er det akkurat det samme.”

Page 46: “Jeg vil ikke være psykolog på fritiden med mine venner, også vil jeg ikke være for vennskapelig eller venne-aktig med pasienter. Jeg vil være profesjonell med pasienter (...) [det kommer til uttrykk i] hvilket språk jeg bruker, altså hvilke ord og begreper jeg bruker i samtalene (...) jeg har ikke tenkt så mye på det med berøring, men det er jo selvfølgelig også et skille jeg opererer med, tror jeg.”

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Page 46: “Det [å jobbe fysisk] krever litt mer våkenhet og nennsomhet, og timing, og litt av hvert. Men det gjør det med all terapi. For så vidt.”

Page 47: “Vi berører [eller ikke] på indikasjon, og du skal være *ganske* god til å vurdere de indikasjonene da, tenker jeg.”

Page 47: “Jeg ser an hva det er de har behov for når vi avslutter, enten timen eller terapiforløpet. Hva de trenger. For det er ikke sikkert de trenger det å ta i hånda og si hadet bra, kanskje de trenger å bare få gått fort ut herfra fordi de synes det er vanskelig å avslutte.”

Page 47: ”Det er ikke så lett å gjøre rede for, for det er noe med kroppsholdning og – ikke sant (...) og akkurat hva det er, det tror jeg er mer en sann type... sosial persepsjon enn at det egentlig er så veldig lett å gjøre nøyaktig rede for hva det er. (...) man får jo liksom bare en sann følelse av det, man får en følelse av hvor folk har grensene sine.”

Page 47: “Jeg gjør det altså, jeg tar utgangspunkt i meg selv [og hva jeg ville vært komfortabel med].”

Page 47: “Hvorfor gjør man det [berører] *ikke*? Skal man begrunne det, så... [vet jeg ikke].”

Page 48: “Jeg vet ikke om jeg kan huske at det står beskrevet noen plass i litteraturen, som jeg har sett, at du *ikke* skal berøre, for eksempel.”

Page 48: “I de manualene jeg benytter meg av, de tilnærmingene jeg benytter meg av, så er det ikke berøring. Det er ikke beskrevet noen plasser at du skal drive med berøring, og derfor tenker jeg at jeg ikke gjør det, da.”

Page 48: “Fordi jeg vurderer at det er ikke terapeutisk (...) Det er skadelig. Det er antiterapeutisk. (...) hvis du [som terapeut] gir etter for det, og hvis man gir pasienten det, når pasienten ønsker det, så blir det å gi etter for pasientens forsvar, deres utagering. Det forsvaret som vi kaller for utagering.”

Page 48: “Jeg kan bekrefte, ”jeg ser du gråter, vil du ha litt papir, dette ble vanskelig for deg”, og romme følelsene uten å ta på, da.”

Page 48: “Jeg tenker at berøring aldri kan skje uavhengig av relasjon, da. Sann at relasjonen vil alltid ha en betydning for hvordan den berøringen oppleves for den som blir berørt.”

Page 49: “Du må være deg bevisst at du er i en maktposisjon.”

Page 49: “(...) tar dem [pasientene] steder hvor de ikke ønsker det (...) så blir det en maktbalanse som forskyves og en usikkerhet i relasjonen. Som (...) kan ende med at pasienten føler seg enda mer underlegen, eller... som den svake part i relasjonen, på en eller annen måte.

Page 50: ”Kan jeg gjøre dette?”, ”kan vi prøve en øvelse?”, ”hvordan er dette for deg?”

Page 50: “Er det greit at jeg tar på deg?”, liksom.”

Page 50: “(...) og da vil man også bruke tid på å forklare, ikke sant, for pasienten, og det handler jo også om forventninger. At pasienten da får et rasjonale og har en forventning om at det er en del av behandlingen, og har en forventning om at det skal forekomme, da.”

Page 50: “Men det er det jo generelt med alle intervensjoner og, ”nå spør jeg på den måten fordi jeg tenker at det hjelper deg til sann og sann”, eller, ikke sant. Jeg synes psykoedukasjon er kjempeviktig, for at klienten skal finne en mening med det som skjer, og ikke minst forstå mer hvorfor de får den hjelpen de får! Fordi da eier de mye mer sin egen utviklingsprosess, og kan ikke minst lære seg å bli sin egen terapeut også, fremover, som er liksom meningen, da.”

Page 50: “For det er noe med at hvis jeg hadde spurt (...) så er det ikke sikkert de [pasientene] hadde turt å si nei! For det er noe med at her sitter det en psykolog, kan være skummel, helsepersonell kan være skumle, de kan ha dårlige erfaringer med autoriteter før, sann at det kan være mye vanskeligere å si nei til det.”

Page 51: “[Har du en opplevelse av at de svarene du får er genuine?] Ja, det har jeg en veldig følelse av. For det spørsmålet kommer jo også i en kontekst, ikke sant, for at det er jo ikke et spørsmål en bare kan stille i hytt og vær, det må jo være... du må jo ha et sann slags relasjonelt fundament da, som kan bære det spørsmålet på en måte, også er du usikker på om det sosiale fundamentet bærer en berøring, men du er, egentlig tenker du at det kunne vært riktig, liksom, og så må du liksom sjekke ut, da. Og da tenker jeg at det svaret man får, er ganske presist, jeg.”

Page 51: “Jeg kan egentlig ikke huske at jeg har gjort det [spurt om det var greit med berøring]. (...) Det ligger så masse nonverbalt i det.”

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Page 51: “Det er pasienter som har tatt det opp, behovet for nærhet, ikke nødvendigvis med meg, men med partneren sin eller noen nær som de skulle ønske de fikk mer omsorg fra, eller klemmer fra, eller oppmerksomhet fra, da. Fysisk berøring og nærhet.”

Page 52: “Det kommer jo an på pasienten, mener jeg.”

Page 52: “Samtidig ville det kanskje vært naturlig å berøre barn i mer grad enn voksne igjen, sånn at hvis man tar et skille mellom det å jobbe innenfor barnepsykiatri, så ville kanskje dette med berøring og dette med å gi klem og ruske i håret og sånn, at det er mer sånn kulturelt akseptabelt.”

Page 53: “Jeg tenker at, spesielt hvis en mann hadde gjort det [berørt] på en dame, så kunne det sendt seksuelle signaler.”

Page 53: “Man er hakket mer tilbakeholden når det er motsatt kjønn da, tenker jeg. Man er mer forsiktig da, liksom. Lettere at det kan bli, eh, misforstått eller feil, eller at det kan bli gærent på en eller annen måte. Pluss at også selvfølgelig så, med sånn glidning i forhold til hva det er som er mitt motiv og hva som er den andres, ikke sant, fordi jeg kan bli tiltrukket av damer og ikke av menn, så da må jeg liksom sjekke ut hvis det er ett eller annet element av tiltrekning der.”

Page 54: “Ja, jeg lurer på om det kan ligge noe i noen kulturer, tror jeg. Du får nok lettere klem av en jente. Men ikke alltid. Generelt, på gruppenivå.”

Page 54: “Og litt også hvor godt du blir kjent, jeg har jo hatt pasienter (...) som jeg kjenner godt, på en måte. Det er jo litt annerledes med de som er helt nye, eller de som jeg bare følger opp sånn litt på slutten.”

Page 54: “(...) og at mange som går i terapi har jo kanskje vært utsatt for at deres grenser er blitt, ikke har blitt respektert, og jeg vil ikke krenke noen eller retraumatisere noen.”

Page 54: “Berøring er jo stort sett ikke noe farlig det, liksom. Nei. Bortsett fra når det oppleves som en grenseoverskridende ting, eller som en slags, for noen så kan det jo være, at det kan ha vært traumatisk og at du på en eller annen måte på en måte liksom.. kobler deg på et traume, da. Og det er klart at hvis du da ikke har kontroll over det, så er jo det uheldig. Berøringen kan få en sånn slags trigger-funksjon.”

Page 55: “(...) pasienter som er traumatisert også

videre, eller som plages med mye angst og spenninger også videre (...)”

Page 55: “(...) en sånn tanke om at for henne, [kunne det være en opplevelse med] kontakt som kunne være noe annet enn seksualisert berøring eller vold da, for det hadde hun mye erfaring med. Det at berøring kunne være noe annet, det var veldig blankt for henne. Den trygge omsorgen, omsorgsfull berøring, liksom.”

Page 55: “Du har jo, sånn som vi sitter nå, nå har vi jo til og med bord mellom oss. (...) Du har jo alltid noe i mellom.”

Page 56: “Det er forskjell også på det å jobbe for eksempel i en poliklinikk og det å jobbe på sengepost, hvor du kanskje er mer, hvor du får *litt* mer en sånn miljøterapeutisk rolle; man følger pasientene mye tettere, så det er mer sånn ustrukturerte møter, man møtes kanskje inne på posten, kanskje inne på pasientens rom, så det er (...) mye tettere kontakt da på en måte.”

Page 56: “Det er sjeldent folk har trøbbel med håndhilsing, liksom.”

Page 57: “En klem er ikke bare en klem, altså en klem kan være mye forskjellig.”

Page 58: “Ja, liksom trykk, bevegelse, ikke sant, du vet at det er forskjell på å ta på noen sånn [trykk] og sånn [stryke]. (...) For jeg tenker at en hånd som er holdt stille er på en måte mer... saklig, liksom. Mens en hånd som er i bevegelse sånn er på en måte mer innlevende og mer intim, da. For det er jo stimulerende på en annen måte. Det er forskjell på å ta noen rundt skulderen sånn, og det å stryke noen på ryggen sånn, det er to veldig forskjellige ting.”

Page 59: “Jo lenger [klemmen er], jo mer intim.”

Page 59: “De rekker ikke fram hånda, eller dem ser ikke på meg, de liksom ser rett på stolen de skal sitte i og går rett til den, ikke sant, det er jo gjerne ved første møte, da. Og hvis de da gjør seg opptatt med andre ting, så tvinger ikke jeg fram et håndtrykk.”

Page 59: “Og da ser jeg det på måten de lener seg litt frem, gir et signal på at, de kanskje sier det, de sier at dette har vært fint og dette har vært viktig for meg, og jeg vil gjerne takke for tiden eller timene og sånn, også ser jeg at de kanskje lener seg litt frem, også følger jeg opp det, da. At de ønsker noe mer enn et håndtrykk. De ønsker kanskje noe mer enn det, for å avslutte. For å få en fin avslutning.”

THE MEANING OF TOUCH IN THERAPY

Page 60: “Og det var fordi at jeg følte, uten at jeg egentlig liksom kan begrunne det så innmari solid, men der følte jeg at for henne, så ville ikke det være ålreit å bli berørt sånn. For der hadde jeg en mistanke om at det kunne være litt rom for at det kunne være ugreit, da. Men jeg vet jo ikke om det er riktig eller ikke, det vet jeg jo ikke.”

Page 60: “Jeg prøver vel å, jeg tenker at det er vanskelig å avvise den klemmen, for det vil fort oppleves som en generell avvísning. Og du avvís nonverbalt, og det blir vanskelig da å ha en verbal samtale om hva det er som skjer og hva jeg tenker om det.”

Page 61: “Jeg ble jo opplært... ikke sant, at det ikke hører til, ikke er nødvendig, ikke skal gjøres, og da... har jeg, eeh... funnet et rasjonale for det i mitt hode, også har jeg liksom bare operert sånn.”

Page 61: “Yrket er på en måte verbalt, da. Så man bruker språket på mange måter, også har man ikke heller nødvendigvis lært å bruke kroppen på så mange måter, eller fysisk kontakt sånn sett. Så det kan jo tenkes at det er mangel på å ha lært hvordan å ha den kontakten?”

Page 62: “Og det er jo en sånn sjekk i seg sjøl, hvis du tenker at nei, dette vil jeg helst ikke fortelle veilederen min om, da... hvis du ikke kan spørre veilederen din om det, så er det antakeligvis ikke lurt å gjøre det. (...) Hvis du liksom tenker at det her burde være hemmelig, da er det noe muffens.”

Page 63: “Andre som er som rollemodeller for meg, sånn som overleger og sånn, som sier sånn ”jeg gir deg en klem, jeg”, og det blir en legitimering av det for meg, da. (...) Og når det er en med høyere stilling og med mer erfaring som gjør det [berører], så ufarliggjør det det for meg, da.”

Page 63: “[og da så jeg at hun] tok på den pasienten flere ganger. Og det er en sånn ting som jeg legger merke til, for jeg synes det er rart. (...) For det er ikke en del av mitt terapeutiske repertoar (...) Så tenker jeg fort at ”jaja, men da er hun en sånn type som synes det er greit, men det er ikke jeg”.”

Page 64: “Og det er vel også noe med at det er litt privat og sånn, at det er litt vanskelig, for du er egentlig kanskje litt redd for at hvis du tar det opp, så skal den du tar det opp med også misforstå, ikke sant. (...) Det var veldig greit å snakke med veilederen om det, men jeg ville nok ikke snakket med hvem som helst om det.”

Page 64: “(...) det er som du kan merke det på folk at de er liksom ikke klemmetypen, og da blir det ikke naturlig å snakke om det. (...) Fordi jeg har en så sterk forventning om at det ikke er noe de praktiserer, ikke sant.”

Page 64: “Det er helt greit å snakke om [berøring]. (...) Jeg synes nok jeg hadde lite ord [om dette temaet], men det er kanskje fordi det er lite inne i min praksis, på en måte.”

Page 64: “Men jeg kjenner jo at det er liksom litt krevende [å snakke om], at jeg må skikkelig tenke, og at jeg bryr meg veldig om det, da. At jeg må velge ordene med omhu, og sånn.”

Page 64: “Men så er det jo situasjoner... kan det dukke opp situasjoner i terapiløp der det er mer... mindre enkelt å være så tydelig på at det ikke skal forekomme.”

Page 65: “Det er jo ikke alltid man sitter sånn her med et bord mellom seg, kanskje man er ute og driver med eksponering, eller møter pasienten ett eller annet annet sted.”

Page 65: “Vi intervenserer på tusen ulike måter for å gi dem [pasientene] støtte og omsorg, og for å gi dem emosjonsregulering. Så kanskje, i noen tilfeller, så kunne berøring være en intervensjon i så måte. For å støtte dem opp, ‘kom igjen, dette klarer du’ (...) At vi kan utvide verktøykassa vår da, med å bruke oss sjøl på den måten og, da.”

Page 65: “(...) men jeg tror ikke det blir bedre av å ikke omtale det mer, og diskutere det mer, og ha det med som en del av et tema. For det oppstår, litt sånn uunngåelig situasjoner der jeg tenker at fysisk kontakt er... faller seg naturlig (...)”

Page 65: “Det finnes jo folk som, hvis jeg hadde nevnt det [berøring i terapi] for dem, så ”nei, det må du aldri gjøre”, også stopper diskusjonen der. Og det er ikke det jeg trenger, liksom. Jeg *vet* det, at du ikke skal gjøre det, det jeg lurer på er når det er unntak liksom, og om unntaket mitt er greit, er refleksjonen min rundt det okei? (...) Det jeg trenger er en *ordentlig* diskusjon om det, da. Og den ordentlige diskusjonen føler jeg at ikke er så lett å finne. (...) det er jo helt klart at det man heller ikke trenger er den ”jaja, kjør på”, ikke sant. Det man trenger er diskusjonen.”

Page 78: “(...) og kanskje også kunne spurt pasientene, det er kjempeinteressant. Kanskje

pasientene opplever, det vet ikke vi, nå er det jo brukermedvirkningens tid, kanskje pasientene opplever at det er veldig rart å sitte og snakke med en person [terapeut] i to år som aldri har tatt på dem, som aldri viser noen tegn til fysisk berøring, kanskje er det heller et problem, enn at vi gjør det for mye? At vi kan tenke at vi ikke skal gjøre det, men så tenker pasientene at vi skulle ha gjort det?”

Appendix L: Extracts from transcript of personal diary

“I’m on my way back from another interview. Eh.. It actually felt quite good to get to interview again, it has been a while since my previous interview. And it feels like I have the interview quite ‘underneath the skin’ still, at least a bit! It was a nice interview, kind of... warm. And this time I got to meet, how to put it, eh, the kind of therapist that I had expected to meet since starting this research, in relation to having very positive attitudes toward the use of physical touch.”

“It was... Exciting. Many interesting reflections that I can take with me. What kind of function can touch have in therapy? It feels like this is a topic that [the therapist] had thought quite a lot about, reflected about, was very reflected, had many associations that just kept coming. This actually made me feel that it was difficult to kind of, structure the whole interview, and to not ask closed questions that would lead [the therapist] in any specific direction. It was complicated for me to stick to the interview guide, because the accounts and descriptions were so advanced and brought a lot of interesting topics to the table. And what more was interesting, was that [the therapist] spoke a lot about what it would be like for the *therapist* to touch! And intimacy, as a psychologist. And I think this is something I might not have thought a lot about myself, I mean, I have thought more about what touch may imply for the *patient*, the patient’s identity and development of how they understand themselves and their own therapy – but here, well yeah, it was like the focus became something different than what I had in mind when I constructed the interview guide. And it’s not *bad* that it turned out that way, it’s just fascinating.”

“And [the therapist] spoke a lot about being close, close to a patient, through touch. And to create a boundary between touch, the body, and the mental, the talking. What is spontaneous and human, and what is considered learned routine? And this I think is something we [clinical psychologists] could benefit from being more counscious about.”